

# TEXAS SYPHILIS ELIMINATION PLAN, 2009

## I. Background

In October 1999, the Centers for Disease Control and Prevention (CDC), in collaboration with federal, state, local, and non-governmental partners, launched *The National Plan to Eliminate Syphilis*. In the plan, CDC identified key strategies needed for successful elimination of syphilis from the United States: expanded surveillance and outbreak response activities, rapid screening and treatment in and out of medical settings, expanded laboratory services, strengthened community involvement and agency partnerships, and enhanced health promotion.

Since its establishment, numerous gains have been made in reducing disease incidence in key groups, raising professional and public awareness of syphilis, increasing financial investment into public Sexually Transmitted Disease (STD) clinic services, and building local public health and community capacity to fight this devastating disease. However, new challenges have emerged. After reaching a historical low in 2001, diagnoses of primary and secondary syphilis are again on the increase.

CDC released *The National Plan to Eliminate Syphilis from the United States* in May 2006. This Plan focused syphilis elimination activities in achieving three strategic goals: Investment in and enhancement of public health services; prioritization of evidence-based, culturally competent interventions; and creating accountable services and interventions. For each of the three goals, CDC recommends that syphilis elimination activities be delivered in three strategic areas (The 3-By-3 approach to syphilis elimination). This results in nine strategies: Surveillance, Clinical and Laboratory Services, Community Mobilization, Health care Provider Mobilization; Tailoring of Interventions; Evidence-based Action Planning, Monitoring and Evaluation; Training and Staff Development; and Research.

In Texas, a state-wide Syphilis Elimination Plan was first distributed in 2000. The Texas Plan outlined the activities that mirrored the National Plan published in 1999. The Texas Syphilis Elimination Plan (TSEP), 2008, updates the 2000 plan to include the following strategies for Texas:

- Surveillance
- Clinic and Laboratory Services
- Community Involvement
- Health Care Provider Involvement
- Priority Interventions
- Monitoring and Evaluation
- Training and Staff Development
- Rapid Response

## II. The Texas Syphilis Elimination Plan (TSEP)

### A. Surveillance

Surveillance forms the backbone of any communicable disease control effort. To eliminate syphilis, surveillance systems must be sensitive and timely to detect changes in morbidity, identify the importation of syphilis into the area, and monitor community morbidity. The Texas Department of State Health Services (DSHS) developed Surveillance Guidelines to provide on

active surveillance information to HIV/STD programs. This ensures that provider and laboratory visits can be used to evaluate the sensitivity, completeness and accuracy of the surveillance system. The Guidelines include strategies for rapid case detection and ways to inform the community and key partners of syphilis trends. In addition to the Guidelines, DSHS defined surveillance efforts that included routine syphilis testing and evaluation of serologic and behavioral data from populations at high risk for syphilis.

DSHS will monitor counties, surveillance jurisdictions, Public Health Regions and the State to ensure that HIV/STD programs focus on activities that facilitate the elimination of high levels of endemic syphilis. The emphases for these programs will be on detecting cases and initiating public health follow-up (PHFU) and analyzing data to determine risk factors for sustained transmission. This ensures effective interventions to interrupt transmission can be developed. DSHS will ensure the HIV/STD programs use surveillance data to evaluate the success of intervention strategies.

DSHS will require all areas of the state to focus on sensitive and timely detection of cases imported from outside the jurisdiction and on interruption of syphilis transmission. DSHS will also recommend that surveillance systems be sensitive in evaluation of cases of genital ulcer disease and suspicious rash illness and in capturing all reactive laboratory reports and cases of syphilis. This will include a rapid communication from providers about presumptive cases of syphilis.

Security, confidentiality and privacy issues related to persons with syphilis are of utmost importance. DSHS has an on-site monitoring process of all HIV/STD programs to ensure confidentiality of data for patients and members of their social and sexual networks (as outlined by DSHS Data Security and Confidentiality Policies and Procedures).

### **B. Clinic and Laboratory Services**

The provision of accessible and timely client-centered counseling, screening, and treatment services in sites frequented by populations at risk for syphilis is needed to eliminate syphilis. High quality syphilis prevention and care must be ensured. DSHS will develop or intensify multi-level activities to promote access to and utilization of high quality care for people infected with or exposed to syphilis. Clinics will be encouraged to develop community specific “express visits systems” where and when clinic access is not optimal. These systems will ensure full examinations are prioritized according to patient needs. Clients without symptoms or identified needs can be tested for syphilis, HIV, gonorrhea and Chlamydia without a full exam.

DSHS will work to enhance timely, high-quality, customer-oriented laboratory services throughout the State. Whenever possible, stat syphilis testing will be provided. STD Clinical Standards can be found in the Program Operating Procedures and Standards (POPS) in Chapter 20 (<http://www.dshs.state.tx.us/hivstd/pops/default.shtm>).

### **C. Community Involvement**

Syphilis is currently endemic in several populations in the state and has waxed or waned in other populations over time. Syphilis is concentrated in geographic or social pockets in the state; this indicates the need for a community approach to the elimination of the disease. Involving communities affected by syphilis in public health activities to eliminate syphilis can:

- Facilitate more effective communication;

- Restore, build and maintain trust between the community and public health institutions;
- Improve access to and utilization of services by populations most affected by syphilis;
- Ensure the development of culturally competent syphilis elimination interventions; and
- Mobilize participation to develop community capacity to eliminate syphilis.

Dallas and Harris Counties will continue to have Syphilis Elimination Coalitions. The Dallas County Coalition will expand to include Tarrant County.

#### **D. Health Provider Involvement**

DSHS will seek the involvement of clinicians working in a variety of health care settings, including:

- Public funded STD Clinics
- Private Providers
- Community Health Care Clinics
- Family planning Clinics
- Emergency Rooms
- Hospitals

Involving health care clinicians who practice in public and private settings is critical for the success of the Syphilis Elimination Plan. For our purposes, clinicians are defined as physicians, physician assistants, nurses and nurse practitioners. Health Departments should build relationships with providers to improve their medical management of syphilis patients. Relationships can be built by:

- Sharing epidemiologic data (the DSHS posts data in the annual report on the website: <http://www.dshs.state.tx.us/hivstd/default.shtm>. Data is also provided during our bi-annual HIV/STD conference.)
- Conducting educational presentations
- Conducting DIS provider visits
- Responding to clinicians' questions
- Developing agreements to facilitate patient access, referral and partner notification

DSHS funded HIV Service providers require that

- if a client was diagnosed as being HIV+ within the last year, a Syphilis test should be done
- Screening for STDs should be done annually at minimum or when necessary (for example, the client is named as a contact to a reportable STD)

Details in establishing and sustaining relationships with providers are found in the POPS Chapter 8 ([http://www.dshs.state.tx.us/hivstd/pops/chapters/pdf\\_hiv\\_and\\_std\\_surveillance.pdf](http://www.dshs.state.tx.us/hivstd/pops/chapters/pdf_hiv_and_std_surveillance.pdf)).

#### **E. Priority Interventions**

The following are the priority interventions of the TSEP.

### **Intervention 1: Screening**

The target populations located in five metropolitan areas in Texas: Bexar County (San Antonio), Dallas County, Harris County (Houston), Tarrant County (Fort Worth), and Travis County (Austin). The target populations include:

- High risk heterosexuals African-American, whites and Hispanics (males and females)
- Men who have Sex Men (MSM)
- HIV positive persons
- Commercial Sex Workers

Of the total Primary and Secondary cases reported in 2007 (1,172), the “Big Five” counties reported 79 % (921/1,172) of cases. The following list details reported cases by county:

- Bexar - 153
- Dallas – 155
- Harris – 461
- Tarrant – 85
- Travis - 67

Screening will take place at local jails and other high risk locations.

### **Intervention 2: Partner Services**

Target populations for the intervention will include the following persons:

- Individuals/persons diagnosed with early syphilis
- Contacts to cases of early syphilis, also called ‘partners’
- Members of the socio-sexual network of cases of early syphilis, also called ‘clusters’ (associates and suspects)

The Partner Services Intervention will be carried out by DIS-trained local health department staff in all Texas HIV/STD Control Programs, including Dallas, Harris, Tarrant, Bexar and Travis Counties. Activities will include partner elicitation and partner notification, including activities required to locate, interview, and bring to treatment partners and associates identified by original patients.

### **Intervention 3: Rapid Response Team (RRT)**

A threshold analysis of reported P&S and total early syphilis cases will be used to identify targeted communities for the RRT intervention. The analysis, conducted every two weeks, is designed to identify unusual increases in early syphilis cases in counties, regions, or surveillance jurisdictions. The Syphilis Elimination Coordinator (SEC), in conjunction with the program manager of the area reporting an unusual increase in syphilis, will perform the initial investigation. If further assessment is warranted, the SEC will report the results of the initial investigation to key central office staff. A rapid response intervention will be set in motion if the investigation identifies a significant increase in syphilis cases and a lack of local resources to address the increase (see Attachment A for more details on the rapid response plan). Within areas identified as a target for rapid response, the following persons will be the target population:

- Persons diagnosed with early syphilis
- Contacts to cases of early syphilis, also called ‘partners’
- Persons within the socio-sexual network of cases of early syphilis, also called ‘clusters’ (associates and suspects)

Racial/ethnic/behaviorally-defined target populations will vary and will be defined for a specific area when a rapid response team response is activated.

#### **Intervention 4: Health Promotion**

The target populations located in five metropolitan areas in Texas: Dallas, Harris, Tarrant, Bexar and Travis Counties are

- High risk heterosexual African-American, whites and Hispanics (males and females)
- Men who have sex with Men (MSM)
- HIV positive persons
- Commercial Sex Workers

Five local health departments, the DSHS central office, and community-based organizations participating in syphilis elimination efforts will design, produce, and distribute media messages. The large media consist of radio and TV ads; the medium media consists of newspaper advertisements, advertisements in target population-specific periodicals, and posters or ads posted in venues frequented by target populations; and the small media include syphilis elimination promotional items, flyers, and pamphlets. The intervention will also include the activities of the Syphilis Elimination Coalitions in Dallas/Fort Worth and Houston.

#### **F. Monitoring and Evaluation**

DSHS will monitor and evaluate all Syphilis Elimination activities to assure they are being performed appropriately. DSHS uses information found in previous on-site program reviews to prioritize future on-site program reviews. The Risk Assessment Tool documents the priority of future on-site program reviews. Public Health Follow-Up (PHFU) consultants are assigned programs. The consultants will lead teams to conduct on-site program reviews. They also review program semi-annual reports as well as other data to help evaluate and assess programs.

#### **G. Training and Staff Development**

DSHS will collaborate with existing Prevention Training Centers to provide on-going clinical, behavioral, and partner services training to staff. The National Network of STD/HIV Prevention Training Centers (PTCs) is a CDC-funded group of regional centers created in partnership with health departments and universities. The PTCs are dedicated to increasing the knowledge and skills of health professionals in the areas of sexual and reproductive health. The National Network provides health professionals with a spectrum of state-of-the-art educational opportunities, including experiential learning with an emphasis on prevention.

Within the National Network of STD/HIV Prevention Training Centers, 10 centers provide [STD Clinical Training](#) [NNPTC], four centers provide [Behavioral Intervention Training](#) [NNPTC], and four centers provide [Partner Services and Program Support Training](#) [NNPTC].

STD Clinical Training centers (Part I) provide up-to-date information to public and private clinicians who diagnose, treat, and manage patients with STDs.

The Behavioral Intervention Training centers (Part II) provide courses that teach the use of evidence-based STD/HIV prevention interventions at the individual, group, and community level. Training is also provided in areas of program support needed to implement and maintain such interventions. The intended target audience is prevention providers in public, private, and community sectors who are responsible for the implementation or supervision of STD/HIV prevention programs in community, clinic-based, or criminal justice settings. These courses teach skills and strategies to influence changes in behaviors that place people at risk for STD or HIV infection. The four Part II centers provide training on several evidence-based behavioral interventions from the CDC's Diffusion of Effective Behavioral Interventions (DEBI) Project, as well as courses that seek to develop skills to support their successful implementation.

Partner Services and Program Support Training centers (Part III) provide courses that are designed for federal, state, and local public health professionals, especially those working in STD/HIV prevention programs. Several courses focus on training to help develop the skills of Disease Intervention Specialists (DIS) and prevention counselors, public health nurses, and family planning providers; other courses are designed to support STD and HIV prevention programs at state, local, and community levels. Courses range from 1 day to 2 weeks, and the inclusion of experiential learning under the guidance of qualified preceptors is integral to all the course offerings.

DSHS serves as one of the four centers funded as a Partner Services and Program Support Training center (Texas PTC III). The Texas PTC III serve a 13-state area encompassing the following states: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Arkansas, Louisiana, New Mexico, Oklahoma and Texas. DSHS sub-contracts with the Dallas County Health and Human Services (DCHHS) to conduct the PTC III courses.

The trainings currently conducted by the Texas PTC III include: Introduction to STD Intervention (ISTDI), Fundamentals of STD Intervention, HIV Partner Counseling and Referral Services (PCRS), and customized courses as requested, when appropriate.

DSHS training specialists also provide training and technical assistance to DIS, STD/HIV program managers, and clinical staff. STD Facts and Fallacies and Mastering VCA are two courses that are currently provided. Several other courses are being developed.

## **H. Rapid Response**

An urgent response to every infectious case is necessary to eliminate syphilis. Local and Regional Programs that perform disease intervention must have a Rapid Response Plan (RRP). The plan must address the steps required to rapidly respond to any unusual increase in disease incidence. In addition, the plan should have a process for determining when an area is experiencing an unusual increase. The plan must also describe methods and standards for the following:

1. Conducting epidemiologic, social, and behavioral assessments;
2. Involving and defining the roles and responsibilities of key health department staff, affected communities and key organizations;
3. Working with communicable disease rapid response teams;
4. Communicating and working across jurisdictions.

The statewide Rapid Response Team will be deployed as needed. Targeted communities for the Rapid Response Team (RRT) intervention will be identified through a threshold analysis of reported Primary & Secondary and total early syphilis cases. The analysis, conducted every two weeks, is designed to identify unusual increases in early syphilis cases in counties, regions, or surveillance jurisdictions. The Syphilis Elimination Coordinator (SEC), in conjunction with the program manager of the area reporting an unusual increase in syphilis, will perform the initial investigation. If further assessment is warranted, the SEC will report the results of the initial investigation to key central office staff. A rapid response intervention will be set in motion if the investigation identifies a significant increase in syphilis cases and a lack of local resources to address the increase. Within areas identified as a target for rapid response, the following persons will be the target population:

- Persons diagnosed with early syphilis

- Contacts to cases of early syphilis, also called ‘partners’
- Persons within the socio-sexual network of cases of early syphilis, also called ‘clusters’ (associates and suspects)

Racial/ethnic/behaviorally-defined target populations will vary and will be defined for a specific area when a rapid response team response is activated.

Each of the areas receiving syphilis elimination funds will designate one or more DIS or FLS to serve on the state RRT. Each RRT member must also be evaluated by the DSHS designated RRT Leader/Syphilis Elimination Coordinator prior to deployment. RRT members will perform program assessments and public health follow-up in areas that require a rapid response deployment based on epidemiologic data and conversations with state, local and/or regional program staff. RRT members must be able and allowed to travel to any part of the state requiring an RRT intervention within 72 hours.

## ATTACHMENT A

### **TEXAS DEPARTMENT OF STATE HEALTH SERVICES HIV/STD PREVENTION AND CARE BRANCH & HIV/STD EPIDEMIOLOGY & SURVEILLANCE BRANCH**

#### **RAPID RESPONSE PLAN**

##### **Purpose**

The purpose of the Texas Department of State Health Services, HIV/STD Prevention and Care Branch and HIV/STD Epidemiology and Surveillance Branch (hereinafter, Central Office) Rapid Response Plan (hereinafter, the Plan) is to coordinate efforts between Central Office, local health departments, public health regional offices, and community based organizations in any area of the state determined to be experiencing a sustained or substantial increase in syphilis morbidity.

Activities in the Plan include:

- Assessment,
- Enhanced surveillance,
- Targeted outreach, screening,
- Diagnostic services,
- Treatment,
- Partner notification,
- Risk reduction education, and
- Evaluation activities.

The collaborative process envisioned by the Plan will result in the development of short and long-term intervention goals that will lead to rapid containment of the spread of syphilis.

The Plan addresses a range of morbidity increases, up to and including an outbreak. Due to the decentralized nature of the Texas public health system, an outbreak must be declared by the local health authority. The Rapid Response Plan process may require no more than a few days of fact-finding and evaluation activities or it may involve the temporary assignment of personnel and resources to the affected area in a process that may unfold over many months. The Plan entails the following six basic steps, some or all of which may be taken in response to an increase in syphilis morbidity:

1. Trigger
2. Central Office Assessment/Evaluation
3. Assessment with local/regional program
4. Development of Action Plan
5. Implementation of Action Plan
6. Evaluation of Action Plan

##### **Rapid Response Process**

###### **Trigger**

The trigger that sets in motion the Rapid Response Plan is a report to the Central Office of an increase in syphilis morbidity. Ideally, the report should come from the local/regional STD



program with jurisdiction for the area. Reports may also come from Central Office or other sources.

Local and regional STD staff are expected to routinely follow the DSHS *HIV/STD Program Operating Procedures and Standards (POPS)*. The Chapter on *Surveillance* is especially important with regard to data entry of information into STD\*MIS, and routinely analyzing STD\*MIS reports so increases in morbidity are quickly apparent and the data necessary to analyze events are available. Before initiating communication with the Central Office, local and regional staff may want to meet to discuss disease trends and risk factors associated with the increased disease morbidity. When the local or regional program determines that an increase in syphilis morbidity is occurring, they should inform Central Office by telephone or electronic mail. The report can be made to any Central Office personnel, but preferably to:

- Syphilis Elimination Coordinator (SEC),
- PHFU Consultant,
- PHFU Manager,
- Senior Public Health Advisor (SPHA), or
- Assistant Senior Public Health Advisor (ASPHA).

The above noted Central Office employees will be called the Rapid Response Core Group, (herein after, Core Group).

Any Central Office employee receiving a report of an increase in syphilis morbidity must immediately pass the information to the SEC; if the SEC is not available, the information can be passed onto any Core Group member. The SEC will document each step starting with this initial communication.

Increases in syphilis morbidity may be detected as the result of the bi-weekly morbidity analysis performed by the Central Office Surveillance and Epidemiology Branch (SEB). The SEB monitors and analyzes early syphilis case reports by county, surveillance jurisdiction, and DSHS Public Health Region. Historic data serves as a baseline for comparison to current reported cases when detecting increases in morbidity. The SEB has developed thresholds that measure the variation in monthly case levels. This method enables the Central Office to monitor trends in counties with very few reported cases, as well as large metropolitan counties that report the majority of the state's morbidity. The use of diagnosis date rather than report date allows the examination of cases within a time frame that approximates time of the incidence of disease and avoids reporting artifacts. When the SEB completes the bi-weekly threshold report, the epidemiologist provides the SEC and other Core Group members with a list of jurisdictions with potential concerns.

The SEC then e-mails the jurisdictions for additional information. Often, these areas will show on several reports in a row and updates are maintained by the SEC.

If an increase of syphilis morbidity is communicated from another source (internal or external) the Core Group will be notified by the person receiving the trigger. The notification should be sent via e-mail to the Syphilis Elimination Coordinator, with a copy to the other Core Group members.

### **Central Office Assessment**

Central Office assessment begins with the SEC meeting with the PHFU Consultant (PHFUC) responsible for the jurisdiction in question. The SEC and/or the PHFUC will call the program for additional information, if necessary, within three days. The SEC will act as official record keeper of any Core Group meetings, maintaining notes of meetings and any documents

pertaining to investigations undertaken by members of the Core Group, subsequent actions, and outcomes.

The Epidemiologist and the STD\*MIS Data Manager should provide all pertinent data from the area experiencing an increase in morbidity to the Core Group members. The Core Group will analyze and discuss the data to determine if the apparent increase in morbidity can be accounted for by reporting artifacts, anomalies, or delays in receipt or entry of data. If the SEC and the Core Group finds no unusual increase in morbidity, the SEC will inform the initiator of the Trigger of the Core Group's findings. If none of those apply, further investigation and response may be justified. If the Core Group finds that further investigation is necessary, the SEC will develop an outline of the additional information needed, particularly from the local program. The SEC will transmit the request for information to the program and arrange for a conference call between the SEC, the STD Program Manager, and appropriate staff from the affected area. The SEC should arrange the conference call as expeditiously as possible (no longer than three days after the request was sent to the area). Below are examples of information the local program may be asked to provide:

- Whether the local program has activated their local Rapid Response Plan
- Identification of the community where morbidity is clustered
- Analysis of data for the previous 12-month period (e.g. cases, rates, morbidity increases and/or decreases)
- Summary of any case management activities relating to the affected community
- Development of a proposed hypothesis for the increased morbidity
- Assessment of risk factors (e.g. drug usage, hangouts, place of work, prostitution, age, race, sex) [See Attachment C, Rapid Response Case Data Form]
- Disease stage and unusual manifestations
- Actions already taken by the program to address the increase
- Summary of the health care providers identifying the cases
- Level and nature of involvement of health care providers
- Assessment of STD Clinic access
- Enhanced surveillance actions
- Outreach/screening activities conducted and/or planned
- Jail screening procedures evaluated/enhanced
- Local/regional program needs

### **Assessment with the Local/Regional Program**

During the conference call, the information provided by the local/regional program will be discussed. If a substantial, significant increase in morbidity is found, methods of containment will be discussed, including the allocation of resources by the Central Office or other entities of additional materials and personnel resources. The STD Program Manager or other designated individual from the affected area will be asked to provide the SEC with a narrative detailing the nature of the problem, a proposed action plan for addressing it, and a request for additional resources (if needed). Once a significant increase in morbidity is identified, the SEC will send an email to appropriate personnel within the Central Office informing them of the situation.

### **Development of Action Plan**

Once the SEC has received the local program's narrative of the increase in morbidity, the SEC and the local program will negotiate an action plan to address the increased syphilis morbidity.

Frequently, the local program may need additional resources to address the problem on a temporary or ongoing basis. The SEC will use the Rapid Response Team Procedure (Attachment D) to deploy staff to the affected area. The following is a partial list of resources the Central Office may assist in providing to the affected area:

- Data entry staff
- Surveillance staff
- Phlebotomists
- Disease Intervention Specialists
- First Line Supervisors
- Program Managers
- Clinicians
- Health Promotion Specialists
- Media/Social Marketing Specialists
- Supplies/medications
- Training
- Equipment

### **Implementation of Action Plan**

The STD Program Manager of the locality where the increase in cases is occurring (or his/her designee) will be responsible for implementing the negotiated action plan in coordination with the SEC and the PHFUC assigned to the local program. During this time, ongoing communication will be maintained between the local program and Central Office. The local STD Program will submit a written progress report regarding implementation of the action plan to the SEC with a copy to the PHFUC within two weeks from the negotiated action plan being implemented. The SEC will, in turn, keep the Core Group informed on progress in implementing the action plan. The Central Office will be responsible for coordinating the identification of additional resources needed to implement the action plan and will keep the local STD program informed. The local STD Program Manager should also advise the Central Office immediately when new needs arise not addressed in the action plan.

### **Process Evaluation and Performance Indicators**

Process evaluation and performance indicators for the RRT intervention are as follows:

1. Summary of cases including: total number of cases, demographics, geographic distribution, and risk factors
2. Summary of control measures implemented
3. Analysis of what worked, what didn't, and why
4. Analysis of what actions could have prevented the increase and a plan to implement and routinize those actions into sustainable systems
5. Plan for increased monitoring of cases in the affected community
6. Consideration of additional permanent resources needed to maintain syphilis elimination efforts

### **Expected Outcomes**

Expected outcomes of the RRT intervention include:

1. Short term: increased case identification through intensive public health follow-up by local staff and RRT members
2. Medium-term: reduction of incidence of new cases due to successful intensive public health follow-up by local staff and RRT members

3. Long term: reduced incidence of new syphilis cases
4. Long term: more successful local disease intervention from institutionalizing processes, strategies, and best practices shared by RRT staff (all must be in agreement with the DSHS *HIV/STD Program Operating Procedures and Standards*)
5. Collateral benefit: increased public awareness and earlier discovery of previously undiagnosed HIV and other STD cases

### **Data Analysis and Adjustments**

Each time the RRT is deployed, a designated RRT member will submit final reports on RRT activities to the SEC. These reports will contain the process and performance evaluation indicators shown above. Within 30 days of the conclusion of the RRT deployment, the local program manager of the area receiving the RRT intervention will submit a report to the SEC. This report will include an analysis of the entire event, from a specific event before, to designated point after, RRT deployment. The reports will be reviewed by the SEC and key DSHS central office staff. A report with key findings will then be developed by the SEC and forwarded to the local program receiving the RRT intervention. Adjustments to approaches will be made based on the conclusions drawn from these reports. At the end of the first year of the intervention, the SEC will provide a report to the HIV/STD Prevention and Care Branch Manager and the Senior Public Health Advisor, detailing recommended changes for the intervention or reallocation of resources to other SE activities.

### **Evaluation of Action Plan**

Evaluation of the action plan should be continuous throughout the process; however, the local program will submit a written evaluation of each component of the action plan with details regarding new activities periodically as negotiated with Central Office to the SEC with a copy to PHFUC. The SEC will make the written report available to other members of the Core Group. The Core Group will meet to discuss progress on the action plan, changes to the action plan will be proposed as needs are identified. The process will continue until the increase in syphilis morbidity is contained.

The Program will submit a report within 90 days of the implementation of the action plan. This report should address the following information:

- Summary of cases including: number of cases, demographics, geographic distribution, and risk factors
- Summary of control measures implemented
- Analysis of what worked and what didn't
- Analysis of what actions could have prevented the increase
- Plan to monitor cases in the affected community
- Analysis of the cost of the response including, but not limited to: description of Temporary Duty (TDY) staff, amount of financial obligations for screenings, vendor doctors, and medications
- Additional permanent resources needed to maintain syphilis elimination efforts

The Central Office may request additional reports if the increase in syphilis cases continues beyond the first 90 days. The SEC will negotiate with the STD Program Manager of the affected jurisdiction regarding the receipt and interval of written reports.

**ATTACHMENT B  
TEXAS DEPARTMENT OF STATE HEALTH SERVICES  
SYPHILIS THRESHOLD PROJECT**

The Syphilis Threshold Project involved the creation of a Microsoft Excel based tool for monitoring monthly levels of Primary & Secondary (P&S) and early syphilis in Texas. This was not designed to replace the setting of thresholds at the local level, nor local monitoring mechanisms. It may, however, provide a model for areas that have not yet set thresholds as part of their syphilis rapid response plan.

**Principles of the Model**

- Keep it simple – The current model monitors monthly reported syphilis cases down to the county level. Currently, the model does not allow a program to further dissect reported syphilis cases (i.e. racial/ethnic or risk factors). Monthly breakdowns are based on date of diagnosis rather than report date to minimize distortions that may be caused by reporting delays.
- This model monitors both P&S syphilis and early syphilis (ES) which consists of P&S cases combined with early latent (EL) cases. The model monitors ES to reduce the possible effects of initial and re-classification of EL cases.
- Warning level thresholds are set at one standard deviation above the mean number of monthly cases reported in the previous 36 months. Rapid Response levels are set at two standard deviations above the mean.
- The Threshold Summary Pages displays thresholds and identifies areas that have exceeded thresholds for the most recent four months. This four month window is needed to monitor syphilis because of reporting delays and the fact that some aspects of a syphilis case report, such as stage of the disease, often change and are updated after the initial case report is entered into STD\*MIS. Therefore, the final number of cases reported in a month may not be known until two or three months later; the local program should continue to monitor thresholds for at least the most recent four month period.
- This model cannot operate without a human filter. If a county or region exceeds a Warning or Rapid Response threshold, it is a signal that there may be a problem and further investigation and communication with local public health officials may be warranted.

**Data Flow**

- Syphilis surveillance data from STD\*MIS is exported every two weeks. The file contains all Texas P&S and EL syphilis cases reported in the past three years.
- The data is transferred into SPSS to be cleaned and formatted. Crosstabs are created of P&S and ES cases by county, Public Health Region and STD Surveillance Region.
- The SPSS crosstabs are pasted into Excel and a macro is used to further format and sort the data. Calculations for the threshold summary pages are updated each time new data is brought into the Excel workbook.

**Threshold Summary Pages**

- There are four threshold summary pages: P&S by County; ES by County; P&S and ES by Public Health Region; P&S and ES by STD Surveillance Region.
- Each summary page has the same format:
  - The first column on the left lists the name of the county or region .

- The next four columns list the calculations that the thresholds are based on: the mean number of monthly cases for the area over the last 36 months; the standard deviation for cases in the area over the same 36 months; the Warning level for the area (the mean plus one standard deviation); and the Rapid Response level for the area (the mean plus two standard deviations).
- The following four columns show the most recent four month's worth of data for the area.
- The last four columns display a message if the area has exceeded its Warning or Rapid Response level in any of the last four months. Also, a message of "Single" will appear in these columns in situations where a very low morbidity area has a single reported case of P&S or ES that has put it above the Warning or Rapid Response threshold.

### **Additional Features**

- The Threshold Monitoring file also includes the following:
  - Tables that list year-to-date reports by county for P&S and early latent syphilis to look at reporting flow and cases added in the two weeks since the file was last updated.
  - A number of graphs that update automatically and display trends in monthly syphilis diagnosis totals for Texas and selected high morbidity counties.

### **Follow Up**

- After the Syphilis Threshold Monitoring Tool is updated every two weeks, an e-mail summarizing counties or regions that have crossed thresholds and might be areas of concern is generated by an STD epidemiologist. This e-mail is forwarded to the Syphilis Elimination Coordinator and the Public Health Follow-Up Consultants for follow-up with surveillance sites.
- The SEC will call the Program Manager of the affected area to discuss trends, risk factors, and any action taken to control the increase in syphilis.

ATTACHMENT C  
**TEXAS DEPARTMENT OF STATE HEALTH SERVICES**  
**RAPID RESPONSE CASE DATA FORM**

Case #	DateTest	DateRx	DX	Titer	TypeSx	Sex/Preg?	Age/Race	Risks	900/901 Status	#Cts	#Clx	#infected	Comments

**ATTACHMENT D  
TEXAS DEPARTMENT OF STATE HEALTH SERVICES  
RESPONSE TEAM (RRT) PROCEDURE**

**Goal and Objective**

Expediently interrupt transmission when syphilis cases surpass locally determined thresholds, a significant increase is identified, and/or an outbreak is declared.

**Staff at all Levels may be provided as needs are identified, including:**

- FLS
- DIS
- Clerical
- Clinical
- Surveillance
- Epidemiologist
- Program Management

**Responsibilities of RRT Members may include:**

- Conduct intensive interviewing, field investigation and case management
- Coordinate with host area to ensure there is an increase in screening and outreach in high risk venues
- Coordinate with host area to guarantee adequate clinical resources are available
- Coordinate with host area to assure education of clients and community
- Coordinate with host area to alert health care providers of the increase

**Steps in Rapid Response Process**

Assessment

The SEC will arrange to deploy the RRT Leader/Member to conduct an assessment to determine the extent of the syphilis increase and the capacity of the local program to respond to the situation. Prior to the deployment, the SEC will forward basic morbidity summary reports (age, race and sex of early cases, morbidity amounts to show increase, case detections and provider information) to the RRT Leader/Member. Within 2 days following the assessment, a report will be sent to the SEC, PHFUC, SPHA, and ASPHA. The report will contain recommendations including the type of assistance needed by the local program to rapidly and completely respond to the increase in syphilis. This report will be discussed/approved and then forwarded to the Host Area within 2 days of its approval.

Rapid Response Assignment

Prior to the deployment of any RRT member, specific objectives must be developed outlining what will be accomplished during the temporary duty assignment (TDY). These objectives will be developed with input from the local program, the RRT Leader/Member, and the SEC. Deployment of RRT members will occur within 7 days of identifying the need for assistance. Prior to the arrival of the RRT member, basic morbidity data and a list of resources that will be needed during the TDY will be sent to the local program (see Responsibilities of the Host Area document below). Within 2 days of the completion of the TDY, RRT members will send a written report to the SEC, PHFUC, SPHA, and ASPHA outlining the progress toward the objectives, summary of all field and interview activities completed, and short/long term



recommendations for responding to the syphilis increase. This report will be discussed/approved and then forwarded to the Host Area within 2 days.

#### Host Area Response to RRT Report

The Host Area will develop an action plan and timeline for implementing the short and long term recommendations within two weeks. This action plan will be developed in consultation with the SEC, PHFU Consultant, and the Region.

#### Follow-Up

**The SEC will be responsible for ensuring a follow-up review of the action plan occurs at least 6 months of an assessment that addresses short- and long-term recommendations. This follow-up review may be conducted in person by the SEC, PHFUC, Regional HIV/STD Program Manager, or RRT Team Leader.**

#### **Rapid Response Standards**

These standards have been developed to ensure consistency among rapid response team (RRT) members and to provide the best quality performance during deployment.

1. RRT members will display a sense of urgency related to syphilis and HIV activities to all local program staff.
2. RRT members will refer to and use the DSHS *HIV/STD Program Operating Procedures and Standards (POPS)*
3. RRT members will demonstrate proper documentation according to DSHS guidelines (date, time, activity, and result) on field records, interview records, FLS audit forms, etc. immediately following all activities.
4. RRT members will demonstrate the appropriate steps of the interview process including: pre-interview analysis, clustering for suspects and associates (including pregnant females), conducting a re-interview with clearly defined objectives within 72 hours, conducting cluster interviews with clearly defined objectives with non-infected partners, suspects, and associates, and participating in field tours (when appropriate) as per the *POPS*.
5. RRT members will demonstrate the ability to prioritize field records to ensure those at highest risk (i.e., exposed to lesions, have suspicious symptoms, or are pregnant) are contacted or interviewed first as per the *POPS*.
6. RRT members will demonstrate ways to turn marginal partners, suspects, and associates and adverse dispositions (H, J, G, & L) into located/examined partners, suspects, and associates.
7. RRT member will demonstrate ways to redirect unproductive interviews.
8. RRT members will use standard case management forms according to DSHS guidelines.
9. RRT members will demonstrate the use of VCA to create flow charts of case relationships.

10. RRT team members will demonstrate the importance of drawing blood on all partners, suspects and associates during first encounter unless the client will be examined on the same day.
11. RRT members will make phone calls, conduct field visits, participate in screenings, and perform other assignments outside normal business hours during temporary duty assignments.
11. Co-facilitate and participate in entry, exit and periodic debriefing sessions.

### **cResponsibilities of the Host Area**

Host areas will be expected to commit to the following when RRT assessment and/or assistance is provided:

1. Participate in an assessment to determine if deployment of the RRT is appropriate to meet the need and, if so, the type and number of personnel to be deployed.
2. Prior to assessment/assistance, gather and prepare a list of needs for the RRT including open field and interview record lists, recently closed interview and field records for review, all adversely dispositioned field records, and a list of recent high titers.
3. Assure proper authorization is granted for RRT members to perform field phlebotomy.
4. Provide logistical necessities for the team including: office space, telephones, access and orientation to locating resources (such as maps, cross directories, resource directories, and internet access) and appropriate ID, where required.
5. Coordinate and conduct all local news media activities and act as the lead on all requests from media.
6. Assure appropriate local officials are informed and updated on RRT activities.
7. Facilitate the use of local STD staff in all aspects of the response effort, including activities that occur outside the scope of a “normal work day” (weekends, evenings) when appropriate. Where this is not immediately possible, the local program area agrees to pursue the necessary approval.
8. Provide clerical support.
9. Co-facilitate and participate in entry, exit and periodic debriefing sessions.
10. Facilitate the identification and utilization of community resources, including appropriate gatekeepers and CBOs to target and garner the support of the at-risk community for intervention efforts.
11. Facilitate availability of appropriate medical and laboratory services, including making such services available beyond the scope of “normal work day” (weekends, evenings).

12. Participate in a post-deployment assessment and respond to recommendations put forward. Pursue a positive response to all capacity building recommendations.