Webinar Q&A: Implementing Trauma-Informed Care in Pediatric and Adult Primary Care Settings

Event Date: October 16, 2017

Responses from Nadine Burke Harris, MD, MPH, FAAP CEO, Center for Youth Wellness

1. ***How does one become a member of the National Pediatric Practice Community (NPPC), and do you have to be in a pediatric practice or can you be an interested professional in a different field?***
   Currently, the National Pediatric Practice Community (NPPC) on Adverse Childhood Experiences (ACE) is specifically targeted toward pediatric medical providers. For more information on NPPC and for information on how to join, please follow this link.

2. ***How may we obtain the Center for Youth Wellness' (CYW) Adverse Childhood Experiences Questionnaire (ACE-Q)?***
   A copy of the ACE-Q can be obtained here, along with a user guide document.

3. ***Without knowing which specific adverse experiences the child has experienced (since only an ACE score is calculated from the screening tool), how can you refer the appropriate psychological and social support?***
   The CYW ACE-Q is intended as a rapid way to screen all patients in a primary care setting for cumulative exposure to adversity and risk of experiencing a toxic stress physiology. Treatment is multidisciplinary, but typically includes a referral to mental health where a more detailed history is obtained to inform psychological and social support. However, CYW is learning more about how understanding of whether the patient has a toxic stress physiology can and should inform clinical management of comorbid conditions such as asthma, attention-deficit/hyperactivity disorder, and growth failure. CYW is working to develop clinical considerations for these comorbid conditions based on the science of toxic stress.

4. ***Understanding the nearly universal impact of trauma, do you think it is possible to have these conversations without an ACE screening tool, or is it a requirement for these types of conversations?***
   I think that it's important for us to stratify patients by risk and do clinical management, surveillance and monitoring accordingly. Just as we perform a body mass index and then use that information to stratify patients by risk and do further investigation and management for patients at high risk, the same is true for ACEs and toxic stress. This also speaks to the question of resource allocation. In order for CYW to make the policy case for resources for ACE/toxic stress intervention, we need to show that we can improve outcomes for high-risk patient populations.

5. ***If patients cannot make it to interventions by the multidisciplinary team, are home visits an option in your program?***
   Yes, CYW understands that coming to the clinic to access multidisciplinary treatment, especially weekly psychotherapy, may be a barrier for some families. CYW assesses this need during the initial outreach and engagement process. Care coordinators may then conduct the comprehensive intake process at the family's home, and psychotherapy may be offered in the home or at the child's school.

6. ***Can you please describe the concept and benefits of Child-Parent Psychotherapy (CPP)?***
   CPP is an empirically validated treatment for trauma-exposed children under the age of six. It is a dyadic treatment, meaning that therapeutic sessions include the child and her/his parent or primary caregiver. It is based in attachment theory, but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Key components include a focus on safety, affect regulation, improving the child-caregiver relationship,

normalization of trauma-related response, and joint construction of a trauma narrative with the goal of returning the child to a normal developmental trajectory. More information can be found at: http://childtrauma.ucsf.edu.

7. ***After engaging leadership and interested staff, how would you recommend developing a team to address ACEs? What are some key first steps?***

CYW recommends the following:

- Consider if your practice has all the necessary staffing, support and resources in place—and/or what you need to put in place—to successfully implement ACEs screening.
- Identify and empower a leader, ideally someone who is a long-time faculty or staff member and can provide continuity in the event of staff turnover. They should be a champion who is willing to lead the campaign, with your support.
- Demonstrate that this isn't simply one person's crusade and that your efforts are at the cutting-edge of where pediatric health care is headed. In fact, the American Academy of Pediatrics (AAP) launched The Resilience Project ("We Can Stop Toxic Stress") and has issued policy statements and reports about the critical role pediatric clinicians should play in preventing and mitigating the health effects of ACEs and toxic stress. Piggyback on AAP's support for addressing ACEs and toxic stress to lend additional legitimacy to your efforts.
- Your plan for screening should be developed in parallel to your educational efforts. Develop a concrete, achievable plan with distinct phases to prepare people for the stages and timing. For example, you may want to include your rationale for screening, program goals, a timeline, target population, screening tool options, ideas for workflow integration, and suggested interventions and partnerships.

8. ***What are some of the strategies/methods used to increase the parents' buy-in to clinical intervention(s)?***

In my experience, it makes a huge difference when the primary care provider explains to the family what we believe is going on. For example, we had a patient with five diagnoses—obesity, insulin resistance, asthma, depression and PTSD. I believe it is really important for the primary care provider to say to the family, "we believe that adversity may be at the root of all of these problems. Because of what your child has experienced, her body may be making more stress hormones than it should. This can affect weight, insulin sensitivity, risk of asthma, and mood. I'd like to refer you to my mental health colleague and we really want to focus on helping you and your child develop the tools to reduce the amount of stress hormones her body is making."

Responses from Eddy Machtinger, MD Professor of Medicine, Director University of California, San Francisco, Women's HIV Program

1. ***What trainings do you recommend for employees?***
We recommend three core trainings for all staff in all positions: (1) Trauma 101—which covers how trauma impacts health and behavior and ways to help patients and providers heal and cope with it; (2) How Trauma Impacts Staff/ Vicarious Traumatization; and, (3) Cultural Humility and Responsiveness. At the San Francisco Department of Public Health, they do a four-hour Trauma 101 training for all staff throughout their system. From this, champions emerge who receive further training to support and inform their leadership in their specific clinical domains. In our clinic, we had the luxury of doing all three trainings by closing the clinic for three half-days over the course of three months. We videotaped these trainings and now new hires are required and supported to watch the videos as a part of their onboarding to the clinic. One thing that has also been helpful is having our trainer come to our clinic after the three core trainings for periodic, two-hour follow up trainings to address practical issues that arise (e.g., de-escalation of a conflict with an upset patient from a trauma-informed perspective).

2. ***How do you make the physical environment trauma-informed?***
There are a number of ways to foster a sense of security and safety and make the physical environment more trauma-informed. We began this process by assessing how our waiting room was perceived by patients. It was noisy and chaotic, so we focused our attention on addressing this. To do this, we trained our receptionists in trauma-informed care and encouraged them to walk around the front desk and greet patients face-to-face upon entry. We also plan to hire a peer who is positioned in the waiting room to welcome patients and help them navigate the clinic. Pepper, a therapy dog, is also positioned in the waiting room to help calm patients and staff. Lastly, to break down the barriers between staff and patients, we started offering a hot breakfast in one of the conference rooms where everyone can come together and socialize. The effect of this has been to decompress the waiting area and allow for certain patients to socialize and others to remain more private. One thing to emphasize about the physical environment: creating a safe and comfortable trauma-informed space is much more about personal relationships and interactions then it is about physical structure. All the fish tanks and warm colors in the world cannot overcome a stressed and judgmental staff. On the flip side, a staff that is trauma-informed, nonjudgmental, compassionate, and loving can create safety and comfort in practically any environment.

3. ***Do you recommend any trauma-informed waiting room materials for patients?***
We feel that there are many opportunities to create better materials to educate patients on the impact of trauma on health and opportunities to heal and cope. The most useful materials that we have encountered thus far come from Futures Without Violence, the majority of which focus on staying safe in the setting of intimate partner violence (e.g. intimate partner violence safety cards and posters for multiple populations). These materials are free and can be ordered from their website: https://www.futureswithoutviolence.org/. More materials addressing lifelong trauma and its impact on health and wellness will emerge soon given the increasing amount of attention being paid to this specific issue.