

California Congenital Syphilis Elimination Summit

Rapporteur Session

Ashley Dockter, MPH & Jessica Frasure-Williams, MPH

California Congenital Syphilis Elimination Summit Thursday, September 20, 2018



CA CS Elimination Summit — Day 1

9:30 - 10:15	The National Congenital Syphilis Crisis			
	Gail Bolan, MD, MPH			
10:30 - 11:30	Congenital Syphilis: Current Management			
	for a Persistent Problem!			
	Pablo J. Sanchez, MD			
12:45 - 2:00	MCAH: A Collaboration to Enhance			
	Congenital Syphilis Response			
	Diana Ramos, MD MPH			
	Denise Smith, PHN MPA			
	Jennifer Day, PHN			
	Facilitator: Ashley Dockter, MPH			
2:15-3:30	Breakout Sessions			
3:45 - 4:55	Offering Services to, and Engaging in Care,			
	Pregnant Women Who Are Unstably Housed			
	or Homeless			
	Dominika Seidman, MD			

Breakout Sessions:

1 Pregnancy Intention + Contraceptive Counseling

Erica Neuman, MS

2 Congenital Syphilis M&M Review Boards

Satvinder Dhaliwal, MPH

- 3 Syphilis Screening in Jails Panel
 - Jena Adams
 - Susan Strong, NP

Facilitator: Jennifer Harmon, MPH

The Harm Reduction Approach to Reducing Risk

Taeko Frost, DrPH

Opening Remarks by Dr. Karen Smith, Director, CDPH



Congenital syphilis is an urgent public health issue and a priority for CDPH.

We need to:

- Have a frank and public dialogue to tackle root causes.
- Build a more robust public health response by bringing in more partners and bringing back the public health infrastructure that has eroded.

I know we will craft unique solutions here in California that involve community partners.

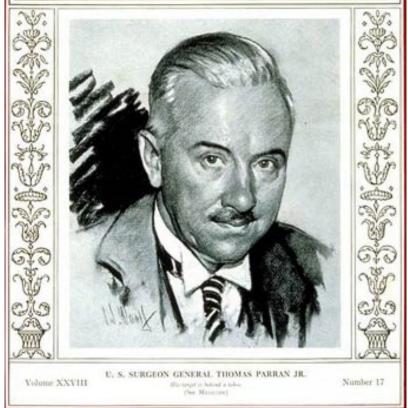


Heidi Bauer MD, MS, MPH

California Congenital Syphilis Elimination Summit Wednesday, September 19, 2018





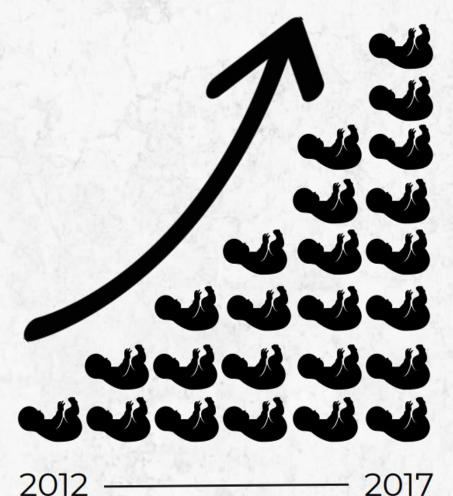


"The first thing to do completely, is to wipe out congenital syphilis.

That is one job that doesn't need to take a generation."

Thomas Parran. 1937. Shadow on the Land: Syphilis. New York, NY: Reynal & Hitchcock

8 decades, 3 generations later, we have failed



The number of infants born with **congenital syphilis** increased for the **5th year** in a row.



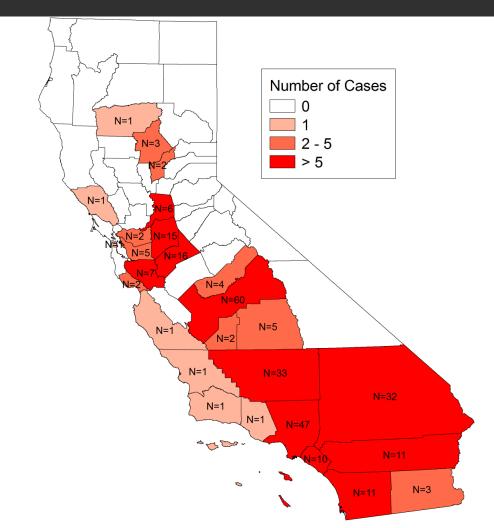
71 of those infants were stillbirths, with 30 stillbirths in 2017 alone.

33 cases

283 cases*

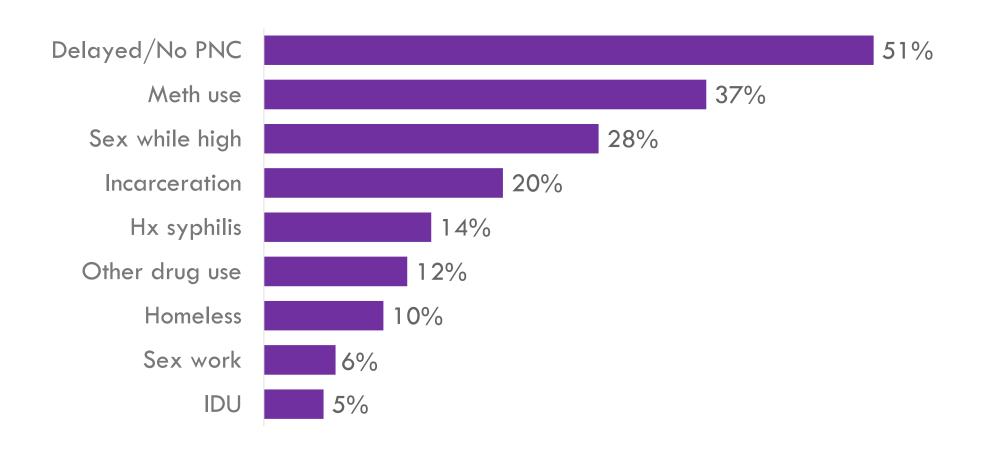
The highest morbidity counties are in Central and Southern California

Congenital Syphilis Cases by County, California, 2017





Maternal Risk Factors reported by mothers of CS infants



Source: 2016-2017 surveillance data, N=298

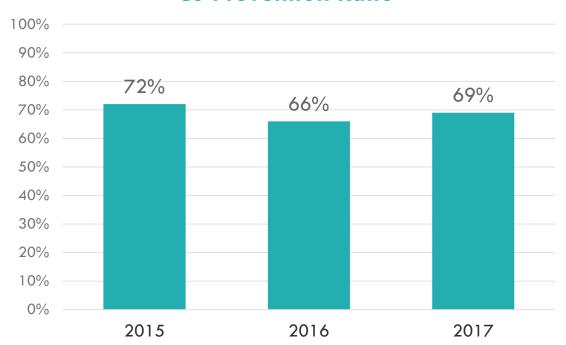
Role of Social Determinants in CS

- Poverty
- Lack of access to care
- Limited transportation
- Gender inequities
- Housing instability
- Sex trafficking
- Law enforcement
- Domestic violence
- Addiction
- Fear of CPS involvement



Congenital syphilis prevention outcomes over time





Number of CS cases prevented





Source: Nicole Burghardt, 2015-2017 CPA surveillance data

High Priority Strategies for Congenital Syphilis Elimination



T1:	
Testin	Ø
	6

- Third trimester and delivery screening in pregnancy
- Corrections, drug treatment, emergency departments
- Family planning, primary care screening reproductive age females

Treatment

- On-site bicillin treatment; adequate reimbursement
- Maximize 340B program
- Evaluation and treatment of exposed infants

Case Review

M&M continuous case review

Public Health

- Active surveillance
- Outbreak response and disease intervention

Access to PNC

- Housing, transportation, social supports
- Substance abuse treatment

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Division of STD Prevention



National Congenital Syphilis Crisis

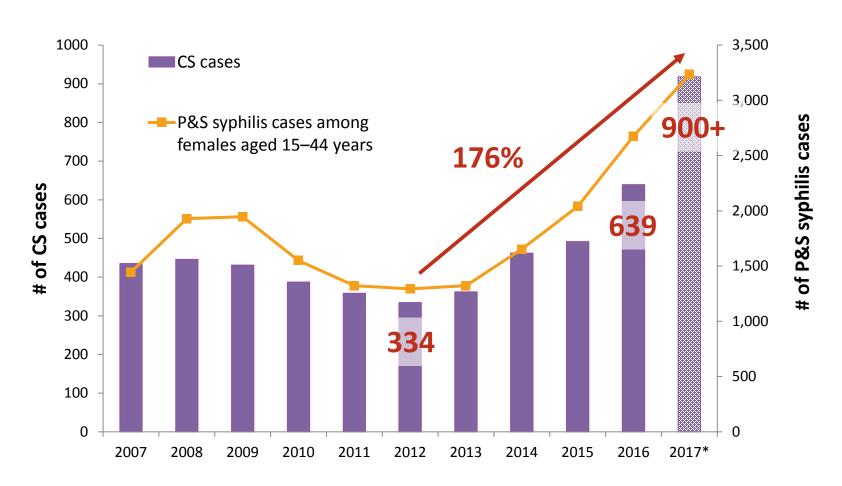
Gail Bolan, MD

Director, Division of STD Prevention

Centers for Disease Control and Prevention

California Congenital Syphilis Elimination Summit Oakland, CA September 19, 2018

Congenital Syphilis (CS) Cases and Primary and Secondary (P&S) Syphilis Cases Among Females of Reproductive Age, U.S., 2007–2017*

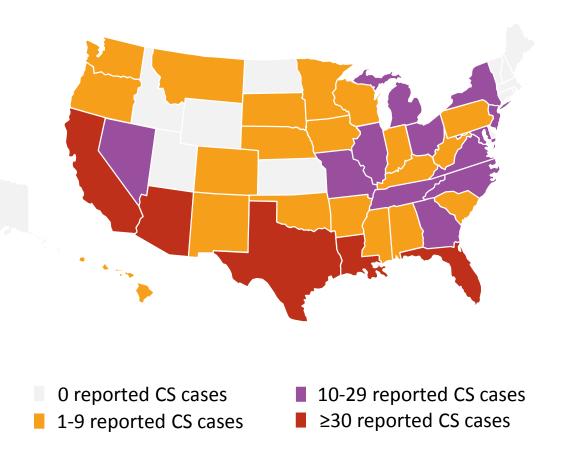


Congenital Syphilis Cases (2017)

In 2017, 5 states represented 70% of all congenital syphilis cases in the U.S.

State	2012 Cases	2017* Cases	
CA	35	281	
TX	78	176	
FL	37	93	
LA	33	59	
GA	16	23	
MD	12	20	
AZ	14	30	
IL	23	21	
ОН	19	18	
U.S. Total	334	918	

^{*}Congenital syphilis data are preliminary as of July 2018



Congenital Syphilis Surveillance Case Definitions and Clinical Diagnoses

- A surveillance case of congenital syphilis may not match a clinical case
- Surveillance case definitions maximize sensitivity and specificity and rarely count all cases
- Differences are related to:
 - A serum quantitative nontreponemal titer that is 4-fold higher than the mother's titer
 - Interpretation of the CSF WBCs and protein results
 - Interpretation of adequate treatment of a mother who is serofast after treatment of syphilis before the pregnancy

- Socioeconomic factors
- Substance use disorders
- Access to care
- Infrastructure reduction
- Lack of awareness by providers and communities
- Community trust
- Confidentiality concerns
- Prevalence within sexual networks





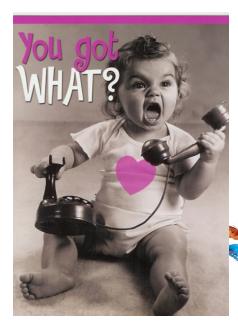




Provision of STD
Clinical Preventive
Services Guidelines

Congenital Syphilis: Clinical Overview











California Congenital Syphilis Elimination Summit
Oakland, CA
9/19/18

Mortality of Congenital Syphilis*

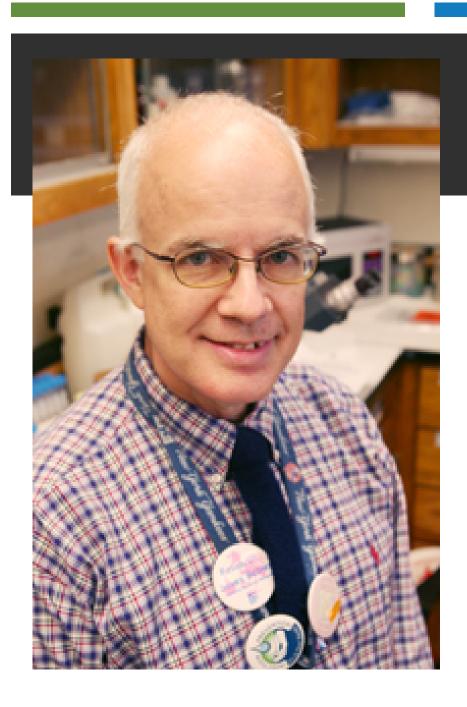
- Case-fatality rate:
 - -Confirmed congenital syphilis: 35% (67/191)
 - Stillbirths: 79% of deaths (53/67)
 - Majority of stillbirths occurred before 28 weeks' gestation (74%)
 - -CDC surveillance case definition: 11%
- CDC surveillance case definition underestimated mortality by >300%

SYPHILIS IN PREGNANCY: THE PARKLAND EXPERIENCE (1988-1998)

	1°	2°	Early Latent	Late Latent
No. of Mothers	26	53	145	27
Outcome (%):				
Stillbirth	1 (4)	14 (26)	31 (21)	1 (4)
Congenital Syphilis	5 (19)	18 (34)	21 (14)	1 (4)
Total	6 (23)	32 (60)	52 (36)	2 (7)

A few things I learned from Dr. Sanchez

- Syphilis can cross the placenta at any point during pregnancy.
- CSF white blood cells are poor markers of disease in the infant.
- Infant titers that are four-fold higher than the mother indicates
 CS, but not having it does not rule out CS.
- 2-14% of infants born to women who were adequately treated in pregnancy still had signs/symptoms of CS.



"Targeted screening is for the birds."

Dr. Pablo Sanchez

Maternal, Child & Adolescent Health (MCAH): A Collaboration to Enhance Congenital Syphilis Response

Panelists:

Diana Ramos, MD, MPH | CA Department of Public Health, MCAH Division

Denise Smith, PHN, MPA | Kern County Public Health Services

Jennifer Day, PHN | Fresno County Department of Public Health

Session Facilitator:

Ashley Dockter, MPH | CA Department of Public Health STD Control Branch

2018 California Congenital Syphilis Elimination Summit | Oakland, CA Wednesday, September 19, 2018



Background Data from MCAH

- 8,084,612 women 18-44 years old
- 240 delivery hospitals
- 491,748 live births
- 1 in 8 babies born in the US

70% of pregnant women in CA cross through the doors of WIC at some point in time

MCAH programs already reach high-risk groups.

- Case management programs
 - Black Infant Health
 - CA Home Visiting Program
 - Other local case management programs
- Medical providers
 - Comprehensive Perinatal Services Program (CPSP) Prenatal care providers
 - Regional Perinatal Programs of California (RPPC) birthing hospitals
- Fetal Infant Mortality Review (FIMR) boards

MCAH-STD Collaboration on Congenital Syphilis Prevention at the State Level

Perinatal Communicable Diseases Working Group

Congenital syphilis presentations to MCAH: RPPC (birthing hospitals), CPSP (prenatal care providers) & local MCAH directors

Leveraging synergies between MCAH FIMR & STD CS M&M Reviews

Exploring ways to support local STD-MCAH collaboration

MCAH-STD Collaboration at the Local Level – Key Takeaways

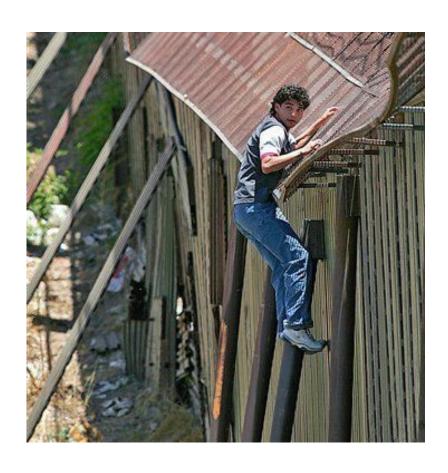
Challenges

- Siloed funding
- Distinct program objectives
- Culture: opt-in vs. opt-out
- Strategies to overcome challenges
 - DIS & PHNs learning about what each other do
 - Establishing relationships, work flows, and communication
 - Quality improvement & creativity

Benefits

- Better patient care
- Increased efficiency
- Increased staff morale
- With our powers combined, we can find folks!
- The "buddy system" in the field

"DIS + PHN = Match Made in Heaven"





Breakout Sessions

Congenital Syphilis Morbidity & Mortality Review Boards: What? Why? How?

Satvinder Dhaliwal, MPH – Auditorium

Syphilis Screening in Jails: An Introduction to Model Programs across the State

Jennifer Harmon, MPH, Jena Adams, Susan Strong, NP – Room 1

Pregnancy Intention + Contraceptive Counseling for Persons with Syphilis: A Strategy for Reducing Congenital Syphilis

Erica Neuman, MS — Room 15

The Harm Reduction Approach to Reducing Risk

Taeko Frost, DrPH – Room 10

Congenital Syphilis Morbidity & Mortality Review Boards What? Why? How?

Satvinder K. Dhaliwal, MPH

California Department of Public Health, STD Control Branch

Congenital Syphilis Elimination Summit, 2018



Each CS case should be examined for missed opportunities and upstream interventions to prevent future cases.

Congenital Syphilis Morbidity & Mortality Review (CS M&M Review): Regular in-depth multidisciplinary review of CS cases

- Identify missed opportunities for prevention
- Follow-up actions aimed at systems level changes
- Multidisciplinary team from across health department

The Congenital Syphilis Morbidity & Mortality Review Toolkit

Instructions

- How to conduct review
- Who should participate
- Framework to identify missed opportunities
- Considerations for associated follow-up interventions

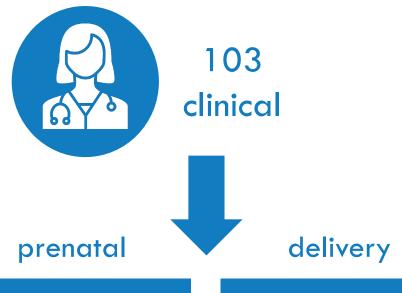
PowerPoint Template

- Case presentation
- Case timeline
- Missed opportunities
- Proposed follow-up actions
- Bright spots

New Tools

- Notes template
- Action items spreadsheet
- Case summary sheets
- Summary table for cases presenting at delivery

172 missed opportunities for prevention were identified among 69 cases reviewed



41 missed screening

27 missed treatment

9 missed diagnosis

16 missed treatment of mother

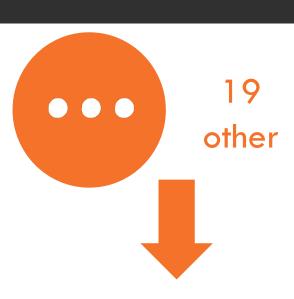
10 missed treatment of infant



28 partners unable to locate

11 patients unable to locate

11 delays in follow-up



9 lack of jail screening

Source: Ashley Dockter, 2016-June 2018

CPA M&M Review Data

Satvinder Dhaliwal – Key Takeaways

- In-depth, multidisciplinary examination of CS cases leads to identification of local actions that can prevent congenital syphilis cases in California. A single case in a jurisdiction is worth reviewing.
- The CS M&M Review Toolkit is the resource and guide for local health jurisdictions to begin conducting CS M&M Review Boards.

Syphilis Screening in Jails: An Introduction to Model Programs across the State

Panelists:

Jena Adams | Fresno County Department of Public Health

Susan Strong, NP | San Bernardino County Department of Public Health

Session Facilitator:

Jennifer Harmon | CA Department of Public Health STD Control Branch



California Congenital Syphilis Elimination Summit 2018

Breakout Session | Room 1

Wednesday, September 19, 2018 | 2:15 - 3:30p



Lessons Learned from Fresno + San Bernardino Counties: Advice to Other Jurisdictions



• Insert broad language into medical service contracts that allows additional screening to be added as public health/communicable disease issues arise

• Establish relationships between jail medical staff + disease investigators

Treatment referrals to Public Health

For more information contact Jena Adams (<u>jadams@fresnocountyca.gov</u>)

- Be persistent + never give up. "Success is the ability to go from failure to failure without losing your enthusiasm." —Winston Churchill
 - Have the right partners; trust, but verify
 - Funding is not the most important part of this work

For more information contact Susan Strong (strong@dph.sbcounty.gov)

Strategies for engaging in this work in your jurisdiction:

Encourage universal routine opt-out screening and provide TA



Collect and share data with partners

Leverage existing policy, identify new policy opportunities

Be involved in contract negotiations for medical services

Pregnancy Intention + Contraceptive Counseling for Syphilis Positive Patients: A Strategy for Reducing Congenital Syphilis

September 19, 2018

Erica Neuman, MS Senior Trainer, Learning Exchange





Pregnancy Status

Are you pregnant now?

When was the 1st day of your last period/monthly bleed (LMP)?

Had sex with any pregnant partners?

Are you in prenatal care?

Pregnancy Intention

Would you like to be pregnant this year?

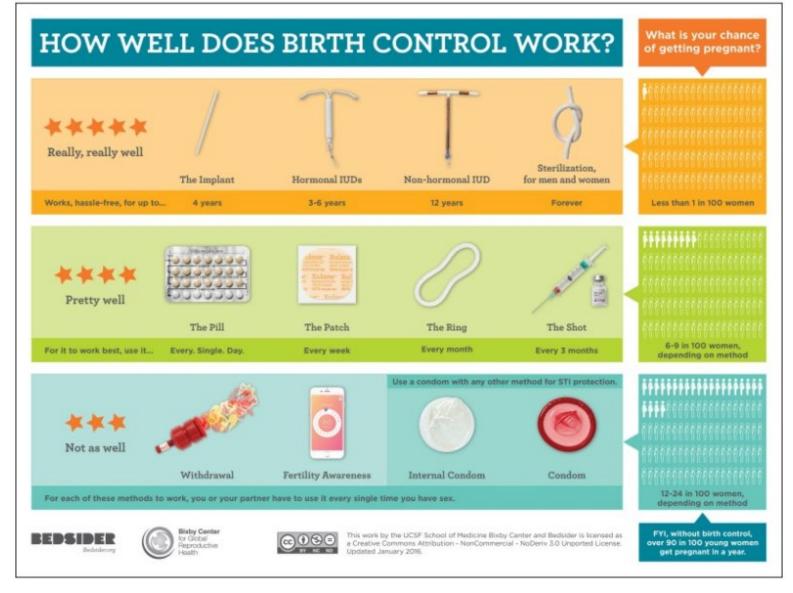
Are you trying to get pregnant now?

How would it be for you if you got pregnant this year?

DYAD ROLE PLAY

(handouts)





Free: http://beyondthepill.ucsf.edu/tools-materials



DYAD ROLE PLAYS

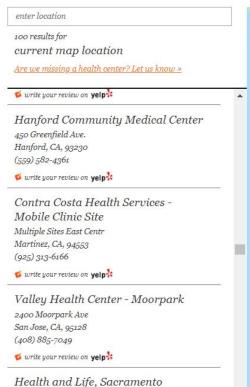


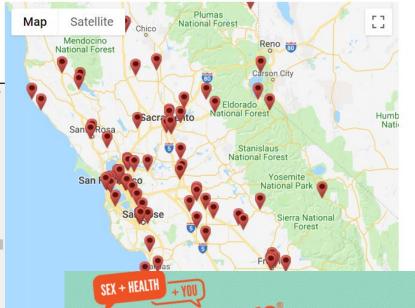
birth control methods where to get it reminders features questions

Home » Find a Clinic

WHERE TO GET IT /

health center locations





Santa Rosa

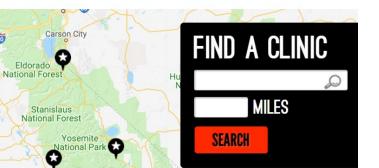
Birth Control Clinic **Finders**



Sacramento



Community Clinic



Harm Reduction for Engagement

Taeko Frost, DrPH Western Regional Director





Taeko Frost - Harm Reduction

Harm reduction is an approach to minimizing risks of drug use and sex work by providing practical tools and policy change to promote the health and well-being of people who use drugs and people who engage in sex work.

- Syringe access to prevent HIV/HCV infections
- Naloxone to prevent overdose
- Policies that decriminalize drug use equipment
- Minimize social harms including incarceration

PRINCIPLES OF HARM REDUCTION

Health and Dignity

Participant Centered Services

Participant Involvement

Participant Autonomy Sociocultural Factors

Pragmatism and Realism

Taeko Frost – Harm Reduction – What can you do?

- Mom first she is the agent of change focus on mom's needs rather than everything she is "doing to the baby"
- People who use drugs know what they need and the order in which they need these things. As a provider – negotiate your need with theirs.

BARRIERS TO CARE

- Stigma
- Trust what else comes with services?
- Competing priorities
- Where people touch the system
- Limited access to services

SOLUTIONS

- Messaging & approach
- Rapport building & demonstrated trust
- Managing expectations
- Networking with other sites and spaces
- Incentives, travel, in-thefield care

Taeko Frost – Harm Reduction – Key Takeaways

Harm Reduction can be applied to congenital syphilis prevention work.

 Building trust and rapport with people at risk can promote engagement and retention in services

Building partnerships with organizations and community networks is key to achieving community-level success in reducing congenital syphilis.

- Address stigmatizing practices and policies
- Develop creative strategies to deliver services in places that are accessible





Offering services to pregnant women who are unstably housed or homeless

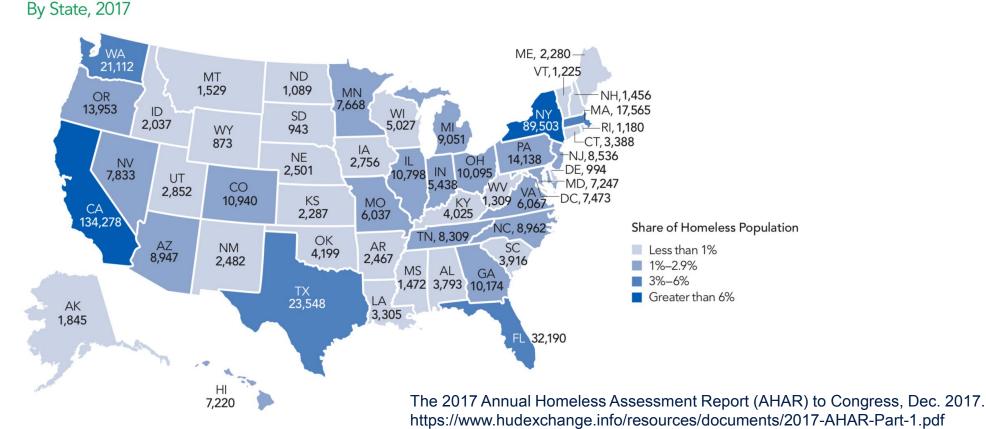
Dominika Seidman, MD MAS





25% of all people in the US experiencing homelessness live in CA.

EXHIBIT 1.6: Estimates of Homeless People







CA had the largest increase in homelessness by state in 2016-17.

EXHIBIT 1.8: Largest Changes in Homelessness by State By State, 2007–2017

2016-2017

Largest Increases	
CALIFORNIA	16,136 / 13.7%
NEW YORK	3,151 / 3.6%
OREGON	715 / 5.4%
NEVADA	435 / 5.9%
TEXAS	426 / 1.8%





Women experiencing homelessness: violence, trauma & PTSD

- Violence is the leading cause of homelessness for women and families
 - 20–50% of homeless women and children are homeless due to violence
- Homeless women are far more likely to experience violence compared with women who are not homeless
- Domestic violence shelters are prohibited from reporting client information→estimates undercount number of homeless women/families
- PTSD among women experiencing homelessness: ~40%





Homelessness and pregnancy intentions, San Francisco

	N=32	
Age (mean)	31 years	
Homeless >1 year	78%	
Unsheltered	69%	
Desire pregnancy in the next year*	(n=30)	
Yes	30%	
Don't know	17%	
How would you feel if you found out you were pregnant today?		
Somewhat or very happy	63%	
Unsure	14%	
Somewhat or very unhappy	27%	
* Two women were pregnant at the time of interview		

Seidman, Newmann, unpublished data 2018.

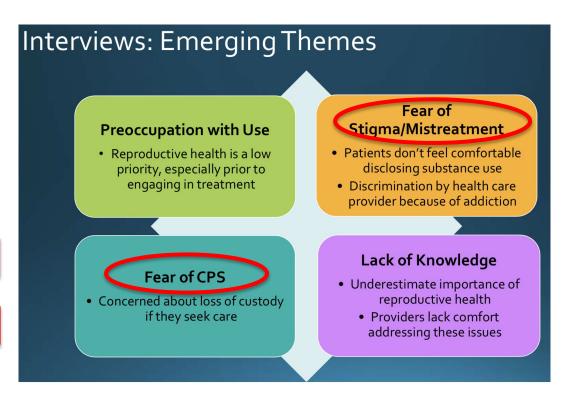




Women accessing care at substance use treatment programs, MI (N=271; facilities=30)

Reproductive Health History	Percent
Sex for money/drugs	55
Pelvic Inflammatory Disease	16
Hepatitis C	24
HIV/AIDS	1

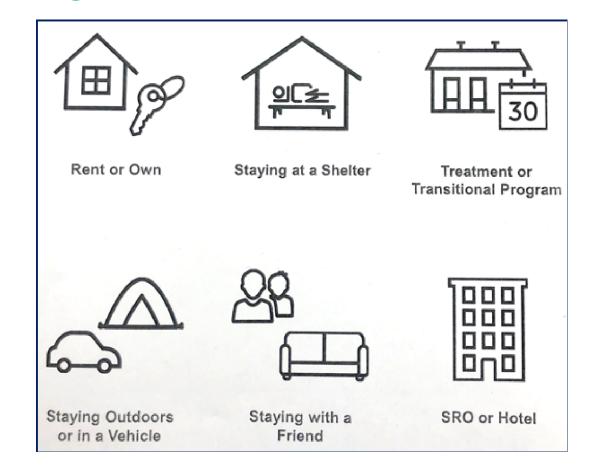
Barriers to Reproductive Health	Percent
Cost	43
Stigma/fear of mistreatment	36
Fear of results	23
Fear of child protective services (CPS)	27
Lack of transport	22
Don't know where to go	23







Identifying women who are homeless or have unstable housing



Dominika Seidman – Key Takeaways

Homelessness is a social determinant.

- What can we do?
 - Provide trauma informed care
 - Apply a reproductive justice lens to our work
 - Make any care visit (ER, jail, methadone) a prenatal or preconception visit
 - Develop partnerships to facilitate warm hand-offs
 - Investigate disparities in CPS outcomes, including processes for tox screening and referrals to CPS
 - Advocate for housing, particularly for pregnant women and families

CA CS Elimination Summit — Day 2

9:00 – 10:45	Pathways to Congenital Syphilis Elimination in California	
	Discussion Leaders: Ashley Dockter, MPH, Jessica Frasure-Williams, MPH & Nicole Burghardt, MPH	
11:00 - 11:45	Bridging Across Groups and STI Transmission Dynamics	
	Martina Morris, PhD	
1:00 – 1:45	Considerations for Statewide Third Trimester Screening Guidelines	
	Sarah C. Lewis, MD, MPH	
	Susan Philip, MD, MPH	
	Facilitator: Jessica Frasure-Williams, MPH	
1:45 – 2:45	Trauma Informed Care - What Is It? And Can It Help?	
1.45 – 2.45	mauma imormed care - what is it: And can it help:	
	Allison Briscoe-Smith, PhD	

Pathways to Congenital Syphilis Elimination

Ashley Dockter, MPH

California Department of Public Health | STD Control Branch

2018 California Congenital Syphilis Elimination Summit | Oakland, CA Thursday, September 20, 2018 | 9:00 – 10:45am



A Plan to Eliminate Congenital Syphilis in California

Vision

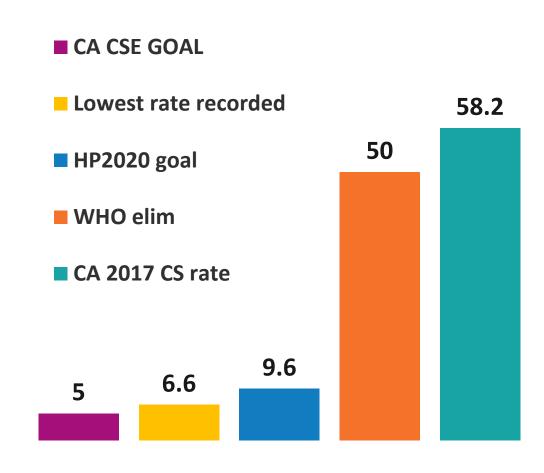
Achieve congenital syphilis elimination in California by 2023.

Purpose

Provide all stakeholders in congenital syphilis prevention with a specific, measurable goal and action steps to guide their prevention efforts.

Proposed Congenital Syphilis Elimination Goal

- Proposed elimination goal for births in CA: 5 per 100,000
 - Lowest rate in CA (2012) was 6.6 per 100,000
 - Healthy people 2020 goal is 9.6 per 100,000
 - WHO elimination defined as 50 per 100,000
 - CA CS rate in 2017 was 58.2 per 100,000
- Where: Statewide AND in every county with over 8,000 births
- By When: 2023



Audience: ALL stakeholders/partners in congenital syphilis prevention

Local health jurisdictions

State government agencies/programs

Healthcare providers

Communitybased organizations

Corrections

Academic and Private Sectors

Policy makers

The public

Framework





BRIDGING ACROSS GROUPS AND STI TRANSMISSION DYNAMICS

Locally grounded network models for HIV policy planning

Martina Morris, PhD
Departments of Statistics and Sociology
University of Washington



Project goals

Build locally grounded projection model to support HIV policy

Models have traditionally been built at the country level

- But there is significant variation in HIV prevalence <u>within</u> countries
- And in the US, prevention happens at the State/Local level
- Start with the heterosexual epidemic in King County

Why?

- Small, but potential for eradication
- First step towards a more comprehensive model
- It's a challenge...

MSM – Heterosexual bridging

- Several papers have shown evidence that there is substantial bridging across subpopulations
 - Based on phylogenetic clustering of HIV sequence data
- In the US: Oster et al. (2015)

"Of heterosexual women for whom we identified potential transmission partners,

- 29% were linked to MSM,
- 21% to heterosexual men
- a higher percentage of women in the West (52%) were linked to MSM"

Key bridging dynamics for Seattle (2)

Racial disparities, but with a specific local pattern

HIV Prevalence: 2016

	Estimated HIV Prevalence/100K
White	314.2
Black	1001.0
Hispanic	434.6

US Born
93%
56%
42%

We see large racial disparities

With profound differences in country of origin by race

Implications for prevention

- Transmission within the heterosexual population is below the persistence threshold in Seattle/King Co.
 - So if infections cross over a bridge to this population, the chains die out pretty quickly

- Boundary infections are the strategic target for prevention activities
 - These are small, identifiable bridging risk groups
 - Effective tailored prevention here will have a large impact

Take home messages

- It is now possible to model local STI epidemics with great fidelity to local empirical data
 - Transmission networks with subpopulations and bridges
 - Natural history of the specific STI pathogen
 - Care continuum
- The data <u>can</u> be collected at the local level
 - But are often not, esp. the network data
- The simulation results can be used to guide local policy
 - Once a model has been properly calibrated and validated



Considerations for Statewide Third Trimester Screening Guidelines

Sarah C. Lewis, MD MPH – Santa Clara County
Susan Philip, MD MPH – San Francisco County
Facilitated by Jessica Frasure-Williams, MPH - CDPH

California Congenital Syphilis Elimination Summit Thursday, September 20, 2018



Third trimester screening occurs when there are negative syphilis tests during pregnancy.

First prenatal screen
- non reactive
serologic tests for
syphilis

28-32 Weeks Third Trimester Screen



Testing for titer response after a syphilis diagnosis during pregnancy is not Third Trimester Screening

First prenatal screen - syphilis diagnosis

Third Trimester Follow-up Titer

First syphilis test during the third trimester are considered the first test and is not included as third trimester screening.

First prenatal visit - syphilis diagnosis

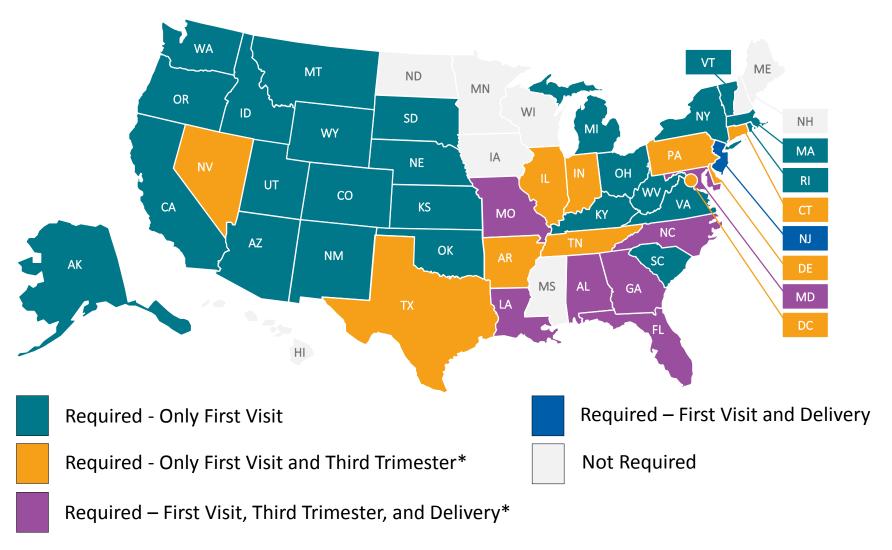
CDC Recommendations regarding third-trimester screening

For communities and populations in which the prevalence of syphilis is high and for women at high risk for infection, serologic testing should also be performed twice during the third trimester: once at 28–32 weeks' gestation and again at delivery.

California Counties with Third Trimester +/- Delivery Syphilis Screening Recommendations for All Pregnant Women



Prenatal Syphilis Screening Laws, 2016



^{*}The following states only require third trimester screening if the patient is at increased risk: Alabama, Indiana, Missouri, Pennsylvania, and Tennessee. The following states only require screening at delivery if the patient is at increased risk: Florida, Georgia, Louisiana, Maryland, and Missouri. Includes state statutes and regulations effective as of 2016

Considerations for Statewide Third Trimester Screening Guidelines – Key Takeaways

- California is meeting thresholds for cost effectiveness to justify statewide third trimester screening guidelines
- "All Public Health is Local" one size may not fit all
- You can affect change in practice when developing or changing clinical guidelines, if you bring all the partners together
- Risk-based screening is hard routine activity helps to normalize practice
- Bundle services together to reduce the number of visits, e.g. third trimester syphilis screening at the same time as Tdap and glucose testing

TRAUMA-INFORMED CARE: WHAT IS IT AND CAN IT HELP?

- Allison Briscoe-Smith, PhD
- The Wright Institute
- September 20th, 2018



FOUR R-S OF TRAUMA-INFORMED CARE

- Recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system
- Realizes the widespread impact of trauma and understands potential paths for recovery
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices and seeks to actively
- Resist re-traumatization
 - SAMHSA

TRAUMA = EVENT, EXPERIENCE, & EFFECT **Event** Actual or extreme threat of harm **Experience** Terror Helpless to Fight / Flight - Freeze horror escape pain Overwhelms brain and body **Effect Dysregulation Dis-integration**

Lasting adverse effects

SFDPH Trauma 101 Slide

REFRAMING RISK BEHAVIORS

- "High risk" behaviors that are attempts at: managing pain feeling in control
- Drugs and alcohol
- Risk-taking behavior
- Self-injurious behavior
- Aggression
- High risk sexual behaviors (where any connection feels better than abandonment and isolation)

TRAUMA AND SUBSTANCE ABUSE

 Co-occurring diagnosis of PTSD and Substance Abuse in addiction treatment facilities - 12% - 34%

• Women in substance treatment – 30% - 59%

Men in substance treatment – 11% - 38%

Typically PTSD symptoms preceded the onset of substance abuse.

Najavits, L. M., (2002) Seeking Safety A Treatment Manual for PTSD and Substance Abuse.

New York: Guilford

TRAUMA AND HIV

- Women who have HIV
 - 55% have experienced IPV
 - 2 times the national rate
 - 61% have histories of sexual abuse
 - 5 times the national rate
 - 30% have PTSD
 - 5 times the national rate

Machtinger, et al AIDS and Behavior, 2012; 16(8): 2091-2100

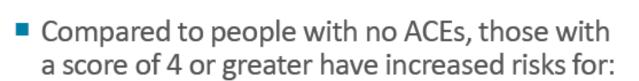
Types of Adverse Childhood Experiences in the ACE Questionnaire

- ✓ Substance abuse among household members
- ✓ Parental separation or divorce
- ✓ Mental illness among household members
- Physically abused by a mother or step-mother
- Criminal behavior among household members
- ✓ Abuse psychological, physical, or sexual
- ✓ Neglect, both emotional or physical





Impact of Trauma: 4 or More ACEs = Tipping Point





» Sexually-Transmitted Infections: 240% greater risk

» Smoking: Twice as likely

» Suicide Attempts: 12 times more likely

» Alcoholism: 7 times more likely

» Injecting Street Drugs: 10 times more likely

Total estimated lifetime costs associated with one year of child maltreatment: \$124 billion



SOURCE: J. Stevens. The Adverse Childhood Experiences Study — the largest, most important public health study you never heard of — began in an obesity clinic. ACEs Too High. Centers for Disease Control and Prevention. 2012.



VICARIOUS TRAUMA (VT)

• Vicarious Trauma is the <u>process of change</u> that happens because <u>you care</u> about the people you serve. Over time, this can lead to changes in your <u>psychological</u>, <u>physical</u>, <u>and spiritual life</u> that also affect <u>your family</u>, <u>your organization</u>, <u>and your patients/clients</u>.

Pearlman, L.A. & McKay, L. (2008). Understanding and addressing vicarious trauma. www.heading-institute.org

Trauma informed care – What can you do?

- Respond through training
 - Develop shared language around trauma
 - Understand what trauma does to the body, relationships, thinking & behavior
 - Understand the intersection of trauma & health related behaviors & risks
 - Develop & refine your intervention with trauma in mind
- Respond through assessment
 - Use screening techniques to identify trauma
 - Shift from 'what is wrong with you?' to 'what has happened to you?'

Allison Briscoe-Smith – Key Takeaways

- Trauma informed care is high quality, evidence-based practice that attends to the impact of trauma on health, relationships and systems.
- Experiences of trauma may result in adaptive behavior that are attempts at managing pain and being in control, but increase health risk and in turn can lead to poor health outcomes.
- There is overlap at the county-level for high syphilis rate among females of childbearing age/congenital syphilis, high adverse childhood events (ACEs) score, and low women's wellness index.
- There are resources and identifiable strategies within reach to integrate into our congenital syphilis prevention work.
- We need to support each other on the potential vicarious trauma that we experience in doing this work.

Thank you

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