DIS Combat Congenital Syphilis

April 22, 2020
This webinar is being recorded. The recording and presentation slides will be emailed to those that registered. These materials will also be placed on the NCSD website.
Objectives

This webinar aims to highlight:

- DIS messaging to encourage prenatal care and syphilis testing
- Local partnerships for engaging with pregnant women and addressing congenital syphilis
- Lessons learned and best practices around congenital syphilis follow-up and DIS engagement with pregnant women
Agenda

1. Brandi Roberts – Arkansas Department of Health

2. Lorena Gjino – Massachusetts Department of Public Health

3. Q&A – submit your question via the chat box
Arkansas Department of Health

Brandi Roberts, MPH, CHES
STD Prevention Program Manager
USING DIS TO ADDRESS CONGENITAL SYPHILIS IN ARKANSAS

BRANDI ROBERTS, MPH, CHES
ARKANSAS DEPARTMENT OF HEALTH
STD PREVENTION PROGRAM MANAGER
OBJECTIVES

OVERVIEW OF CONGENITAL SYPHILIS IN ARKANSAS

DIS ROLE IN CONGENITAL SYPHILIS FOLLOW-UP PROCESS

SUCCESSES AND NEXT STEPS FOR CS
- Mostly rural, low population density.
- Medicaid expansion in 2013.
- In 2018, 20.4% of infants were born to a woman receiving inadequate prenatal care.
- Arkansas ranked #6 for rate of reported CS cases in 2018.
EARLY SYPHILIS – RATE OF REPORTED CASES PER 100,000 POPULATION BY COUNTY, ARKANSAS, 2018

Source: Arkansas STI Surveillance Report, 2018
CONGENITAL SYPHILIS – RATES OF REPORTED CASES BY STATE AND TERRITORY, U.S., 2018

Source: CDC Surveillance Report. *Case Rate per 1000,000
CONGENITAL SYPHILIS – REPORTED CASES BY YEAR ARKANSAS, 2015-2018

Source: Arkansas STI Surveillance Report, 2018
CONGENITAL SYphilis - Rate per 100,000 Live Births
Arkansas and United States, 2018

Source: Arkansas STI Surveillance Report, 2018
STD PREVENTION PROGRAM

Program Structure

The DIS are housed within the STD prevention program to provide partner services for STD/HIV and linkage to care services.

- STD Field Operations Manager
- 5 Regional DIS Supervisors
- 20 DIS
CHALLENGES

➢ Competing program priorities
➢ Delayed reporting
➢ Duplication of efforts
➢ Training on surveillance systems
➢ Utilization of perinatal coordinator in dual role as CS coordinator.
…OUR SOLUTION!

DIS

Congenital Syphilis DIS
TRANSITION FROM DIS TO CS DIS

DIS
- Partner Services – HIV/STD
- Referral and LTC
- Congenital Syphilis
  - Obtain pregnancy status.
  - Interviews pregnant mom and partners.
  - Surveillance staging.
  - Initiates maternal records in PRISM.
  - Referrals to prenatal care.

CS DIS
- Completion of CS Reporting Form.
- Follow – up on pregnant women with previous and current syphilis infection.
- Pregnancy status ascertainment.
- Primary contact person for medical providers.
- Partnership with DIS to obtain required maternal information or additional follow-up for pregnant women.
CS DIS FOLLOW – UP PROCESS
Pregnant Mother

Surveillance
- Initiate positive syphilis test (mother).
- Time Frame - 24-48 hours

DIS Supervisor
- FR is assigned to DIS Supervisor.
- DIS Supervisor assigns FR to DIS.
- Time Frame - 24 hours

DIS/CS DIS
- Verify pregnancy status
- Partner Services
- Completes maternal record for all pregnant women with positive serology.
- Notify CDNS and CS DIS to provide information from maternal record to initiate STD 36,12
- Time Frame - Notification to CDNS - 24-48 hours
- Time Frame - DIS completion FR - 7 working days

DIS Supervisor
- Review FR /IR.
- Task Complete to Surveillance.
- Assign maternal record to CS DIS

Surveillance
- Receives completed FR/IR.
- Close maternal record once complete by CS DIS.
**Child**

**Surveillance**
- Initiate positive syphilis test.³
- Notify CS DIS & CDNS of reported baby
- CS DIS - Links baby to mother.
- If mother is unknown, note in PRISM.
- Time Frame - 24 - 48 hours

**DIS Supervisor**
- FR is assigned to DIS Supervisor.
- DIS Supervisor assign congenital record to CS DIS.
- Time Frame - 24 hours

**CS DIS**
- CS DIS to input treatment information to close and disposition baby FR.
- Complete congenital records
- Program nurse to approve all congenital and maternal records.
- Time Frame - DIS notification to CDNS - 24 hours
- Time Frame - CDNS completion of STD- 36 - 72 hours
- Time Frame - DIS to input (CDC - 36) congenital record into PRISM - 24 hours.

**DIS Supervisor**
- Review FR/IR record.
- Review maternal and congenital record.
- Disposition and close FR.
- Task Complete to Surveillance.

**Surveillance**
- Receives completed FR/IR.
- Perinatal Coordinator to QA/QC all completed maternal and congenital forms and assigns CDC case ID and enters on PRISM record.
PARTNERSHIPS

Hospitals

OB/GYNs

Maternal and Child Health Program

FQHC

Pregnancy Crisis Centers

Congenital Syphilis Review Board
**SUCCESSES**

- **STREAMLINED CS WORKFLOW**
- **IMPROVED COMMUNICATION WITH PROVIDERS**
- **MORE TIMELY REPORTING OF CS CASES TO CDC**
- **IMPROVED ACCURACY OF INFORMATION**
NEXT STEPS

- Congenital Syphilis Awareness Campaign
- Congenital Syphilis Symposium – Provider Education
- Electronic Reporting – CS Reporting Form
- Improved CS Process
Addressing Congenital Syphilis in Massachusetts

Lorena Gjino
Field Epidemiologist
Massachusetts Department of Public Health
MADPH STD Prevention Division

- 18 Field Epidemiologists (FE) formerly known as DIS
- 4 Field Operations Managers
- 1 Public Health nurse Lila Coverstone, RN
- 1 Medical Director Kathy Hsu, MD, MPH
Landscape of Congenital Syphilis in MA in 2019

• 7 presumptive congenital cases

• 3 syphilitic still births
  • 2 born to infectious staged mothers, both early latent
  • 1 born to late latent

• The main contributing factors were late entry into prenatal care. These included late entry into the US and comorbidity with substance use disorder.
Ensuring adequate follow-up of individuals biologically capable of pregnancy

- All reproductive age individuals biologically capable of pregnancy (age 14 to 49) receive follow-up when MDPH receives positive syphilis serologic test results to obtain current pregnancy status (in addition to other routine field follow-up).
  - Field initiated cases
  - Provider calls through the reactor desk for non-field assigned cases
    - If no pregnancy test we ask about birth control and menstrual cycle, last period
  - Field initiated cases require FE follow-up with an emphasis on documentation of medication, dose and dates of treatment well as interviewing and partner elicitation.
Ensuring adequate syphilis treatment of pregnant women

- Pregnant women are identified as pregnant through the reactor desk, investigation of sexual partners or by case report form submission.
- Case prioritization – high priority
- Clinical information from provider must be thorough
  - Stage and symptoms of syphilis, HIV status, number of weeks pregnant when positive syphilis serology is determined, treatment and treatment dates (documented weekly if multiple doses are prescribed), expected date of delivery and partner testing and treatment information.
- Notify public health nurse of case
- We encourage interviews to be done in clinic at the time of treatment (buy in with the patient)
- Encourage patients to bring partner at the next appointment
- Importance of transportation. Great opportunity for patients to be introduced to the STD clinics and get tested as often as they want and a means to connect to care
- Bicillin Distribution Program
MA Public Health Nurse Follow-up

• PNH is a resource for field staff and clinicians if questions or problems are incurred during the investigation process. Provide clinical guidance as requested

• For routine cases the PHN engages with prenatal care providers to support the treatment and follow-up testing of the pregnant case
  • This follow-up includes ensuring the timely treatment with Bicillin and 3rd trimester screening

• Additionally the PHN obtains information on the planned delivery hospital and send a informational letter to the labor and delivery ward to prepare them for the required testing, monitoring, and reporting of a possible congenital cases.
  • This letter includes instructions for clinician to notify PHN by cell phone at time of delivery
Following up on CS cases

• All infants reported to MDPH are reviewed and follow-up on by our PHN
• Many of these cases are expected/known to our PHN prior to reporting, as they have already received follow-up through the maternal follow-up process (pregnant case).
• For cases that are not known to the PHN prior to delivery, priority follow-up is initiated as soon as possible after the report is received. Many providers are aware of the public health nurse and reach out to her prior to MDPH receiving reports of lab results for the infant.
• Nurse will provide letter to hospital with guidelines on testing and treatment for mom and baby
• Post delivery PHN works with the delivery hospital and pediatricians to ensure complete maternal and infant evaluations at time of birth and monitoring testing of the infant by the pediatrician as needed. Usually 3-6 month check in with pediatrician
Following up on CS cases cont...

• In case of syphilitic still birth the PHN communicates with the delivery hospital and medical examiners office to obtain all necessary testing/evaluation/reports for complete documentation.

• PHN is responsible for complete documentation of all required maternal and infant variables for CDC reporting.
Encouraging prenatal care and STD testing (to pregnant women and OB/GYNs)

- Encourage STI screening at initial prenatal visit
- Create rapport with providers
- Education for providers
- Test and test often
- Partner Services pamphlets for providers in waiting area
- FE and PHN presentations
- Creating rapport with patient
- Patient education through the interviewing. Addressing their needs to get tested
Local partnerships to engage with pregnant women and address CS

- FEs are located in different regions of the state and have created partnerships with the providers in those areas of the state.
- We have the ability to offer direct provider support for clinical issues around uncertainly of congenital syphilis and other STDs. Providers calls come into the BIDLS and are given direct access to PHN for their concerns or questions.
- We have also initiated technical assistance protocols when providers use treatments that are not standard or do not offer treatment to contacts as recommended in the guidelines. PHN will assess the situation and offer guidance.
- Requires time to build partnerships
Challenges

• Lack of prenatal care. Opportunity for intervention
  • Homelessness
  • Opioid use
  • Health Disparities
  • Undocumented status
  • No communication, lack of phone
  • Language barriers
  • Transportation
  • Mental Health Issues
  • Domestic Violence

• Insurance issues not being able to receive preferred treatment and not having access
The secret sauce ingredients

- Electronic Laboratory Reporting (ELR) access
- 100% assentation of women in childbearing ages
- Exchange of information with providers. Ability to provide historical data such as past labs and treatment records.

- Clinician to clinician relationships
  - Public health nurse with experience in clinical care
  - Sylvie Ratelle PTC Training Center. Kathy Hsu MD creating trainings for local providers to inform and make them aware of recent updates on CS cases with direct access to providers

- FE creating better relationships with CHC and private providers
  - Prioritization of all pregnant untreated STIs
  - Quick response and intervention
  - Bicillin Distribution Program
Submit your question in the chat box!

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• If you are a DIS and want to connect with peers around the country and share tips and resources, you can join NCSD’s DIS Slack workspace at the link below. It is also in the chat box.  [http://bit.ly/ncsd-dis](http://bit.ly/ncsd-dis)

• Please complete the webinar evaluation once the webinar ends.

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