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Promoting Effective Local Public Health Practice

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Local Approaches to Addressing the Nation's STI Epidemics

What's Inside...

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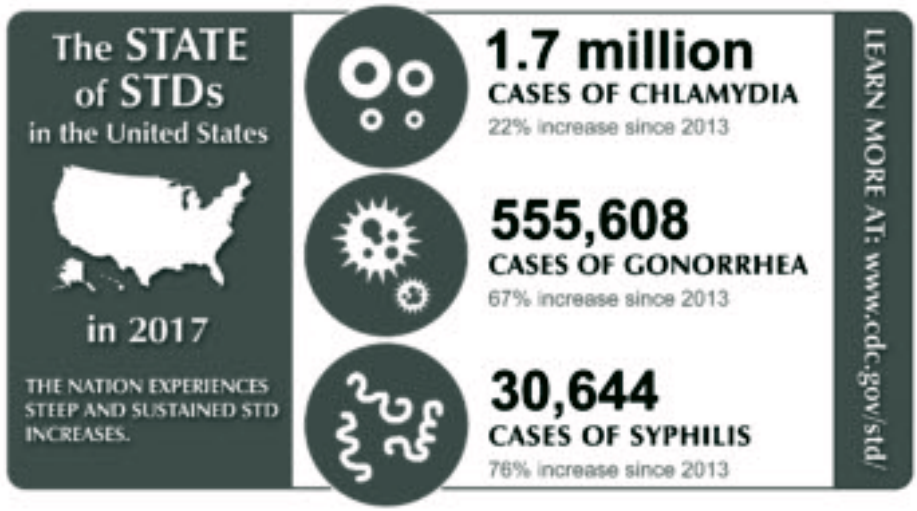

The Essential Role of Local Health Departments in Addressing STI Epidemics in the United States

By Lori Tremmel Freeman, MBA, Chief Executive Officer, NACCHO

Sexually transmitted infections (STIs) are at crisis levels in the United States and pose a significant threat across the country. The Centers for Disease Control and Prevention (CDC) estimates there are 20 million new infections in the U.S. each year, with nearly 2.3 million cases of chlamydia, gonorrhea, and syphilis reported in 2017 alone. While historic, these numbers likely underestimate the true burden, as many cases are not reported and even more remain undiagnosed.

Chlamydia, gonorrhea, and syphilis are curable with antibiotics, but when cases go undiagnosed and untreated, severe health effects may result, such as infertility, stillbirth, and an increased HIV risk. Additionally, STIs cost the healthcare system an estimated $16 million dollars annually.[1] Emerging trends, including the growing threat of antibiotic-resistant gonorrhea and large increases in syphilis and congenital syphilis (i.e., transmission from a pregnant person to the fetus), make early diagnosis and treatment even more important. The CDC deemed syphilis elimination a reasonable and achievable goal in its *1999 National Plan to Eliminate Syphilis*, yet, in 2017, 37 states reported at least one case of congenital syphilis, totaling 918 cases, and preliminary data shows further increases in 2018.

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The Essential Role of Local Health Departments in Addressing STI Epidemics in the United States

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In many communities, local health departments (LHDs) are the primary provider of services to test, treat, and prevent STIs. This issue of *NACCHO Exchange* will highlight ways in which LHDs are working to move the field forward to better address STIs across the country.

Leading the Way: Local Approaches to Addressing Rising STI Rates

Shifting the tide of rising STI rates starts at the local level. As trusted community providers, LHDs across the country are well-positioned to provide leadership to improve access to STI services for all, especially for those populations who are disproportionately impacted. According to NACCHO's *2016 National Profile of Local Health Departments*, 65 percent of LHDs provide STI testing and 63 percent provide STI treatment.[2] Many LHDs operate STI clinics, providing a high quality of care at a low cost and often offering walk-in and same-day appointments. These are preferred by many for receiving STI services[3] and are shown to most effectively identify and treat STIs.[4] Unfortunately, numerous STI clinics have closed in recent years due to funding cuts, and many others are overburdened and must turn patients away. As we confront record-setting STI rates, the role of LHDs is more essential than ever to this work. In the articles that follow, you will find examples of LHD efforts to address STIs and learn how NACCHO is partnering with LHDs across the country to develop innovative STI programming.

For example, LHDs can implement express STI visits[5] and use self-collected samples and technology to contact patients with their test results, ultimately lessening the burden on both the LHD and the patient. Additionally, we know that offering STI testing in non-traditional and non-clinical settings—including schools, jails, and even libraries—is essential to reducing barriers to testing and treatment, such as cost, transportation, missed time from work or school, and privacy concerns. At-home and mobile testing are additional strategies to make STI screening more private and convenient. Beyond clinical services, LHDs conduct partner services, surveillance, and prevention, and work with community partners and private healthcare providers to assure that STIs are being identified and treated.

To truly make an impact, we must also work to address STI stigma. LHDs can do this by providing more universal testing for STIs and widely publicizing destigmatization campaigns that educate about STIs and sexual health through messages normalizing condom use, conversations with partners and providers about sex, and testing. Engaging the community in campaign message development, implementation, and evaluation is critical, because it enables LHDs to develop more relevant, targeted, and culturally competent health information. Finally, incorporating STI testing and treatment more broadly into other parts of the health department where clinical services are offered is another effective approach that makes STI services more available and less stigmatized.

Despite the amazing work that our members do, we know that LHDs cannot curb rising STI rates alone. Collaboration is critical. Private providers conduct a large portion of STI testing and treatment and should provide services consistent with the U.S. Preventive Services Task Force *Recommendations for STD Screening* and CDC's *STD Treatment Guidelines*. LHDs should educate healthcare providers about these recommendations, provide support for implementing appropriate protocols, encourage use of interventions like

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extragenital testing and expedited partner therapy, and promote the integration of STI screening into all healthcare settings.

Engaging Beyond the Community: The Need for Federal Support and Funding

While much of the day-to-day work of STI prevention and treatment occurs at the local level, federal leadership is also needed to stem the rise in STIs. The development of an STI Federal Action Plan[6] by the U.S. Department of Health and Human Services (HHS) Office of Infectious Disease and HIV/AIDS Policy is encouraging. NACCHO and LHDs offered input to inform the plan's development and are eager to support the execution of recommendations. Similarly, there is a real opportunity to address the STI epidemics as part of the federal government's *Ending the HIV Epidemic Initiative*.[7] HIV is an STI, and these epidemics are occurring jointly. Investing in STI clinics to support the expansion of services to include prescribing pre-exposure prophylaxis (PrEP) and linkage to treatment is a way to better reach people at high risk for HIV and, in doing so, enable more frequent STI testing among this population. As we commit to ending one epidemic, we can and must commit to addressing them all. But none of this will be accomplished without strong federal funding to support LHDs' critical STI and HIV services. NACCHO will continue to be the voice of all local health departments at the federal level to help ensure that national policy and funding levels are informed by the realities that LHDs face each day.

Spurring Change: A Collaborative Effort

NACCHO is proud to work with the CDC, LHDs, national partners, and other key stakeholders in addressing STIs and supporting its members engaged in this work, which is essential for all communities. This issue of *NACCHO Exchange* highlights how NACCHO, its LHD members, and our national and federal partners are leading the way to address high STI rates by developing and piloting innovative approaches to STI prevention and treatment in this critical moment. I hope the information shared here can help spur even more good work to address STI rates in all our communities.

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Leveraging Partnerships and Wraparound Services to Prevent Congenital Syphilis

By Jessica Del Toro, BA, Management Analyst, Sian Elmore, BA, Program Manager, and Anita Kurian, MBBS, MPH, DrPH, Assistant Director of the Communicable Disease Division, San Antonio Metropolitan Health District (TX); and Amy Secrist, MPH, Maternal Referral and Congenital Syphilis/Perinatal HIV Program Coordinator, Baltimore City Health Department

Congenital syphilis (CS) is passed from a pregnant person to their fetus during pregnancy or delivery. It can be prevented through screening and treatment during pregnancy. Congenital syphilis cases have more than doubled from 2013-2017.[1] There were 918 cases of congenital syphilis in 2017, a 20-year high, and preliminary data indicates that the number increased even more in 2018. This increase in cases underscores the need for all pregnant people to receive early prenatal care that includes syphilis testing at their first visit, and then follow-up testing for those at high risk of infection, including as a result of living in a high-prevalence area.

As a result of the rising rates, the CDC has ramped up support for high-burden jurisdictions to strengthen local prevention systems and improve their ability to identify and treat pregnant people with syphilis. This included a supplemental grant to the highest-burden states to address their congenital syphilis with local health departments. This supplemental CDC funding supported two local response projects in San Antonio, TX and Baltimore, MD.

Healthy Beats: A Local Effort to Prevent Congenital Syphilis in Bexar County

In 2012 and 2013, Bexar County had 17 CS cases. In 2017, the rate of CS in Bexar County was 60.3 per 100,000 live births, which was approximately 2.5 times higher than the national rate of 23.3 per 100,000 live births. The resurgence of CS in Bexar County points to missed opportunities for prevention within the public health and healthcare systems. The rise in cases sparked conversation around the common risk factors associated with CS. Through interviews conducted by San Antonio Metropolitan Health District's (Metro Health) Disease Intervention Specialists (DIS), Metro Health was able to determine that the most common risk factors associated with CS in the county are lack of access to prenatal care, multiple sex partners, substance abuse, history of incarceration, and a history of sex work.

The Healthy Beats program was created at Metro Health in October 2013 with 1115 Medicaid Waiver funding. The program was designed to address the increasing rates of CS in Bexar County by developing a prenatal case management program that catered to pregnant women who are encountered at the clinic or in the field. The goal of the program is to help pregnant women access and maintain prenatal care, offer referral services for needs identified, and ensure screening and treatment for syphilis routinely occurs. Healthy Beats staff try to ensure third trimester testing is completed according to Chapter 81.090 of the Texas Health and Safety Code, which states the ideal time for third trimester testing is between 28 and 32 weeks.[2] Healthy Beats' primary objectives include enrolling 120 pregnant women into case management services and conducting follow-up for those who test positive for primary or secondary syphilis.

At the time of enrollment, Healthy Beats has a conversation with the patient that may identify certain needs. Topics discussed during this conversation may include WIC, Medicaid enrollment, OB/GYN providers, barriers to care, domestic violence, counseling services, access to baby items, housing assistance, and drug treatment programs. Healthy Beats can identify needs and refer clients to the proper resources

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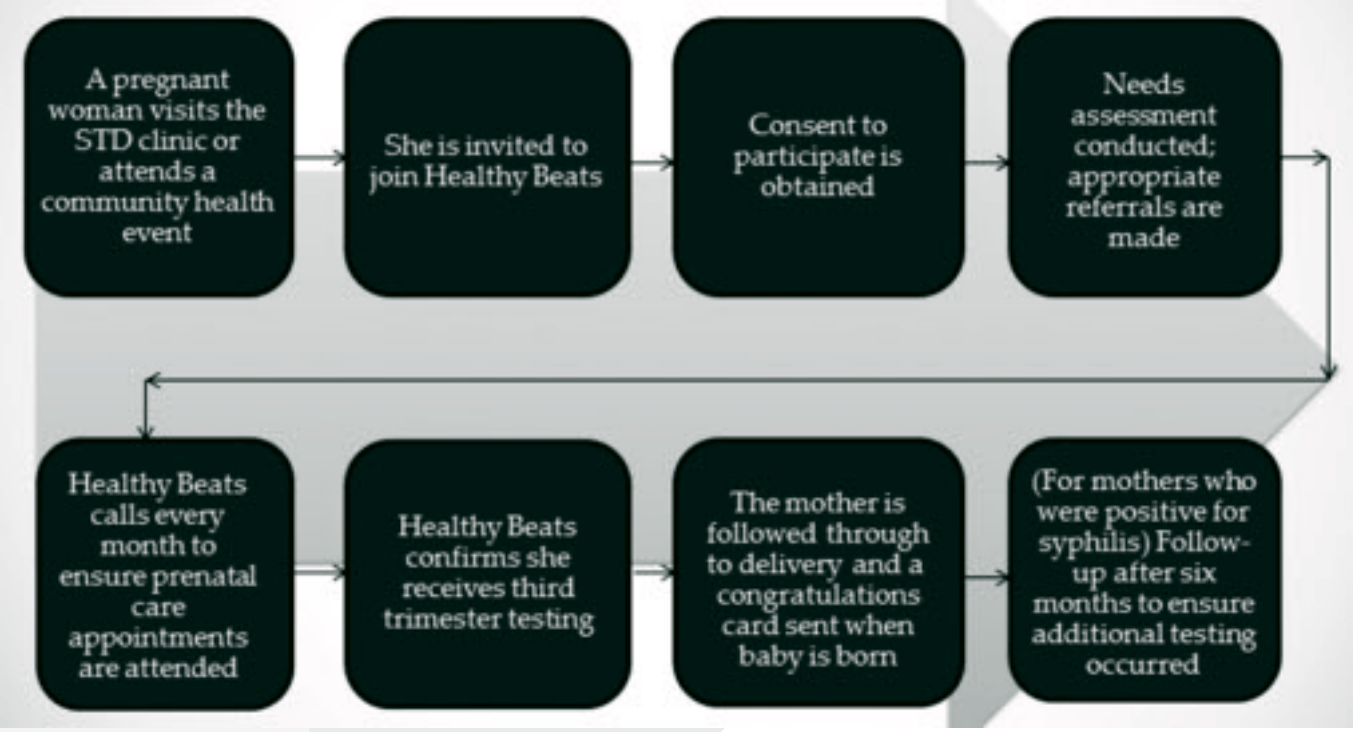

Healthy Beats Case Management Process

with a warm handoff (i.e., the transfer of care between two members of a healthcare team). In addition to referrals, staff can provide bus vouchers for transportation to and from appointments. After initial enrollment, follow-up is conducted once a month. Staff is available to provide testing, follow-up, and treatment in the field to meet patients where they live or work. Healthy Beats staff also follow up with the patient's OB/GYN to ensure third trimester testing has been completed and, if needed, that adequate treatment has been provided to the patient more than 30 days prior to delivery.

In November 2017, Metro Health hosted their inaugural Fetal Infant Morbidity Review Board on Syphilis (FIMR-S). The Community Review Board meetings are hosted on a quarterly basis to review probable and/or confirmed congenital syphilis cases, including syphilitic stillbirths. FIMR-S allows Metro Health and community partners the opportunity to assess key elements using chart abstractions and maternal interview summaries in order to recognize missed opportunities in the prevention of mother-to-child transmission. In addition to the Community Review Board—which includes representatives from the local and state health department, healthcare providers, community-based organizations, social workers, and local detention centers—FIMR-S also includes a Community Action Board, which is responsible for discussing different approaches on implementing the recommendations made at Community Review Board meetings. This process is used to inform Metro Health of missed opportunities and can inform the work of the Healthy Beats team.

Metro Health's Healthy Beats team continues to try and expand its presence in the community and build a rapport with patients to lay the groundwork, so they may take charge of their own health.

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Addressing Congenital Syphilis in Baltimore City

Maryland ranked seventh nationally in cases of congenital syphilis (CS) in 2017.[3] Over the past seven years, more than half of all CS cases reported in the state were among residents of Baltimore City. The Maryland Department of Health (MDH) was one of nine CDC-supported project areas awarded supplemental funding in October 2017 to enhance CS prevention efforts.

Due to the high number of CS cases reported in Baltimore in 2015-2016, MDH partnered with Baltimore City Health Department (BCHD). BCHD has a well-established Maternal and Child Health (MCH) citywide initiative, B'more for Healthy Babies, which focuses on promoting the health and well-being of pregnant women and their children from birth through adulthood, using a care coordination approach. BCHD also has a robust STD prevention program focused on screening, diagnosis, treatment, and partner services, including syphilis case investigation by DIS and treatment verification.

The supplemental CS grant paved the way for BCHD to implement a model partnership with a multi-disciplinary team of STD and MCH staff, including administrators, epidemiologists, outreach workers, and DIS using the established care coordination platform. The partnership included HealthCare Access Maryland (HCAM), a quasi-governmental agency that is the care coordination arm for B'more for Healthy Babies, which works to connect individuals to healthcare coverage and assist them with navigating health and social services. Each partner played a key role in ensuring pregnant women with syphilis received appropriate care and services.

A systems approach was taken to improve coordination of care between Baltimore City Health Department STD Prevention, BCHD's Maternal and Child Health initiative, and HealthCare Access Maryland. Grant funds supported two MCH pregnancy engagement specialists (PES) based at HCAM. BCHD's STD Prevention and MCH programs collaboratively developed a workflow to improve coordination and referral between the STD Prevention program's DIS, who receive morbidity reports on public and private sector patients, and HCAM's PES. When a patient with a positive syphilis serology is identified as pregnant, a DIS interviews the patient for sex partners, ensures treatment, and makes a warm handoff to the PES. Using a trauma-informed approach, the PES then connects the patient to prenatal care.

PES also ensure each patient has a

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completed Maryland Prenatal Risk Assessment (MPRA). The MPRA is a vital tool used to identify any other needs the patient may have and serves as the central referral for HCAM's Care Coordination Unit, connecting families to healthcare, insurance, home visiting services, food, housing services, and more. The PES follow-up with the patients after three and six months to ensure the patient is still in prenatal care and, if necessary, reconnect the patient to care.

Increases in syphilis in Maryland over the past several years, especially among females, have been driven in part by the opioid epidemic. Pregnant women exchanging sex for drugs and/or money are at increased risk for transmitting syphilis to their unborn babies, since they are less likely to seek prenatal care. Late entry into prenatal care, inconsistent prenatal care, or no prenatal care means mothers may not be treated for syphilis more than 30 days prior to delivery. Their infants, therefore, would meet the surveillance definition of congenital syphilis. The warm handoff between DIS and PES ensures that the patient is connected to screening, treatment, consistent prenatal care, neonatal care for their infants, and essential community support services.

From January 1 through December 31, 2018, seven pregnant women with syphilis were referred to HCAM for assistance. Six were successfully located by the PES. Each of these clients was engaged in prenatal care. In addition to prenatal care, clients were referred to evidence-based home visiting programs, Supplemental Nutrition Programs, and other community programs based on their needs. One client was referred to the Crisis, Information and Referral Line to address untreated behavioral health needs.

Moving ahead, BCHD's STD Prevention and MCH programs are jointly supporting a new Congenital Syphilis Surveillance Coordinator. BCHD will continue assessing pregnancy status of all women with syphilis, referring between DIS and PES for all pregnant women with syphilis, ensuring connection to prenatal care, and conducting follow-up serologies to ensure treatment and assess for re-infection. The BCHD STD Prevention program will continue to hold quarterly Congenital Syphilis Morbidity Review meetings with STD Prevention and MCH staff from the state health department and BCHD. Additionally, BCHD's STD Prevention and MCH programs will continue annual retrospective reviews of congenital syphilis cases to improve systems by identifying systems-level barriers to care and missed opportunities for prevention.

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Health Equity for Adolescents in Los Angeles County: How a Diverse Coalition is Creating Holistic Change for Good

By Kristin I. Meyer, PhD, Director of Youth Prevention Programs, Division of HIV and STD Programs, Los Angeles Department of Public Health, and Co-Principal Investigator, Keeping It Real Together (KIR-T)

Youth constitute a critical population for STI prevention and health equity efforts as they are more susceptible to infection, may experience barriers in navigating healthcare, and may be dissuaded from seeking care due to stigma.[1,2]

The Los Angeles Department of Public Health Division of HIV and STD Programs (DHSP) is committed to promoting and advancing health equity among youth. By building community capacity and mobilizing parents, teachers, and youth, the division aims to shift the direction of STI cases among teens and advance health equity where it is most disparate.

One initiative supporting this aim is Keeping It Real Together (KIR-T), a multi-tiered, adolescent health program designed to address upstream factors that influence STI spread, such as stigma, risk awareness, and open, non-judgmental access to condoms and care. A five-year collaborative funded by the U.S. Department of Health and Human Service's Office of Adolescent Health, KIR-T creates change by shifting community norms, fostering greater connections between teens and important adults in their lives, and empowering health and education networks to better protect and serve youth. KIR-T is a diverse partnership that includes DHSP, the University of Southern California, Los Angeles and Compton Unified School Districts (LAUSD, CUSD), LA Trust for Children's Health, Planned Parenthood Los Angeles, Visión Y Compromiso, Cardea Services, District 2 Community Advisory Coalition (D2CAC), and Connect 2 Protect Los Angeles.

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Leading with Policy

California has a strong legal foundation undergirding efforts to build health equity among youth. This includes the California Healthy Youth Act (CHYA), which requires that all public and charter schools provide "comprehensive sexual health education" to youth in middle school and high school.[3] Curricula must be skill-building; define consent and healthy relationships; be inclusive of different identities and orientations; highlight methods of birth control and HIV/STI prevention approved by the U.S. Food And Drug Administration (FDA); and outline all pregnancy options, among other topics. Supplementing CHYA are California Minor Consent and Confidentiality Laws, which ensure teens age 12 and older can obtain STD services (i.e., screening and treatment) and those of any age can access pregnancy-related care (e.g., birth control, pregnancy testing, abortion) without a parent present.[4] Under the law, youth also have the right to obtain these "sensitive services" during the school day. While this component has received some opposition from school administrators, it was enacted to protect the most vulnerable, particularly youth who are victims of abuse or trafficking.

Prioritizing Equity in Healthcare

Access to quality healthcare is integral to health equity. In Los Angeles, it's also central to our Center for Health Equity Action Plan.[5] We've been working with community partners since 2004 to connect youth in high-burden STI areas to youth-sensitive clinics through PocketGuideLA.org (PGLA). PGLA is a youth-designed resource site featuring descriptions and contact information for over 150 community clinics (and growing) offering low- to no-cost sexual health services. Unlike other referral lists, PGLA clinics are visited and assessed by our team with an eye to their youth-supportive characteristics and STI screening and treatment modalities. These include their operating hours and payment options (e.g., accepting Medi-Cal or Family PACT), how and when they treat STIs, whether they practice Patient-delivered Partner Therapy (PDPT) and Quick Start initiation of birth control, as well as other factors. Additionally, we evaluate each clinic setting for youth-friendly features including street visibility, extended hours, proximity to mass transit, welcoming and clean facilities, and reception staff knowledge of youth rights to access confidential care.

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If a clinic misses key inclusion criteria, it is not included in PGLA. However, all receive resources and tailored feedback that highlights their strengths and areas for improvement. This includes revisiting clinics ranked most poorly to provide rigorous technical assistance, a strategy for capacity building that is a priority component of the Health Equity Action Plan.

Promoting Equity through Comprehensive Education

Access to quality education is also a priority under our health equity strategy.[6] Since 2010, DHSP has collaborated with LAUSD and CUSD to deliver age-appropriate, evidence-based health education to over 60,000 youth. We partner with schools in high STI-incidence areas and work directly with teachers and parents to build the capacity of these critical adult allies. Unlike models that use "outside experts," we recruit, train, and provide ongoing support to teachers, building their confidence and comfort with the curriculum over time. While resource-heavy, we've found pairing this model with well-designed curricula has led to greater teacher enthusiasm and commitment and improved program sustainability.

Parent-youth communication is enhanced through homework activities and an evidence-based, parent-centered workshop called *Families Talking Together*. Delivered in Spanish or English by our partner promotoras (lay Hispanic/Latino community members who receive specialized training to provide basic health education in the community) at Planned Parenthood LA and Visión Y Compromiso, this communication program has been well received by adult allies across the county. We've learned that many parents want to better communicate with their teens about sexual health, but many never received comprehensive health education themselves. Since launching in 2015, over 2,000 parents have been trained. By fostering greater communication connections between parents and teens, we are making use of one of the most powerful influencers of youth: their parents.

Finally, we partner with school nurses and educators to support Condom Availability Programs (CAP) in LAUSD and CUSD high schools.[7,8] CAP enables high school teens to obtain condoms from trusted school staff, no questions asked. School nurses, health educators, and approachable staff are annually recruited to serve as "distributors" and trained on the policy. Parents have the right to "opt [their teen] out," but most youth have access. However, youth awareness is an ongoing challenge. We plan to draw greater attention to this resource through student health clubs, teen ambassadors, and social media. Since 2017, we've provided over 82,000 condoms to LAUSD and CUSD schools.

The reduction of STI acquisition among adolescents is a complex challenge that relates to underlying social conditions and is rooted in issues of health equity. By applying a holistic approach, teaming with a diverse coalition of partners, and using evidence-based programs, we are fostering upstream change and constructing a stronger, more vital, and equitable health framework for our youth and our shared future.

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Increasing Access to PrEP in a Health Department Setting Using Community Partners

By Brittany Sanders, DNP, ANP-C, GNP-C, Lead Nurse Practitioner, Specialty Clinic at the Jefferson County Department of Health (AL)

Pre-exposure prophylaxis (PrEP) has been available since 2012; Truvada is currently the only medication that has been FDA-approved for PrEP.[1] PrEP is often underused by persons at greatest risk for HIV acquisition, and health departments have been identified as a potential provider to ensure that PrEP is "available to persons at substantial risk for HIV acquisition."[2] The Jefferson County Department of Health (JCDH) in Birmingham, Alabama began prescribing PrEP in 2017 to increase access to our community and among current patients. Specifically, the local health department began offering PrEP in response to requests from patients in our STI clinic who were unable to access PrEP in other clinics—most notably, those who were uninsured, underinsured, or unable to make appointments at other clinics.

JCDH's STI Clinic: An Overview

The STI clinic at JCDH provides testing, treatment, and education about STIs, along with risk reduction strategies for patients. The providers in the STI clinic obtain a sexual history and perform an exam on all patients who present for a visit. The clinic staff, which includes providers, nurses, and Disease Intervention Specialists (DIS), interact with many people who are at high risk for HIV acquisition—due to recent diagnosis/treatment of an STI, drug use, or identification as a sexual contact to a person with HIV or another STI—and are able to discuss PrEP during their visit. Patients who are HIV negative and interested in taking PrEP are scheduled for a PrEP appointment.

Offering PrEP in the STI clinic, in addition to testing and education about risk reduction, was important to decrease the number of patients who were referred to external clinics for PrEP and did not attend the initial appointment. Providing PrEP and conducting routine testing for STIs at JCDH allows patients to discuss their sexual health in a clinic where they are already comfortable with staff. JCDH can track patients who have been referred for or have started PrEP to keep them retained in

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care, instead of depending on reports from another clinic. If the patient misses an appointment, the social worker contacts the patient to follow up and reschedule the appointment. The STI providers are proficient at obtaining sexual histories and performing exams, and providing PrEP was a natural progression to provide well-rounded sexual healthcare at JCDH.

Collaborating to Establish JCDH as a PrEP Provider

When JCDH began offering PrEP, the health department collaborated with a local university partner that had been successfully operating a PrEP clinic since 2012. The university's clinic shared patient handouts, protocols, and forms that were adapted by JCDH. This collaboration allowed the health department to begin offering PrEP sooner, because JCDH was able to follow a model that had proven successful in Jefferson County, and it also alleviated some provider fears about the components of a PrEP visit.

The providers had fears about obtaining the medication for uninsured patients, retaining new PrEP patients in care, and providing a new service in a limited appointment slot. In addition to the information received from the university clinic, the providers read the *Preexposure Prophylaxis for Prevention of HIV Infection in the United States-Update Clinical Providers' Supplement*[3] to ensure JCDH followed the current recommendations for PrEP visits. The health department used industry resources including information from Gilead Sciences, Inc., the manufacturer of Truvada. The company's medical scientists and medical liaisons are available to offer educational materials and guidance to providers as well as other clinic staff. JCDH's initial PrEP training for clinical staff was conducted by one of Gilead's medical liaisons. The in-person training was hosted for clinic staff at three JCDH sites that service different areas of the county. This engaging training allowed JCDH clinical staff to ask questions that a new PrEP provider may be faced with and possibly be unable to answer.

JCDH's PrEP program started very small: only one clinic staff member assisted with patient education and appointment scheduling. A single provider offered appointments two days a week in the Adult Health Clinic. As time passed, providers in the STI clinic expressed interest in prescribing PrEP, which increased appointment availability from two days to five days a week. A social worker was hired in 2018 for the STI clinic; she serves as the patient navigator for PrEP. She schedules appointments, screens patients for PrEP using CDC guidelines, completes medication assistance documents, and addresses other social service needs within the clinic. This patient navigator role could also be served by a DIS or another staff member. The navigator is available to speak with patients, assist with the completion of applications for medication, and provide general follow-up.

As JCDH providers became more comfortable prescribing PrEP and appointment capacity increased, JCDH began to collaborate with other community partners who provide HIV testing in the community and encounter persons at high risk for HIV (e.g., AIDS service organizations, drug treatment facilities, other community-based organizations). JCDH's social worker is the liaison between the local health department and community partners. This collaboration facilitates an environment for JCDH to accept referrals and attend community events with partners in order to seamlessly educate the community about PrEP. Potential PrEP patients that are encountered at community events become familiar with the social worker, which has resulted in increased appointment attendance of referred patients. The local health department's collaboration with community partners has been instrumental to JCDH's success as a PrEP prescriber. JCDH's partners trust that the patients they refer will receive high quality, culturally sensitive, timely care. Further, JCDH's relationships with collaborators has also resulted in strengthened interactions for other projects unrelated to PrEP.

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Lessons Learned

Although JCDH joined forces with a clinic that had been successfully prescribing PrEP for several years, there were still a few hurdles with payers and billing when PrEP services were initiated. There are several online tools to assist with diagnosis codes that may be used for PrEP. There are still some insurance restrictions related to the frequency with which certain tests may be covered, but adding the correct diagnosis codes will help decrease the number of uncovered labs. Before starting a PrEP program at a local health department STI clinic, it's important to identify how often the payer will cover required/recommended tests with specific diagnosis codes. Knowing this information prior to roll-out will decrease patients' out-of-pocket costs for uncovered tests and decrease staff time spent addressing these issues.

Here's a few tips for starting a new PrEP practice in a health department setting:

1. **Use resources from clinics that are already successful.** Learn from their successes and failures and adapt your health department's approach accordingly.
2. **Start small.** As the initial provider(s) becomes comfortable prescribing PrEP, they will share successes and other providers may be willing to join in.
3. **Identify a PrEP champion/ patient navigator.** This person will be very helpful with keeping patients engaged in care, maintaining information about the number of patients who have been served, and providing other patient assistance as needed.
4. **Develop a cheat shee**t for providers with diagnosis codes and frequency of labs.

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Division of STD Prevention Strategic Goals and Priorities

By Gail Bolan, MD, Director, Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Centers for Disease Control and Prevention

Sexually Transmitted Diseases Continue to Challenge Public Health Systems

The United States is experiencing unprecedented increases of sexually transmitted diseases (STDs). Congenital syphilis remains at an all-time high, and antibiotic-resistant gonorrhea is a growing threat. The Centers for Disease Control and Prevention's Division of STD Prevention (DSTDP) provides national leadership in programming, science, and policy to promote and support the prevention and control of STDs and their complications.

DSTDP Priorities

DSTDP is focused on eliminating congenital syphilis, preventing primary and secondary syphilis, tackling the increasing threat of untreatable gonorrhea, and preventing infections that can lead to pelvic inflammatory disease, ectopic pregnancy, and infertility. The Division concentrates on three priority populations disproportionately affected by STDs: adolescents and young adults, men who have sex with men (MSM), and pregnant women. Americans younger than 25 years old account for half of all reported STD cases in the U.S., while MSM make up two-thirds of syphilis cases. And pregnant women are particularly essential as infections can pass to their fetus while pregnant, causing stillbirth and other adverse health outcomes in infants.[1]

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DSTDP Programs and Policy

Using a multi-faceted approach that implements surveillance, prevention, and data science programs with policy, DSTDP has developed several key initiatives to address increasing STD rates.

Since 1987, DSTDP has monitored trends in *Neisseria gonorrhoeae* antimicrobial susceptibility through the Gonococcal Isolate Surveillance Project. However, to combat further antimicrobial resistance, DSTDP has since initiated two other projects: the STD Surveillance Network (SSuN) and the Strengthening the U.S. Response to Resistant Gonorrhea (SURRG) project. SSuN provides enhanced behavioral, demographic, and clinical information on gonorrhea cases, while SURRG builds local capacity for rapid detection and public health response to gonorrhea infections.

DSTDP continues to engage local, state, and community partners through funding opportunities with Strengthening STD Prevention and Control for Health Departments (STD PCHD) and Community Approaches to Reducing STDs (CARS). STD PCHD focuses on the core public health functions: surveillance and outbreak response, disease investigation and intervention, promoting CDC recommended screening, diagnosis, and treatment practices, policy, and data-driven program improvement. CARS, on the other hand, has a more concentrated emphasis on community engagement and health equity to reduce disparities, promote sexual health, and advance community wellness.

DSTDP remains true to its commitment to a strong, robust evidence base with innovative, cost-effective, and high-impact projects. DSTDP is exploring network and transmission dynamic research—especially with MSM network structures. Additionally, the Division is investigating alternative models to increase access to STD screening and treatment through express visits, field-testing, telemedicine, electronic case reporting, and clinical decision support tools.

Surveillance, prevention, and data science programs all connect to DSTDP policy work. Most recently, DSTDP issued a call to action to tackle the rising syphilis rates. DTSDP also analyzes the impact of laws related to STD prevention, such as third trimester syphilis screening and expedited partner therapy.

Reducing STDs Will Take a Village

Infectious disease epidemics are dynamic. New challenges with environmental, cultural, and social factors have changed the STD landscape since Congress passed the Venereal Diseases Control and Prevention Act in 1938. This rich history of STD prevention and control adds to today's research, skills, and world perspectives. However, large-scale changes require involvement from all sectors. Healthcare, communities, providers, biomedical industry, academia, and policymakers are crucial to halting the rising tide of STDs in the U.S.

For more information, visit www.cdc.gov/std.

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Raising Awareness About STIs at the National Level

By Rebekah Horowitz, JD, MPH, Senior Analyst, HIV, STI & Viral Hepatitis, NACCHO; Matt Prior, MPH, Director of Communications, National Coalition of STD Directors; Ben Klekamp, MSPH, Communicable Disease Epidemiology Manager, Nate Mack, BA, Business Analyst, Shawn Kiernan, MPH, Senior Epidemiologist, and Ben Schwartz, MD, Director and Medical Epidemiologist, Fairfax County Health Department

For the fourth year in a row, rates of reportable STIs (i.e., syphilis, chlamydia, and gonorrhea) increased in the United States in 2017, reaching historic highs. According to CDC's *2017 STD Surveillance Report*,[1] there were over 20 million new cases of STIs, and early data from 2018 show these steep increases continuing. Since 2013, syphilis cases have increased by 80%, gonorrhea cases by 67%, and chlamydia cases by 22%. Cases of congenital syphilis—meaning syphilis spread to the fetus in utero or at delivery—have more than doubled and may result in stillbirth or early infant death in up to 40% of cases. Young people (ages 14-25) and other marginalized populations increasingly bear the brunt of these epidemics.

STI prevention and treatment programs and sexual health clinics are essential access points to sexual healthcare and STD testing. Unfortunately, the historic rise in STIs has been coupled with health departments being asked to do more with less—facing effectively a 40% reduction in federal funding since 2003,[2] and many are also experiencing budget cuts on the local and state levels. Many jurisdictions across the country have closed clinics and/or reduced hours or staff. STI/sexual health clinics and STI prevention programs are often safety nets for those most at risk, and the depletion of this network guarantees more people will continue to be infected and suffer from the often-devastating health consequences of undiagnosed and untreated STIs.

Attention to the rising rates of STIs, and the need for more funding for the essential services of public health STI programs and clinics, is critical. The National Coalition of STD Directors (NCSD) has been leading the effort to share the needs of the STI field by bringing the field's stories directly to the halls of Congress through Days of Action and congressional briefings. In April, for STD Awareness Month, NCSD hosted both

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to educate Congress on the importance of prevention and treatment. For the Day of Action, individuals working in the STI field from 10 key states went to Capitol Hill to call for support for STI prevention and provide valuable information to policymakers about the STI epidemics happening in their communities. Over 55 meetings were held with those key offices responsible for determining national STI funding levels. Members of Congress were asked to sign onto "Dear Colleague" letters that reflected a call for a $70 million increase in federal STI funding. A total of seven more senators than last year signed onto their letter—for a total of 18 signers—and 32 representatives signed the House letter. These increases are clearly tied to the direct outreach done by those working in the STI field.

NCSD also hosted *STDs: A Rising Threat to Women, Children, and Families.* This congressional briefing gave an in-depth view of rising rates of congenital syphilis and the serious health consequences when untreated. The expert panel offered data and stories about what they have experienced first-hand in their jurisdictions as clinicians, disease intervention specialists (DIS), and public health officers.

The hard work of sharing the alarming rates of STIs in the U.S. and the needs of the field to address these increases appears to be having an impact. This year, the House passed the Fiscal Year 2020 Labor, Health and Human Services (LHHS) appropriations bill that includes a $10 million increase for STD prevention. The bill also included increases to essential related programs, including the CDC's Division of Adolescent and School Health and CDC's National Center for HIV, Hepatitis, STD, and Tuberculosis Prevention for the "Ending the HIV Epidemic" initiative, in which STIs feature prominently. But actual increases to funding for STI prevention and treatment on the federal, state, or local levels still face an uphill battle. What is clear is that raising the profile of the STI field and what is needed to address these increasing STI epidemics is essential and effective, and more jurisdictions need to be involved—on every level. We must all play a role in the ongoing fight to end the STI epidemic and make sure the field receives the funding it needs.

To learn how changes to funding impact service provision and community reach at local health departments, read about Fairfax County, Virginia's experience.

From Free to Fees: Evaluating the Local Health Impact of a Public Health STI Clinic Policy Change

Financial challenges at state and local health departments, and the expansion of Medicaid, have led to increased cost-recovery efforts at public health clinics nationwide. One change that has occurred in many jurisdictions is a shift at STI clinics from providing no-cost, walk-in services to operating as an appointment-based clinic with sliding-scale fees. In Virginia, this statewide policy change occurred in July 2017. Located in Northern Virginia, Fairfax District public health clinics experienced an immediate and sustained impact, with the STI clinic patient load decreasing by over 50%. This change raised the question of whether STIs are now going undiagnosed among those not being seen. If so, this would not only raise the health risk for those undiagnosed persons, but also for the community.

To answer this question, health department staff analyzed chlamydia and gonococcal laboratory data from our clinics, which helped to assess the impact on local public health services, as well as electronic laboratory reports (ELR) data from all Fairfax County residents, to understand the impact jurisdiction-wide. For ELRs, we classified the location of diagnosis as Fairfax Health Department clinic, other public health setting, or private clinic. An interrupted time series analysis was used to assess disease trend differences between the three years before and one year after the policy change, excluding July 2017 as a

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transition period.

We first assessed the number of laboratory-confirmed diagnoses at our clinics. Compared to the baseline, the average number of diagnoses per month decreased significantly: by 46 percent for chlamydia and 21 percent for gonorrhea. This finding affirmed our concerns about infections potentially going undiagnosed. But the most important question to examine was whether the result of this policy change had an impact on overall trends in chlamydia or gonorrhea diagnoses for residents of the entire jurisdiction. The results indicated that no change in the disease burden trend occurred; for both infections, there was no discontinuity at the time of the policy change and no significant change in the upward slope comparing the before and after periods. Additionally, no significant differences in demographics of those with confirmed infections were identified. However, a significant shift in the *location* of chlamydia diagnoses was observed. Before the policy change, our clinics diagnosed 11.9% of all chlamydia cases. Following the policy change, this dropped to 6.6%, but a commensurate increase occurred at other public health and private clinics, thus, overall, no change occurred.

Although our data indicate that other public health and private clinics are identifying chlamydia and gonococcal infections that previously were identified at the health department, there might still be a risk to public health if other providers are not as comprehensive in identifying and treating potentially infected contacts. One potential benefit of the decrease in patient load at county health department clinics is the opportunity to add services that address other potential health needs of STI clinic patients. Fairfax County Health Department has now introduced screening for substance abuse, depression, and intimate partner violence among STI clinic clients and implemented brief interventions or referrals based on screening results.

Take Action!

Are you or others in your jurisdiction involved in promoting a focus on STIs at the local or state level? Tell us what you are doing by sharing your story at http://bit.ly/2TndRlq. Additionally, there are several ways that local health departments should be engaged to have their voices heard on this important issue:

- Sign up for STI news from NCSD (see http://bit.ly/2TgyPlS) and NACCHO (see http://bit.ly/2TfNP3n) to receive weekly updates with the latest on the STI field and what is happening on the federal level as it pertains to STIs.
- Join NCSD's Take Action for STD prevention (see http://bit.ly/2TiS4v4) and NACCHO's Congressional Action Network (see http://bit.ly/NACCHOCAN), free services that let you contact your Members of Congress with important STI-related information and actions.
- Come to STD Engage, the annual meeting for STI programs across the U.S. This year, the conference will be in the Washington, D.C. area (November 19 – 22) and will include attendees from across the country heading to Capitol Hill for a day of meetings with their congressional representatives (see http://bit.ly/2TizJy1).

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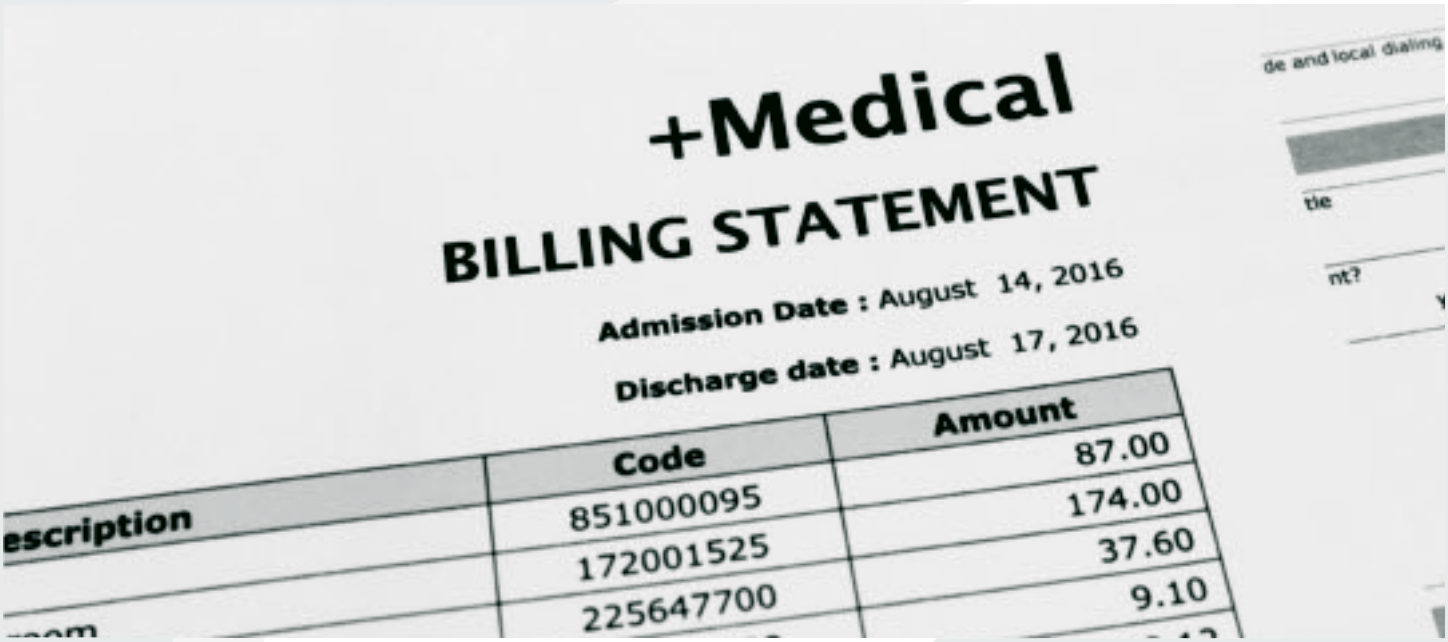

Shedding Light on Gonorrhea Resistance

By Masayo Nishiyama, RN, Nursing Program Manager, Tri-County Health Department (CO); Laura Triplett, MS, Infectious Disease Technical Supervisor and Karen Wendel, MD, Director of HIV/STD Prevention and Control, Denver Health

Antibiotic-Resistant Gonorrhea (ARGC) is an emerging, worldwide public health concern. The detection of ARGC has been associated with treatment failures, as demonstrated by a recent extensively drug-resistant (XDR) *Neisseria gonorrhoeae* (GC) case reported in the United Kingdom.[1,2,3] Although the current standard for GC treatment is dual therapy with ceftriaxone and azithromycin, an increasing number of GC isolates with reduced susceptibility to azithromycin have been identified in the United States—up 4.4% in 2017 from 0.6% in 2013.[4]

The CDC conducts extensive ARGC surveillance via the Gonococcal Isolate Surveillance Project (GISP); Enhanced GISP (eGISP); and Strengthening the U.S. Response to Resistant Gonorrhea (SURRG). These programs provide data on trends in antimicrobial susceptibility that inform treatment guidelines and identify best practices to control the emergence of ARGC in the U.S.

Most clinics rely on nucleic acid amplification tests (NAAT) for GC diagnosis and lack access to GC culture and antimicrobial susceptibility testing (AST). Therefore, strategic clinical preparation and development of an effective ARGC response plan are warranted. The below recommendations are based on current CDC guidelines and should be updated as new CDC guidance becomes available.

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1) Counsel patients to return if symptoms persist. All protocols and patient information resources should instruct patients to return to the clinic if symptoms do not resolve within 3–5 days after appropriate treatment.

2) Implement a test-of-cure (TOC) protocol. If alternative regimens (azithromycin with either gentamicin or oral cephalosporins) are used for pharyngeal infection, patients should return to the clinic for a repeat GC NAAT in 14 days.

3) Diagnose and manage treatment failure.

a. If reinfection is excluded and symptoms persist 3–5 days after treatment, treatment failure should be evaluated with GC culture, and, if more than seven days have passed since treatment, GC NAAT should also be collected.

b. In an asymptomatic patient with a positive TOC NAAT without potential reinfection, GC culture should be obtained.

c. To determine treatment for patients with persistent symptoms and/or laboratory evidence of persistent GC, refer to the current CDC treatment guidelines[5] and/or consult STD experts through the National Network of Prevention Training Center's STD Clinical Consultation Network.[6]

d. Suspected treatment failures (especially cephalosporin) should be reported to the local/state health department and the CDC[7] for treatment advice and guidance on obtaining cultures and sending specimen to the Neisseria Reference Laboratory/CDC for AST.[8]

e. Sex partners in the last 60 days should be evaluated and presumptively treated. Engaging disease intervention services should be considered.

4) Build GC Culture and AST Capacity.

1. GC culture options should be discussed with the clinic's laboratory. Options include:
   a) Direct inoculation of plates (e.g., JEMBEC system, INTRAY® GC, Chocolate Agar medium), which requires expeditious transportation to the lab or access to a CO^2 incubator, or
   b) Swab and culture tube systems (e.g., Copan ESwab®, BD ESwab™), which allow for greater flexibility in transportation time to the laboratory, usually up to 24 hours.
2. AST options should be explored with the clinic's laboratory and may require collaboration with other commercial labs such as the Associated Regional and University Pathologists, or, in cases of suspected treatment failure, consultation with health departments or CDC.

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How NACCHO Supports Local Health Department STI Prevention Efforts

By Kat Kelley, BA, Program Analyst, HIV, STI, & Viral Hepatitis, NACCHO

NACCHO has a long history of supporting local health department (LHD) STI prevention programs, from providing capacity-building assistance and identifying and sharing best practices, to facilitating peer-to-peer information exchange among LHDs and their partners. NACCHO also advocates on behalf of LHDs with federal policymakers for adequate resources and appropriate public health legislation. NACCHO undertakes this work in close partnership with LHDs, whose essential, on-the-ground perspective guides NACCHO's efforts and informs the work of federal funders, other national organizations, academic partners, and other stakeholders engaged in efforts to address our national STI crisis.

Highlights of NACCHO's STI Program Activities

■ Through its **STI Express Clinic Initiative**, NACCHO works closely with health department STI clinics and partners across the country to further explore, define, strengthen, and evaluate the provision of express STI testing and treatment models. This is important because express services offer the potential to expand access to STI screening without increased strain on overburdened STI clinics. By fostering peer learning through a Community of Practice and convening seven STI clinics in a collaborative evaluation project, we are supporting real-time practice transformation and collecting and developing tools and resources to drive clinic decision-making and quality improvement.

■ NACCHO is **developing tools and resources to support the use of CDC's forthcoming Recommendations for Providing Quality STD Clinical Services,** which outline which STI-related clinical services should optimally be available in various healthcare settings. NACCHO established an advisory group of LHD STI clinicians, administrators, and experts to inform the development of project materials. These tools and resources will guide STI clinics through a process of critically assessing which services are available in their facility. This assessment will help them determine whether additional services can or should be made available to offer STI services that are appropriate both for their clinical setting and for the individuals seeking care.

■ NACCHO recently launched a project to **identify and evaluate models for connecting STI clinic patients to substance use disorder treatment and other behavioral health services.** NACCHO will provide funding and technical assistance for up to three LHD STI clinics to implement an intervention using a screening, brief intervention, and referral to treatment (SBIRT) framework. These pilot projects will provide insight into sex- and drug-linked behaviors and outcomes among STI clinic patients; the feasibility and benefits of implementing SBIRT in STI clinics; and potential models and promising practices for the administration of SBIRT in STI clinic settings.

■ In 2018, NACCHO conducted two important **surveys to better understand health department STI programs; the availability of safety net STI clinical services; the demographics and needs of patients seeking services at STI clinics; and STI clinic capacity, services, and ability to bill insurance.** Similar surveys were conducted in 2013 and 2014, allowing for critical comparisons to assess trends and the continued ability for CDC, NACCHO, health departments, and the STI field to better understand the landscape for service delivery, optimize the role of STI programs and clinics, and make funding and policy decisions.

These highlighted program activities, among others, are supported by CDC's Division of STD Prevention (DSTDP). NACCHO works closely with DSTDP, as well as other divisions across the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, to support health departments and their local partners operating on the front lines of the STI epidemic.

To learn more about NACCHO's STI programming, visit bit.ly/NACCHOHSH. We also encourage you to engage with us by joining the HIV, STI, and Viral Hepatitis Workgroup, participating in the HIV, STI, and Viral Hepatitis Sentinel Network, signing up for our e-newsletter, or joining our virtual community to share and request information from colleagues across the country—all things that you can do by visiting bit.ly/2TgAjfW.


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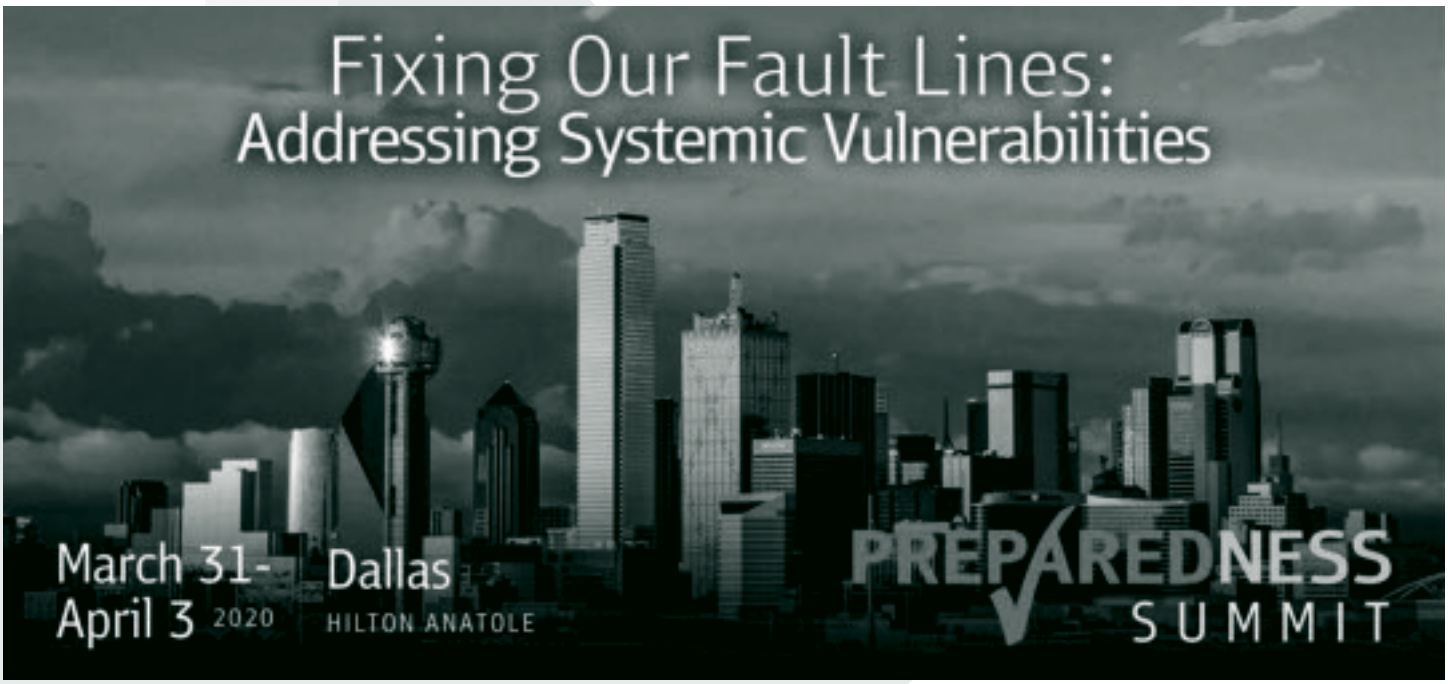

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NACCHO Exchange, the quarterly magazine of the National Association of County and City Health Officials (NACCHO), reaches every local health department in the country. It presents successful and effective resources, tools, programs, and practices to help local public health professionals protect and improve the health of all people and all communities.

Mailing and Contact Information

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October:	National Health Education Week
November:	U.S. Antibiotic Awareness Week

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