Putting *Trauma-Informed Care into Practice Series*

**Implementing Trauma-Informed Care in Pediatric and Adult Primary Care Settings**

October 16, 2017, 1:00-2:30 pm ET

For Audio Dial: **888-576-4390**

Passcode: **964379**

*Made possible through support from the Robert Wood Johnson Foundation*
Questions?

To submit a question, please click the question mark icon located in the toolbar at the top of your screen.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Multi-year initiative supported by the Robert Wood Johnson Foundation

**Objective:** Understand and spread practical strategies for implementing trauma-informed approaches across the health care sector.

- **Two-year multi-site pilot demonstration** and learning collaborative with six leading health care organizations
- **National dissemination** of project lessons to spread emerging best practices
- **Implementation analysis** conducted by the Urban Institute
Individual trauma results from an event, series of events, or set of circumstances that are experienced by an individual as physically or emotionally harmful or life threatening and that have lasting effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

- Substance Abuse and Mental Health Services Administration (SAMHSA)
Types of Adverse Childhood Experiences (ACEs) in the ACEs 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: Health, Behavior, and Life Potential

- ACEs can have lasting effects on...

**Health** - obesity, diabetes, depression, suicide attempts, STIs, heart disease, cancer, stroke, COPD, broken bones

**Behaviors** - smoking, alcoholism, drug use

**Life potential** - graduation rates, academic achievement, lost time from work

ACEs have been found to have a graded dose-response relationship with 40+ outcomes to date.

*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcomes.*

SOURCE: Centers for Disease Control and Prevention, “About the ACEs Study”. Available at: https://www.cdc.gov/violenceprevention/acesstudy/about.html
What is Trauma-Informed Care?

- Takes the individual’s experience of trauma into account
- Instead of asking “What’s wrong with you?” asks “What happened to you?”
- Must occur at clinical AND organizational levels


“Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture change is like throwing seeds on dry land.”

-Sandra Bloom, MD, creator of the Sanctuary Model
## Key Ingredients of Trauma-Informed Care

### ORGANIZATIONAL

1. Lead and communicate about the transformation process
2. Engage patients in organizational planning
3. Train clinical as well as non-clinical staff members
4. Create a safe environment
5. Prevent secondary traumatic stress in staff
6. Hire a trauma-informed workforce

### CLINICAL

7. Involve patients in the treatment process
8. Screen for trauma
9. Train staff in trauma-specific treatment approaches
10. Engage referral sources and partner organizations

Core Principles of a Trauma-Informed Approach

**Patient empowerment:** Using individuals’ strengths to empower them in the development of their treatment

**Choice:** Informing patients regarding treatment options so they can choose the options they prefer

**Collaboration:** Maximizing collaboration among health care staff, patients, and their families in organizational and treatment planning

**Safety:** Developing health care settings and activities that ensure patients’ physical and emotional safety

**Trustworthiness:** Creating clear expectations with patients about what proposed treatments entail, who will provide services, and how care will be provided

Source: M. Harris and R. Fallot (Eds.). “Using Trauma Theory to Design Service Systems.” New Directions for Mental Health Services, no. 89; (2001).
Today’s Speakers and Agenda

Using ACEs Screening to Inform Pediatric Practices

Nadine Burke-Harris MD, MPH, FAAP, Founder and CEO, Center for Youth Wellness

Adopting Trauma-Informed Primary Care to Treat a Complex Adult Patient Population

Edward Machtinger, MD, Professor of Medicine and Director of the Women’s HIV Program at University of California, San Francisco
Prevent, Screen and Heal

Nadine Burke Harris, MD, MPH, FAAP
CEO/Founder, Center for Youth Wellness
October 16, 2017
Adverse Childhood Experiences

**ABUSE**
- Physical
- Emotional
- Sexual

**NEGLECT**
- Physical
- Emotional

**HOUSEHOLD DYSFUNCTION**
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce

Image courtesy of the Robert Wood Johnson Foundation
ACEs Across Race and Ethnicity

“A Hidden Crisis: Findings on Adverse Childhood Experiences in California,” Center for Youth Wellness and Public Health Institute 2014
State Ranking Map of the Proportion of Children 0-17 with $\geq 2$ ACEs

Prevalence of Adverse Child and family Experiences among US Children Age 0-17 years, 2011/2012 National Survey of Children’s Health
Source: Bethell, C 2016
ACEs Dramatically Increase Risk for 7 out of 10 Leading Causes of Death

<table>
<thead>
<tr>
<th>Leading Causes of Death in US, 2013</th>
<th>Odds Ratio Associated with ≥ 4 ACEs</th>
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<tbody>
<tr>
<td>1  Heart Disease</td>
<td>2.1</td>
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<tr>
<td>2  Cancer</td>
<td>2.3</td>
</tr>
<tr>
<td>3  Chronic Lower Respiratory Diseases</td>
<td>3.0</td>
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<tr>
<td>4  Accidents</td>
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<tr>
<td>5  Stroke</td>
<td>2.4</td>
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<td>6  Alzheimer’s</td>
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<tr>
<td>7  Diabetes</td>
<td>1.5</td>
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<tr>
<td>8  Influenza and Pneumonia</td>
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<td>9  Kidney Disease</td>
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<tr>
<td>10 Suicide</td>
<td>30.1</td>
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Odds Ratio associated with ≥ 4 ACEs
CDC 2015, Feletti 1998, BRFSS 2013, Hughes 2017
Health and Behavioral Outcomes in Children

- Developmental delay
- Growth delay
- Failure to thrive
- Sleep disruption
- Asthma
- Pneumonia
- Viral infection
- Atopic disease
- Learning difficulties
- Behavioral problems
- Obesity
- Diabetes
- Headache
- Abdominal pain
- Teen pregnancy
- Hyperthyroidism
- Pubertal changes

The Biology of Adversity
Multi-systemic Alterations

Neurologic
- Dysregulation of HPA and SAM Axes
- Activation of the amygdala
- Inhibition of the prefrontal cortex
- Hippocampal neurotoxicity
- VTA and reward center dysregulation

Immunologic
- Increased inflammatory mediators and markers of inflammation such as interleukins, TNF alpha, IFN-γ
- Inhibition of anti-inflammatory pathways
- Impaired cell-mediated acquired immunity

Multi-systemic Impacts

**Endocrine**
- Long-term changes in ACTH, cortisol, adrenaline and other hormones
- Inhibition of thyroid function
- Alterations in Growth Hormone and pubertal hormones

**Cardiovascular**
- Increased plasma endothelin 1, total peripheral resistance, DBP and pulse wave velocity

**Epigenetic**
- Altered epigenetic regulation leads to differential gene expression
- Changes in the way DNA is read and expressed leads to changes in the way the brain and organ systems respond to stress.
- Telomere erosion leads to premature cell death and altered cell replication
EARLY LIFE ADVERSITY

Protective factors → Predisposed vulnerability

TOXIC STRESS

CLINICAL IMPLICATIONS

<table>
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<tr>
<th>Epigenetic</th>
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<td>Inflammatory</td>
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<td>Cardiovascular</td>
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Adapted from Bucci 2016
We can mitigate the impacts of ACEs with early identification and intervention
Education and Intervention

Screening

Prompt intervention

Enhance protective factors

Appropriate treatment
## Screening Tool

**CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child**

<table>
<thead>
<tr>
<th>To be completed by Parent/Caregiver</th>
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</thead>
<tbody>
<tr>
<td>Today’s Date: ______________________</td>
</tr>
<tr>
<td>Child’s Name: ______________________ Date of birth: ______________________</td>
</tr>
<tr>
<td>Your Name: ______________________ Relationship to Child: ______________________</td>
</tr>
</tbody>
</table>

Many children experience stressful life events that can affect their health and well-being. The results from this questionnaire will assist your child’s doctor in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number on the line provided.

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box.  

### Section 1. At any point since your child was born...
- Your child’s parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child’s private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box.

### Section 2. At any point since your child was born...
- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

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- Child and teen versions
- Self-report/caregiver report
- Responses de-identified
**Scoring Algorithm**

- **ACE Score 0-3 w/o symptoms**
  - Anticipatory guidance

- **ACE 1-3 with symptoms or ≥4**
  - Counsel and Refer
Clinical Presentation

• 2 year 9 mo female presents for Well Child Exam

• Presenting concern: Growth – Patient is “small”. Previously had diarrhea when she started on cow’s milk. Symptoms went away when mom changed to almond milk.

• Otherwise well. No other complaints.
History

- BHx: Full term, NSVD, BW: 6lb 8oz (25%)
- Growth Hx: Went from 25% height and weight to progressively decreasing until she was consistently below the 3rd percentile for height, weight and BMI.
- Previous doctor said that they need to offer her more foods and recommended PediaSure but it didn’t seem to help.
- Mom’s height is at 30%, dad’s height is at 20%
Evaluation

- Normal physical exam, initial labs. Delayed skeletal maturity (chronological age 3y 7m, bone age 2y 6m)
- ASQ: WNL
- MCHAT: WNL
- ACE Score – 7+0
Assessment

- 2 yr 9 month female with failure to thrive. Likely due to toxic stress physiology.

Plan:

- Sleep, Exercise, Nutrition, Mindfulness, Mental Health, Healthy Relationships
- PediaSure, 1 can BID
- Referred to WIC
- Referred to CYW for Child Parent Psychotherapy (CPP)
Multidisciplinary Care

• Explanation to mom about the pathophysiology of toxic stress:
  
  • “I think that because of what your daughter has experienced, her body is making more stress hormones than it should and this may be what’s affecting her growth. I want to refer you to a specialist that help you learn how to support her and reduce the amount of stress hormones that her body is making.”
  
  • “We also know that a healthy caregiver is one of the most important ingredients for healthy children, so an important part of helping your daughter heal will involve managing your own stress level and practicing taking care of yourself.”
Multidisciplinary Care

• Connection to Child Parent Psychotherapy (CPP). Warm hand-off would be the gold standard, but referral with follow up is more typical.

• Discussion with treating mental-health clinician about the pathophysiology of toxic stress.

• Buy-in from the entire team (including mom) about diagnosis and treatment plan.
Discussion

Toxic stress response:

• Neuro-endocrine-immune and genetic regulatory disruption

• There is currently no established clinical diagnostic criteria for toxic stress. An ACE screen can help us identify patients who might be experiencing a toxic stress physiology and deliver more effective and efficient care.
Discussion

Treatment strategy:

• Reducing the dose of adversity – decreased activation of the HPA axis, decrease adrenaline and cortisol dysregulation

• Enhancing the ability of the caregiver to provide a safe, stable and nurturing environment, as well as regulate her own physiology so that she can biologically buffer the child’s stress response is critical, especially for younger kids.

• The 2-generation nature of the CPP intervention was important for this age range.
Corollary

• 9 month-old brother, who was not the index patient, also had 3 ear infections and 2 pneumonias in his first year of life.

• Seemed like he was “always sick”, per mom.

• Referred to ENT for evaluation of frequent ear infection.

• After CPP intervention started, patient had many fewer URI’s and no more ear infections in the subsequent year.
National Pediatric Practice Community

• Integrating ACEs screening into the workflow and using a toxic stress framework to enhance the quality of patient care and health outcomes.

- Support Early Adopter Pediatricians
- Foster Partnerships & Awareness
- Learn Together
- Educate on Emerging Science
- Develop Best Practices
- Spread What Works
- Collect Data
- Prepare for Validated Screening Tool

NPPCaces.org
Questions?

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From Treatment To Healing

The Promise of Trauma-informed Primary Care

Edward Machtinger, MD
Professor of Medicine
Women’s HIV Program
University of California, San Francisco
Edward.machtinger@ucsf.edu
Learning Objectives

1. Discuss a practical model of trauma-informed primary care (TIPC) for adults;

2. Identify solutions to challenges we encountered implementing the model; and

3. Propose steps you can take right now to move towards a more trauma-informed approach.
WHP Project Team

**Clinical Implementation Team:**
- Edward Machtinger
  MD, Professor of Medicine
- Katy Davis,
  LCSW, PhD, Director of Trauma-Informed Care
- Beth Chiarelli
  LCSW, Social Work Lead
- Esther Chavez
  Social Work Associate
- Roz DeLisser
  NP; Lead, HERS Substance Use Program

**Partner Organizations in Clinic:**
- South Van Ness Behavioral Health Services
  Family Case Management/therapy
- Catholic Charities/Rita de Casia
  Family Case Management
- Medea Project: Theater for Incarcerated Women
  Expressive Therapy Intervention
- Positive Women’s Network-USA (PWN-USA)
  Peer-based Leadership and Empowerment Intervention

**Peer-Empowerment Team:**
- Naina Khanna
  Executive Director, PWN-USA
- Vanessa Johnson
  J.D., Training and Leadership Director, PWN-USA
- Rhodessa Jones
  Medea Project: Theater for Incarcerated Women

**WHP Research Team:**
- Carol Dawson-Rose
  PhD, RN, Professor of Nursing, Dir. of Research & Eval
- Yvette Cuca
  PhD, MPH, Research Specialist
- Martha Shumway
  PhD, Professor

**WHP Administrative Team:**
- Al Paschke
  RN, Administrative Nurse Manager
- Vishalli Loomba
  Program Coordinator
The Women’s HIV Program at UCSF

Among first programs in country for women living with HIV
Female-focused services provided in a “one-stop shop”

- Primary care
- Pharmacy program
- Ob/GYN
- Therapy / Psychiatry
- Social work
- Case management
- Partner agencies
- Case management
- Breakfast

Patients

- Mostly African American or Latina
- 15% transgender women
- 15-71 years old
- Marginally housed, low income
- Medically and psycho-socially complex
Recent Deaths at WHP

1. Rose  *murder*
2. Amy   *murder*
3. Patricia  *suicide*
4. Regina  *suicide*
5. Vela   *suicide*
6. Iris   *addiction/overdose*
7. Mary   *addiction/organ failure*
8. Nadine  *addiction/lung failure*
9. Lilly  *pancreatic cancer*
10. Pebbles  *non-adherence*
A Model Based on Evidence and Experience

- Expert meeting
- Follow-up consultations
- Literature review
- Identified existing evidence-based strategies to use as building blocks
Trauma-informed Primary Care

SCREENING
Inquiry about current & lifelong abuse, PTSD, depression and substance use.

RESPONSE
Onsite and community-based programs that promote safety and healing.

FOUNDATION
Trauma-informed values, robust partnerships, clinic champions, support for providers and ongoing monitoring and evaluation.

Responding to IPV

Prioritizing Safety and Autonomy

1. Safety Plan

2. Danger Assessment

3. Link with DV/legal agencies

4. Prompts and Standardized documentation in EMR

5. Clinic-wide panel management of active IPV cases
# Healing from Lifelong Trauma: Improving Damaged Connections

## Improving Connections with Others

1. Trauma-specific individual and group therapies

2. Peer-led empowerment, support and leadership training.

## Improving Physiological Connections

3. Trauma specific psychiatry and physiologic techniques

## Improving Connections with Our Bodies

4. Body/Mindfulness-Focused Healing

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Lessons: Our first steps

• Educate all of our staff about trauma and health

• Look for community partnerships
  ▪ Trauma Recovery Center
  ▪ Medea Project Expressive Therapy
  ▪ Positive Women’s Network - USA

• Create a calmer environment
Lessons: Supporting our Team

Make time for an interdisciplinary team meeting prior to every clinic

- Unburden individual clinicians with weight of “holding” so many intense patient situations
- Create community and respect among all types of providers and community partners
- Coordinate care and logistics for pending clinic
Lessons: Coordinating Care

Coordinating TIPC Services: Creating a psychosocial “service matching team”

Patients
- Algorithm for assessing needs; identifying and connecting to appropriate services
- Coordination so services are not fragmented; resources are appropriately allocated; and patients receive care best suited to their needs

Clinic/clinicians
- Build cohesion across agencies
- Coordinate services and compare perspectives
- Educational and emotional support
- Prioritize psychosocial aspect of care
Lessons: Stakeholder Input

• Patient input needs to be consciously integrated in an ongoing way

• Patient priorities are not always the same as clinic priorities:
  ▪ Focus group discussions led by Positive Women’s Network-USA (PWN)
  ▪ Monthly stakeholder group meeting

Naina Khanna, Executive Director, Positive Women’s Network - USA
Lessons: Addressing Substance Use

• Many patients have been unable to participate in trauma interventions due to active substance use

• A few patients who did participate in trauma interventions relapsed afterwards

• A study of our patients by Katy Davis, LCSW, PHD, identified substance use as a key factor why women stay in abusive relationships
  - New SAMHSA grant to integrate medication-assisted treatment and substance use counseling into trauma-informed primary care clinic
What Can You Do Tomorrow?

1. **Realize** that a lot about who we are and what we do are because of things that happened to us.

2. **Embrace** trauma-informed values for yourself.

3. **Distribute literature** in the waiting room about the impact of trauma on health.

4. **Get training (ideally for the clinic)** about the impact of trauma on health, trauma-informed skills, and screening for IPV and the impacts of lifelong trauma.

5. **Assemble a team** that is interested in this issue to get educated, collaborate on steps forward and support one another in the process.
Conclusions

• People can heal; deep cycles of violence can be broken; ACEs in children can be reduced; and entire communities can benefit by addressing trauma in adults

• The problems faced by most of our patients can be more effectively treated if primary care becomes genuinely trauma-informed

• TIPC holds the potential to transform the caregiving experience for providers, creating environments and supporting them to be healers
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Upcoming Webinar

Implementing Trauma-Informed Care into Organizational Culture and Practice

October 30, 12:30-2:00 pm ET

Building a Trauma-Informed Organizational Culture

Ken Epstein, PhD, LCSW, Director, Child, Youth, and Family System of Care, San Francisco Department of Public Health

Implementing Trauma-Informed Care Across a Health System

Rahil Briggs, PsyD, Director of Pediatric Behavioral Health Services at Montefiore Medical Group

Visit www.chcs.org to register.
Learn about CHCS' Advancing Trauma-Informed Care project

Download practical resources for adopting trauma-informed approaches to care, such as:

- Key Ingredients for Successful Trauma-Informed Care Implementation
- Strategies for Encouraging Staff Wellness in Trauma-Informed Organizations
- Understanding the Effects of Trauma on Health

Subscribe to CHCS e-mail and social media updates to learn about new programs and resources