

Program Operations Guidelines for STD Prevention



Areas of
Special Emphasis

Table of Contents

FOREWARD	iii
INTRODUCTION	iv
Program Operations Guidelines Workgroup Members	vi
Areas of Special Emphasis Subgroup Members	vii
Areas of Special Emphasis Internal/External Reviewers	vii
INTRODUCTION	SE-1
CORRECTIONS	SE-1
ADOLESCENTS	SE-3
MANAGED CARE	SE-3
STD/HIV INTERACTION	SE-5
SYPHILIS ELIMINATION	SE-6
OTHER HIGH-RISK POPULATIONS	SE-7
Appendix SE-1 DSTD Project Area Correctional Health Care Assessment	SE-9
Appendix SE-2 Range of Correctional Activities	SE-17
References	SE-18

Foreword

The development of the Comprehensive STD Prevention Systems (CSPS) program announcement marked a major milestone in the efforts of CDC to implement the recommendations of the Institute of Medicine report, *The Hidden Epidemic, Confronting Sexually Transmitted Diseases, 1997*. With the publication of these STD Program Operations Guidelines, CDC is providing STD programs with the guidance to further develop the essential functions of the CSPS. Each chapter of the guidelines corresponds to an essential function of the CSPS announcement. This chapter on areas of special emphasis is one of nine.

With many STDs, such as syphilis, on a downward trend, now is the time to employ new strategies and new ways of looking at STD control. Included in these guidelines are chapters that cover areas new to many STD programs, such as community and individual behavior change, and new initiatives, such as syphilis elimination. Each STD program should use these Program Operations Guidelines when deciding where to place priorities and resources. It is our hope that these guidelines will be widely distributed and used by STD programs across the country in the future planning and management of their prevention efforts.

Judith N. Wasserheit
Director
Division of STD Prevention

Introduction

These guidelines for STD prevention program operations are based on the essential functions contained in the Comprehensive STD Prevention Systems (CSPS) program announcement. The guidelines are divided into chapters that follow the eight major CSPS sections: Leadership and Program Management, Evaluation, Training and Professional Development, Surveillance and Data Management, Partner Services, Medical and Laboratory Services, Community and Individual Behavior Change, Outbreak Response, and Areas of Special Emphasis. Areas of special emphasis include corrections, adolescents, managed care, STD/HIV interaction, syphilis elimination, and other high-risk populations.

The target audience for these guidelines is public health personnel and other persons involved in managing STD prevention programs. The purpose of these guidelines is to further STD prevention by providing a resource to assist in the design, implementation, and evaluation of STD prevention and control programs.

The guidelines were developed by a workgroup of 18 members from program operations, research, surveillance and data management, training, and evaluation. Members included CDC headquarters and field staff, as well as non-CDC employees in State STD Programs and university settings.

For each chapter, subgroups were formed and assigned the task of developing a chapter, using evidence-based information, when available. Each subgroup was comprised of members of the workgroup plus subject matter experts in a particular field. All subgroups used causal pathways to help determine key questions for literature searches. Literature searches were conducted on key questions for each chapter. Many of the searches found little evidence-based information on particular

topics. The chapter containing the most evidence-based guidance is on partner services. In future versions of this guidance, evidence-based information will be expanded. Recommendations are included in each chapter. Because programs are unique, diverse, and locally driven, recommendations are guidelines for operation rather than standards or options.

In developing these guidelines the workgroup followed the CDC publication “CDC Guidelines -- Improving the Quality”, published in September, 1996. The intent in writing the guidelines was to address appropriate issues such as the relevance of the health problem, the magnitude of the problem, the nature of the intervention, the guideline development methods, the strength of the evidence, the cost effectiveness, implementation issues, evaluation issues, and recommendations.

STD prevention programs exist in highly diverse, complex, and dynamic social and health service settings. There are significant differences in availability of resources and range and extent of services among different project areas. These differences include the level of various STDs and health conditions in communities, the level of preventive health services available, and the amount of financial resources available to provide STD services. Therefore, these guidelines should be adapted to local area needs. We have given broad, general recommendations that can be used by all program areas. However, each must be used in conjunction with local area needs and expectations. All STD programs should establish priorities, examine options, calculate resources, evaluate the demographic distribution of the diseases to be prevented and controlled, and adopt appropriate strategies. The success of the program will depend directly upon how well

program personnel carry out specific day to day responsibilities in implementing these strategies to interrupt disease transmission and minimize long term adverse health effects of STDs.

In this document we use a variety of terms familiar to STD readers. For purposes of simplification, we will use the word patient when referring to either patients or clients. Because some STD programs are combined with HIV programs and others are separate, we will use the term STD prevention program when referring to either STD programs or combined STD/HIV programs.

These guidelines, based on the CSPS program announcement, cover many topics new to program operations. Please note, however, that these guidelines replace all or parts of the following documents:

- Guidelines for STD Control Program Operations, 1985.
- Quality Assurance Guidelines for Managing the Performance of DIS in STD Control, 1985.
- Guidelines for STD Education, 1985.
- STD Clinical Practice Guidelines, Part 1, 1991.

The following websites may be useful:

- CDC www.cdc.gov
- NCHSTP www.cdc.gov/nchstp/od/nchstp.html
- DSTD www.cdc.gov/nchstp/dstd/dstdp.html
- OSHA www.osha.gov
- Surveillance in a Suitcase www.cdc.gov/epo/surveillancein/
- Test Complexity Database www.phppo.cdc.gov/dls/clia/testcat.asp
- Sample Purchasing Specifications www.gwu.edu/~chsrp/
- STD Memoranda of Understanding www.gwumc.edu/chpr/mcph/moustd.pdf
- National Plan to Eliminate Syphilis www.cdc.gov/Stopsyphilis/
- Network Mapping www.heinz.cmu.edu/project/INSNA/soft_inf.html
- Domestic Violence www.ojp.usdoj.gov/vawo/
- Prevention Training Centers www.stdhivpreventiontraining.org
- Regional Title X Training Centers www.famplan.org
- HEDIS www.cicatelli.org
- Put Prevention Into Practice www.jba-cht.com
- www.cdc.gov/nchstp/dstd/hedis.htm
- www.ahrq.gov/clinic/ppipix.htm

Program Operations Guidelines Workgroup Members

David Byrum	Program Development and Support Branch, DSTD
Janelle Dixon	Health Services Research and Evaluation Branch, DSTD
Bob Emerson	Training and Health Communications Branch, DSTD
Nick Farrell	Program Support Office, NCHSTP
Melinda Flock	Surveillance and Data Management Branch, DSTD
John Glover	Program Development and Support Branch, DSTD
Beth Macke	Behavioral Interventions and Research Branch, DSTD
Charlie Rabins	Illinois Department of Public Health
Anne Rompalo	Johns Hopkins School of Medicine
Steve Rubin	Program Development and Support Branch, DSTD, New York City
Lawrence Sanders	Southwest Hospital and Medical Center, Atlanta
Don Schwarz	Program Development and Support Branch, DSTD
Jane Schwebke	University of Alabama Birmingham
Kim Seechuk	Program Development and Support Branch, DSTD
Jerry Shirah	Training and Health Communications Branch, DSTD
Nancy Spencer	Colorado Department of Public Health
Kay Stone	Epidemiology and Surveillance Branch, DSTD
Roger Tulloch	Program Development and Support Branch, Sacramento, DSTD, California

Areas of Special Emphasis Subgroup Members

Stu Bermen	Office of the Director, DSTD
David Byrum	Program Development and Support Branch, DSTD
Janelle Dixon	Health Services Research and Evaluation Branch, DSTD
Molly Parece	Office of the Director, DSTD
Don Schwarz	Program Development and Support Branch, DSTD
Rich Voigt	Program Development and Support Branch, DSTD

Areas of Special Emphasis Internal/External Reviewers

Lynda Anderson	Health Services Research and Evaluation Branch, DSTD
Fred Bloom	Behavioral Interventions and Research Branch, DSTD
Kathleen Ethier	Behavioral Interventions and Research Branch, DSTD
Bruce Heath	Office of the Director, DSTD
Fred Martich	Behavioral Interventions and Research Branch, DSTD
Steve Middlekauff	Program Development and Support Branch, DSTD

Areas of Special Emphasis

INTRODUCTION

Areas of special emphasis have direct relevance to multiple essential functions of a comprehensive STD prevention program and represent high priority prevention opportunities. Current areas of special emphasis are corrections, adolescents, managed care, STD/HIV interactions, syphilis elimination, and high risk populations. Programs will be involved in special emphasis areas to different degrees, depending on local priorities and epidemiology. All project areas need to address all areas of special emphasis.

CORRECTIONS

Adult and juvenile correctional populations are an integral part of the larger community. The majority of people in jails and juvenile facilities are housed there for short periods of time and quickly return to their communities. If infected and untreated for STD, they can potentially spread diseases to the larger population upon their release.

Several studies have confirmed the high prevalence of STDs in jail populations and significant other jail-based infectious disease morbidity. At Riker's Island in New York, approximately 35% of female arrestees had reactive syphilis tests, 27% had chlamydia, and 8% had gonorrhea (Blank, 1997; Holmes, 1993). In Los Angeles juvenile detention facilities, approximately 27% of girls screened were positive for chlamydia, and nearly two-thirds of those testing positive for gonorrhea also tested positive for chlamydia. The majority

of these infections were asymptomatic and would have gone undetected had screening not occurred (CDC Jail STD Prevalence Monitoring Project, 1998; Los Angeles County Juvenile Hall Prevalence Monitoring Project, 1997). An analysis of STD morbidity by the Chicago STD program found that nearly 25% of newly diagnosed syphilis cases were identified at the Cook County Jail (Skolnick, 1998).

All arrestees are at high risk for STD infections and complications due to drug use and risky sexual behaviors characteristic of this population. STD testing and treatment in jail settings presents a unique public health and cost-effective opportunity to provide health services to a high risk, otherwise hard to reach population. Jail populations are transient, often use aliases and false identifying information, and rarely have a permanent address. For this reason, released offenders are difficult to locate and follow up for treatment and partner services. Furthermore, incarcerated populations often have minimal interaction with the health care system as a result of limited access to health care services and poor health care seeking behavior. Because STD infection is often asymptomatic, especially in women, STDs may remain unnoticed and untreated, leading to further transmission and costly complications.

Programs are strongly encouraged to assess the need for STD services in adult and juvenile correctional facilities. One tool that can be used to accomplish this is the 1997 DSTDC Correctional Health Care Assessment (Appendix SE-1). During an on-site assessment, programs may want to look at several variables, some of which are listed below.

- point prevalence data
- intake process and inmate flow
- admissions/day and census
- physical layout of the facility
- percent of arrestees released within 48 hours of intake
- percent of women arrested for prostitution or drug charges
- staffing at the facility, potential capacity to place DIS in the facility
- laboratory used
- length of time between intake, testing, treatment, counseling, and interviewing
- STD-specific contract language (if there is a private correctional health contractor)
- percent of all inmates tested
- under what circumstances are inmates tested for STDs.

Programs should also look at the sensitivity of their surveillance system, the demographics of STD infected individuals, and the resources that should be redirected from less productive activities and interventions and dedicated to activities in correctional settings.

Based on the assessment, programs can decide the degree to which they will be involved with corrections. Appendix SE-2 lists some examples of correctional activities from low to high intensity. At a minimum, all programs should implement some of the low intensity activities. This will improve disease intervention, facilitate collaboration, and build an infrastructure between corrections and STD prevention programs.

Several programs have developed special project coordinator positions or specialized corrections positions to improve and expand STD prevention and treatment services for high risk adult and juvenile correctional populations. These positions have been tailored to address the specific needs and circumstances found in these program areas. Some responsibilities of special project coordinators have included:

- Expanding STD services within the criminal justice system

- Collaborating with health departments to ensure that clients diagnosed with STD receive HIV prevention counseling and testing
- Surveying correctional facilities and drug treatment facilities to determine the extent of STD services
- Providing technical assistance on STD prevention and control to correctional and drug treatment facilities
- Maintaining collaborative relationships between the health department, correctional entities and drug treatment facilities to deliver STD services
- Ensuring integrity of surveillance systems and evaluating disease trends
- Serving as the principal corrections/STD representative on health department and corrections committees

Recommendations

- Programs should assess the need for STD services in adult and juvenile correctional facilities.
 - At a minimum, all programs should implement the following low intensity correctional activities (also listed in Appendix SE-2).
 - Visit the facility to assess the need for STD services
 - Meet regularly with corrections representatives
 - Distribute STD Treatment Guidelines and other relevant guidelines to adult and juvenile facilities
 - Provide referrals to the STD clinic for inmates being released
 - Refine the surveillance system to capture jail-based morbidity
 - Programs should consider developing special project coordinator positions or specialized corrections positions.
-

ADOLESCENTS

Adolescents are among the groups at highest risk for STDs. Targeting adolescents for specific prevention activities can promote healthy sexual behaviors and help prevent the establishment of risky behaviors. Because barriers to care faced by adolescents are different from those of older individuals, STD prevention programs should develop specific prevention activities for adolescents.

In general, STD prevention programs should seek to increase awareness and knowledge of STDs among adolescents, facilitate and increase access to care among adolescents, improve STD care offered to youth, and involve youth in prevention activities. Relevant STD information should be incorporated into HIV, reproductive, and comprehensive health education curricula, which could then be used by individuals or community groups who sponsor youth activities (e.g., adolescent health care providers, Boys and Girls Clubs, CBOs). The obstacles faced by adolescents that prevent them from utilizing categorical STD clinics should be evaluated and addressed, referrals by prevention partners to STD care should be facilitated, and availability of services to adolescents at risk for STDs should be increased. This could be accomplished by establishing services at new and existing locations and by utilizing newly available technology such as urine-based STD testing. Care providers serving youth should be encouraged to provide STD testing and counseling consistent with CDC guidelines, and STD staff should receive training to allow them to serve adolescents comfortably and competently. Programs should involve youth in programs as focus group leaders and peer educators. This requires the training of youth and an on-going effort on the part of the program.

Having one person within an STD prevention program responsible for coordinating youth activities can help focus and coordinate the activities and avoid duplication of services. Programs should consider identifying a person to serve as “youth liaison” to prevention partners and to help develop and improve youth services. This individual could facilitate effective partnerships with agencies and organizations involved with youth. For example, partnership with the Comprehensive School Health Program Projects supported by

CDC’s Division of Adolescent and School Health would encourage the integration of prevention activities across organizations.

STD rates among youth in detention facilities are usually high. Programs should provide testing for as large a percentage of youth in detention as is feasible. Adolescent girls are at higher risk for acquiring some STDs than adult women because of an immature cervix and because they are more likely to have had multiple partners over a shorter period of time. They are at higher risk than adolescent boys because they are more likely to have older male partners and those older partners may be more likely to have multiple partners. In addition, the relationship dynamic between adolescent girls and their adult male partners may prevent negotiation of condom use.

Recommendations

- Programs should consider identifying a person to serve as “youth liaison” to prevention partners and to help develop and improve youth services.
- Programs should facilitate effective partnerships with agencies and organizations involved with youth.
- Programs should focus adolescent screening efforts on those at highest risk, e.g., youth in detention.
- Programs should train staff to counsel and educate adolescents.
- Programs should assess barriers for adolescents in seeking and accessing care.

MANAGED CARE

An important change in the health care delivery system in the United States is the growth in managed care arrangements. Managed care encompasses a complex array of structures ranging from highly-structured group and staff model health maintenance organizations (HMO) to more loosely-structured point of ser-

vice (POS) products (CDC Managed Care Working Group, 1995). Since the early 1990s, all types of managed care organizations (MCOs) have seen considerable gains in enrollment. In 1996, for example, the total number of HMO members grew by an estimated 8.4 million people, to 67.5 million (American Association of Health Plans (AAHP), *Managed Care Facts*, 1998).

In the public sector, many health departments are in some stage of transition from providing only directly delivered clinical services in categorical clinics to adding other delivery models that involve managed care. Medicaid recipients and uninsured patients have traditionally relied upon the public health clinic system. To control costs, many State Medicaid agencies have contracted with MCOs to care for eligible persons. Between 1991 and 1996, the number of Medicaid recipients enrolled in Medicaid managed care programs more than quadrupled, from 2.7 million to 13.3 million (Health Care Financing Administration, 1997). These changes will have an impact on the way in which STD prevention and control are conducted in both the public and private sectors (ASTHO, 1995).

With more diagnostic and treatment services for STDs moving into the private sector, new partnerships are needed between MCOs and public health agencies to design and implement essential STD-related prevention services in innovative ways. Public health agencies and managed care organizations have the potential to work together to improve the health of the public that neither system could achieve alone (Institute of Medicine, 1997; Office of Inspector General, 1999). According to the IOM and other recent reviews (Gunn 1998; Gonen, 1999), managed care organizations may improve STD-related prevention services in several ways. Managed care can facilitate the integration of STD care into primary care and prevention given its expanding reach into private and public sector coverage. This is particularly appealing because managed care and public health departments share a commitment to prevention. Some types of managed care, such as staff model plans, have a population-based perspective toward enrollees that may extend to the larger community. Managed care organizations have the potential to employ their information systems to moni-

tor STD-related trends and have a greater accountability to both beneficiaries and purchasers through such mechanisms as performance measures. Other potential areas of collaboration include behavioral surveillance, laboratory practice, and health education (ASTHO, 1995).

Although MCOs have the potential to benefit STD prevention and control, there are also countervailing forces that need to be considered. This includes, but is not limited to, differences between managed care and public health with respect to culture, mission, and legal obligations; increased competition and turbulence in managed care markets as MCOs try to survive ever-increasing health care costs; and competing costs and priorities for finite resources (Scholes, 1999). There is the potential for less collaboration if MCOs fail to invest in adequate data systems or fail to engage state and local public health agencies to help improve the health of their covered populations (ASTHO, 1995). Finally, less collaboration will result if MCOs fail to understand the wide range of services encompassed by STD prevention.

As indicated by a report from the Jacobs Institute (1997), STDs have not been a high priority for most MCOs, and MCOs vary widely in their technical ability to provide services for which they do not see demonstrated cost saving. This is a critical area in need of considerable work. Since 1992, CDC established the STD Prevention Partnership, a coalition of national organizations that “share concern about the continuing spread of STDs, including HIV.” The Partnership’s membership includes national trade organizations for managed health care plans (e.g., American Association of Health Plans). The mission of the Partnership is to support and encourage partnerships among public, private, and voluntary sections with the aim of developing and implementing plans to reduce the incidence and effects of STDs (STD Prevention Partnership, 1996).

During the past several years, specific programmatic activities in managed care and STDs have been initiated. Three recent developments are worth noting here. One is the Health Plan Employer Data and Information Set (HEDIS) 2000 performance measure on chlamydia screening in women (NCQA, 1999). This

measure assesses the “percentage of Medicaid and commercially enrolled women between the ages of 15 and 25 years, who are sexually active, who have received at least one screening test for chlamydia during the reporting year.” The measure is important because it represents the first time that STDs are included to assess how well managed care organizations are performing.

A second development is the “Purchasing Specifications for Services for Sexually Transmitted Diseases.” These managed care purchasing specifications were developed by George Washington University in collaboration with the Division of STD Prevention. They define STD services, delivery of services, and quality of care that should be included in any contract between STD prevention programs and MCOs, Medicaid, or other providers of STD services (Center for Health Policy Research, 1998). The following websites will provide sample purchasing specifications (<http://www.gwu.edu/~chsrb/>) and information on STD memoranda of understanding (<http://www.gwumc.edu/chpr/mcph/moustd.pdf>).

The third activity is a project examining managed care’s role in STD prevention and control, which was conducted by investigators at Group Health Cooperative at Puget Sound Center for Health Studies, in collaboration with CDC and AAHP. The objectives were to identify ways in which current managed care environments can become more productively involved in the emerging STD health care agenda, and to make specific recommendations that are practical ‘next steps’ toward achieving effective policies and programs from managed care and public health perspectives. Based on findings from the published literature and qualitative interviews, recommendations were grouped by stages of change (i.e., increased interest in STD prevention, planning for action, taking action, building sustainability) and were directed at MCOs, national MCO trade and professional organizations, and public health agencies.

Recommendations

- STD prevention programs need to collaborate with state and national-level MCO groups to promote STD prevention and control (e.g., best practices guidelines in MCOs; develop local and other surveillance data on STDs; feasibility projects examining innovative strategies for capturing and reporting performance data, including the HEDIS chlamydia screening measure; outreach methods to attract populations at high-risk for STD screening; and provide the range of partner services through partner elicitation through partner notification and management).

STD/HIV INTERACTION

In the presence of STDs, there can be increased HIV infection transmission to persons not infected and an accelerated progression of HIV disease in the infected person. In addition, in the presence of HIV, there may be an alteration in the natural history, diagnosis, or response to therapy of STDs (Wasserheit, 1992). Studies have demonstrated the increased risk of HIV seroconversion to be associated with both genital ulcer disease and non-ulcerative STDs (Telzak, 1993; Levine, 1998). HIV transmission has been associated with concurrent infection with syphilis, herpes, chancroid, gonorrhea, or chlamydia. Treatment of STDs can reduce the prevalence and magnitude of viral shedding (Cohen, 1997).

Despite sound scientific evidence for treating STDs to prevent HIV, the question remains how to best structure such an intervention. To effectively target STD treatment for HIV prevention, an intervention must target populations with a high incidence of STDs and HIV. Because STDs increase both infectivity and susceptibility, detection and treatment should target both HIV infected and high-risk HIV uninfected persons. An intervention might include such elements as referral of HIV infected persons for care (including screening, diagnosis, and treatment for STDs), increasing access to care for STD clients, promoting risk assess-

ment and screening of persons asymptomatically infected with STDs, rapidly diagnosing symptomatic STDs, ensuring effective treatment for STDs, and counseling, follow-up, and partner services for persons with STDs.

Programs should explore the feasibility of linking STD diagnostic and treatment services with HIV counseling, testing, and treatment services in a wide variety of settings. These settings may include STD clinics, HIV testing and counseling sites, HIV care sites, drug treatment sites, prenatal and family planning clinics, correctional facilities, emergency medical and urgent care facilities, adolescent clinics, primary care settings in the private sector, and community health centers. As a part of linking STD and HIV services, program managers should review the epidemiology of STD and HIV trends in their community, identify where high risk persons are currently accessing health care and other social services, what types of services are available, and what gaps exist in available services.

The Advisory Committee for HIV and STD Prevention (ACHSP) reviewed data on the relation between curable STDs and the risk for sexual transmission of HIV. ACHSP considered that the evidence was strong that early detection and treatment of other STDs is an effective strategy for preventing sexually transmitted HIV. The ACHSP has recommended the following.

- Early detection and treatment of curable STDs should become a major, explicit component of comprehensive HIV prevention programs at national, state, and local levels.
- In areas where STDs that facilitate HIV transmission are prevalent, screening and treatment programs should be expanded.
- HIV and STD prevention programs in the United States, together with private and public sector partners, should take joint responsibility for implementing this strategy (CDC, 1998).

Recommendation

- Programs should link STD diagnostic and treatment services with HIV counseling, testing, and treatment services.

SYPHILIS ELIMINATION

With the large decrease in primary and secondary syphilis occurring during the mid to late 1990s, the United States is faced with a unique opportunity to eliminate syphilis within its borders. Syphilis is easy to detect and cure, given adequate access to and utilization of care. Nationally, it is at the lowest rate ever recorded and it is confined to a very limited number of geographic areas. The last epidemic peaked in 1990, with the highest syphilis rate in 40 years. In 1998, over 50% of infectious (primary and secondary or P&S) syphilis cases were reported from only 28 (<1%) counties, the majority of which are in the South. In addition, where syphilis does persist in the U.S., it disproportionately affects African Americans living in poverty. Although the Black:White ratio for reported syphilis rates has decreased by almost one-half since the early 1990s, the 1998 P&S syphilis rate for non-Hispanic Blacks was still 34 times greater than that for non-Hispanic whites.

Elimination of syphilis would have far-reaching public health implications because it would remove two devastating consequences of the disease –increased likelihood of HIV transmission and compromised ability to have healthy babies due to spontaneous abortions, stillbirths, and multi-system disorders caused by congenital syphilis acquired from mothers with syphilis. In addition, more than \$996 million is spent annually as a result of syphilis. Eliminating syphilis in the United States would be a landmark achievement because it would remove these direct health burdens, and it would significantly decrease one of this Nation’s most glaring racial disparities in health.

The persistence of high rates of syphilis in the United States is a sentinel event identifying communities in which there is a fundamental failure of basic public health capacity to control infectious diseases and ensure reproductive health. In these areas, syphilis elimination will be the leading edge of a broader effort to begin rebuilding this capacity. Based on the repeatedly observed seven- to ten-year syphilis cycle, there is currently a narrow window of opportunity to eliminate this disease while cases are still on the decline.

At the national level, syphilis elimination is defined as the absence of sustained transmission in the United States. At the local level, syphilis elimination is de-

defined as the absence of transmission of new cases within the jurisdiction except within 90 days of report of an imported index case. It is anticipated that these definitions will translate to $\leq 1,000$ cases (0.4/100,000 population) of P&S syphilis reported nationally each year.

The national goal, therefore, is to reduce P & S syphilis cases to 1,000 or fewer and to increase the number of syphilis-free counties to 90% by 2005.

While many other endemic diseases such as polio, measles, and smallpox have been eliminated through widespread use of vaccines, the strategies for syphilis elimination differ from these efforts largely because there is currently no vaccine. Past experience shows that continuing current STD prevention and control efforts, alone, will not be sufficient. New strategies are also required. Combining intensified traditional approaches with innovative approaches can generate new synergy and enhance the effectiveness of syphilis elimination efforts. Furthermore, the plan will evolve over time as new lessons are learned and applied.

There are five strategies that are critical for eliminating syphilis from the United States. Two cross-cutting strategies, enhanced surveillance and strengthened community involvement, are key tools for evaluating and facilitating the implementation of the three additional intervention strategies, rapid outbreak response, expanded clinical and laboratory services, and enhanced health promotion.

While national in scope, the syphilis elimination initiative focuses on areas with high syphilis morbidity and those areas with potential for syphilis re-emergence. High morbidity areas (HMAs) are areas with continuing syphilis transmission, usually signaling the need to improve preventive services and to strengthen the capacity to conduct surveillance and provide access to clinical and laboratory services. HMAs must address all five of the syphilis elimination strategies. Potential re-emergence areas (PRAs) are areas that currently experience little or no syphilis transmission but that are at significant risk for syphilis reintroduction because 1) they had a history of high syphilis rates in the 1990s or more recently; 2) they are a port or border jurisdiction or are located along migrant streams; 3) they are located along drug trafficking corridors; or 4) they include groups that are disproportionately

affected by syphilis (e.g. drug users, people exchanging sex for money or drugs, men who have sex with men, and minority and migrant populations that are affected by racism, high rates of unemployment, poor educational opportunities, and poverty). PRAs should focus primarily on enhanced surveillance and rapid outbreak response. Low morbidity areas that are not PRAs will sustain the activities of a strong STD prevention program (Wasserheit 1999).

The National Plan to Eliminate Syphilis from the United States is intended to serve as a resource and blueprint for the many partners vital to the success of this effort. Eliminating syphilis in the U.S. requires the commitment, investment, and collaboration of opinion leaders as well as program managers at local, state, and national levels. Members and leaders of affected communities must be involved in designing and delivering syphilis services, and have the opportunity to share ownership in interventions that improve the health status of their communities.

For more detailed information regarding this national initiative, programs are urged to consult The National Plan to Eliminate Syphilis from the United States. The publication is available from the Centers for Disease Control and Prevention (CDC), and on the WorldWideWeb at <http://www.cdc.gov/Stop Syphilis/>

Recommendations

- STD prevention programs should identify a person to coordinate syphilis elimination activities.
- STD prevention programs should implement the national syphilis elimination plan.

OTHER HIGH-RISK POPULATIONS

In addition to the populations specifically outlined in previous sections, many programs are targeting interventions at other populations, some of whose members engage in high-risk behaviors. Some of this work has been accomplished through HIV community planning groups. STD prevention programs must now build

on past experience and knowledge to develop interventions that are appropriate to risk behaviors occurring in members of these populations. It is important to maintain the focus of the intervention on the risk behavior rather than the population. The concept of high risk populations has been criticized because it can stigmatize groups of persons rather than focus on behavioral, social, and other factors that put persons at risk regardless of their group categorization.

STD prevention programs should identify populations that include persons engaging in high risk behaviors for transmission of STDs or persons with barriers to access for STD prevention and care services. Information indicating high risk behaviors or barriers to access among members of a particular population may be obtained through surveys or through examination of patient records to determine which demographic categories are over- or under-represented, indicating the possibilities of greater high risk behaviors in the former or barriers to access in the latter.

Following are some examples of activities that some programs are conducting.

Strategies to reduce barriers to care:

- Working with community based organizations that serve prostitutes and transvestites to make services known and to identify ways of offering STD screening to these populations.

- Performing STD screening in single room occupancy hotels and shelters where many homeless or transient individuals reside on a temporary basis.
- Working with substance abuse agencies and drug treatment centers to ensure that clients are tested for STDs.
- Performing STD screening in sex clubs and bath houses to reach populations such as men who have sex with men.
- Offering STD testing to minorities, many of whom are undocumented aliens.

Strategies to identify persons engaging in high risk behaviors:

- Working with HIV community planning groups to identify populations whose members engage in high risk behaviors and select targeted interventions to meet these population members' needs.

Recommendation

- STD prevention programs should identify populations that include persons engaging in high-risk behaviors or persons with barriers to care and develop appropriate interventions.

Appendix SE-I

DSTD PROJECT AREA CORRECTIONAL HEALTH CARE ASSESSMENT

1. Project Area _____
- 2a. Person completing assessment from health department _____
Telephone _____
- 2b. Person assisting assessment completion from the facility _____
Telephone _____
3. Health Department FTE working on correctional health issues _____ Telephone _____
4. Date completed _____

Facility Profile

5. Name and Address of Facility _____
Please specify type of facility
(county, city, etc.) _____

6. Chief Medical Director _____
Telephone _____
7. Number of correctional health staff having attended CDC/state sponsored STD Prevention/Training Center Courses in 1996/1997.
____ Comprehensve (2 weeks)
____ Intensive (1 week)
____ Part-Time Intensive (3 days)
____ Advanced (1 week)
____ Laboratory Methods (1-3 days)
____ other (specify) _____
8. What key person(s) at this facility represents correctional health care issues on the local HIV prevention community planning group? (If none or unknown, please state.)

9. Are health care services for inmates privatized?
Yes ____ **No** ____ **Unknown** ____

If yes, please specify the health services company having the service delivery contract.

DSTD PROJECT AREA CORRECTIONAL HEALTH CARE ASSESSMENT, continued

10. Is the facility accredited by the National Commission on Correctional Health Care (NCCHC)?
Yes ____ **No** ____ **Unknown** ____

STD Testing and Treatment

11. Are all arrestees *offered STD testing* and are *all* women arrestees *offered pregnancy testing*? Please check only those STDs for which inmates are routinely offered testing. If information is unknown, please write "unknown" in the space provided.

	Males	Females
chlamydia	_____	_____
gonorrhea	_____	_____
syphilis	_____	_____
hepatitis B	_____	_____
pregnancy	_____	_____

12. Of the total number of arrestees, what *percentage* (%) receive **STD testing** within the specified time frames. The total for both males and females should add up to 100%.

	Males	Females
<24 hours	_____	_____
24-48 hours	_____	_____
3-7 days	_____	_____
8-14 days	_____	_____
>14 days	_____	_____
not tested	_____	_____
unknown	_____	_____
Total	100% _____	100% _____

13. If STD testing is not offered to all arrestees and pregnancy testing is not offered to all women arrestees, under what conditions are arrestees tested for the following STDs and pregnancy? Check all that apply.

Males	Symptoms	Request	Court Order	Not Tested	Unknown
chlamydia	_____	_____	_____	_____	_____
gonorrhea	_____	_____	_____	_____	_____
syphilis	_____	_____	_____	_____	_____
hepatitis B	_____	_____	_____	_____	_____
Females	Symptoms	Request	Court Order	Not Tested	Unknown
chlamydia	_____	_____	_____	_____	_____
gonorrhea	_____	_____	_____	_____	_____
syphilis	_____	_____	_____	_____	_____
hepatitis B	_____	_____	_____	_____	_____
pregnancy	_____	_____	_____	_____	_____

DSTD PROJECT AREA CORRECTIONAL HEALTH CARE ASSESSMENT, continued

14. What *percentage* (%) of *all* arrestees are tested for the following STDs and pregnancy? If information is unknown, please write "unknown" in the space provided.

	Males	Females
chlamydia	_____	_____
gonorrhea	_____	_____
syphilis	_____	_____
hepatitis B	_____	_____
pregnancy	_____	_____

15. Is a *written* protocol followed for **STD screening**?

Yes _____ **No** _____ **Unknown** _____

If yes, please specify:

_____ CDC Chlamydia Screening Guidelines

_____ Internal document

_____ Health department document

_____ other (specify)

16. Is a **STAT RPR** protocol *routinely* used to screen for syphilis?

Yes _____ **No** _____ **Unknown** _____

If **no**, what are the obstacles for implementing STAT RPR testing at intake?

Lack of:

_____ space

_____ money

_____ trained medical staff

_____ equipment

_____ time during intake medical exam

_____ unknown

_____ Other _____

17. Are chlamydia and gonorrhea screened using **LCR** or **PCR** testing?

Yes _____ **No** _____ **Unknown** _____

If **no**, what are the obstacles for implementing LCR or PCR testing for chlamydia and gonorrhea at intake?

Lack of:

_____ space

_____ money

_____ trained medical staff

_____ equipment

_____ time during intake medical exam

_____ unknown

_____ Other _____

DSTD PROJECT AREA CORRECTIONAL HEALTH CARE ASSESSMENT, continued

18. Is a *STAT pregnancy* test protocol *routinely* used?

Yes _____ No _____ Unknown _____

If **no**, what are the obstacles for implementing STAT pregnancy testing for all women of child-bearing age?

Lack of:

- _____ space
- _____ money
- _____ trained medical staff
- _____ equipment
- _____ time during intake medical exam
- _____ unknown
- _____ Other _____

19. Does this facility *routinely* offer HIV counseling and testing for inmates with diseases characterized by ulcers (e.g. syphilis, chancroid, genital herpes)?

Yes _____ No _____ Unknown _____

20. Are pap smears *routinely* offered to women inmates?

Yes _____ No _____ Unknown _____

22. Check the average **turnaround time** for laboratory results. *Check only one response for each condition.*

chlamydia	_____ <24 hours	_____ 24-48 hours	_____ 3-7 days	_____ >1 week
	_____ no testing avail	_____ unknown		
syphilis	_____ <24 hours	_____ 24-48 hours	_____ 3-7 days	_____ >1 week
	_____ no testing avail	_____ unknown		
gonorrhea	_____ <24 hours	_____ 24-48 hours	_____ 3-7 days	_____ >1 week
	_____ no testing avail	_____ unknown		
pregnancy	_____ <24 hours	_____ 24-48 hours	_____ 3-7 days	_____ >1 week
	_____ no testing avail	_____ unknown		

23. Specify the site(s) where laboratory STD **diagnostic testing** takes place.

	On-Site	Off-Site (state public health lab)	Off-Site (other)	Unknown
chlamydia	_____	_____	_____	_____
syphilis	_____	_____	_____	_____
gonorrhea	_____	_____	_____	_____
pregnancy	_____	_____	_____	_____

DSTD PROJECT AREA CORRECTIONAL HEALTH CARE ASSESSMENT, continued

24. Specify the site(s) where **STD treatment** is conducted.

	On-Site	Off-Site	Unknown
chlamydia	_____	_____	_____
syphilis	_____	_____	_____
gonorrhea	_____	_____	_____

25. Are inmates treated presumptively on-site for STD infection if symptomatic?

Yes _____ **No** _____ **Unknown** _____

26. Is a written protocol followed for STD treatment?

Yes _____ **No** _____ **Unknown** _____

If yes, please specify:

- _____ CDC/STD Treatment Guidelines
- _____ Internal document
- _____ Health department document
- _____ Other (specify) _____

27. If inmates are treated off-site for STD infection, are jail cases differentiated from other cases when morbidity is reported from this off-site facility?

Yes _____ **No** _____ **Unknown** _____ **Not Applicable** _____

Inmate Population Profile

In the last two sections of this document, data will be requested to supplement and strengthen the information already given. For questions 28–39 use data from the last full month it is available. *Please report all data from the same month/year.* If information is unknown, please write “unknown” in the space provided.

28. **Month/Year** of data being reported in this section _____

	Males	Females	Total
29. Average # of admissions per day	_____	_____	_____
30. Average census per day	_____	_____	_____
31. Average length of stay (days):	_____	_____	_____
32. Average percent of arrestees released:			
<24 hours	_____	_____	
24-48 hours	_____	_____	
3-7 days	_____	_____	
8-14 days	_____	_____	
>14 days	_____	_____	

DSTD PROJECT AREA CORRECTIONAL HEALTH CARE ASSESSMENT, continued

	Males	Females	Total
33. Average percentage of <i>female</i> arrestees charged with:			
prostitution		_____	
drugs offenses		_____	

STD Testing Volume During Last Full Month

For questions 34–39 please provide data from the last full month it is available. The month/year of data reported in this section should be the same as the month/year in the previous section. If any of the information requested in this section is unknown, please write “unknown in the space provided.

34. **Month/Year** of data being reported in this section _____

	Males	Females	Total
35. Number of chlamydia tests done	_____	_____	_____
a. Type of test(s) used. Check all that apply.			
Culture	_____	_____	
Gen-Probe	_____	_____	
PCR	_____	_____	
LCR	_____	_____	
EIA	_____	_____	
DFA	_____	_____	
Unknown	_____	_____	
Other (list) _____	_____	_____	
b. # of positive tests	_____	_____	_____
c. of those testing positive, provide the # of untreated inmates leaving facility requiring field follow-up	_____	_____	_____
d. of those requiring field follow-up, provide the # closed with C disposition (brought to treatment)	_____	_____	_____
e. of those requiring field follow-up, provide the # closed with E disposition (previously treated)	_____	_____	_____
f. <i>total</i> number of cases of chlamydia in the <i>county</i>	_____	_____	_____

DSTD PROJECT AREA CORRECTIONAL HEALTH CARE ASSESSMENT, continued

36. Number of **gonorrhea** tests done

	Males	Females	Total
a. Type of test(s) used. Check all that apply.			
Culture	_____	_____	
Gen-Probe	_____	_____	
PCR	_____	_____	
LCR	_____	_____	
Gram Stain	_____	_____	
Unknown	_____	_____	
Other (list) _____			
b. # of positive tests	_____	_____	_____
c. of those testing positive, provide the # of untreated inmates leaving facility requiring field follow-up	_____	_____	_____
d. of those requiring field follow-up, provide the # closed with C disposition (brought to treatment)	_____	_____	_____
e. of those requiring field follow-up, provide the # closed with E disposition (previously treated)	_____	_____	_____
f. <i>total</i> number of cases of gonorrhea in the <i>county</i>	_____	_____	_____

37. Number of serological tests for **syphilis** done

a. Type of test(s) used. Check all that apply.			
RPR	_____	_____	
VDRL	_____	_____	
FTA	_____	_____	
TPPA	_____	_____	
Unknown	_____	_____	
Other (list) _____			
b. # of positive tests	_____	_____	_____
c. of those testing positive, provide the # of inmates tested, diagnosed, and treated for early syphilis while incarcerated	_____	_____	_____

DSTD PROJECT AREA CORRECTIONAL HEALTH CARE ASSESSMENT, continued

	Males	Females	<i>Total</i>
d. of those testing positive, provide the # of inmates leaving facility requiring field follow-up	_____	_____	_____
e. of those requiring field follow-up, provide the # closed with C disposition (brought to treatment for <i>early syphilis</i>)	_____	_____	_____
f. of those requiring field follow-up, provide the # closed with E disposition (previously treated for <i>early syphilis</i>)	_____	_____	_____
g. of those requiring field follow-up, provide the # closed with F disposition (not infected)	_____	_____	_____
h. <i>total</i> number of cases of early syphilis in the <i>county</i>	_____	_____	_____
38. Number of HIV tests done	_____	_____	_____
a. # of positive tests	_____	_____	_____
39. Number of pregnancy tests done		_____	
a. # of positive tests		_____	
40. What type of technical assistance would STD program managers like from the Division of STD Prevention at the CDC? Check all that apply.			
___ site visit assessment			
___ protocols of currently established and effective models of STD screening and treatment in jail settings			
___ CDC STD guidelines for treatment and screening			
___ consultation/mini-assessments			
___ training (specify) _____			
___ other (specify) _____			

41. What <i>percent (%)</i> of the <i>current</i> resources at the state-level STD Prevention Office is directed toward STD prevention activities in correctional health care facilities? _____			
Additional comments:			

Appendix SE-2

RANGE OF CORRECTIONAL ACTIVITIES

Below is a sample of correctional activities ranging in intensity. Programs can use these examples to develop activities in correctional settings that reflect the outcomes of their assessments and available resources.

Low Intensity

- Visit the facility to assess the need for STD services
- Meet regularly with corrections representatives
- Distribute STD Treatment Guidelines and other relevant guidelines to adult and juvenile facilities
- Provide referrals to the STD clinic for inmates being released
- Refine the surveillance system to capture jail-based morbidity

Medium Intensity

- Conduct periodic point prevalence studies
- Rotate DIS to the facility once a week or bi-weekly to draw bloods/collect specimens
- Assign a DIS part or full time to the facility
- Designate a corrections liaison
- Supply resources to promote prompt STD testing and treatment
- Facilitate the development and delivery of appropriate STD prevention messages and behavioral interventions
- Assess training needs of correctional health care providers and provide appropriate training
- Ensure timely STD counseling for those with STD infection

High Intensity

- Test arrestees based on locally determined criteria.
Possible options:
 - Test based on risk assessment
 - Test all female arrestees
 - Test all female arrestees and male detainees
 - Test all arrestees
 - Test STD infected women for pregnancy and HIV
 - Expand STD services to drug courts, parole/probation, holding centers, and alternative sites
 - Selective STAT testing and treatment
 - Provide case management and follow-up for those testing positive
 - Apply for the jail prevalence monitoring project or enhanced projects, or utilize other funding opportunities
 - Submit for a special projects coordinator who works in part with corrections
 - Redirect and commit resources from base funding to correctional health services.

References

- American Association of Health Plans, Managed Care Facts. January, 1998.
- Association of State and Territorial Health Officials. Managed Care Monograph Series: Communicable Disease Control in a Managed Care Environment. November, 1995.
- Blank S, McDonnell D, Rubin S, Neal J, Brome M, Masterson M, Greenspan J. New Approaches to Syphilis Control: Finding Opportunities for Syphilis Treatment and Congenital Syphilis Prevention in a Women's Correctional Setting. *Sexually Transmitted Diseases*. 1997; 24(4): 218-228.
- CDC Managed Care Working Group. Prevention and Managed Care: Opportunities for Managed Care Organizations, Purchasers of Health Care, and Public Health Agencies. *MMWR*, November 17, 1995; 44(RR14): 1-12.
- Center for Health Policy Research. Sample Purchasing Specifications for Services for Sexually Transmitted Diseases. The George Washington University School of Public Health and Health Services, December, 1998.
- CDC. HIV prevention through early detection and treatment of other sexually transmitted diseases—United States Recommendations of the Advisory Committee for HIV and STD Prevention. *MMWR* 1998;47(RR12): 1.
- Cohen MS, Hoffman IF, Royce RA, et al. Reduction of concentration of HIV-1 in semen after treatment of urethritis: implications for prevention of sexual transmission of HIV-1. *Lancet* 1997; 349: 1868-73.
- Division of STD Prevention, CDC. Jail STD Prevalence Monitoring Project Update. March, 1998.
- Gonen JS. Confronting STDs: A challenge for managed care. *Women's Health Issues* 1999; 9(2): 36s-46s.
- Gunn RA, Rolfs R, Greenspan J, Seidman RL, Wasserheit J. The changing paradigm of sexually transmitted disease control in the era of managed health care. *JAMA* 1998;279(9): 680-684.
- Health Care Financing Administration, National Summary of Medicaid Managed Care Program and Enrollment, June 30, 1997.
- Holmes M, Safyer S, Bickell N, Vermund S, Hanff P, Phillips R. Chlamydial Cervical Infection in Jailed Women. *American Journal of Public Health*. 1993; 83(4): 551-555.
- Institute of Medicine: The Hidden Epidemic, 1997.
- Jacobs Institute of Women's Health. Confronting STDs: A Challenge for Managed Care. October, 1997.
- Levine WC, Pope V, Bhoomkar A, et al. Increase in endocervical CD4 lymphocytes among women with nonulcerative sexually transmitted diseases. *J Infect Dis* 1998; 177: 167-74.
- Los Angeles County STD Program. Juvenile Hall STD Prevalence Monitoring Project Progress Report, Feb-Sept 1997.
- National Committee for Quality Assurance, 1999.
- Office of the Inspector General. Public health and managed care: Opportunities for collaboration. U.S. Department of Health and Human Services, July, 1999.
- Skolnick A. A Look Behind Bars for Key to Control of STDs. *JAMA*. 1998; 279(2): 97-98.
- STD Prevention Partnership, Brochure. Atlanta(GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1996.
- Telzak EE, Chiasson MA, Bevier PJ, Stoneburner RL, Castro KG, Jaffe HW. HIV-1 seroconversion in patients with and without genital ulcer disease. A prospective study. *Ann Intern Med* 1993; 119: 1181-6.
- Wasserheit JN. Epidemiological synergy. Interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases. *Sex Transm Dis* 1992; 19: 61-77.
- Wasserheit JN, Valdiserri RO, Wood RW. Assessment of STD/HIV prevention programs in the United States: national, local, and community perspectives. In Holmes KK, et. al. Eds. *Sexually Transmitted Diseases*, 3rd Edition. New York: McGraw Hill, 1999: 1255-1271.