AGENDA

AAP-CA2 and First 5 LA ACEs Aware Peer-to-Peer Learning Session 2: Childhood Adversity & Health Systems Change

February 11, 2021 • 6:00 – 7:30 p.m.			
Item	**Description**	**Presenter**	**Time**
1	Welcome	Christine Thang, MD, FAAP	6:00 – 6:10 (10 min)
2	Childhood Adversity & Health Systems Change	Adam Schickedanz, MD PhD FAAP	6:10 – 6:35 (25 min)
3	Q&A	Adam Schickedanz, MD PhD FAAP	6:35 – 6:40 (5 min)
4	Clinical Case Study	Adam Schickedanz, MD PhD FAAP	6:40 – 6:45 (5 min)
5	Breakout: Discuss Case Study	Facilitators from AAP-CA2 ACEs Committee and First 5 LA	6:45 – 7:10 (25 min)
6	Idea Share from Breakouts	Adam Schickedanz, MD PhD FAAP	7:10 – 7:25 (15 min)
7	Closing and Evaluation	Tina Chinakarn, MPH, First 5 LA	7:25 – 7:30 (5 min)

Upcoming sessions will be posted on: https://aapca2.org/aces-aware/

BIOGRAPHY

Adam Schickedanz, MD PhD FAAP

Adam Schickedanz is a general pediatrician and health services researcher at UCLA who works clinically within the Los Angeles County Department of Health Services at Olive View-UCLA Medical Center. His work focuses on developing new models of pediatric primary care to address families' social and economic determinants of health. He has helped large and small health systems and clinics implement assessment and evaluation programs to address patients' basic needs, including food, housing, and transportation.

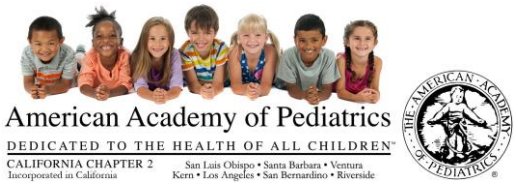
Dr. Schickedanz received his medical training at UCSF and came to Los Angeles as a Robert Wood Johnson Clinical Scholar at UCLA. He received his doctorate in Health Policy and Management at the UCLA Fielding School of Public Health, focusing on the relationships between Adverse Childhood Experiences (ACEs) in one generation and behavioral health problems in the next generation of children.

Dr. Schickedanz is currently on faculty in the UCLA Department of Pediatrics in Westwood. He is also the Chair of the ACEs Committee of the Southern California American Academy of Pediatrics Chapter.

American Academy of Pediatrics – Chapter 2 (AAP-CA2) and First 5 LA present:

ACEs Aware Peer-to-Peer Learning Series

A Provider Engagement Activity



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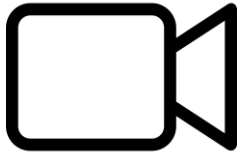
Zoom Etiquette

Please MUTE yourself upon entering the Zoom call;
Unmute yourself before you speak
(press *6 to unmute yourself and *9 to raise hand via phone)

Add your organization to your name;
Hover over your name in the Participant box to “Rename”

Feel free to use the chat box throughout the meeting

Join us by video if you can!



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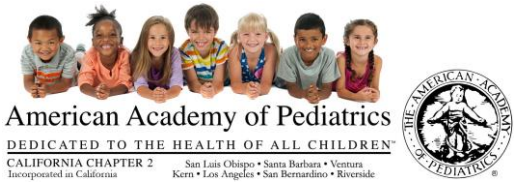

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Childhood Adversity & Health Systems Change

Adam Schickedanz, MD PhD

Department of Pediatrics
University of California Los Angeles

February 11, 2021

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David Geffen School of Medicine | UCLA Health System

Learning Objectives:
By the end of this session, learners will be able to…

- Describe common barriers to identifying and addressing adverse childhood experiences
- Examine health system barriers to identifying and addressing adverse childhood experiences in their own practices.
- Assess readiness to deliver trauma-informed care in one's practice

Recap of Last Session - January 7th with Dr. Christine Thang

ACEs Study Conclusions from Dr. Anda:

- *ACEs are common.*
- *The cumulative impact of multiple exposures can be captured in an "ACE Score".*
- *The ACE Score likely captures the cumulative (neuro)developmental consequences of traumatic stress.*
- *The ACE Score has a strong, graded relationship to numerous health, social, and behavioral problems throughout a person's lifespan.*

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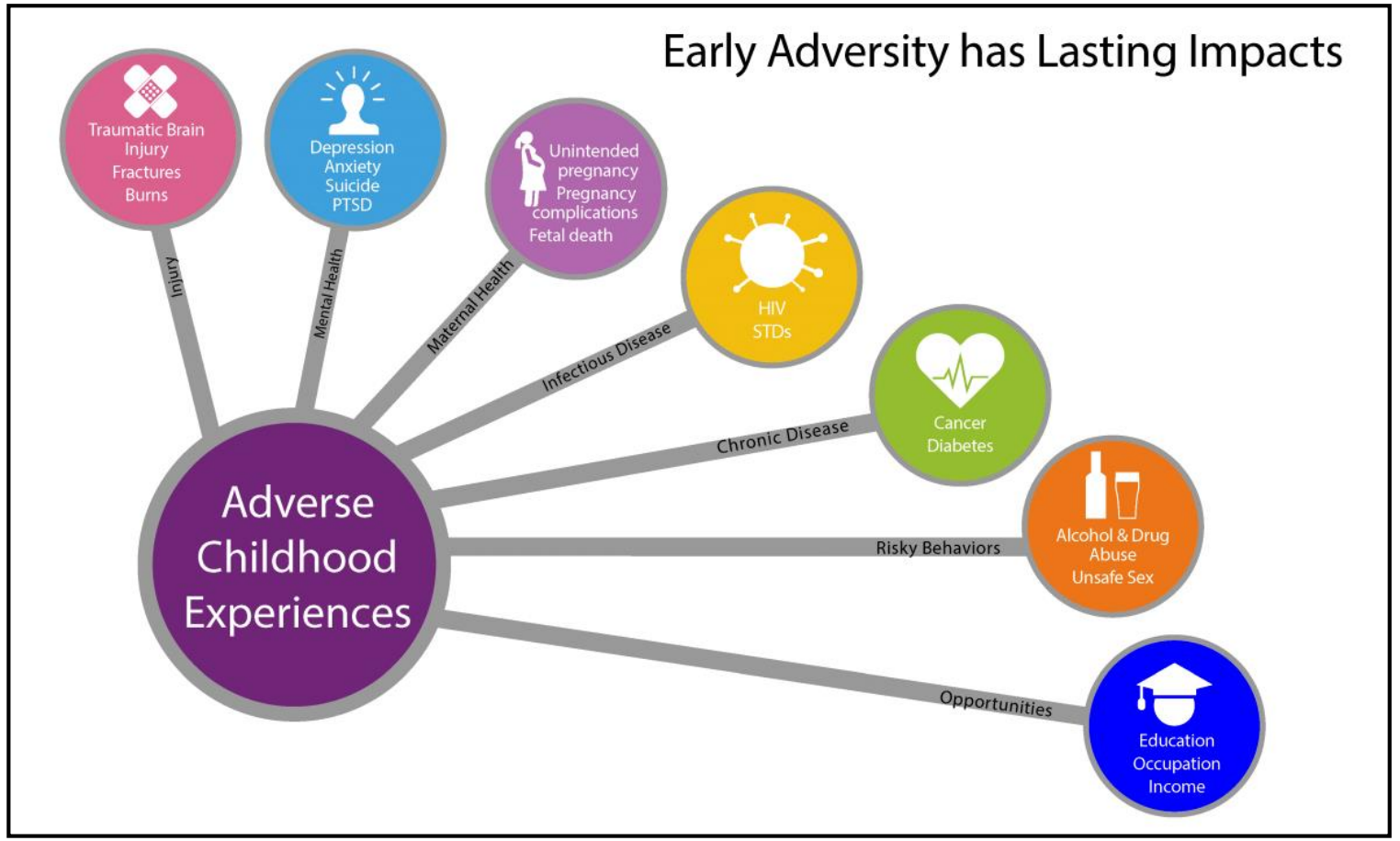
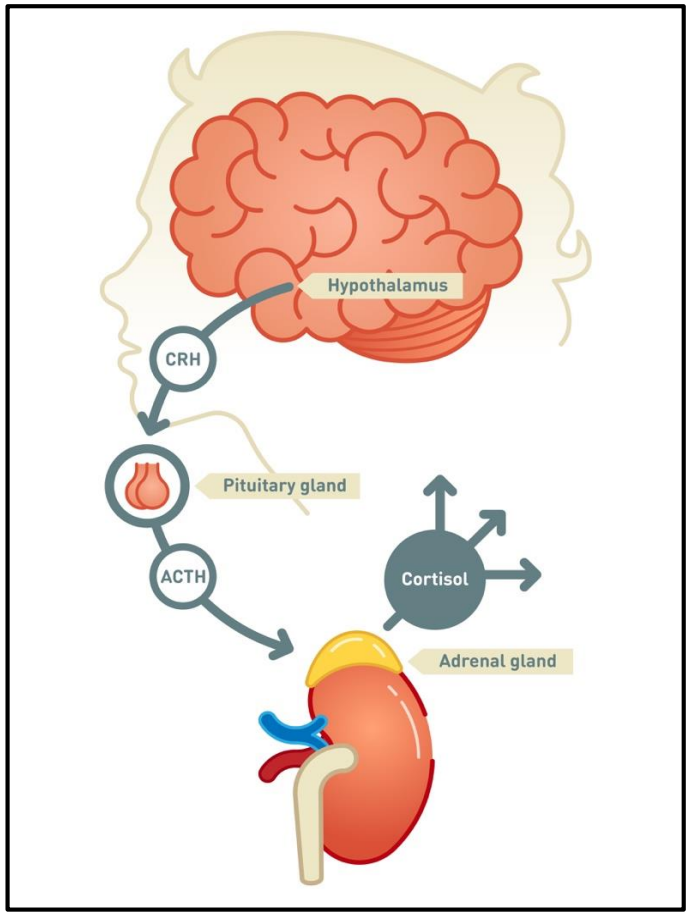
[1]Anda R. The Health and Social Impact of Growing Up With Adverse Childhood Experiences The Human and Economic Costs of the Status Quo.

Adversity, Neuroendocrine Response, & Life Course Health Outcomes





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THREADS: The Resiliency Factors of Childhood

Resiliency skills as the **THREADS** of childhood:

- **T**hinking and learning brain
- **H**ope
- **R**egulation or self control
- **E**fficacy
- **A**ttachment
- **D**evelopmental skill mastery
- **S**ocial connectedness

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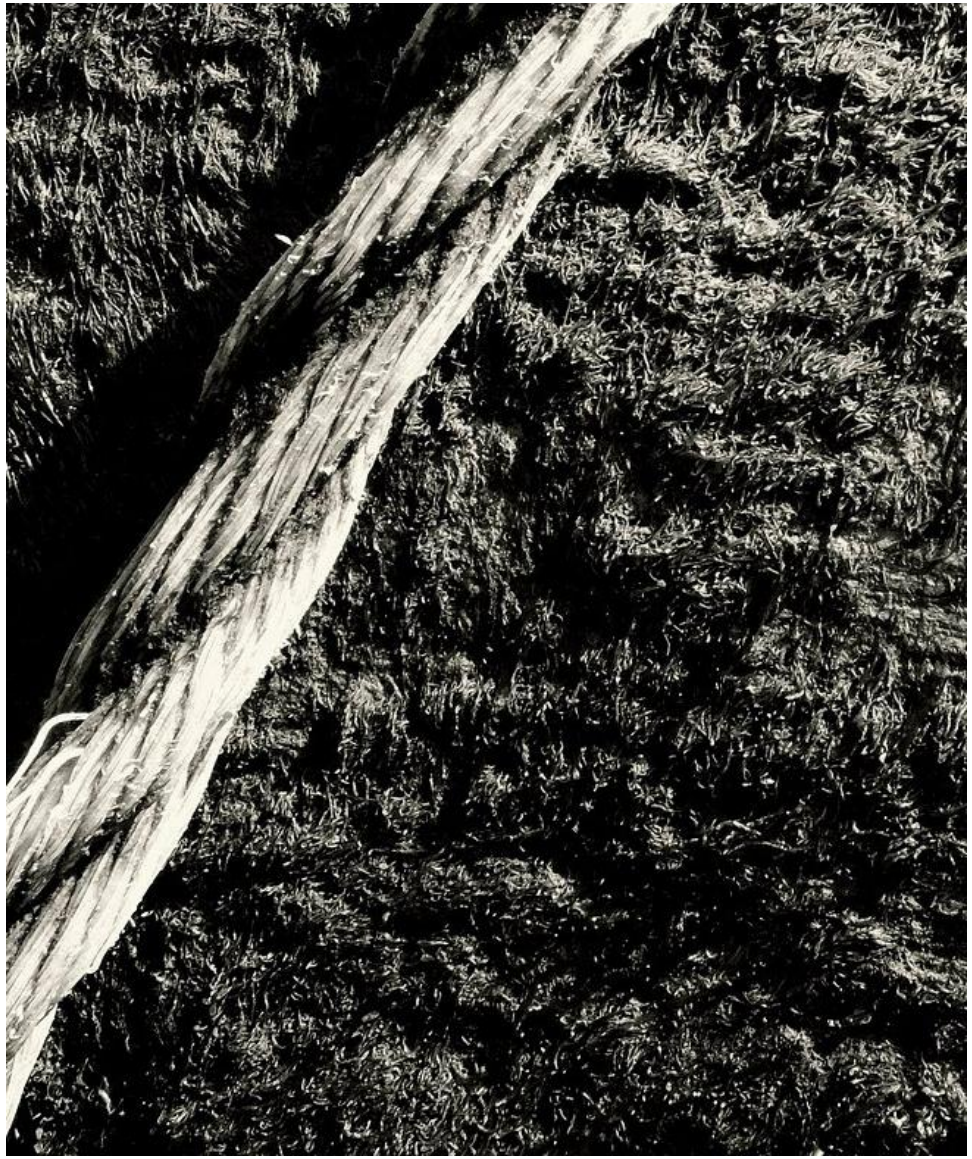


When the THREADS of Resilience are FRAYED

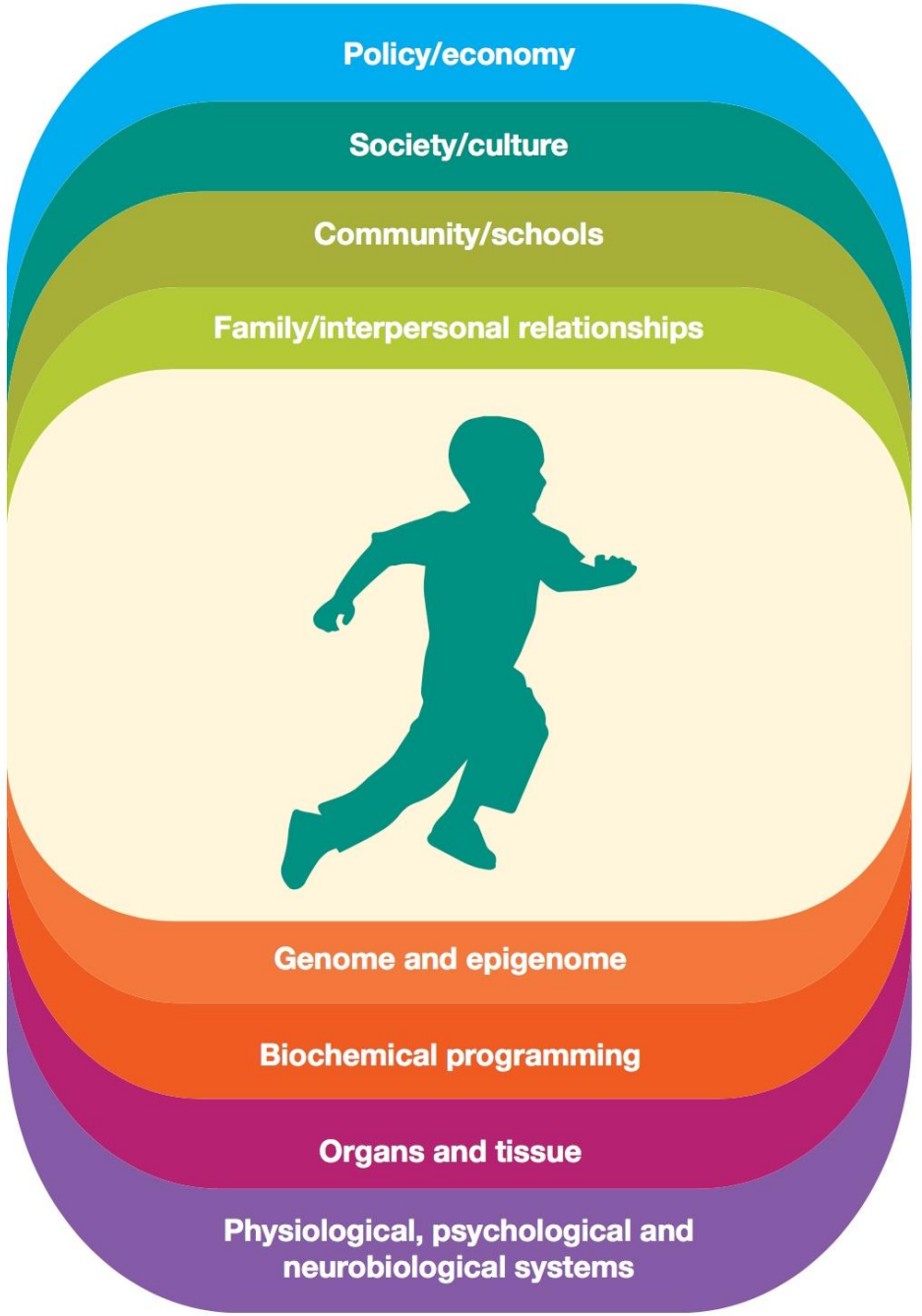
You are **FRAYED** (and at the end of your rope):

- **F**its, **F**rets and **F**ear
- **R**estricted development
- **A**ttachment concerns
- **Y**elling and yawning
- **E**ducational delays
- **D**efeated/dissociation

Upstream Health Care & Life Course Health

Root Causes of Poor Health Outcomes are Found Upstream

- Upstream in the Life Course: Adverse Childhood Experiences
- Upstream of a Medical Diagnosis: Social Determinants of Health & Social Risks



Norris, Lake, and Draper, 2019 (See References)

Upstream Health Care & Life Course Health

Root Causes of Poor Health Outcomes are Found Upstream

What Happens Here… **Impacts Health Here**

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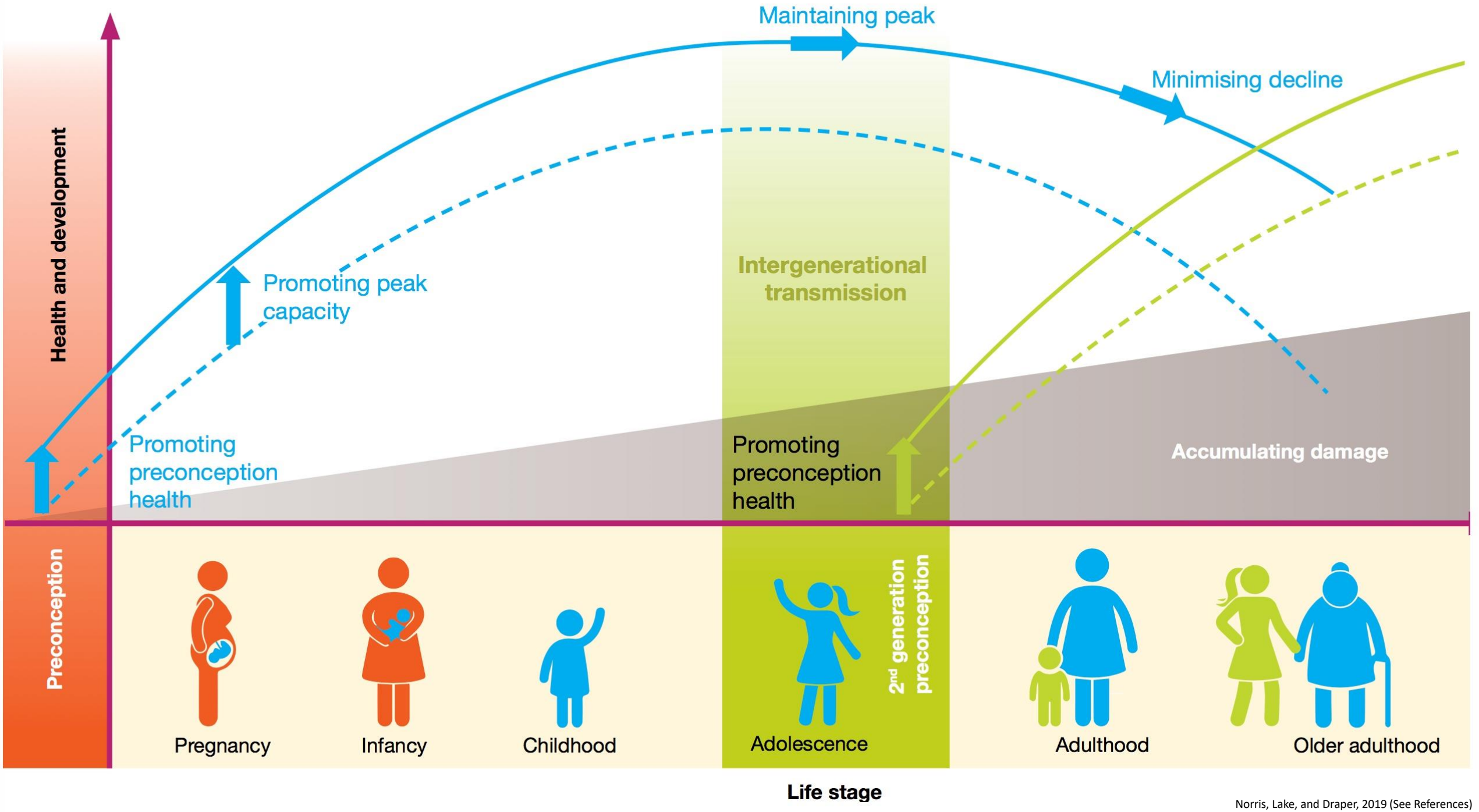

Norris, Lake, and Draper, 2019 (See References)

Health Care Volume to Value

Health Care Structures & Payment Catching Up with Upstream Care

- *Alternative Payment Models & Value-Based Care*
  - *Medicare Shared Savings, Managed Care Orgs, Accountable Care Orgs, Accountable Health Communities, etc.*
- *State Medicaid Waivers & Social Risk-Based Payment*
  - *Many now support SDOH screening and intervention*
  - *Ex. Massachusetts Medicaid MCO adjustment for homelessness*
- *Further State level innovation, such as CA ACEs Aware*
  - *Medi-Cal Reimbursement for ACEs Screening, Funded by CA Prop 56*

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Jones & Muller, Deloitte (See References); Fryer J & Keckley P; Lumeris (See References); Prop 56: https://www.dhcs.ca.gov/provgovpart/Prop-56

Integration & Coordination Across Systems

Moving Upstream Means New Partnerships

- Practices are coordinating with upstream services to address adversity and social risk
  - Federal Accountable Health Communities model incentivized coordination with social resource agencies to address food, housing, etc.
  - California ACEs Aware encouraging Trauma-Informed Networks of Care
- Addressing ACEs is part of a larger shift upstream

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Castrucci & Auerbach, 2019; CMS Accountable Health Communities (See References); CA Office of the Surgeon General, ACEs Aware Networks of Care (See References)

Audience Poll – Upstream Practice Readiness 1

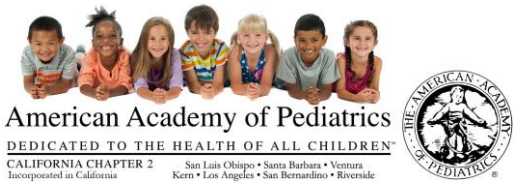
Does your clinic/practice…

A) screen for ACEs and/or social risks/needs systematically **and** refer to resources outside of clinic?

B) screen for ACEs and/or social risks/needs systematically **but not** refer to resources outside of clinic?

C) not screen for ACEs - ACEs surveillance **and** considering systematic ACEs screening?

D) not screen for ACEs - ACEs surveillance **but not** considering systematic ACEs screening?



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Does your clinic/practice…

A) screen for ACEs and/or social risks/needs systematically and refer to resources outside of clinic?	B) screen for ACEs and/or social risks/needs systematically but not refer to resources outside of clinic?	C) not screen for ACEs – ACEs surveillance and considering systematic ACEs screening?	D) not screen for ACEs – ACEs surveillance but not considering systematic ACEs screening?	E) I'm not sure

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Audience Poll – Upstream Practice Readiness 2

What resource does your clinic/practice need most to take the next steps toward <u>systematically</u> identifying and addressing ACES?

Respond at ***PollEv.com/ACEsPoll or text ACESPOLL to 37607*** *and your choice will appear*

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What resource does your clinic/practice need most to take the next steps toward systematically identifying and addressing ACES?

A) More time with patients
B) More training or guidance
C) Clinical protocols
D) Care coordination resources
E) Social work resources
F) Mental/behavioral health resources
G) Something else
H) I'm Not sure

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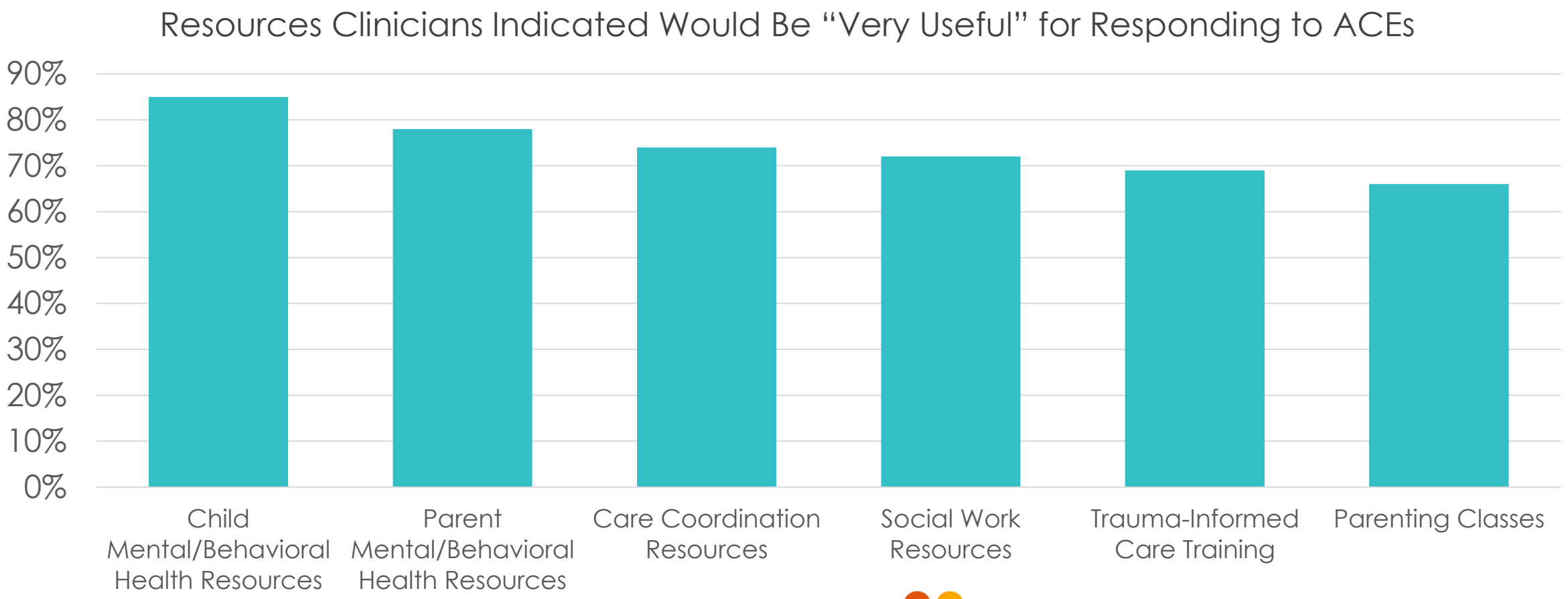
Where to Start?

- It's fine to start small – add one area of risk/need at a time
- Consider your patients'/families' biggest risks/needs
  - Ideally from their perspective and with their input
- Focus on risks/needs with established interventions
- Anticipate pushback, primarily from clinicians
- Design and change care experience, not just care processes

Foundations for ACEs Screening & Intervention

- Trauma-Informed Care (TIC) is foundational
  - TIC must be in place first or addressing ACEs is non-starter
- Remember that ACEs are just risk factors, not destiny (like LDL!)
  - Consider context and apply clinical judgement
  - See forthcoming American Academy of Pediatrics policy statement on trauma-informed systems of care, which will emphasize not just ACEs/social risk but symptoms, functional impact, and strengths
- First do no harm

Resources Clinicians Want for ACEs Intervention



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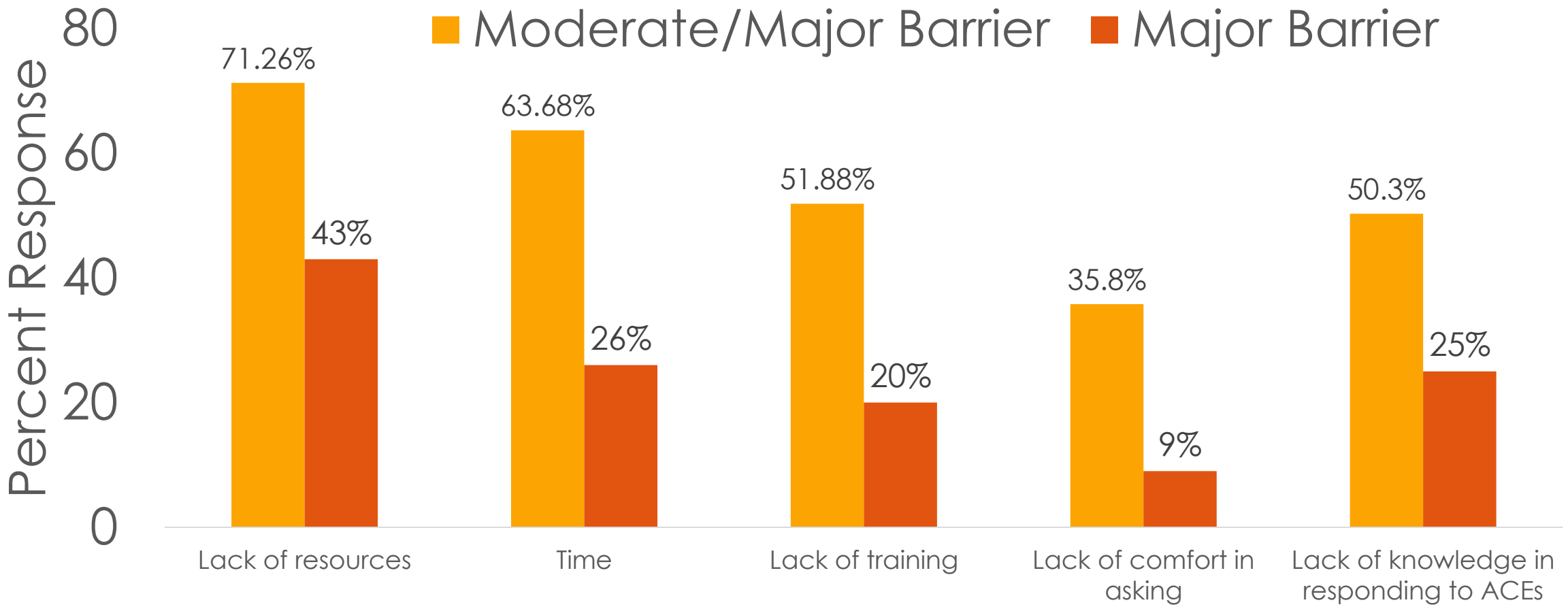
Unpublished data from survey of 166 American Academy of Pediatrics members in Southern California.

Common Barriers to ACEs Screening



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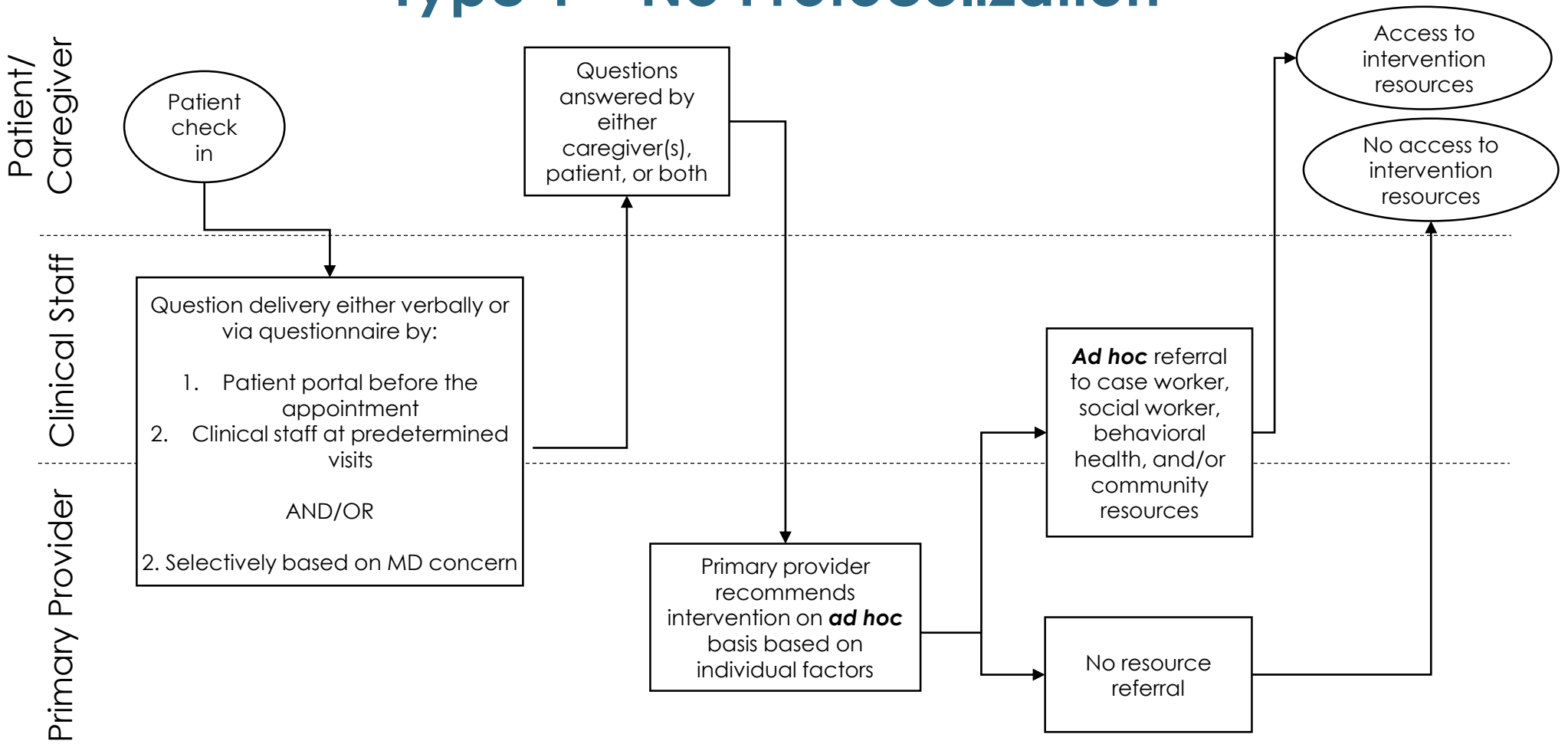
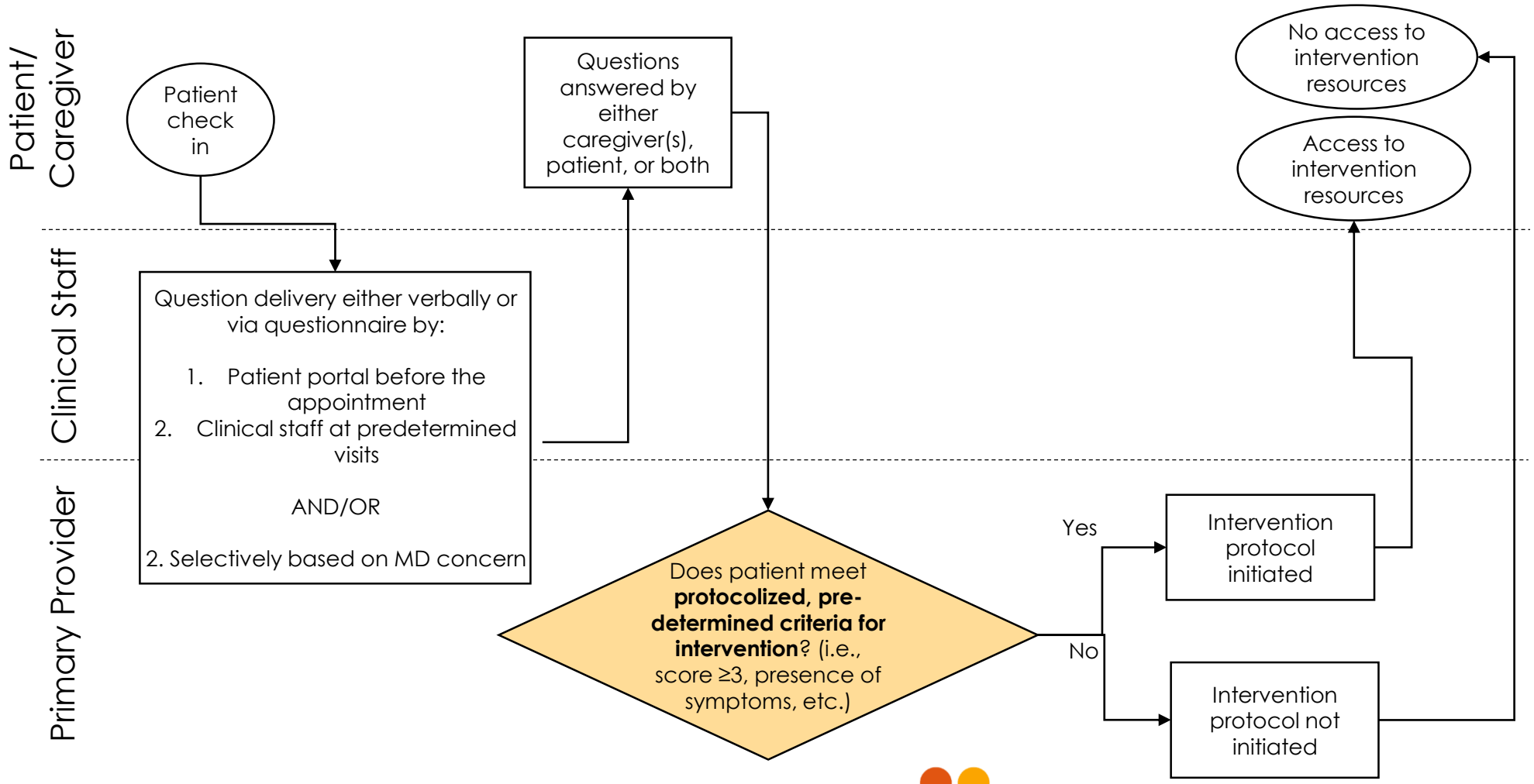
ACEs Screening & Response Workflows
Type 1 – No Protocolization



ACEs Screening & Response Workflows
Type 2 – Protocolization of Intervention Threshold



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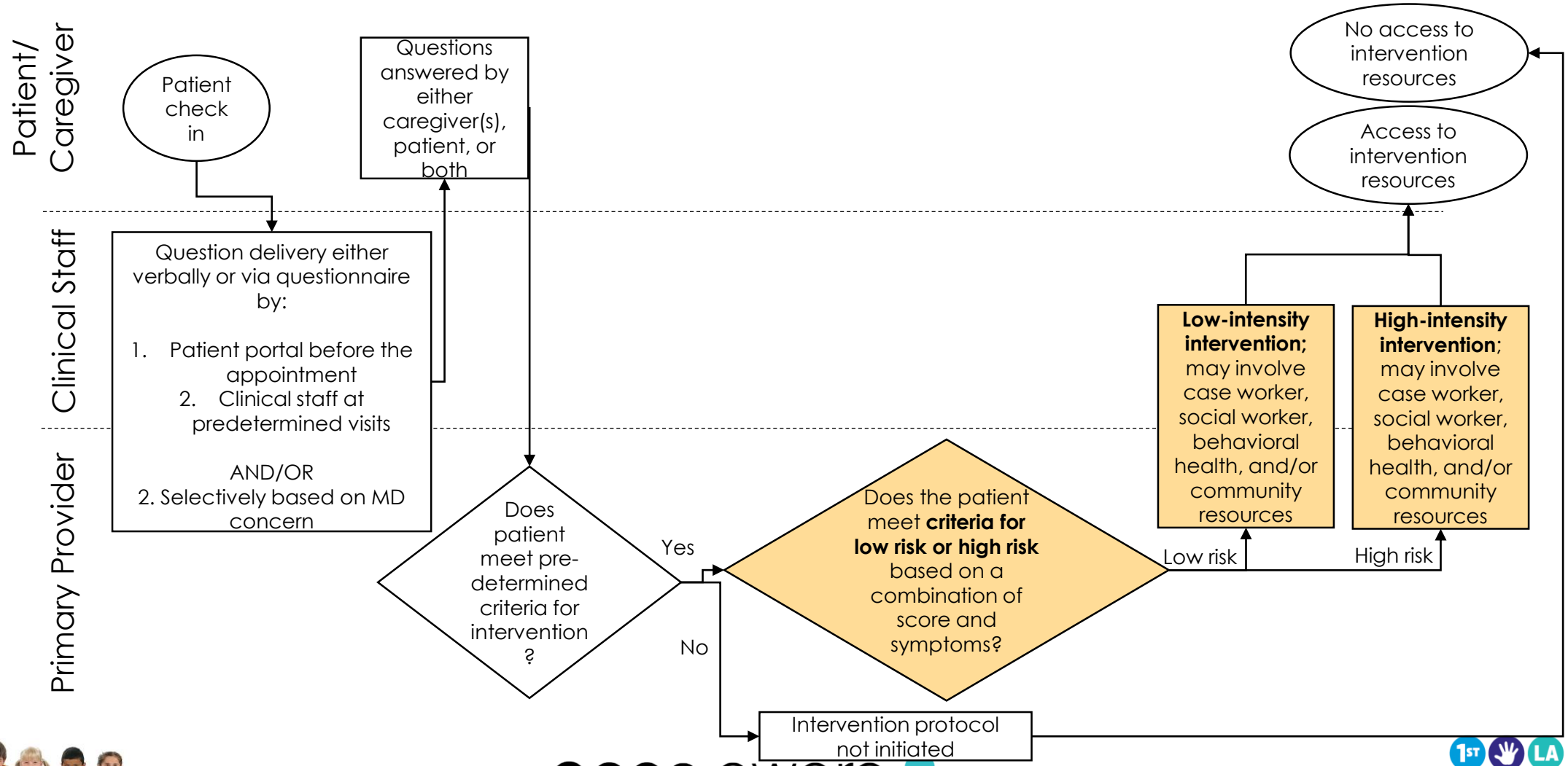
ACEs Screening & Response Workflows
Type 3 – Protocolization of Intervention Threshold & Intensity



ACEs Aware Screening & Response Workflows

Adverse Childhood Experiences (ACEs) and Toxic Stress Risk Assessment Algorithm | Pediatrics

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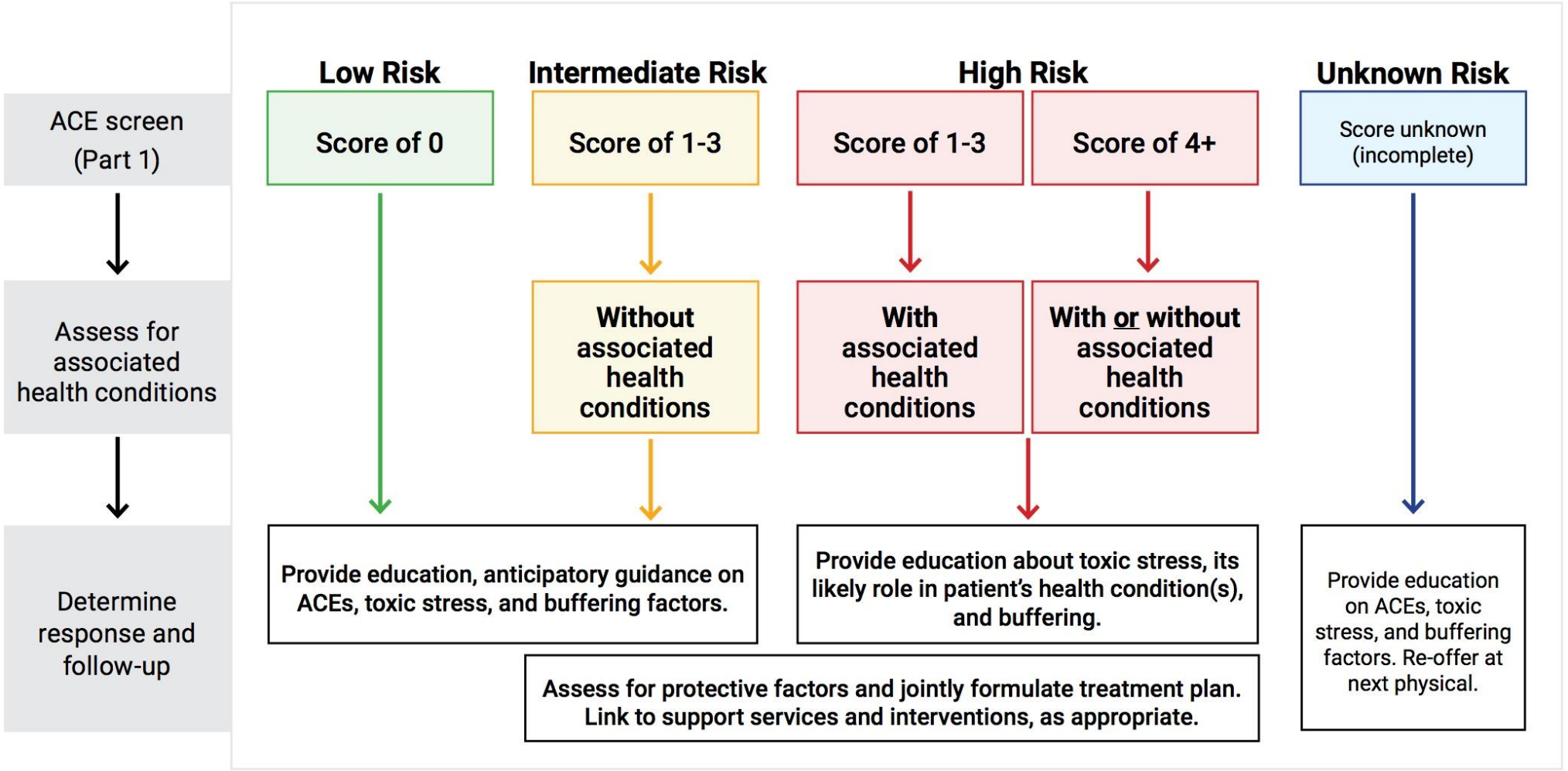
SCREEN. TREAT. HEAL.



https://www.acesaware.org/treat/clinical-assessment-treatment-planning/

Questions?

Email: ASchickedanz@mednet.ucla.edu

Want more info on AAP-CA & ACEs?
Visit aapca2.org/aces/

Returning to our clinical case

(case shared by Dr. Adwoa Osei)

- 12yo boy ("Henry") comes in with mother for well child visit. Mother has no concerns today. "We are here for his annual physical and shots."

- **PMH/PSH:** Asthma diagnosed at 3yo, fairly controlled. Albuterol inhaler used PRN. Sometimes misses school because of wheezing episodes. No allergies to drugs or medications.

- **SHx:** Henry resides with his mother & mat grandmother. Occasional contact with his father who is now remarried and has another child. When questioned alone and directly about his father, Henry is open to the discussion and bluntly reports, "I feel unloved by my father. There is no point in being alive." He is also very sad about losing his "best uncle" 2 years ago to witnessed assault. He was like a father to him. He is afraid "his mother will die too." He is happy to have his grandmother and mom who care "deeply about him." He has no health concerns for today's visit and shrugs his shoulders when asked about school. Mom reports he struggles with his 6th grade schoolwork. Per mom, "if only he got off those video games and paid attention, he would do better in school." When questioned directly, Henry reports, "I don't get math, and the words don't make sense when I read. School is boring." Henry confides in you that this is his third school, and kids always pick on him. He barely speaks to anyone in school because the kids are "mean and dumb." Video games make him happy, "oh and church," he adds. He would like to study coding and programming in the future. He stays up until 2AM playing games most nights and struggles to wake up for school in the mornings. When asked to turn it off, he becomes "very angry and threatens to burn down the house." Mom reports she is "tired of this behavior but doesn't know what to do." Mom also reports she lives with an anxiety disorder and has trouble sleeping if Henry is awake due to safety concerns.

- You review his depression screening which shows a high risk for moderate to severe depression. Screening for alcohol and substance abuse is negative.

- **FHx:** Mom has generalized anxiety disorder, depression, pseudo seizures, diabetes, and hypertension. She had a cerebrovascular accident a few years ago that has affected her memory. Dad is otherwise healthy.

- **ROS:** Increase in weight and difficulty concentrating but otherwise negative.

- **Physical exam:** BP 110/70, RR 18, BMI >99% percentile, Height 75% percentile

- He is calm and well appearing, avoids eye contact and plays on his phone through the visit.

- His psychiatric assessment reveals that he has passive thoughts of harming himself but has no specific plans. The last time he thought about that was 2 months ago.

Clinical case summary

(case shared by Dr. Adwoa Osei)

Over 3 clinical visits and 3 months, you identified that…

- Henry is a 12yo boy with history of multiple ACEs (parental separation, witness to physical assault and death of uncle, maternal mental illness; possible bullying) who has…
  - Behavioral symptoms consistent with depression plus episodes of passive thoughts of self-harm.
  - Risks also include social isolation after multiple school transitions, poor sleep hygiene, apathy regarding academics.
  - Strengths include relationships with mother, grandmother, and church community, as well as willingness to engage in dialogue with you, his health care provider.

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Breakout Objectives

1. Recognize clinical cases as opportunities for systematic adversity and resilience identification

2. Examine barriers to identifying childhood adversity as a routine part of clinical cases

3. Consider practice changes to routinize identification of and response to childhood adversity

Breakout Questions
Imagine this child was in your practice

1. **What routine practice changes might have made identification more straightforward, if any?**

2. How might you overcome potential barriers to these routine practice changes?

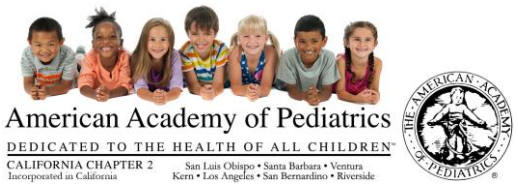
3. Reach Question: What system/policy-level changes would facilitate these practice improvements?

Report Out

1. Briefly summarize your group's discussion

2. 1-2 surprising points that came from our breakout session, *and/or*

3. Any action items that were brought up.



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Closing and Evaluation

- Thank you for your attendance and participation!
- Please complete the post-session survey at http://tinyurl.com/PeerToPeerSession2 (Required to receive CME credit).
  This link will also be emailed to you.

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AAP-CA2 and First 5 LA Peer-to-Peer Learning Session Series

Session	Date	Topic	Speaker
Session 1	January 7, 2021	ACEs Science – The Physiology of Toxic Stress	Christine Thang, MD, FAAP
Session 2	February 11, 2021 {TODAY}	Childhood Adversity, Health Systems Change, and the Future of Trauma-Informed Pediatric Practice	Adam Schickedanz, MD, PhD, FAAP
Session 3	**March 18, 2021**	**After screening: Building ACEs Response Interventions and Overcoming Barriers to Referrals**	**Carlo DeAntonio, MD, FAAP**
Session 4	April 22, 2021	Beyond the screen: What does it mean to be trauma-informed?	Nirupama Madduri, MD, FAAP and Adwoa Osei, MD, FAAP

Upcoming sessions posted here: **https://aapca2.org/aces-aware/**

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References

- *Figures on Slides 11 and 13: Norris SA, Lake L, Draper CE. Child health matters: A life course perspective. Child and adolescent health: Leave no one behind. South Africa: University of Cape Town. 2019:63.*
- *Slide 14, MA Medicaid Waiver: Jones J & Muller S. Social determinants of health and Medicaid payments. https://www2.deloitte.com/us/en/insights/industry/public-sector/medicaid-social-determinants-of-health.html*
- *Slide 14, APM Penetration: Lumeris Report on APMs: https://www.lumeris.com/the-future-of-alternative-payment-models-in-healthcare-a-strategic-perspective/*
- *Slide 15, CMS AHC Model: https://innovation.cms.gov/innovation-models/ahcm*
- *Slide 15, ACEs Aware Trauma-Informed Networks of Care: https://www.acesaware.org/wp-content/uploads/2020/12/Draft-Network-of-Care-Roadmap-Final-12-14-20-For-Public-Comment.pdf*

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