INNOVATIONS IN SYPHILIS POLICY PLAYBOOK: STRATEGIES FROM THE STI SECTOR

National Coalition of STD Directors

ABOUT THIS PLAYBOOK

When people hear the term "playbook," they often think of sports—a detailed guide to a team's strategies, plays, and procedures. Similarly, this playbook serves as a strategic guide, but it's designed for the unique needs of the STI sector and grounded in public health best practices. It presents six distinct syphilis prevention strategies, each of which can be reviewed on its own and adapted for use across the nation.

In short, this playbook is an opportunity for public health partners to pull from relevant themes in syphilis prevention strategies that fit within their landscape and align with operational and structural needs. It is meant for readers to select the parts that are most important or applicable for them.

Each policy innovation includes:
1) Region and health department type, as defined by the U.S. Census Bureau[1] and the Association of State and Territorial Health Officials[2];
2) Background information that summarizes development;
3) Key implementation steps integral to its progress; and
4) Lessons learned and considerations.

ABOUT NCSD

Located in the nation's capital, the National Coalition of STD Directors (NCSD) is a national public health membership organization representing health department STD directors, their support staff, and community-based partners across 50 states, seven large cities, and five US territories.

Our mission is to advance equitable, effective STI prevention programs and services in all communities across the country. We do this as the voice of our membership.

Our vision is a nation where all people can lead sexually healthy lives.

[1]"Geographic Divisions and Regions." https://www.cdc.gov/nchs/hus/sources-definitions/geographic-region.htm. Accessed, September 2025.

[2]"State and Local Health Department Governance Classification System. https://www.astho.org/globalassets/pdf/state-local-governance-classification-tree.pdf. Accessed, September 2025.

NCSD would like to thank its numerous partners in the STI sector who agreed to be interviewed for the development of this policy aid, which include: Amelia Aibina Mazzei, Brett Dechambre, Anathea Edleman, Lawrencia Gougisha, Elsa Huber, Jessica Leston, Elizabeth Lindsay, Rachel Malloy, Dr. Jorge R. Mera, Lacy Mulleavey, Rob Nutt, Brigg Reilley, Rebecca Scranton, Kacie Taylor, and Natifa Walters.

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National Coalition of STD Directors

PART 1: TESTING IN CORRECTIONAL FACILITIES

COLORADO

OPT-OUT SYPHILIS TESTING IN JAILS THROUGH STATE AND LOCAL HEALTH DEPARTMENT PARTNERSHIPS

REGION
- Mountain West

KEY PARTNERS
- Local county jails
- 340B

HEALTH DEPARTMENT TYPE
- Decentralized

Background

In 2021, the Colorado Department of Public Health and Environment (CDPHE) partnered with the Pueblo Department of Public Health and Environment (PDPHE), a health agency in a county with disproportionate syphilis burden. Together, they applied for the Catalyzing Congenital Syphilis Prevention project under the Center for Disease Control and Prevention's (CDC) Epidemiology and Laboratory Capacity (ELC) grant. CDPHE and PDHPE used the funding to pilot an opt-out syphilis testing program in partnership with the Pueblo County Jail and Detention Center, addressing the high number of missed syphilis cases among previously incarcerated women.

Through partnership-building, screening integration, and word-of-mouth tactics that generated buy-in and trust, the program was successfully launched.

In its initial year (2021-2022), PDPHE screened 634 patients, of whom 175 tested positive for syphilis (27.6% positivity rate).[3] Following this pilot phase, CDPHE worked with several counties across the state to replicate and expand opt-out testing in jails.

[3]"Syphilis Testing in Detention Centers: A Partnership Success Story in Colorado." https://ncsddc.org/wp-content/uploads/2025/02/Colorado-Success-Story-Policy-2.pdf. Accessed, April 2025.

Key Implementation Steps

1. CDPHE was awarded state funds earmarked for syphilis prevention and leveraged the supplemental money to partner with six additional counties for replication.

2. When replicating and expanding the opt-out syphilis testing protocol, it was important to recognize there was no one-size-fits-all approach between each local health department, the detention centers, and their co-managed dynamic.

3. The medical unit in El Paso County (the first site to replicate) used a separate waiting room and had three people tested at once after intake during designated times. This proved to be more efficient and effective than intake testing.

4. In response, the originating county (Pueblo) implemented a quality improvement (QI) plan that decreased their refusal rate from 40 to 0 by removing testing from the intake process—a time when people recently arrested on drug charges may be experiencing the effects of substances and experience challenges with consenting to tests. In fact, all counties involved in the implementation process have since developed robust QI plans that have enabled them to assess why individuals may refuse testing to improve testing workflows.

Individuals involved in the project are working on a toolkit that will showcase protocol examples, quality improvement plans, as well as other resources, for local, county, and state health departments considering opt-out testing models in detention centers.

Lessons Learned & Considerations

> "You wouldn't think floor plans affect public health, but they do," noted Elsa Huber, Southern Regional Disease Intervention Specialist in Colorado Springs. "In Pueblo County, we would go into the wards individually for testing and were able to give correctional officers a list of who met demographics to be tested and say things like 'medical is here to see you.' But in El Paso County, we do not go into the wards; they come to a medical unit instead," she explained. This latter strategy proved to be more effective.

GENERATE BUY-IN FROM THE DETENTION CENTER STAFF AND SHERIFF.
The sheriff secures the contract and brings medical vendors on board and is a key gatekeeper to engage with and cultivate a supportive dynamic. It's imperative to educate the sheriff on the cost-savings a testing program affords and how it interrupts community transmission.

REMEMBER COVID-19'S IMPACT.
Many detention center staff noted that the COVID-19 pandemic defined their experience with local health departments and left an indelible impression. Therefore, it is important to understand a detention center's history and how their past experiences can inform discussions and guide strategies. For example, knowing how a facility responded to required policies during COVID-19 can help health departments refine their messaging.

CREATE OPPORTUNITIES FOR ONGOING PROBLEM-SOLVING.
CDPHE convenes regular meetings between local health departments and detention center staff, including in-jail medical personnel, to facilitate routine conversations about the needs from both sides and flag opportunities for problem-solving. Scheduling routine cross-collaborative conversations has made implementation easier.

OREGON

EXPANDING SYNDEMIC STI TESTING THROUGH HEALTH DEPARTMENT AND STATE PRISON PARTNERSHIPS

REGION
- Pacific West

KEY PARTNERS
- State prisons
- 340B

HEALTH DEPARTMENT TYPE
- Decentralized

Background

While conversations about STI testing in prisons typically originate within health departments, Oregon's Department of Corrections took the initiative to contact its state health department first. In 2020, Rob Nutt, Chief Pharmacy Officer for the Oregon Department of Corrections (ODOC), was tasked with identifying ways to leverage 340B drug savings to improve patient care across the state's twelve operating prisons. Through this process, he learned that by receiving support from the state's federally funded STI program, if certain requirements were met, ODOC could access discounted drugs for the corrections populations.[4]

Mr. Nutt contacted the Oregon Health Authority (OHA) and they enthusiastically agreed to partner with ODOC through a Memorandum of Understanding (MOU) that enabled the department to further support a population vulnerable to high STI rates. By January 2024, an opt-out testing protocol for comprehensive STI panels —including syphilis, HIV, and hepatitis C—began its first stages of implementation.

[4]"A Syndemic Approach to STD 340B Correctional Facility Partnerships for Health Department Prevention Programs." National Coalition of STD Directors and the National Alliance of State and Territorial AIDS Directors. Issued, June 2023.

Key Implementation Steps

1. ODOC had to create internal workflows that included 340B protocols to ensure compliance with the federal program, such as identifying an authorizing official and correctly meeting the 340B patient definition.

2. In contrast with some local jails where public health staff are brought in for testing, ODOC would rely on nursing staff to conduct testing.

> "It was a strategic decision [to implement opt-out testing at the primary intake facility] so there is an initial touchpoint with each person who comes through the system, especially since the intake facility is also the state's only women's facility," said Amelia Mazzei, the HIV/STI Strategic Initiatives Coordinator for the OHA. She noted that 340B reimbursement reinvestments have allowed ODOC to expand services, which can be an accessible entry point to sexual health conversations.

One of the key differences between prisons and jails is the amount of time a person stays in the facility. "Prisons need to be viewed as long-term care facilities," stated Robb Nutt, Chief Pharmacy Officer for the Oregon Dept. of Corrections.

3. As ODOC and OHA collaborated on an opt-out protocol, they developed a model that included opt-out testing at intake because it centralized and reached every person going through the system.

4. Because entering prison can be a stressful and traumatic experience, ODOC and OHA also created a "semi-opt-in" touch point six months after the first opt-out test to see if the person felt more comfortable saying yes to tests they previously declined.

5. The OHA's testing algorithms given to ODOC for implementation included screenings, vaccinations, and treatment options not only for syphilis, but also for: HIV, hepatitis A, hepatitis B, hepatitis C, tuberculosis, gonorrhea, chlamydia, trichomoniasis, and HPV.

Results

Currently, ODOC is collecting data without an electronic health record (EHR) system, which has limited their ability to provide comprehensive data quickly. While the EHR is being implemented through a step iterative process, the data that has been provided to OHA speaks volumes about the program's success.

According to the 2024 ODOC Annual Report, "since implementing opt-out screening, ODOC has seen an increase of 29% for STI testing...when comparing 2023 quarterly data to the same period in 2024."[5]

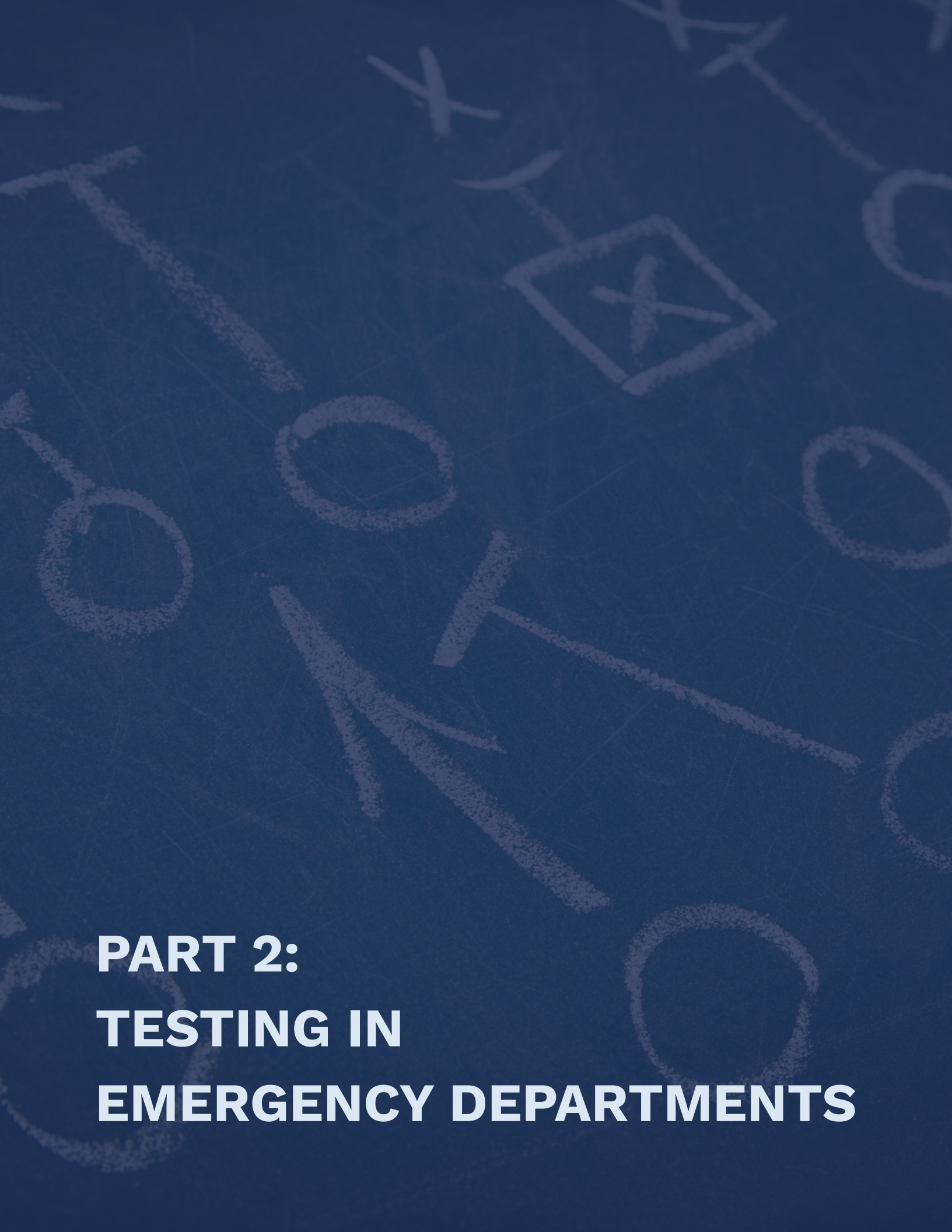
In addition to these increases, ODOC revised its form that is used when a person who is incarcerated is transferred to a different facility; this form now includes sexual health history questions.

Lessons Learned & Considerations

IMPLEMENTATION IS NOT A QUICK PROCESS AND PATIENCE IS REQUIRED. The OHA and ODOC signed an MOU in 2020, but did not start the program until January 2024. This is due to behind-the-scenes structural development, including the creation of workflows, placement of staff, 340B compliance measures, and more. Rob Nutt noted if health departments want to work with their state prisons, they need to "give them time and room for mistakes." He also stated that "what you say you're going to may not be deliverable right away," and recommends a flexible timeframe.

UNDERSTANDING 340B. In addition to the expanded service offerings, ODOC has used its 340B reimbursement reinvestments to improve patient care outcomes. "A lot of departments of corrections don't recognize they're already STI clinics," Rob noted. He emphasized that because correctional facilities are doing some level of testing and reporting, they can utilize 340B to expand and improve STI prevention priorities that are in alignment with 340B eligibility.

[5]ODOC Annual Report of 340B Program and STI Services. Accessed, April 2025.



PART 2: TESTING IN EMERGENCY DEPARTMENTS

CHEROKEE NATION & THE RAVEN COLLECTIVE

OPT-OUT SYPHILIS TESTING IN EMERGENCY DEPARTMENTS

REGION

- West South Central & Mountain West

KEY PARTNERS

- Emergency room departments
- Local health clinics

HEALTH DEPARTMENT TYPE

- Tribal

Background

Congenital syphilis rates have disproportionately impacted Native communities across the United States. In 2023[6] and 2024[7], the Indian Health Services (IHS) Chief Medical Officer released guidelines for syphilis screening in adults as a response to the crisis.

Since then, IHS data indicate improvements in screening for syphilis in primary care settings across tribal nations[8], but emergency departments (EDs) require unique policy strategies for implementation. NCSD interviewed individuals from Cherokee Nation Health Services and The Raven Collective, a Native-owned public health organization, to understand what opt-out syphilis testing looks like across Indian Country in EDs.

The implementation of opt-out syphilis testing differs facility-by-facility and is not a one-size-fits-all approach. However, key implementation strategies stand out that can be replicated.

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[6]Fall 2023 HIS STI Treatment Guidance. ODOC Annual Report of 340B Program and STI Services. Accessed, April 2025.

[7]U.S. Department of Health and Human Services. (2024). Dr. Loretta L. Christensen. ODOC Annual Report of 340B Program and STI Services. Accessed, April 2025.

[8]Syndemic Data. HIV Statistics, Indian Health Services. Accessed, May 2025.

Example 1

PRESUMPTIVELY TEST FOR STIS VIA AUTOMATED, OPT-OUT SYSTEMS. Cherokee Nation established a laboratory-triggered screening process in 2015 that enabled infectious disease technicians to test random samples of blood for hepatitis C (HCV) from patients not initially seeking STI testing at the ED. In 2019, HIV was added to this process and Cherokee Nation Health Services (CNHS) improved the protocol by applying an automated electronic health alert to flag patients who had not opted out of HIV and HCV screenings. In 2023, building off new IHS guidelines for syphilis prevention, CNHS added syphilis to its existing protocol. Since implementation, syphilis screenings went from 300-400 patients per month to over 4,000 screenings and cases increased from 4-5 per month to 50 or higher.

Image 1

Example 2

CENTER STI RESOURCES VISIBLY. Some EDs have developed educational materials that encourage patients to request a bundled STI test while waiting for other services; this enables the ED to explicitly advertise STI testing without having to adopt an opt-out testing protocol. While it does not guarantee patients will ask for a test, it ensures emergency room settings are an outlet in which STI-related information is more visible and increases testing awareness.

Image 3

As another example, Tuba City Regional Health Care Corporation (TC Health) in Navajo Nation generated handouts for ED partners that simplify messaging about STI testing (image 3, above). TC Health also launched a campaign this year focused on STI testing in primary and non-urgent health care settings, including billboard advertising (image 1, left).

Example 3

DELEGATE FOLLOW UP CARE OUT OF THE ED.
The Raven Collective emphasized the need for transferring follow up care out of the ED and delegating who will be responsible for working with patients after they receive their STI results.

"Following up on testing results is the one of the biggest policy and practice challenges [in EDs]," noted Brigg Reilley, an epidemiologist with 15 years' experience working with health facilities in Indian Country and who currently works with The Raven Collective. He said that when opt-out testing is paired with clear delegation protocols, ED staff can hand off patients with positive test results to a public health nurse or other health care worker. This gives ED personnel more confidence to expand testing.

In California, minimally defined responsibilities for ED personnel may have been why an ED syphilis testing bill failed to make it out of committee. AB2960 would have required universal syphilis testing in ERs to anyone over the age of 15 who is sexually active. It was opposed by various groups, including the California Emergency Nurses' Association, who noted* that, "mandating syphilis screening in EDs, even for a small portion of the qualifying patients cared for in EDs, would add to the burden of emergency providers caring for very sick or injured patients, with an unintended consequence of increased ED crowding."

*Accessible as a PDF under "4/20/24 - Assembly Health"

Lessons Learned & Considerations

ACCREDITATION AGENCIES MATTER TO EDS.
Emergency rooms are concerned that new policies requiring syphilis testing will amplify liabilities with accreditation agencies. Policies need to be written with flexibility that recognize and incorporate the way in which an ED site will be held accountable by accrediting agencies to make them more palatable. Confirm with ED personnel which existing laws and policies protect them from liability with any new syphilis testing requirement.

CREATE CONCISE MATERIALS AND CONSIDER PEER MENTORING.
EDs that have been able to expand syphilis screening are sharing a patchwork of ideas that take into account their setting's unique workflow and constraints. Currently, a small group of Indian Country ED physicians is planning to work as informal mentors to other EDs for ongoing support, especially for facilities with high turnover. Developing a simplified menu of policy considerations and templates, including ones specific to electronic health record platforms, can better align with EDs' limited capacity.

ARIZONA

OPT-OUT SYPHILIS TESTING IN EMERGENCY DEPARTMENTS AND MEDICAID INCENTIVES

REGION

- Mountain West

KEY PARTNERS

- State Medicaid agency
- Emergency room departments
- State, local, and tribal health departments
- Community members

HEALTH DEPARTMENT TYPE

- Decentralized

Background

The Arizona Department of Health Services (ADHS) engaged in a multi-year process to identify policy mechanisms for increasing syphilis screening in emergency room departments (EDs). In 2019, they released a Request for Proposals (RFP) for EDs to receive funding for screening implementation, but the COVID-19 pandemic disrupted hospital systems' ability to initiate new projects. However, through a congenital syphilis collaborative that included over 100 people from 66 different STI-related agencies, ADHS continued to develop protocol options. In 2024, they published a health alert about syphilis screening recommendations in EDs. By 2025, they created an ED syphilis testing resource guide (Image 3, page 18), and the Arizona Medicaid system introduced a fee-for-service adjustment that would financially reward eligible hospitals for meeting syphilis testing performance standards.

Key Implementation Steps

1. ADHS co-led a congenital syphilis collaborative with their State Medicaid Agency that included a wide range of STI professionals to gather data, ideas, and strategies. The collaborative included over 100 people from 66 different agencies, including tribal nations, local health departments, harm reduction experts, and corrections. The group was responsible for shaping the strategies that ultimately led to initial meetings with EDs.

2. Separate from the collaborative, ADHS and Medicaid partnered to encourage ED participation in syphilis testing. The differential adjusted payment (DAP) regulation posted in 2025 by Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), offers a new opportunity to incentivize testing. EDs can receive a .25% increase in their fee-for-service rates with AHCCCS if they meet specific performance milestones, including 1) submitting a letter of intent to participate in the Maternal Syphilis Program; 2) developing a policy that meets syphilis testing standards; and 3) starting to test individuals for syphilis in the ED under the new policy no later than January 1, 2026.[9]

3. Following the launch of ADHS updated guidance in 2024, AHCCCS also implemented a new policy that requires syphilis testing for all sexually active individuals over 15 years of age. ADHS was able to include this Medicaid requirement in its talking points and advance its partnerships with EDs.

4. In addition, the ADHS team gathered and provided a list of relevant CPT codes to further engage ED personnel by preemptively consolidating the specific billing information they may need to integrate syphilis testing more easily and quickly in their ED operations.

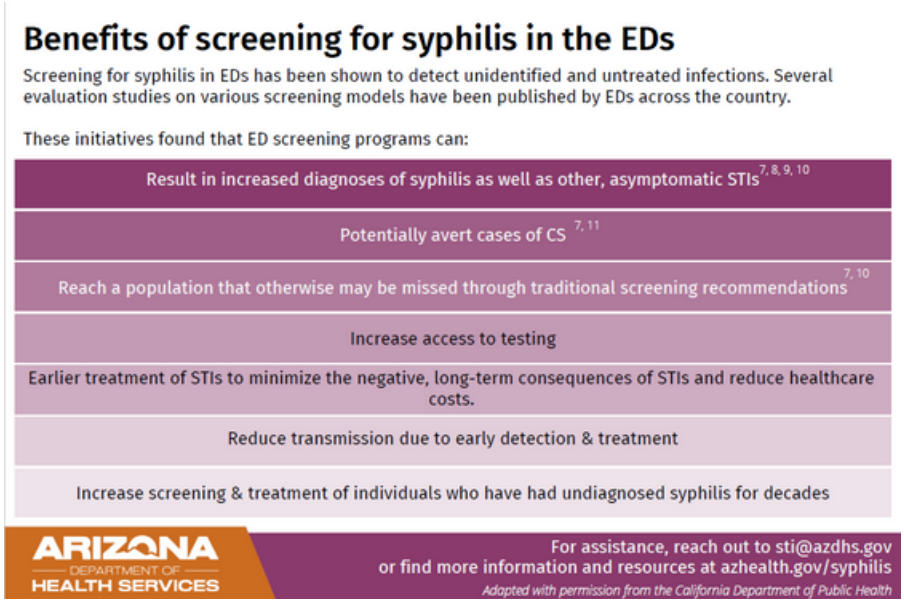


Image 3 - a sample from the ED syphilis testing guide

[9] "AHCCCS Differential Adjusted Payment (DAP) CYE 2026 Final Public Notice." Arizona Health Care Cost Containment System. Published, March 18, 2025. Fall 2023 HIS STI Treatment Guidance. ODOC Annual Report of 340B Program and STI Services. Accessed, April 2025.

Lessons Learned & Considerations

ADDING FLEXIBILITY FOR STI CLINICAL SERVICE FUNDING COULD MAKE THEM MOVE FASTER.

None of the Arizona partnerships were built quickly because they take time, patience, and consistency. ADHS also highlighted that if there were greater funding flexibility for clinical STI services, there would be more opportunities to support safety-net testing and treatment for uninsured and underinsured persons.

EMPHASIZE THE IMPORTANCE OF COMMUNITY TRANSMISSION DISRUPTION.

Partnering with EDs to implement a point-of-care (POC) syphilis tests and administering at least one dose of treatment at the time of diagnosis helps disrupt community transmission, especially for patients in the early stages of syphilis. Through effective messaging, this encourages EDs to increase syphilis testing even if they lose patients to follow-up (often a cited concern) because initial treatment can help stop transmission within many sexual networks.

PART 3:
LEVERAGING PARTNERSHIPS

LOUISIANA

PARTNERING WITH MEDICAID MANAGED CARE ORGANIZATIONS TO INCREASE PRENATAL SYPHILIS SCREENING

REGION

- West South Central

KEY PARTNERS

- State Medicaid agency
- Managed Care Organizations
- Community members

HEALTH DEPARTMENT TYPE

- Largely centralized

Background

In 2023, the Louisiana Department of Health (LDH) participated in a perinatal quality commission and simultaneously received media coverage on its increases in congenital syphilis rates. Some people on the commission were shocked by the numbers, including individuals representing Managed Care Organizations (MCOs), which contract with state Medicaid to provide services to eligible beneficiaries. Capitalizing on this synergy, LDH and some of the MCOs decided to partner on a pilot to ascertain how Medicaid providers in the state could better measure prenatal syphilis screening and increase access to congenital syphilis prevention.

Key Implementation Steps

1. LDH contracted with an independent consulting firm to develop seven key indicators that would be used to measure prenatal syphilis screening among Medicaid enrollees from several MCOs. The metrics measured syphilis screening within multiple stages of pregnancy across all live births to capture a comprehensive picture of screening frequency.

2. The contracted consulting firm worked with MCO staff and LDH to collect data in 2024, and will remeasure in 2025 and 2026, with 2023 serving as the baseline period for evaluation purposes.

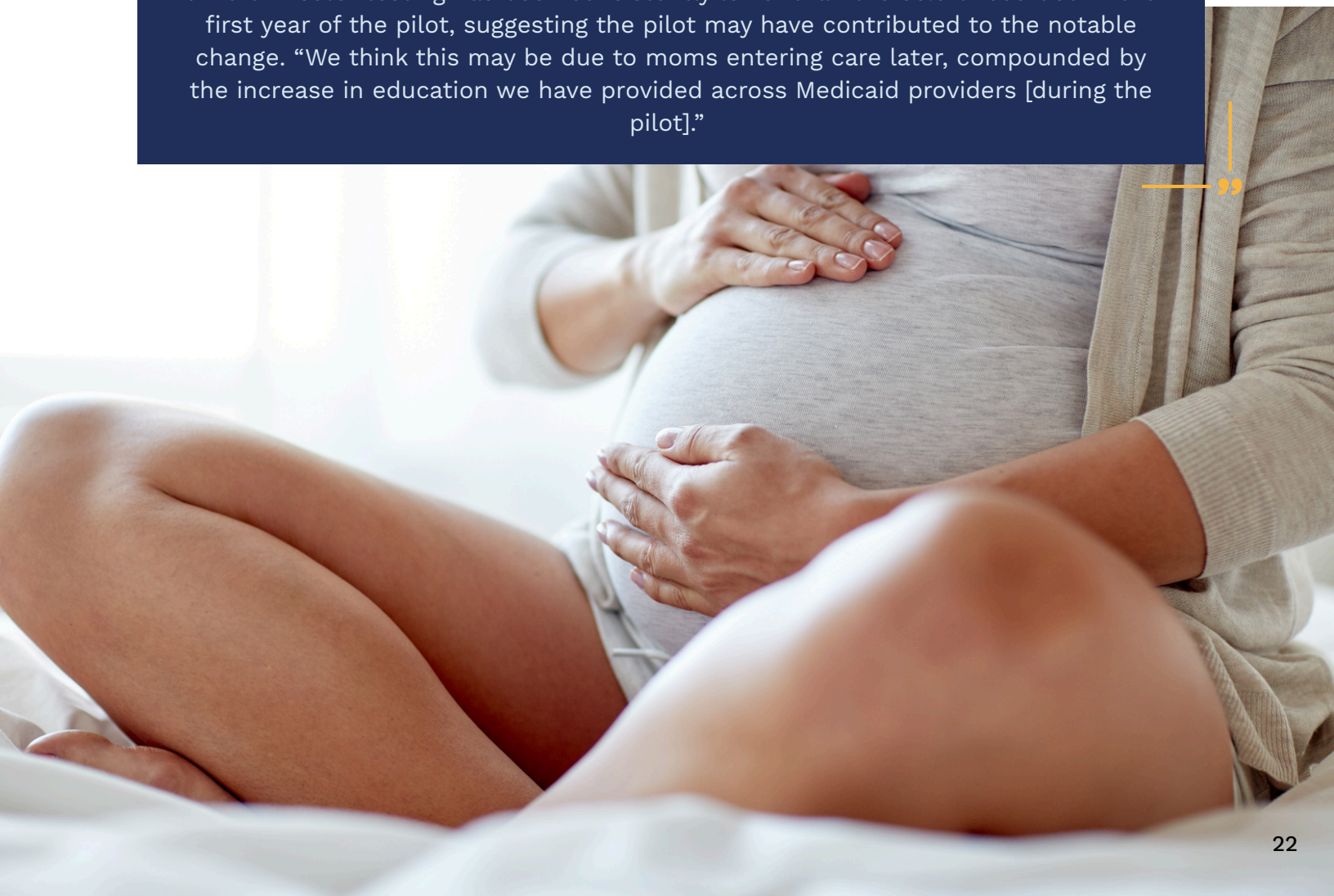
3. LDH provided expertise to identify all relevant billing and diagnostic codes that may appropriately capture anyone using Medicaid benefits who is also potentially vulnerable to or diagnosed with syphilis during a prenatal visit.

4. LDH began reaching out to MCO providers to educate them on congenital syphilis prevention and planned various community outreach events to expand awareness across both clinicians and patients.

Results

In 2024—the first year of the pilot—the percentage of all Medicaid pregnant patients who received a syphilis testing during their first trimester dipped from 59% to 57%. However, Medicaid deliveries that included a third-trimester syphilis test increased significantly, from 51.69% to 55.3%.

> “This may be an access to care issue,” mentioned Elizabeth Lindsay, Perinatal Surveillance Supervisor for the state’s STI/HIV/Hepatitis Program. She pointed out that historically, Louisiana has seen fluctuations in first trimester testing, but that third trimester testing has been consistently lower than the 55.3% recorded in the first year of the pilot, suggesting the pilot may have contributed to the notable change. “We think this may be due to moms entering care later, compounded by the increase in education we have provided across Medicaid providers [during the pilot].”



Lessons Learned & Considerations

MEDICAID PROVIDERS MAY NOT BE AWARE OF THE NEED FOR TIMELY TESTING, OR LACK STRATEGIES TO ADDRESS STIGMA.
LDH recognized through their collaboration in the first year of the pilot that many providers were not equipped with enough resources to mitigate the unique stigma that accompanies pregnant patients vulnerable to syphilis and other STIs.

By collaborating with community and MCO providers, LDH was able to address this issue through free and accessible community events, such as a community baby shower for pregnant women that offered testing to everyone (Image 4). They also planned several lunch-and-learns with MCO providers to ensure congenital syphilis prevention information was being circulated.

THERE CAN BE A DISCONNECT BETWEEN MCOS AND COMMUNITY.
While many MCOs employ case managers who assess health needs and offer incentives for testing, many resources are not reaching the people who need them the most. This may be due to structural challenges, such as risk assessments that skew toward chronic diseases and miss STIs. Other contributing factors include the need for robust workforce development and wider distribution of incentives by improving awareness.

Image 4 - LDH staff at a community baby shower

NEW YORK

REGION
- Middle Atlantic

KEY PARTNERS
- State and local health departments
- Community members

HEALTH DEPARTMENT TYPE
- Decentralized

Background

New York's Congenital Syphilis Elimination Framework (The Framework) started in March 2023. The state experienced a considerable increase in congenital syphilis from 2013 to 2022. In fact, cases in 2022 accounted for over 20 percent of all congenital syphilis cases within the previous ten years and half of the state's syphilitic stillbirths occurred between 2020 and 2022.[10] In response, the New York State Department of Health (NYSDH), in partnership with the New York City Department of Health and Mental Hygiene, established a multidisciplinary team of 43 community members who envisioned and enacted robust policy recommendations to reduce congenital syphilis transmission. The group, which met over 13 months, ultimately developed a report with 26 recommendations that address health equity, prevention access, and policies. The report was created to ensure public health professionals, policymakers, and other institutional leaders have the information they need to enact changes that prevent more congenital syphilis cases.

[10]Walters, Natifa. "Engage, Envision, Eliminate: Partnerships to End Congenital Syphilis in New York State." Presentation, STI Engage: Shaping the Nation's Health. Washington, D.C.. 2 June 2024.

Key Implementation Steps

1. The group deliberately recruited a wide range of experts to support The Framework's development, including community members, members of state and local health departments, and affiliates who have collaborated on STI prevention work.

2. The Framework was rooted in five key missed prevention opportunities, including: 1. Late identification of seroconversion during pregnancy, 2. No timely prenatal care and no timely syphilis testing, 3. No timely syphilis testing despite proof of timely prenatal care, 4. No adequate maternal treatment despite proof of timely syphilis diagnosis, and 5. Clinical evidence of congenital syphilis despite completion of treatment.

3. The group's structure was then further broken down into seven subcommittees to address congenital syphilis from a comprehensive lens: prevention, education, community-based programming, surveillance & research, medical care & treatment, policy & planning, and marketing & advocacy.

4. Each subcommittee included subject matter experts and prioritized draft recommendations using various tools, including an electronic tool administered by the AIDS Institute's Office of Program Evaluation and Research to measure magnitude of impact, immediacy of impact, and funding.

5. The recommendations were then further evaluated and assessed against other subcommittee-specific recommendations, and ultimately prioritized through weighted, combined, and averaged scores.

6. The entire Framework was conceptualized through a health equity lens, recognizing explicitly that Black and Brown women in New York were disproportionately vulnerable to syphilis during pregnancy and other harmful maternal health outcomes.

Image 5 - Congenital syphilis prevention campaign materials from the Department of Health in New York State

Results

The final report included a total of 26 recommendations with six priority recommendations highlighted for high impact and feasibility:

1. Expand access points and integrate syphilis testing into existing sites and settings.
2. Create congenital syphilis education messaging for patients, partners, and the public.
3. Partner with multi-specialty medical societies to increase education about syphilis and congenital syphilis.
4. Promote awareness and compliance of third trimester syphilis screening among providers and healthcare systems.
5. Enable real-time access to all syphilis records to ensure timely diagnosis and treatment across New York State jurisdictions through the creation of a statewide surveillance registry.
6. Create a positive syphilis testing alert system within hospitals or birthing centers.

Starting in Spring 2025, NYSHD and its partners will be disseminating information from The Framework through discussion forums that target key audiences under specific themes, including the private sector, the public sector, providers, and medical guidelines. Each discussion forum held from April to October 2025 will enable these specific groups of stakeholders to understand The Framework, provide input, and generate ideas for implementation within their respective settings, creating a decentralized approach to disseminate the group's policy goals.

Lessons Learned & Considerations

TO BE EFFECTIVE, ANY FRAMEWORK NEEDS TO HAVE COLLABORATORS BEYOND THE HEALTH DEPARTMENT.
One of the most crucial outcomes of The Framework since its inception was the deliberate collaborative approach with a multidisciplinary team. This allowed the health department to prioritize areas in which it can impact policy change and ensure other policies have realistic implementation strategies by delegating out responsibilities. For example, each recommendation in the report names the collaborators who would be required to make the policy change happen, such as emergency rooms, children's health centers, federal agencies, and more.

STRUCTURES WITH BUILT-IN ACCOUNTABILITY GO A LONG WAY.
The Framework resulted from a specific group structure that included subcommittees, each with their own co-chairs, to cultivate leadership opportunities and ensure the development of recommendations did not inadvertently stall without routine support and coordination. The co-chair structure also ensured consistency and standardization across all seven subcommittees.

EDUCATE PROVIDERS ON RELEVANT STATE POLICIES.
One of the recommendations to come out of The Framework was to promote compliance with New York's third trimester testing rule, which requires providers to test during the third trimester for syphilis. New York had previously only required it during the first prenatal visit until a budget bill in 2023 expanded screening rules. NYSHD has started enforcing this statutory requirement by sending a letter to any birthing center associated with a congenital syphilis case that requests a root cause analysis of the congenital syphilis case, also known as an "event letter." If the third trimester testing law is broken, NYSHD has the authority to send a statement of deficiency, which they see as "one tool in the toolbox" for mandated enforcement.

KEY TAKEAWAYS

UNDERSTAND AND ANTICIPATE THE NEEDS OF PARTNERSHIPS.
When proposing to implement a new policy, protocol, or procedure to reduce syphilis rates, it is important to not only know which partners to engage, but how to engage them meaningfully. From emergency room personnel concerned about accreditation agencies to prison and jail systems that have unique infrastructural challenges, learning the primary needs of entities involved in a potential partnership will increase the chances of a successful collaboration.

CREATE REALISTIC TIMELINES.
Due to the urgent demand behind syphilis as an ongoing epidemic in the U.S., it is easy to fall into timelines that move quickly. However, many of the partnerships involved in this playbook noted the benefit of slowing down their timeline to ensure effective structural changes were put into place to facilitate and streamline policy implementation. Whether it is generating the right MOU, hosting multiple meetings with a congenital syphilis taskforce or community group, or taking the time to work through nuances in administrative or management systems, deliberately creating a realistic timeline can help ensure success.

COME PREPARED WITH TAILORED MESSAGING AND USEFUL DATA.
It helps to remember that not every potential partner in syphilis prevention will be aware of why the issue is so important. Learn in advance why someone would care about proposed policy changes and identify key data that feels relevant to them, rather than providing an overabundance of details. Whether working with partners in Medicaid, incarceration systems, or emergency rooms, the most pertinent data should float to the top for convincing messaging.

REMAIN FLEXIBLE.
Almost everyone interviewed for the development of this playbook noted some kind of unexpected bump along the way that required them to pivot or reframe a strategy. Remaining as flexible as possible enables the policy to still be implemented, but recognizes that the steps for implementation can shift based on changes in local, state, and federal law, health department priorities, funding mechanisms, or workforce capacities.

For questions related to this policy aid, please reach out to NCSD's policy team at policyteam@NCSDDC.org

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