Ending a Failed Intervention: STD Performance Measures

To the Editor:

We read with great interest the article by Peterman et al.[1] and applaud their work in highlighting the value of implementation science and program evaluation. In their 4-year long evaluation of data in nearly 60 health jurisdictions, the implementation of STD performance measures was associated with little improvement in STD program performance. Seen as an intervention, performance measures were initially introduced in the hopes of improving performance. The authors state, "We thought that if we measured and reported programs' performance on specific activities, then program performance would improve. We expected that the low-performing programs would identify factors that contributed to their low performance and take steps to improve."[1] Although the data presented showed that the STD performance measures were not effective, the authors insist, "…we believe it is too early to abandon performance measures."[1] But if not now, when? What is not considered in the piece by Peterman is the work necessary for the local health department. Data must be collected, cleaned, analyzed, and uploaded to Center for Disease Control and Prevention through the performance measures mechanism. As public health resources continue to be lost, maintaining a basic programmatic infrastructure is challenging.[2] Continuing to participate in an "intervention" that has been shown to be unproductive not only adds stress to a fragile system without any identified benefit but also undermines the whole point of program evaluation. If data-based decision making is the goal, why are we ignoring these data?

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Outcomes of HIV Partner Services for People With HIV and STD Coinfection Versus New HIV Diagnosis: Implications for HIV Prevention Strategies

To the Editor:

In the April issue of STD, Hague et al.[1] reported a disturbingly high incidence of STDs in the 5 years following HIV diagnosis among young black men who have sex with men (MSM) in Baltimore in 2004. In New York City (NYC), we have also observed high rates of new STDs in HIV-infected clients.[2] Although we agree with the authors' conclusion that prevention counseling regarding STD needs to continue for years following HIV diagnosis, identification of an effective and affordable prevention strategy for this high-risk group poses a number of challenges.

The NYC Health Department's HIV Field Services Unit (FSU) provides HIV partner services (PS) at 19 high-volume HIV clinics in NYC neighborhoods most affected by the HIV epidemic. From February 2009 to June 2010, we expanded the range of clients offered PS to include HIV-positive persons with newly reported gonorrhea (GC) or chlamydia (CT). We matched cases from NYC's STD surveillance registry newly diagnosed with GC or CT at these facilities to the NYC HIV Surveillance Registry, then selected for PS cases with an HIV diagnosis date at least 2 years prior. In 2009, FSU partner facilities had approximately 14,000 active HIV-infected patients and reported ~1000 new HIV diagnoses.

Over these 14 months, 171 GC- or CT-coinfected patients met our criteria and were offered PS, 20 (12%) of whom were reinfected at least twice.

We compared PS outcomes of the STD coinfected to 1237 newly HIV-diagnosed patients without coinfection receiving PS during the same period (Table 1). Coinfected patients were more likely to be under 25 years old (33% versus 19%) or MSM (72% versus 58%). Interview rates among both groups were comparable (82% coinfected versus 87% newly diagnosed); however, significantly fewer coinfected (49%) than newly diagnosed (68%) named partners, and partners elicited per index patient interviewed was also lower (0.89 versus 1.12). Median days from case assignment to interview was longer for coinfected than newly diagnosed patients (13 versus 6; $P < 0.05$). Proportions of partners according to HIV status category (positive, negative, or

TABLE 1. Demographics, Risk Behaviors, and Partner Services Outcomes for HIV-Positive Patients Coinfected and Newly Diagnosed

	Coinfected* (n = 171) (%)	Newly Diagnosed** (n = 1237) (%)	*P*
Length of diagnosis (months)			
Mean	101	0.6	<0.0001
Median	78	0.23	
Range	7–354	0–6	
Race/ethnicity			0.71
Black	96 (56%)	758 (61%)	
Hispanic	57 (33%)	367 (30%)	
White	10 (6%)	69 (6%)	
Other	8 (5%)	43 (3%)	
Sex			
Male	94 (55%)	828 (67%)	0.002
Female	77 (45%)	409 (33%)	
Age group			
15–24	57 (33%)	236 (19%)	<0.0001
25–39	58 (34%)	426 (34%)	
40–59	56 (33%)	496 (40%)	
60+	0	79 (6%)	
Transmission risk			<0.0001
Heterosexual	18 (11%)	182 (15%)	
IDU	6 (4%)	40 (3%)	
MSM†	66 (70%)	364 (44%)	
MSM/IDU†	2 (2%)	12 (14%)	
Perinatal	17 (10%)	0	
NIR	62 (36%)	639 (52%)	
Exchanged money or drugs for sex	25 (15%)	149 (12%)	0.32

*Coinfected cases are prevalent (diagnosed with HIV >2 years from report).
**Newly diagnosed cases (diagnosed with HIV within 6 months of date of referral for partner services).
†Percentage of males.
IDU indicates injection drug use; MSM, men who have sex with men; NIR, no identified risk.

unknown) were similar. Of the notified partners with negative or unknown serostatus, those named by the newly diagnosed were more likely to accept HIV testing, and 14% were newly diagnosed with HIV as a result of PS. None of the 28 partners of the coinfected tested through PS was positive.

Providing PS to coinfected patients with long-standing HIV diagnoses required far more resources compared to the newly diagnosed, which we attribute to the lack of accurate and current locating information, and lag time caused by the need to match registries. PS outcomes among the coinfected were more modest, stemming from coinfected clients' frequent refusal to name partners, on the basis that their partners "were already aware" of their serostatus or had received STD treatment. Unable to justify the resources required, we no longer prioritize this group for PS, but instead have focused on obtaining provider referrals for HIV/GC- or HIV/CT-infected clients deemed most likely to benefit from PS. Although continued prevention efforts are needed with this group, the crucial question is how they can be provided efficiently and effectively.

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Erratum

The direct cost of chlamydial infections: estimates for the employer-sponsored privately insured population in the United States, 2003–2007: Erratum

The article that appears on page 519 of the August 2010 issue of the journal had an error in Table 1.

In Table 1, the outpatient cost shows $108. The correct cost is $101.

REFERENCE

Owusu-Edusei K Jr, Doshi SR, Apt BS, et al. The Direct Cost of Chlamydial Infections: Estimates for the Employer-Sponsored Privately Insured Population in the United States, 2003–2007. Sex Transm Dis. 2010; 37:519–521.