

Chlamydia Challenge

Winter 2007

A Newsletter of the Region VI Infertility Prevention Advisory Committee (RIPAC)
Arkansas, Louisiana, New Mexico, Oklahoma and Texas

EXPEDITED PARTNER THERAPY: A NEW OPTION FOR CONTROLLING SEXUALLY TRANSMITTED DISEASES

Expedited Partner Therapy (EPT) is an evidence-based public health approach for addressing the high rates of chlamydia and other STDs among adolescents and young adults. EPT makes it possible for partners of patients who are infected with an STD to be treated without a medical evaluation or face-to-face counseling. EPT may entail a patient bringing medication or a prescription to their partner, or making arrangements for the partner to pick up medication at a provider's office, a clinic, or a pharmacy.

The chief reason for the public health interest in EPT is that studies over the past several years have shown high rates of reinfection among women who were recently diagnosed with chlamydial infection. Few of these infections are caused by treatment failures ("tests-of-cure" are only recommended for pregnant women) but rather the majority of them result from the patient having unprotected intercourse with an untreated partner. This is of special concern because women with repeat infections are at increased risk of developing pelvic inflammatory disease (PID). These repeat infections are so frequent that the 2006 CDC STD Treatment Guidelines strongly encourages providers to retest all women with chlamydial infection three months after treatment.

Health departments have traditionally offered partner notification services to ensure treatment of partners. Shrinking budgets and competing priorities have caused some health departments to reduce these services. Also improved testing technologies, such as accurate urine tests for gonorrhea and chlamydia, and successful educational efforts to increase screening for STDs as a part of primary care, have resulted in a growing percentage of STDs now being diagnosed in the private sector. Private providers are not always familiar with community referral resources for partners who may be adolescents, uninsured, or who may not belong to the same managed care organization as their patient. In situations such as these, EPT offers the provider an option for treating a partner who is not able or perhaps not willing to access care.

Several research studies supported by the Center for Disease Control and Prevention (CDC) and subsequently published in peer-reviewed medical journals have demonstrated that heterosexual patients with uncomplicated gonorrhea or chlamydia infections have lower rates of reinfection when provided with antibiotics or prescriptions for their sexual partner(s).

In 2005, a "Dear Colleague" letter from Dr. John M. Douglas Jr, Director of the CDC Division of STD Prevention, stated that the "CDC has concluded that EPT is a useful option to facilitate partner management, particularly for treatment of male partners of women with chlamydial infection or gonorrhea." Dr. Douglas's letter went on to urge state health departments to work toward removing legal and administrative barriers that prevent use of EPT. A CDC

report issued in 2006 (available online: <http://www.cdc.gov/std/treatment/EPTFinalReport2006.pdf>) summarizes the medical literature on EPT and includes the perspectives gained from two expert consultation meetings held by the CDC. The report is intended as a reference document for use by public health agencies.

While EPT has thus far been implemented in only a small number of states (California, Oregon, Washington, Tennessee),

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other public health departments are currently working on EPT. The CDC is providing technical assistance to assist state health departments in determining what barriers may exist to EPT since the exact legal status of EPT varies from state to state. Some states have specific laws or regulations that will need to be amended to allow for EPT. California, one of the first states to enact a statewide EPT program, chose the legislative route. The California state legislature passed a bill that allowed EPT for chlamydia only and this past year they passed a law for using EPT for gonorrhea.

In New Mexico the legal impediment to EPT is the state Medical Practice Act that defines “unprofessional or dishonorable conduct” as “prescribing drugs . . . to a patient when there is no established physician-patient relationship.” In 2004, The New Mexico Clinical Prevention Initiative, a collaboration between the state Department of Health and the state Medical Society began discussing the public health arguments in support of EPT. Over the next two years there was a unanimous vote in support of EPT by the NM Medical Society, an endorsement by the Department of Health, and a hearing on the subject by the NM Medical Board. Discussions were also held with the NM Board of Nursing and the NM Board of Pharmacy. In November 2006, the NM Medical Board took public testimony from representatives of the Department of Health to amend the Medical Practice Act to allow for treatment of STDs “in accordance with the Expedited Partner Therapy guidelines and protocol published by the NM Department of Health.” The Medical Board will vote on this change at their next public meeting.

While the Department of Health EPT Guidelines have not yet been approved, there is a general consensus that they will follow the recommendations put forward by the CDC in their 2006 Report and by the California Department for Health. These general guidelines follow:

1. The best approach is for the partner(s) of a patient diagnosed with any sexually transmitted disease (STD) to be evaluated, examined, tested, counseled, and treated by a medical provider. Any patient diagnosed with an STD should be counseled to have their partner(s) evaluated by their primary care provider or at a public health clinic, and not to resume sexual intercourse with that partner until they have been adequately evaluated and/or treated. Ideally, a written referral that names the specific infection to which the partner is believed to have been exposed, and where to obtain medical care should be provided to every patient.
2. Patients diagnosed with gonorrhea, chlamydia, or trichomoniasis should be given the choice of contacting their sexual partner(s) within the past two months, and providing them with a written referral, or, if they prefer, to be provided with medication or a phoned or a written prescription to take to their partner(s).
3. The most appropriate patients for EPT are the male partners of women with a laboratory-confirmed diagnosis of gonorrhea, chlamydia, or trichomoniasis. EPT may be provided if the patient believes that their partner(s) will refuse or will not be able to obtain medical care.
4. Ideally, female partner(s) of an infected male index case should be evaluated by a clinician to rule out pregnancy and pelvic inflammatory disease, to check for other gynecological or medical problems that may require treatment, and to receive counseling, and if appropriate, to be provided with emergency contraception if there was unprotected intercourse within the previous 5 days, and to receive other contraceptive services.
5. Clinicians have the option of providing EPT for male and female partners of patients with gonorrhea, chlamydia, or trichomoniasis infections. Heterosexual male patients with gonorrhea or chlamydia should be informed that it would be best for their female partners to be seen in a medical setting, but if they feel that their partner is unlikely to comply with this plan, EPT may be provided unless the partner is known to be pregnant.
6. There are no studies demonstrating the effectiveness of EPT for men who have sex with men (MSMs). MSMs who are contacts to gonorrhea or chlamydia should be examined and tested for other STDs, such as syphilis and HIV, and therefore male partners of MSMs should be encouraged to be evaluated whenever possible.
7. Medication for EPT will be provided for all sexual partners within two months prior to diagnosis or, if there were no partners in the past two months, the most recent sexual partner. Medications should not be provided to treat other sexual partners of partners to the index case. Untreated sex

The Texas Department of State Health Services (DSHS) has issued a position paper supporting the use of Expedited Partner Therapy (EPT) as a valuable strategy for reducing STD morbidity in Texas.

EPT is the practice of treating the sex partners of persons with an STD without an intervening medical evaluation or professional prevention counseling of the partner. The usual implementation of EPT is through patient-delivered partner therapy (PDPT), although other methods may be employed.

For more information about the Texas position paper, www.tdh.state.tx.us/hivstd/tx.us, or Alicia Nelson, Alicia.nelson@dshs.state.tx.us

For more information regarding EPT from the CDC, www.cdc.gov/std/treatment/EPTFinalReport2006.pdf

partners of partners who have symptoms of an STD should be encouraged to seek medical evaluation.

8. A note in the patient's medical chart should document the number of partners who are being provided with EPT, any reported allergies to medications, the medications provided, dosages, and instructions given. Patients should be told to refrain from sexual intercourse for one week after taking their medication. The names of partners who receive EPT are not written in the chart of the index patient. A prescription may be written in the name of the partner receiving EPT, or the index case may be given a prescription for a sufficient quantity of medication to also treat partners.
9. Whenever possible, telephone contact should be made with partner(s) to explain the reason for providing EPT, to ask about allergies to medications, and other medical problems and medications being taken, to ask about other symptoms of STDs (ie, whether there are sores, ulcers, discharge, testicular, or abdominal pains that need medical evaluation), and to provide instructions on taking the medication, and to answer questions. Female partners for EPT should be asked if they are pregnant or breastfeeding, and if they have any symptoms such as abdominal pain that will require immediate medical evaluation. Medications should not be provided to pregnant partners. Refer pregnant women to their prenatal care provider or to another medical provider. Partners should be advised to abstain from intercourse for seven days after taking the medication.

10. Partners will be treated according to the most recent treatment guidelines issued by the Centers for Disease Control and Prevention (CDC). Whenever possible, treatment will be with single dose medications.
11. Every patient should be provided with a Department of Health information sheet (to be available in English and Spanish) for each partner who will receive EPT. The information sheet includes information that encourages partners to be clinically evaluated after they take their EPT, informs them of symptoms that need immediate evaluation, discusses not taking medication if allergic and common side-effects and how to respond to them, provides telephone numbers to call for information, and the addresses and phone numbers of public clinics where medical care can be obtained.
12. These guidelines are only for treatment of gonorrhea, chlamydia, and trichomoniasis. There is limited evidence to support this intervention with any other STDs at this time.
13. Tests-of-cure are not routinely recommended for non-pregnant patients or partners who are treated for gonorrhea, chlamydia, or trichomoniasis. However, the CDC recommends that any woman with gonorrhea or chlamydia infection be re-tested 3 months after treatment. This is a test for reinfection.
14. The Guidelines will include a list of clinicians who can be contacted if any questions arise about EPT and a telephone number for reporting any adverse events that occur as a result of EPT.

The 2005 STD Surveillance Report and the 2005 Trends document are now available the CDC public web site.

Visit <http://www.cdc.gov/STD/stats/default.htm>

CDC's new HPV brochure for clinicians is now available online at:

www.cdc.gov/std/HPV/hpv-clinicians-brochure.htm

STD TREATMENT GUIDELINES, CDC, 2006

<http://www.cdc.gov/std/treatment/>

These guidelines for the treatment of persons who have sexually transmitted diseases (STDs) were developed by CDC after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta, Georgia, during April 19–21, 2005. The information in this report updates the Sexually Transmitted Diseases Treatment Guidelines, 2002 (MMWR 2002;51[No. RR-6]). Included in these updated guidelines are an expanded diagnostic evaluation for cervicitis and trichomoniasis; new antimicrobial recommendations for trichomoniasis; additional data on the clinical efficacy of azithromycin for chlamydial infections in pregnancy; discussion of the role of *Mycoplasma genitalium* and trichomoniasis in urethritis/cervicitis and treatment-related implications; emergence of lymphogranuloma venereum proctocolitis among men who have sex with men (MSM); expanded discussion of the criteria for spinal fluid examination to evaluate for neurosyphilis; the emergence of azithromycin-resistant *Treponema pallidum*; increasing prevalence of quinolone-resistant *Neisseria gonorrhoeae* in MSM; revised discussion concerning the sexual transmission of hepatitis C; postexposure prophylaxis after sexual assault; and an expanded discussion of STD prevention approaches.

Arkansas News

A NEW PUBLIC HEALTH LABORATORY

On October 4, 2006, colleagues of the Arkansas Department of Health and Human Services, Division of Health (DOH), Governor Huckabee, and other officials dedicated a new state-of-the-art public health laboratory that has the capacity to culture and identify dangerous bacteria and viruses that may be released by terrorists. This laboratory will place Arkansas in the forefront in the fight against new infectious diseases and potential bioterroristic agents. Moving into the new facility is scheduled to be complete by early December 2006.

Governor Mike Huckabee stressed the need for the new facility and how completion of the facility will strengthen the safety measures needed to protect the health of Arkansans. "The aftermath of the terrorist attacks on our country helped us to understand that a laboratory building, designed to allow testing for agents such as anthrax and smallpox, is urgently needed. We're also seeing an onslaught of newly discovered infectious diseases such as SARS, West Nile virus, avian influenza and monkey pox. The Centers for Disease Control and Prevention says 30 new infectious diseases have been identified during the past 20 years. It's clear this laboratory is a necessity for Arkansas."

John Selig, DHHS Director, said, "This is a great day for public health in Arkansas. Our mission is to protect the health and welfare of the citizens of our state, and this new laboratory will greatly enhance that effort."

Dr. Paul Halverson, DOH Director and State Public Health Officer, said, "Our public health laboratory is a vital part of our state public health system. Providing a current state-of-the-art facility to meet the public health challenges facing Arkansas was on the minds of Governor Huckabee and our state legislature as they strongly supported this important project to replace our aging and increasingly problematic laboratory space that was built in 1969. In this day of a potentially lethal bioterrorist substance and increasingly complex technology, we need a facility that can effectively serve the citizens of our state. Our new lab is designed to meet these challenges in an effective manner."

Dr. Joe Bates, Deputy State Health Officer, said, "The opening of this laboratory marks another major advance taken to protect the health of Arkansans. This laboratory and its professional staff provide laboratory support for 94 public health units throughout the state where more than 800,000 individual patient visits are recorded each year. In addition, this laboratory regularly tests public drinking water



from more than 1,000 sources and food and drink from more than 14,500 food establishments to ensure that what Arkansans drink and eat meets all standards for health protection."

Dr. Glen Baker, Director of the Public Health Laboratory, pointed out that it is important to recognize that the Arkansas Public Health Laboratory protects the health of Arkansas citizens every day by insuring that highly infectious diseases are promptly recognized and controlled, and all new born babies are tested for serious genetic defects. In addition, the laboratory serves as a resource for other laboratories throughout the state for training and technical support. Baker stated that the Public Health Laboratory performs over 800,000 tests each year on nearly 500,000 individual specimens.

The facility, located on the existing campus just south of the present Division of Health headquarters, was funded by a bond issue and financed with fees charged by the Division of Health. Construction of the laboratory began in September 2004 and cost approximately \$24,600,000. The lab provides approximately 80,000 square feet for the 138 laboratory employees. Building new public health laboratories has been an important function in many states over the last ten years where new laboratories have been built in Alaska, Arizona, California, Colorado, Georgia, Minnesota, Missouri, Ohio, Texas and Virginia.

Designing and constructing a complex public health laboratory requires a team of diverse professionals with special skills. Architectural services were provided by The Wilcox Group of Little Rock, and the Lord, Aeck and Sargent firm of Atlanta, Georgia. Engineering services were provided by the TME firm of Little Rock, and the general contractor was Nabholz Construction Company.

UPCOMING COURSE OFFERINGS FOR STD STAFF OF ARKANSAS, OKLAHOMA AND LOUISIANA

STD Intensive

Raleigh, NC
Jan. 22–26, 2007

STD Part-Time Intensive

Birmingham, AL
Jan. 31–Feb. 2, 2007

STD Part-Time Intensive

Raleigh, NC
Mar. 5–7, 2007

STD Part-Time Intensive

Birmingham, AL
April 23–25, 2007

STD Part-Time Intensive

Raleigh, NC
May 14–16, 2007

STD staff in Texas and New Mexico should contact Southeast Prevention Training Center at http://depts.washington.edu/nnptc/regional_centers/centers/florida.html

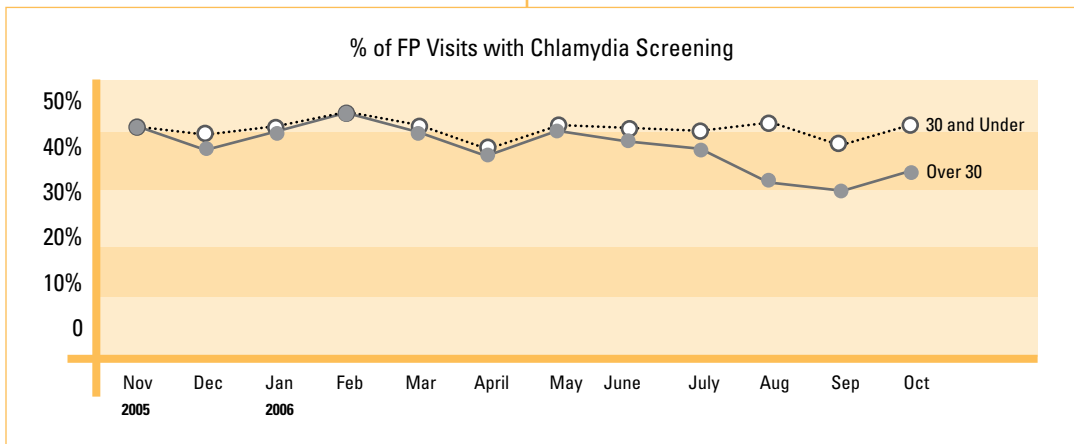
Louisiana News

EXPEDITED PARTNER THERAPY

Currently, Expedited Partner Therapy (EPT) is not permissible in the state of Louisiana. However, we are anxious to see what will happen in other states. We were hoping to introduce EPT in the 2007 Legislative Session. Updates will follow as we proceed.

In August of 2006, the Louisiana Family Planning Program implemented a revised Chlamydia screening policy. The changes

include 'targeted' screening of sexually active women/ men below the age of 30, symptomatic individuals, and asymptomatic individuals over 30 at increased risk for infection. (A change from universal annual screening.) A rough analysis of tests reported through the Family Planning patient visit database indicates that the change is being implemented. As shown on the following chart.



Oklahoma News

OKLAHOMA FAMILY PLANNING ADOLESCENT SURVEY

One of the priorities of the Oklahoma Family Planning Program (OFFP) is the encouragement of family involvement in adolescent decisions to receive reproductive health services. To assist in this promotion, the OFFP developed a survey to ascertain the attitudes and perceptions of adolescents in Oklahoma State Department of Health (OSDH) and contract family planning clinics regarding family involvement in their decision to seek reproductive health services.

The survey was developed in collaboration with multiple staff in the Maternal and Child Health Service along with input from community-based adolescent pregnancy prevention coordinators to assess the readability, length, and appropriateness of the survey tool. Collaboration also occurred with Community Health Services to evaluate the effectiveness of the survey in the clinic setting and ensure buy-in at the county level.

The survey will obtain demographic information such as age, gender, race, and ethnicity to establish a demographic profile for each participant. The survey also contains questions geared to obtaining

the adolescent's relationship with their family and the extent to which the adolescent might be willing to communicate with their family concerning family planning services. Several questions ascertaining sexual history were also inserted to test hypotheses in relation to level of sexual activity and willingness of communication with family. The target audience will be adolescents age 17 and younger.

The survey was mailed to county health departments and contract providers during the first and second week of November 2006. The clinics were asked to make the survey available to adolescent clients for a four-week period during which at least one day of family planning services should be offered.

When the completed surveys have been returned to the OFFP, analyses will be conducted and the results will be used to evaluate current programmatic activities, policies, and procedures. Following evaluation, recommendations will be made to enhance family planning services to our adolescent clientele.

LESSONS FROM STORM BENEFIT PREPARATION FOR DEADLY GLOBAL VIRUS

"Hurricane Katrina was more than a test of CDC's hurricane response—it was a test of its resilience in the face of overwhelming chaos and destruction. CDC did not flinch. CDC fulfilled its public health mission when put to the test. CDC also did not flinch when it was time to learn the lessons this historic natural disaster could teach it to prepare for one still on the horizon—pandemic influenza. A mile-wide swirling wind storm may seem very different from a microscopic virus; but to CDC's professionals, that storm provided a "road map" through which the agency can gauge and improve its performance and achieve its urgent mission during the next emergency."

*Julie Gerberding, MD, MPH,
Director of CDC*

Texas News

As a part of the Region VI Infertility Prevention Project (IPP), the Texas IPP collaborated with a central Texas charter high school and People's Community Clinic (PCC) to determine Chlamydia risk factors and positivity rates in a charter school student population. Two separate mass screening events were held on campus coordinated by a team consisting of Texas IPP, PCC, and Texas Department of State Health Services staff. The urine Aptima test for Ct and GC used for the screening was supplied by Gen-Probe.

The success of this effort was due to the dedication of all team members involved. Advanced planning and preparation was necessary to coordinate this event with school staff and students and manage the data and specimen collection process while maintaining student confidentiality and care.

Prior to the screening events, a letter to parents of students was sent out by the school to inform them about the "STD screening" to take place on campus. The screening team also met with school staff to answer any questions they had about the screening. The week prior to the events, team members visited each classroom to advertise the testing opportunity to the students. The students were told they could visit with a non-school staff counselor on the screening day to

ask questions and receive STD information. At that time they could choose whether or not to test for chlamydia and gonorrhea. Students that chose to test went through a brief counseling session to obtain demographic and behavioral risk factor information. The student then signed a consent form and was escorted to a restroom. After giving a specimen, the student would return to class.

All test results were given face-to-face to students the week following the testing. When test results were given, positives were treated and referred for a full STD exam. The importance of testing and treating partners was also discussed.

A total of 176 students were tested—50% -70% of the students attending school on the screening dates. Eighteen chlamydia positives were detected and 1 Ct/GC co-infection. The projected demonstrated a high need for STD testing in this student population with an overall chlamydia positivity rate of 10.3% (males 5.1%; females 16.7%). Additionally, the screening events linked students to other clinic services, such as pregnancy testing, prenatal care and partner services. It was excellent outreach opportunity for the school clinic and an example of a successful collaboration.

New Mexico News

New Mexico has moved one step closer toward implementing Expedited Partner Treatment (EPT) in the state. On November 16, 2006, the New Mexico Medical board held a public hearing to hear testimony on how the Department of Health (DOH) intends to implement EPT, what protocols will be used to regulate the practice and how patient confidentiality will be protected. The NMDOH Chief Medical Officer addressed all the concerns presented by the board and responses were well received. We anticipate the rest of the process will take a few months, at which time we will consider putting out a press release.

Because it is impossible for the STD program to contact all partners of chlamydia and gonorrhea cases, this Expedited Partner Treatment (EPT) offers a hope for effectively decreasing chlamydia and gonorrhea morbidity in the state. When this is implemented, the state might expect to see a decrease in reported morbidity due

to patients being presumptively treated without accessing a health care facility.

New Mexico started the Charter School Aptima Screening Project in March 2006. Two sites participated in the project, both of which have school-based health centers (SBHC) on-site. One of the sites is at an alternative school in inner city of Albuquerque. The other site is a countywide site in Northern New Mexico. Our goal is to screen ~400 students on an on-going basis. Since the project was started late in the school year and there is no summer school at these 2 sites, we have extended the project until the new school year started in September 2006. Students are counseled and tested using urine sample, and if positive, followed and treated according to the screening protocol. It has been our experience that having a SBHC on-site increases the school's screening acceptability.



Web Sites of Interest

www.centerforhealthtraining.org/ipp/ip_06.html

Center for Health Training Region VI Infertility Prevention Website now includes a link to the file for Region VI IPP Advocacy Brochure materials. The brochure is also available from CLabaj@jba-cht.com

Recent addition to CDC's HPV website www.cdc.gov/std/hpv: CDC's Division of STD Prevention has recently updated its HPV Vaccine fact sheet for health care providers. We encourage you to distribute this information widely to providers and colleagues in the field. Please visit www.cdc.gov/std/HPV/STDFact-HPV-vaccine-hcp.htm

Also new Infertility Prevention websites from the CDC are located at:

- Infertility & STDs
www.cdc.gov/std/infertility/default.htm
- IPP
www.cdc.gov/std/infertility/ipp.htm

ASK THE EXPERT



Laboratory
Question
Answered

Response from Dr. Louis Trachtman,
RIPAC Associate Member:

The overriding problem is that there are not enough disease intervention specialists (DIS) in the Sexually Transmitted Disease (STD) Control programs to interview all the people with chlamydia and gonorrhea. Those we have, give priority to interview those patients with syphilis and HIV infections. In the case of chlamydia and gonorrhea we must use patients, themselves, to tell their partners of exposure to these infectious diseases. We have ethical obligations to let sex partners know of exposure to infection and of their need for medical referral for evaluation and testing.

Patients should be instructed to refer their sex partners for evaluation, testing and treatment if they had sexual contact with the patient during the 60 days preceding onset of symptoms in the patient or diagnosis of chlamydia or gonorrhea. Patients should be instructed to abstain from sexual intercourse until they and their sex partners have completed treatment. Abstinence should be continued until 7 days after a single-dose regimen or after completion of a 7-day regimen. Timely treatment of sex partners is essential for decreasing the risk for reinfection in the index patient. Providers also are strongly encouraged to retest all women treated for chlamydial infection whenever they next seek medical care within the following 3-12 months, regardless of whether or not the patient believes that her sex partners were treated. The majority of post treatment infections result from reinfection, frequently occurring because the

I work in a public health clinic in a state where Expedited Partner Therapy (EPT) is currently prohibited by rules governing medical practice. What suggestions do you have to encourage patients with positive Chlamydia and gonorrhea tests to get their partner or partners to treatment?

patient's sex partners were not treated or because the patient resumed sex with a new partner infected with *C. trachomatis*. Repeat infections confer an elevated risk for Pelvic Inflammatory Disease (PID) and other complications when compared with the initial infection.

Counseling staff should consider the individual circumstances of their patient to determine if the patient wants to inform the partners either verbally or in writing. Consideration of the patient's history with the clinic is also extremely important, e.g. has the patient been previously infected and was he or she successful in having one or more sex partners come in for medical evaluation and treatment? Discuss with the patient that there are advantages to having their partners evaluated for other STDs in addition to that to which they were exposed, but may have, too. Some clinics find it effective to give patients a referral card which explains the disease, why they are at risk, and where to go to get testing and treatment. As with any STD, assure the patient of confidentiality.

Dr. Louis Trachtman, MD, MPH is the medical director at the Department of Health and Hospitals in Louisiana's Sexually Transmitted Disease Control Program.



Don Clark, Executive Director of the National Coalition of STD Directors, spoke with the members and participants at the RIPAC meeting in Austin, Texas October 24, 2006. Mr. Clark spoke to the Region VI committee about activities the group could support to increase awareness and funding of the Infertility Prevention Project.

www.ncsddc.org/about.htm

The National Coalition of STD Directors (NCSDD), established in 1997, represents the 65 Directors of public health sexually transmitted disease prevention programs in states, large cities / counties and territories of the United States. NCSDD provides dynamic leadership that strengthens STD Programs by advocating for effective policies, strategies, and sufficient resources and by increasing awareness of their medical and social impact.

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Meet our New Members: Marcia Sims, R.N., CNS & Elease M. Lewis, MBA



MARCIA Sims, R.N., CNS, will be representing the Family Planning Program as a new RIPAC member from Texas Department of State Health Services. Marcia is a nurse consultant in the Community Health Services Section at the Department. She has over 12 years experience in Women's Health and Family Planning. In her vast experience at the Department, Marcia has worked extensively with Family Planning providers agencies, performing on-site monitoring visits, providing clinical policy recommendations and advice and developing and reviewing service contract proposals.

She has also has experience in the diabetes and HIV programs at the Department as well. Marcia received both her BS and Masters degrees in nursing from the University of Texas at Austin.

In her tenure on RIPAC she hopes to share her experiences with the IPP sentinel clinic sites with other FP clinics across the state. She attended her first RIPAC in October in Austin although she has been meeting with the Texas IPP workgroup for about 5 months.

ELEASE earned a BA from Dillard University in New Orleans and an MBA from the University of Wisconsin-Madison. She has been employed with the Louisiana Department of Health and Hospitals Office of Public Health (OPH) for over five years. She has worked in the Healthcare Industry for over eight years. Prior to working with OPH, Elease worked as an Assistant Business Manager in Family Medicine at Louisiana State University Health Sciences Center for three years.

Elease began her career with OPH by working as a Program Specialist with the Chronic Disease Program. She worked in Tobacco Control for four and a half years. During that time, she worked on many projects, interfaced with several programs, and grew tremendously. In March, 2006, Elease was afforded the opportunity to become the Family Planning Program Manager.

Working in the Family Planning Program has allowed Elease to realize the true meaning of being a public health professional. She looks forward to learning more in her new position and contributing to the quality of care of the citizens of Louisiana.



Give us your input and feedback! Please call, fax or mail to:

Carol Labaj, Infertility Prevention Project

Center for Health Training, 1106 Clayton Lane, Suite 410 E, Austin, Texas 78723

Phone (512) 474-2166 Fax: (512) 476-0326 email: clabaj@jba-cht.com



Mark Your Calendar!

**International Union Against Sexually
Transmitted Infections (ISSTD)**

July 29–August 1, 2007—Seattle, WA

Regional VI Advisory Committee Meetings (RIPAC)

April 23–25, 2007—Little Rock, AR

Center For Health Training

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