Leadership and Sustainability: Sustaining and Spreading Trauma Informed Care in Clinical Practice

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Background

What we're doing… and why we decided to do it this way…

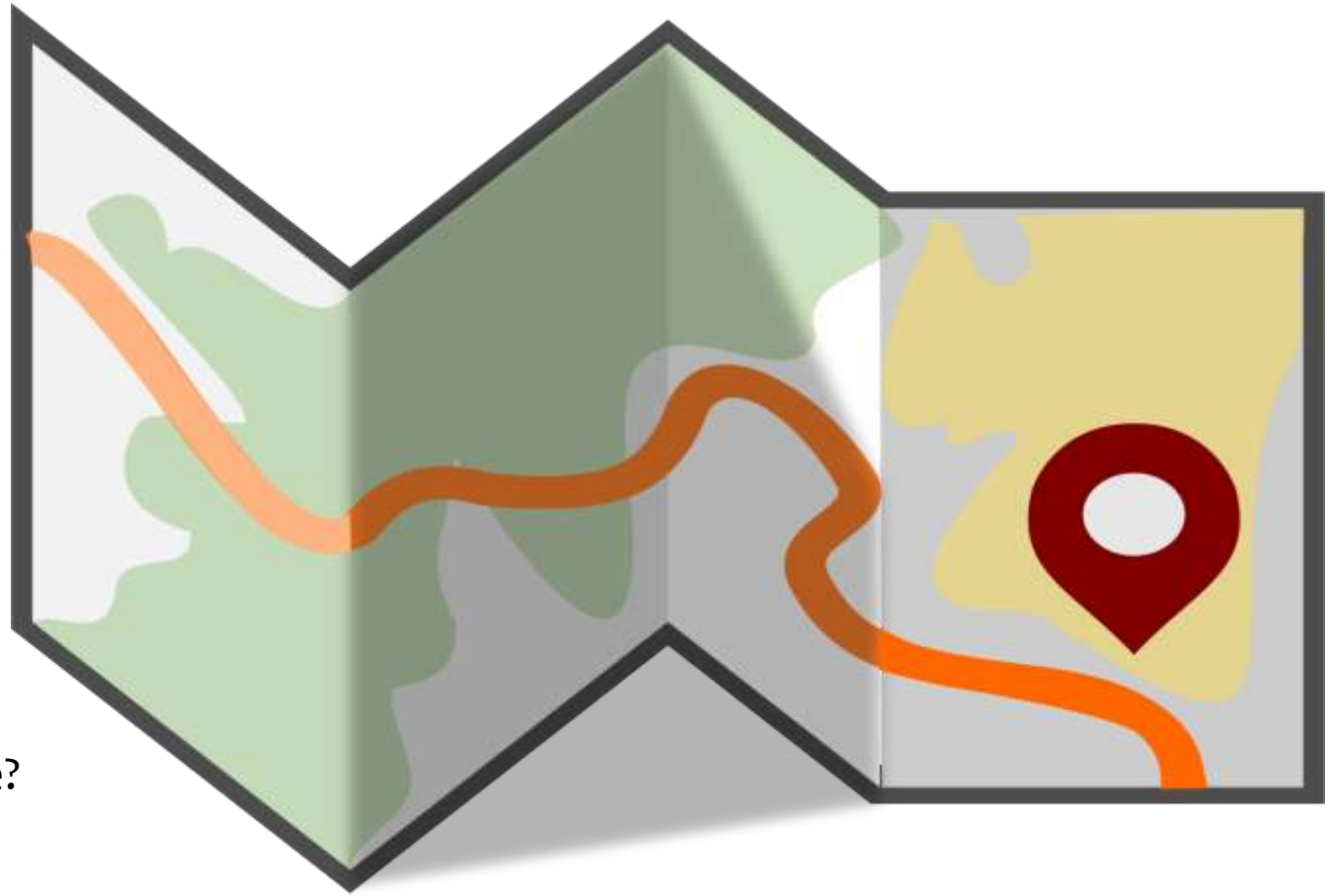
A Word from the American Academy of Pediatrics…

- Pediatric medical homes should:
    1. strengthen their provision of anticipatory guidance to support children's emerging social-emotional-linguistic skills and to encourage the adoption of positive parenting techniques;
    2. actively screen for precipitants of toxic stress that are common in their particular practices;
    3. develop, help secure funding, and participate in innovative service-delivery adaptations that expand the ability of the medical home to support children at risk; and
    4. identify (or advocate for the development of) local resources that address those risks for toxic stress that are prevalent in their communities.

What was missing…

Who do we screen?

Do we screen once, or multiple times?



When do we screen?

What tool do we use?

WHAT DO WE DO IF WE FIND IT???

Stories from the literature – why parent trauma matters….

1. Correlations exist between parent ACE scores and child's ACE score… the more ACEs a parent experiences, the more ACEs the child is likely to experience.
2. Parenting styles are at least in part inherited: if a parent experienced harsh parenting, they are more likely to engage in harsh parenting styles themselves.
3. Parents have new brain growth in the first six months after their child's birth – in both the amygdala (emotional center) and frontal cortex (logical center) UNLESS they are experiencing stress, which impairs frontal cortex development.
4. Children who have experienced three or more ACEs before entering Kindergarten have lower readiness scores: literacy, language and math skills are lower – and rates of behavioral problems are higher.

The assumption

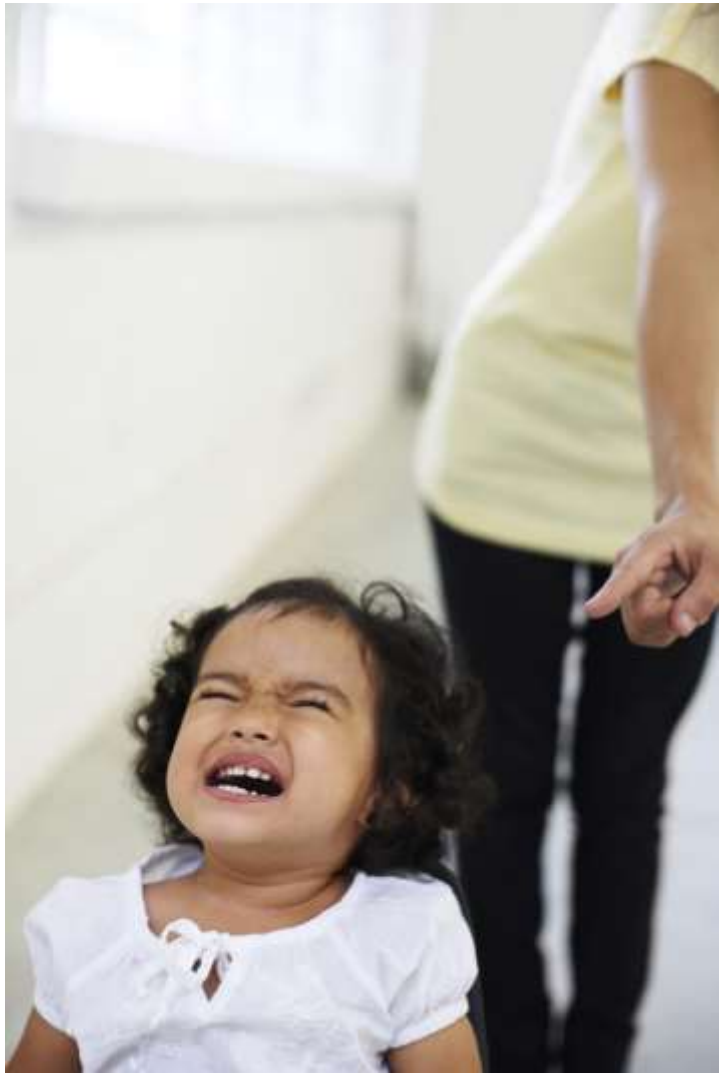
If…

- we can identify parents who are at greatest risk
- bring their trauma histories out of the closet
- agree to support them when they feel most challenged in a non-judgmental way

…we will be able to create a new cycle of healthier parenting.

The Theory…

- Certain moments in the life of an infant or toddler will be stressful
  - Tantrums, colic, toilet training, hitting / biting, sleep problems are examples
- What happens to a parent who has experienced trauma? Will their response be:
  - Fight?
  - Flight?
  - Freeze?
  - Can it be something else?
- How can we better prepare at-risk parents for these inevitable moments?



And thinking further…

- If a parent experienced trauma, do they have appropriate skills / ideas for:
  - Taking care of themselves?
  - Identifying when they need help?
  - Modeling appropriate conflict resolution?
  - Discipline that is developmentally appropriate?
  - Playing with their child?
- In other words, can we teach parents and children to be more resilient?

Case Study: The Children's Clinic

- 30 providers in three practice sites
- Strong interest in early childhood development / developmental promotion
- Since 2008 have implemented multiple standardized universal screening protocols
  - Developmental delay
  - Autism
  - Maternal Depression
  - Adolescent Depression
  - Adolescent Substance Abuse
- Adolescent questionnaire has always included questions about dating violence; many providers ask about bullying in their history for school aged children.

The Children's Clinic
welcoming families since 1911

How do I Find it? Our First Step

- Eight providers piloted screening
- At the four month visit, parents are given the ACE screener, along with a questionnaire about resilience and a list of potential resources.
    - Cover letter explaining the rationale for the screening tool, and what we plan to do with the information
- Created a confidential field in the EMR that does not print into notes, but perpetuates into visits to document results while minimizing risk to families.
- Added questions about community violence, bullying, racism / prejudice and foster care exposure.

Big Idea #1: Be intentional with spread…use a pilot of people willing to get their hands dirty.

Initial Goals

- How do we best assess parental ACEs in primary care?

- (Is it feasible to assess parental ACEs in the course of a primary care visit?)

Reaching Out for Guidance

- Clinic sent a multidisciplinary team to a Pediatric Integrated Care Collaborative (PICC) led by Johns Hopkins University
- MD, RN, Care Coordinator and Parent Partner (mostly from our QI team) participated in several face-to-face sessions
  - Trauma-Informed Care basics
  - Engaging Parents
  - Teaching Resilience
  - Options for screening
- Arranged for Trauma-Informed Care Trainings through Oregon Pediatric Society

Big Idea #2: Use a team, including parents / patients

Adjusted risk for suspected developmental delay

	Relative Risk (95% CI)	
	[a]Maternal (n=311)	[b]Paternal (n=122)
[c]ACE		
≥ 1	1.25 (0.77, 2.00)	2.47 (1.09, 5.57)**
< 1 (Ref)	-	-
≥ 2	1.78 (1.11, 2.91)**	3.96 (1.45, 10.83)***
< 2 (Ref)	-	-
≥ 3	2.23 (1.37, 3.63)***	0.82 (0.12, 5.72)
< 3 (Ref)	-	-
Payer source		
Public	1.67 (1.05, 2.67)**	0.87 (0.37, 2.03)
Private (Ref)	-	-
Gestational age at birth		
< 37 weeks	1.70 (0.89, 3.24)	7.76 (3.12, 19.33)***
≥ 37 weeks (Ref)	-	-

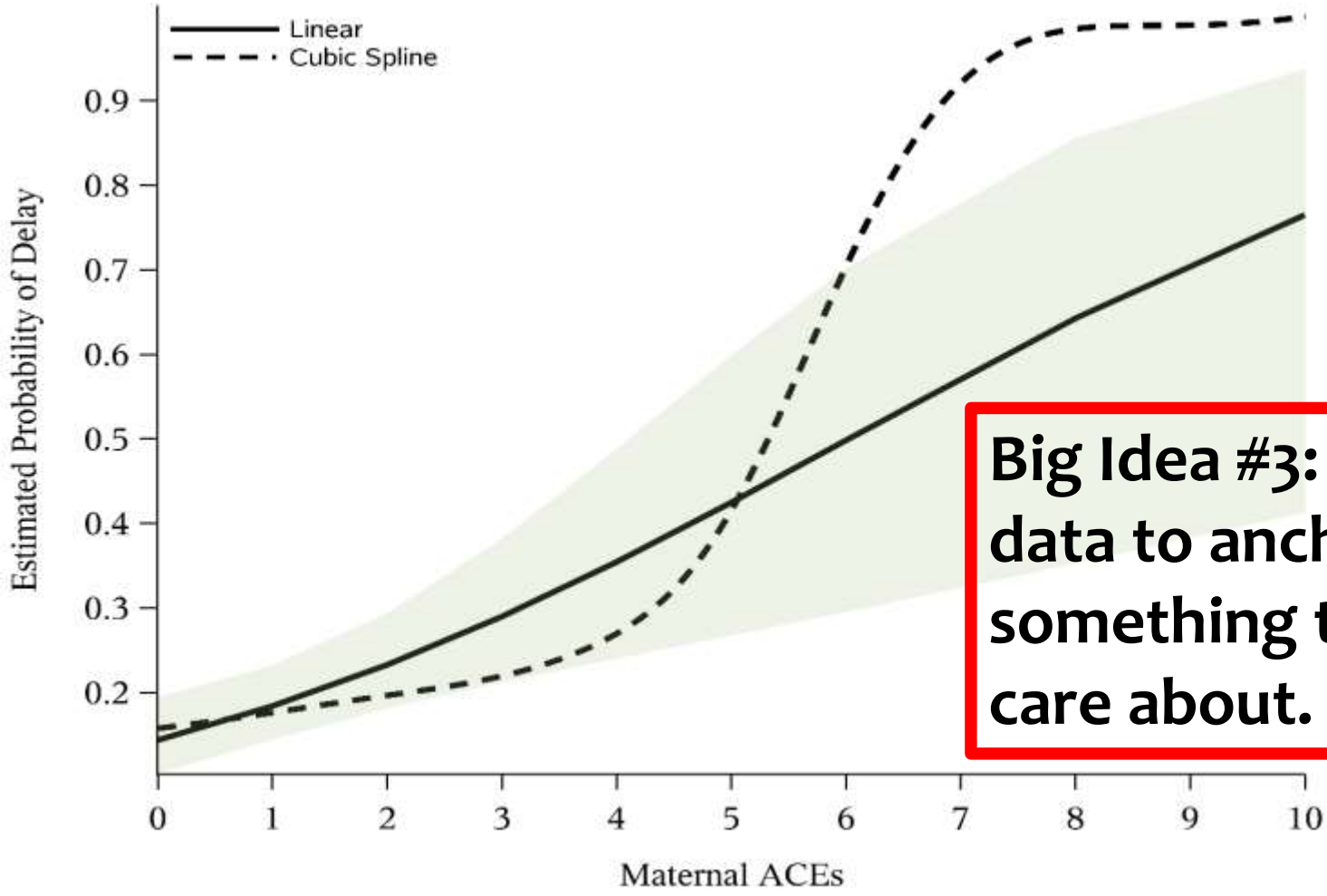
* = p <0.1, ** = p <0.05, *** = p <0.01

Domain-specific developmental risk by Maternal ACE exposure

	Maternal ACEs		Relative Risk (95% CI)
	≥ 1 (*n*=149)	<1 (*n*=162)	
Communication, *n* (%)	24 (16.3)	18 (11.1)	1.47 (0.83, 2.60)
Gross Motor, *n* (%)	20 (13.5)	17 (10.6)	1.28 (0.70, 2.35)
Fine Motor, *n* (%)	18 (12.1)	16 (9.9)	1.22 (0.65, 2.31)
Problem Solving, *n* (%)	17 (11.6)	8 (5.0)	2.31 (1.03, 5.20)**
Personal-Social, *n* (%)	19 (12.9)	17 (10.6)	1.22 (0.66, 2.26)
	≥ 2 (*n*=60)	<2 (*n*=251)	
Communication, *n* (%)	12 (20.3)	30 (12.0)	1.69 (0.92, 3.11)*
Gross Motor, *n* (%)	12 (20.0)	25 (10.0)	1.99 (1.06, 3.73)**
Fine Motor, *n* (%)	9 (15.0)	25 (10.0)	1.51 (0.74, 3.06)
Problem Solving, *n* (%)	11 (18.3)	14 (5.7)	3.23 (1.55, 6.76)***
Personal-Social, *n* (%)	9 (15.0)	27 (10.9)	1.38 (0.68, 2.77)
	≥ 3 (*n*=39)	<3 (*n*=272)	
Communication, *n* (%)	10 (26.3)	32 (11.8)	2.23 (1.19, 4.16)**
Gross Motor, *n* (%)	9 (23.1)	28 (10.4)	2.23 (1.14, 4.36)**
Fine Motor, *n* (%)	8 (20.5)	26 (9.6)	2.15 (1.05, 4.40)**
Problem Solving, *n* (%)	6 (15.4)	19 (7.1)	2.17 (0.92, 5.10)*
Personal-Social, *n* (%)	8 (20.5)	28 (10.4)	1.97 (0.97, 4.01)*

* = p <0.1, ** = p <0.05, *** = p <0.01

Dose response relationship between Maternal ACE and risk for suspected developmental delay



Big Idea #3: Use your own data to anchor screening to something that providers care about.

Parental ACEs and Behavioral Outcomes

- Compared to children whose parents have no ACEs, a child whose parent has 4+ ACEs has:
  - 2.3 point higher score on the Behavior Problems Index (BPI)
  - 2.1x higher odds of hyperactivity
  - 4.2x higher odds of emotional disturbances
- Correlations were stronger for maternal ACEs than paternal ACEs.

Schickedanz et al., *Pediatrics*. 2018;142(2).

Parental ACEs and Health Outcomes

- For each additional parental ACE:
  - Worsening overall health status (aOR 1.19)
  - Increase rates of asthma (aOR 1.19)
  - Increase in excessive media use (aOR 1.16)

- Since these effects are cumulative, if a parent has 6+ ACEs, their child has 6.38x the risk of asthma.

Lê-Scherban et al., *Pediatrics*. 2018;141(6).

Parental ACEs and Utilization Patterns

- For each additional maternal ACE, there is a 12% increased risk of missing well visits in the first two years.
- This did not result in missing immunizations.

- However, given the risk of developmental delays, it is likely that:
  - Parents are not receiving anticipatory guidance on developmental promotion.
  - There may be an increased risk of missing on-time administration of standardized developmental screens, meaning a potential delay in referral to services.

Eismann EA et al.(… Gillespie RJ), J Pediatr 2019;211:146-51.

In other words…

- By addressing parental ACEs, we are tackling big-ticket items that providers care about:
  - Developmental health
  - Behavioral health
  - Utilization patterns (no-shows)
  - Some chronic illnesses like asthma
- Plus we're primarily using our clinic's data…which adds to buy-in and "believability".

Big Idea #4: Integrate ACE Assessments into other Screenings

- ACE assessments (and other Social Determinants of Health Assessments) aren't really "one more thing" for providers to do…
- They integrate into an overall screening strategy at a clinical level and help to tailor a treatment plan for:
  - Developmental delays
  - Maternal depression
  - Behavioral / social-emotional disturbances

Public Health Level	Types of Prevention	Approaches to Toxic Stress	Examples	Approaches to Relational Health
3	Tertiary	**Indicated Treatments** for toxic stress related symptoms and diagnoses (e.g., anxiety, PTSD)	ABC PCIT CPP TF-CBT	**Repair** strained or compromised relationships
2	Secondary	**Targeted Interventions** for those at higher risk of toxic stress responses	Parent/Child ACEs SDoH BStC	**Identify / Address** potential barriers to SSNRs
1	Primary	**Universal Preventions** (anticipatory guidance, consistent messaging)	Positive Parenting ROR Play	**Promote** SSNRs by building 2-Gen relational skills

Slide adapted from *Thinking Developmentally: Nurturing Wellness in Childhood to Promote Lifelong Health*, Garner and Saul, 2018. Used with permission.

Public Health Approach to ACE Assessments

- Primary Prevention:
  - ACE assessment tools become an opportunity to provide UNIVERSAL education about trauma and resilience
- Secondary Prevention:
  - ACE assessment tools help to identify families that MAY BE AT RISK and therefore get extra help in positive parenting, relational / attachment repair, or other interventions
- Tertiary Prevention:
  - ACE assessments give an opportunity to identify TRAUMA SYMPTOMS and therefore which patients / families need further evidence-based treatments

Future State

How we're pulling all of this together in 2020

Universal Resilience Interventions

- Complements of Amy Stoeber, PhD – all providers are trained in a series of interventions that will be implemented universally at well visits
- Interventions relate to parent self-care, promoting attachment / attunement, and building resilience in parents
- Building in data collection to measure outcomes for kids based on whether interventions were delivered (and which ones)

Resilience Curriculum

- 3-5 days: Circle of Support
- 2 weeks: Parental Self-Ccare
- 2 months: Mirror work: Becoming a Baby Observer
- 4 months: Focusing on Attachment
- 6 months: Special Time
- 9 months: Review Mirror Work & Special Time
- 12 months: Beginning Discipline

Expanding our Assessment for Kids at Risk

- Currently the AAP guidelines for maternal depression recommend specific social emotional screening for kids whose parents experience depression
- Given the effects of ACEs on a parent's attachment and attunement with their child, makes sense to create an analogous workflow for positive ACEs
- TCC has added integrated Behavioral Health Consultants into practice
  - BHCs will be engaged with families to conduct screening and give more in-depth interventions for families at risk
  - Planning co-visits with pediatrician and BHC at 6 month visits as needed

Big Idea #5: Use an expanded care team to offer more tailored services to families in need.

Expanded workflow / clinical response

- **Parent ACE score 0**
  - Resilience interventions
  - Universal education about trauma and resilience
- **Parent ACE score 1-3**
  - Resilience interventions
  - Universal education about trauma and resilience
  - Safety assessment and resource needs assessment
    - Refer to Care Coordinator or Help Me Grow as needed
- **Parent ACE score 4+, or 1-3 with symptoms / safety concerns**
  - Resilience interventions
  - Universal education about trauma and resilience
  - Safety assessment and resource needs assessment
    - Refer to Care Coordinator or Help Me Grow as needed
  - Schedule joint 6 month visit with BHC
    - Social emotional development screening
    - Video interaction intervention
    - If concerns - schedule joint 9 month visit, consider referral to PCIT or other therapy

Big Idea #6: Adapt your model of care based on patient and family needs.

The Questions We Want to Answer

- Can we prevent the developmental outcomes for kids whose parents experienced ACEs?
- Can we improve, in a measurable way, parental resilience?
- Can we prevent ACEs?

Big Idea #7: Be curious. Screening is more sustainable if it stays up-to-date with new information and ideas.

Leadership and Sustainability: Sustaining and Spreading Trauma Informed Care Across Systems

CTIN OVERVIEW: HISTORY AND BACKGROUND

History and Background

- CPCCO responds to community request; funds and hires an FTE (Sr. Program Development Specialist)
- The higher the ACE score, the higher the risks of health and social problems
- Increase community and institutional support utilizing trauma informed approaches can build resiliency

CTIN OVERVIEW: VISION AND OVERARCHING GOAL

VISION

- The vision is to build resilient communities that are engaged in a CTIN, which is supported by a robust community investment plan.

Overarching Goal

- Improve health and life outcomes for children, families and communities across Clatsop and Columbia counties by addressing childhood trauma and building resilience in children and families.

CTIN OVERVIEW: DEVELOPMENT AND EFFORTS TO DATE

Efforts to Date

- Listening tour

- Yearlong design and planning process
  - Two-year timeline
  - Strategic framework
  - Roles and responsibilities
  - TIC principles and values
  - Strategic plan

CTIN OVERVIEW: ROLE OF ORGANIZATIONS

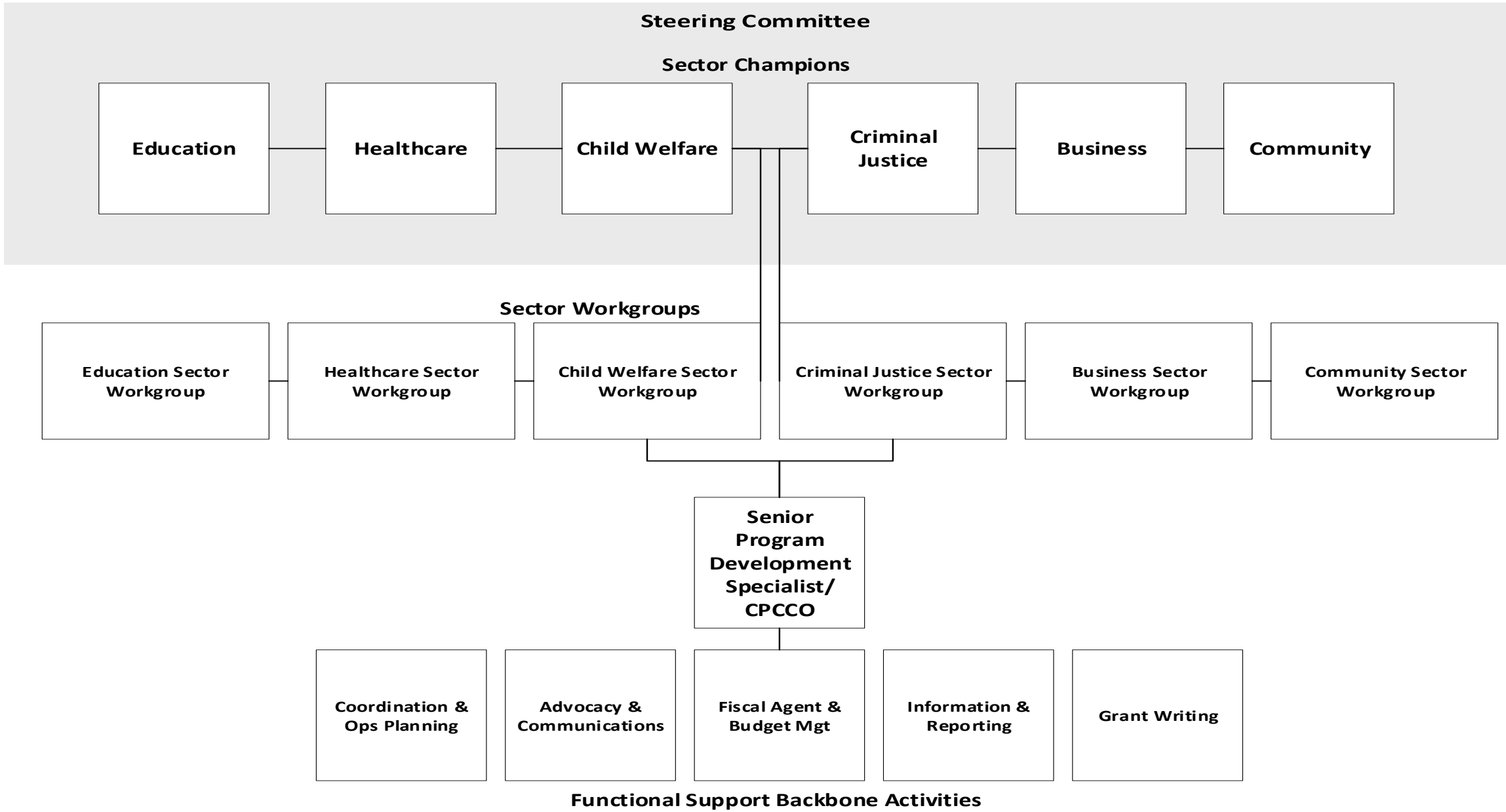
ROLE OF ORGANIZATIONS/AGENCIES

- To commit to reducing childhood trauma and building resilience in children and families

- To participate in the network (steering committee or sector workgroups)

To join the network organizations must sign a letter of commitment.

Resilient Clatsop County



Where is your work on the collaboration spectrum?

Compete	Co-exist	Communicate	Cooperate	Coordinate	Collaborate	Integrate **Trust**
Competition for clients, resources, partners, public attention	No systematic connection between agencies	Inter-agency information sharing (e.g. networking)	As needed, often informal, interaction on discrete activities or projects	Orgs. adjust and align work with each other for greater outcomes	Longer term interaction based on shared mission, goals; shared decision-makers and resources	Fully integrated programs, planning, funding

Turf

Loose ⟷ **Tight**

CTIN OVERVIEW: ROLE OF COLLECTIVE IMPACT

COLLECTIVE IMPACT

NEXT STEPS FOR A RESILIENT CLATSOP AND COLUMBIA COUNTY

Coming in 2020

- Finalize strategic plans
- Formation of sector workgroups
- Launch Spring 2020

Questions