


Building Relationships With Your Policymakers

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NCSD 2009 Annual Meeting

- ◆ What was the goal of the policy initiative?
 - ◆ 10 year period of focus
 - ◆ Why?
 - ◆ How we worked with our policymakers:
 - ◆ internal and external
 - ◆ proponents and opposition
 - ◆ Was it worth it?
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- A decorative graphic at the bottom right of the slide, consisting of a silhouette of a mountain range in various shades of teal and blue, extending from the right edge towards the center.

The Goal: New Law, New Code



- ◆ Re-write the Florida Statute section on *blood testing* of pregnant women
 - *broaden testing other than blood*
 - *require that practitioner inform the woman of the testing that would take place*
 - **And**, *retain authority of department to specify conditions.*

The Why: The Historical Framework

- ◆ 1,000s of old landmark publications on STIs in pregnancy,
 - Pathogen specific, treatment efficacy, specific assays

however

- Cohort often from clinic setting or multiple clinic environments, not population based
- Scope of new data limited by access to medical records and extent of funding resources

Acknowledge:

- ◆ new standards of care
- ◆ better understanding of disease processes
- ◆ recognition of what was missing from our *evidence base*

Sought to:

- ◆ *To create an environment that would support program operations and reduce disease transmission*
- ◆ *Build foundation for programmatic structural response*
- ◆ *Drive improvement in reporting timeframes and quality of data*
- ◆ *Reframe the historical knowledge (and biases) with recent evidence with information associated with new technology, our capacity to control more variables and standards = the assurance aspect of public health practice*

The How

*Five principles: listen, humility, honesty, consistency and reciprocity
iterative process*

- 1- review of national laws and administrative codes/ regulations for model language
- 2- met with internal policy stakeholders from Prenatal, HIV, Epidemiology, Legislative Planning
- 3- honed the principles and rationale to seek the change at this time
- 4- sought the common ground on statutory language
- 5- framed the “common” messages
- 6- boulders we might encounter

The How, continued

Five principles: listen, humility, honesty, consistency and reciprocity
iterative process

- 7- gathered list of external stakeholders
- 8- identified who would initially reach out to external stakeholders
- 9- created DLs for future email and phone updates
- 10- sought support of key legislators; a shared responsibility to communicate, educate etc
- 11- And again and again.....



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Florida Administrative Code 64D-3

◆ Revised the relevant sections

- *clarified requirements in 1st & 3rd trimesters, postpartum*
- *made routine CT, GC, Hep B, HIV, syphilis*
- *notify the woman of the testing that would take place, and her rights*
- *direct ED refer women not yet in care after the 12th week to county health departments*
- *required documentation on birth, fetal death certificates of infection and treatment events*

The How, continued

Five principles: listen, humility, honesty, consistency and reciprocity
iterative process

Internal Challenges

- ◆ Penalties
- ◆ Turf for the lead
- ◆ Rules for “closure”
- ◆ Quarantine for Pan Flu

External Challenges

- ◆ Child abuse reporting
- ◆ Obstructive individuals
- ◆ “Unfunded mandates”
 - Florida Hospital Association; ED physicians
 - Sought other stakeholder support
- ◆ Language clarification

Was it worth it?

- ◆ Contributed to enhanced structure now in place for better evaluation of:
 - our STD programmatic practices
 - our “assurance” of practice in community, e.g., levels of screening by practice category, community
 - improved disease intervention
 - real time STD related data in pregnancy vs medical record extraction and special studies
 - we are producing “evidence”
 - positioned to assist in use of various data streams of interest to internal partners

So where are we in 2009?

Made progress on our *Evolutionary Trajectory*.....

and have the either the advantage or opportunity to:

- Broaden(ed) population-based surveillance analyses
- Automate(d) new linked data sets from diverse source applications
- Expand(ed) capacity to control variable bias
- Update(d) knowledge and document “evidence”
- Revise(d) standards of care and drive policy
- Identify economic advantage to process improvement
- Reduce STD associated stigma – *maybe someday...*

- *And if we are very lucky....improve perinatal health outcomes....the critical impetus for a change in our posture*

Dog that caught up with the truck....

- ◆ Had to simultaneously build epi-analytical capacity
- ◆ Huge amount of data
- ◆ Many requests now from all the stakeholders who helped....
- ◆ Previously we also had to build capacity in Field Operations (DIS training, performance measures etc etc etc



Pre Modernization

- ❖ During 2005, **1.3%** of all infants born in FI were delivered to women who had an STD reported during pregnancy or at delivery
- ❖ 3,500 case reports in pregnancy

◆ Post Modernization

- During 2007, **5.5%** of all infants born in FI were delivered to women who had an STD reported during pregnancy or at delivery
- 13,114 case reports in pregnancy
- ◆ Broader range of infections
 - From one to six
 - Case definitions established
- ◆ Scope of condition details expanded
 - Partner treatment status
 - Baby's status at end of pregnancy
 - Prenatal care components

Observations of Interest

(wrap up of the 2008 data)

- Timing of identification of infections during the pregnancy/postpartum period
- Distribution in the adolescent pregnant and young adult
- Appropriateness of treatment, and timing of treatment
- Ethnicity/race distribution
- Treatment status of primary partners
- Birth status of babies
- DIS performance measures for interviews, etc
- Cost of associated field operations
- Analyses of provider performance
- Analyses of laboratory performance

Credits

An army of Florida folks

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