# 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.**

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<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Presenter</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome</td>
<td>Christine Thang, MD, FAAP</td>
<td>6:00 – 6:10 (10 min)</td>
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<tr>
<td>2</td>
<td>Childhood Adversity &amp; Health Systems Change</td>
<td>Adam Schickedanz, MD PhD FAAP</td>
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<td>Adam Schickedanz, MD PhD FAAP</td>
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<td>Clinical Case Study</td>
<td>Adam Schickedanz, MD PhD FAAP</td>
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<td>5</td>
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<td>Facilitators from AAP-CA2 ACEs Committee and First 5 LA</td>
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<td>6</td>
<td>Idea Share from Breakouts</td>
<td>Adam Schickedanz, MD PhD FAAP</td>
<td>7:10 – 7:25 (15 min)</td>
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<td>7</td>
<td>Closing and Evaluation</td>
<td>Tina Chinakarn, MPH, First 5 LA</td>
<td>7:25 – 7:30 (5 min)</td>
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Upcoming sessions will be posted on: [https://aapca2.org/aces-aware/](https://aapca2.org/aces-aware/)
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.
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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!

If you have any technical difficulties, feel free to private chat the Host, Tomas Torices
Childhood Adversity & Health Systems Change

Adam Schickedanz, MD PhD
Department of Pediatrics
University of California Los Angeles
February 11, 2021
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
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.

Adversity, Neuroendocrine Response, & Life Course Health Outcomes

Early Adversity has Lasting Impacts

Adverse Childhood Experiences

- Traumatic Brain Injury
- Fractures
- Burns
- Depression
- Anxiety
- Suicide
- PTSD
- Unintended pregnancy
- Complications
- Fetal death
- HIV
- STDs
- Cancer
- Diabetes
- Alcohol & Drug Abuse
- Unsafe Sex
- Risky Behaviors
- Opportunities
- Education
- Occupation
- Income

Hypothalamus

CRH

Pituitary gland

ACTH

Cortisol

Adrenal gland
THREADS: The Resiliency Factors of Childhood

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

- Thinking and learning brain
- Hope
- Regulation or self control
- Efficacy
- Attachment
- Developmental skill mastery
- Social connectedness
When the THREADS of Resilience are FRAYED

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

- Fits, Frets and Fear
- Restricted development
- Attachment concerns
- Yelling and yawning
- Educational delays
- Defeated/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
Root Causes of Poor Health Outcomes are Found Upstream

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

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

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?
When poll is active, respond at [PollEv.com/acespoll](http://PollEv.com/acespoll)

Text ACESPOLL to 37607 once to join

### DGIT | Digital Technology

**Does your clinic/practice...**

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Start the presentation to see live content. For screen share software, share the entire screen. Get help at [poll.ev.com/app](http://poll.ev.com/app)
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E) I’m not sure
What resource does your clinic/practice need most to take the next steps toward systematically identifying and addressing ACES?

Respond at PollEv.com/ACEsPoll or text ACESPOL to 37607 and your choice will appear.
Digital Technology (DGIT)

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

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H) I’m Not sure
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

Resources Clinicians Indicated Would Be “Very Useful” for Responding to ACEs

- Child Mental/Behavioral Health Resources
- Parent Mental/Behavioral Health Resources
- Care Coordination Resources
- Social Work Resources
- Trauma-Informed Care Training
- Parenting Classes

Unpublished data from survey of 166 American Academy of Pediatrics members in Southern California.
Common Barriers to ACEs Screening

Unpublished data from survey of 166 American Academy of Pediatrics members in Southern California.
Questions answered by either caregiver(s), patient, or both

1. Patient portal before the appointment
2. Clinical staff at predetermined visits
   AND/OR
2. Selectively based on MD concern

Primary provider recommends intervention on ad hoc basis based on individual factors

Ad hoc referral to case worker, social worker, behavioral health, and/or community resources

No resource referral

Access to intervention resources

No access to intervention resources

Patient check in

Question delivery either verbally or via questionnaire by:

Primary Provider

Clinical Staff

Patient/ Caregiver

ACEs Screening & Response Workflows
Type 1 – No Protocolization
Questions answered by either caregiver(s), patient, or both

Question delivery either verbally or via questionnaire by:
1. Patient portal before the appointment
2. Clinical staff at predetermined visits
AND/OR
2. Selectively based on MD concern

Does patient meet protocolized, predetermined criteria for intervention? (i.e., score ≥3, presence of symptoms, etc.)

Yes
- Intervention protocol initiated

No
- Intervention protocol not initiated

No access to intervention resources

Access to intervention resources
ACEs Screening & Response Workflows
Type 3 – Protocolization of Intervention Threshold & Intensity

**Patient/ Caregiver**
- **Patient check in**

**Clinical Staff**
- Question delivery either verbally or via questionnaire by:
  1. Patient portal before the appointment
  2. Clinical staff at predetermined visits
  AND/OR
  2. Selectively based on MD concern

**Primary Provider**
- Questions answered by either caregiver(s), patient, or both
- Does patient meet predetermined criteria for intervention?
  - Yes
  - No: Intervention protocol not initiated

- Does the patient meet criteria for low risk or high risk based on a combination of score and symptoms?
  - Low risk: Low-intensity intervention; may involve case worker, social worker, behavioral health, and/or community resources
  - High risk: High-intensity intervention; may involve case worker, social worker, behavioral health, and/or community resources

**Flowchart Details**
- No access to intervention resources
- Access to intervention resources

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

aces aware
GRANTEE

first 5 la
Giving kids the best start
Questions?
Email: ASchickedanz@mednet.ucla.edu

Want more info on AAP-CA & ACEs?
Visit aapca2.org/aces/
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.
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.
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.
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.
# AAP-CA2 and First 5 LA Peer-to-Peer Learning Session Series

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