Pediatric Trauma-Informed Care at Various Levels of Integration

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Learning Objectives

1. Review ACE (Adverse Childhood Experiences) and PCE (Positive Childhood Experiences)

2. Summarize how to implement and use results from a TIC site self-assessment tool

3. Describe the importance and results of facilitated community meetings to build relationships between local primary care clinics and key community referral agencies.

4. Review strategies used by clinics with and without integrated behavioral health clinicians to conduct childhood adversity screening and link families to internal and external services and supports.
Presenter Disclosure

• No relationships to disclose.
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  – Jeanne Ryer, EdD
  – Holly Tutko, MS
Adverse Childhood Experiences

Types of ACEs

ABUSE
- Emotional
- Physical
- Sexual

NEGLECT
- Emotional
- Physical

HOUSEHOLD CHALLENGES*
- Substance misuse
- Mental illness (including attempted suicide)
- Divorce or separation
- Incarceration
- Intimate partner violence or domestic violence

OTHER ADVERSITY
- Bullying
- Community violence
- Natural disasters
- Refugee or wartime experiences
- Witnessing or experiencing acts of terrorism

* The child lives with a parent, caregiver, or other adult who experiences one or more of these challenges.

https://www.cdc.gov/violenceprevention/aces/resources.html#anchor_1626996630

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ACEs Can Increase Risk for Disease, Early Death, and Poor Social Outcomes

Research shows that experiencing a higher number of ACEs is associated with many of the leading causes of death like heart disease and cancer.

**CHRONIC HEALTH CONDITIONS**
- Coronary heart disease
- Stroke
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Cancer
- Kidney disease
- Diabetes
- Obesity

**MENTAL HEALTH CONDITIONS**
- Depression
- Suicide or attempted suicide

**HEALTH RISK BEHAVIORS**
- Smoking
- Heavy drinking or alcoholism
- Substance misuse
- Physical inactivity
- Risky sexual behavior

**SOCIAL OUTCOMES**
- Lack of health insurance
- Unemployment
- Less than high school diploma or equivalent education

https://www.cdc.gov/violenceprevention/aces/resources.html#anchor_1626996630
Some Groups Are More Likely to Have Experienced ACEs

Multiple studies show that people who identified as members of these groups as adults reported experiencing significantly more ACEs:

- Black, Hispanic/Latino, or multiracial people
- People with less than a high school education
- Lesbian, gay, bisexual, or transgender people
- People making less than $15,000 per year
- People who are unemployed or unable to work

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Positive Childhood Experiences

As a child, how often/how much did you....

• Feel able to talk to your family about your feelings
• Felt family stood by you during difficult times
• Enjoy participating in community traditions
• Feel a sense of belonging in school
• Feel supported by friends
• Have at least 2 non-parent adults who took genuine interest in you
• Feel safe and protected by an adult in your home

<table>
<thead>
<tr>
<th>PCEs</th>
<th>Benefit</th>
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</thead>
<tbody>
<tr>
<td>6-7</td>
<td>&gt;70% less likely to have adult depression</td>
</tr>
<tr>
<td>6-7</td>
<td>3.5 times more likely to have social/emotional support as an adult</td>
</tr>
<tr>
<td>3-5</td>
<td>50% less likely to have adult depression</td>
</tr>
</tbody>
</table>

*above is true even accounting for ACEs

(Bethell, Jones, Gombojav, Linkenbach, & Sege, 2019)
SAMHSA Domains of Trauma-Informed Care

- Screening and comprehensive assessment of trauma
- Workforce development
- Safe and secure physical and emotional environments
- Data collection and performance improvement
Practice Guide

• A tool designed to help teams throughout the entire implementation process

• How it is used
  – Training and education around trauma and resiliency
  – Defining current and future state
  – Aids in decision making
  – Recommendation for workflows
  – Guidance for responding to positive scores
  – Recommendations for capturing patient voice
  – Encourages importance of individual and systems level self care
Quality Improvement Process

Preparation → Implementation → Sustaining
Getting Started

- Gathering the team
- Identifying a champion
- Mapping current state
- Determine population
- Selecting a screening tool
- Set SMART Goals
Carrying Out the Work

Implementation

- Meet regularly
- Map future state
- Train staff
- Start small
- Collect and review data
- Risk Stratification
- Plan Do Study Act
- Increase and spread as appropriate
Maintaining the Accomplishments

- Meet regularly (less often)
- Train new staff and providers
- Create control plan
- Continue to collect data
- Continue to collect patient voice
- Practice team resilience (individual and system self-care)
Community Meetings

• 20 community meetings
• Improvements
  – Clinician knowledge and confidence
  – Workflow
  – Communication strategies

“I didn’t know you guys did all that stuff! I definitely have families I could have referred!”

- Pediatrician about local family resource center
Levels of Integration

COORDINATED CARE
- Screening
- Consultation
- Care management/Navigation

CO-LOCATED CARE
- Co-location

INTEGRATED CARE
- Health Homes
- System-level Integration
## Practice Variances

<table>
<thead>
<tr>
<th></th>
<th>Setting</th>
<th>Practice Affiliation</th>
<th>Team Members</th>
<th>EHR Control</th>
<th>Level of Integration</th>
<th>Conflicting Priorities</th>
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<tbody>
<tr>
<td>Practice A</td>
<td>Rural</td>
<td>Small System</td>
<td>8</td>
<td>Yes</td>
<td>Fully Integrated</td>
<td>Provider changes</td>
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<td>Rural</td>
<td>Small System</td>
<td>2</td>
<td>Yes</td>
<td>Coordinated Care</td>
<td>EHR migration</td>
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<tr>
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<td>Urban</td>
<td>Independent</td>
<td>7</td>
<td>N/A</td>
<td>Coordinated Care</td>
<td>Location move</td>
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<td>Urban</td>
<td>Large System</td>
<td>3</td>
<td>No</td>
<td>Coordinated Care</td>
<td>Staffing shortages</td>
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<tr>
<td>Practice E</td>
<td>Rural</td>
<td>Small System</td>
<td>8</td>
<td>Yes</td>
<td>Co-located</td>
<td>Loss of resources</td>
</tr>
</tbody>
</table>
# Risk Stratification Tool

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Screening Assessment</th>
<th>Example Of Screen Results Meeting This Classification</th>
<th>Follow-Up Action</th>
</tr>
</thead>
</table>
| No/Low Risk   | Screening identifies no concerns for toxic stress OR that sufficient buffers are available to keep toxic stress in check. | Screening identifies no risk factors OR one to three risk factor that is/are already being addressed effectively by the family | Primary Prevention Strategies include:  
• anticipatory guidance about toxic stress,  
• positive parenting techniques, and  
• promoting family bonding. |
| Moderate Risk | Screening identifies multiple concerns for toxic stress, though child/family is not exhibiting trauma symptoms | Screening identifies one or more risk factors for toxic stress AND limited family capacity/resilience to address the risk factor(s). | Above Primary Prevention Strategies PLUS Secondary Prevention Strategies include:  
• Identifying and addressing barriers (ex. Screening for social determinants) to families providing safe and supportive nurturing relationships (ex. Facilitating linkages to food or housing)  
• Augmenting family coping capacity and resilience.( parenting classes, youth mentoring programs, parent-child playgroups, etc.) |
| High Risk     | Screening identifies multiple concerns for toxic stress OR patient/parents are exhibiting/have been diagnosed with trauma symptoms or disease | Screening identifies 4 or more risk factors for toxic stress OR child/family is currently exhibiting trauma symptoms or has trauma-related diagnosis (regardless of number of risk factors) | Tertiary Prevention Strategies include:  
• Addressing trauma-related symptoms/conditions (ex. Trauma-informed Cognitive-Behavioral Therapy)  
• Rebuilding unhealthy family relationships (ex. Child-Parent Psychotherapy) |
Provider Feedback

- “The tools we are using give us important information that we would not have had before and are important in catching the trauma in people you wouldn’t expect”

- “We will continue to use the registry we developed after the project has ended. It helps to track our high-risk families.”

- “The number one eye opening experience about this whole thing is that we are learning about resources in the community that we have never known before. I have already started utilizing a lot of that...we have a lot more specific information that we can do on our end to help patients get connected to help.”

Patient feedback

- “I am super impressed that they are doing this (screening). They are cutting edge”
Lessons learned for practices to replicate

- Providers benefit from real world examples and hearing from others doing the work
- Making sense of screening tools with teams eliminates initial barriers
- Facilitating connections with community providers
- Don’t assume providers know all available resources

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Additional Resources

• Healthy People 2030
• ACEs and Resilience
  ▪ Harvard Center for the Developing Child
  ▪ Deepest Well: Nadine Burke Harris
  ▪ ACES connection
  ▪ ACEs Aware
• NHPIP
  ▪ www.nhpip.org

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- Center on the Developing Child at Harvard University, In Brief: How Resilience is Built (Apr 22, 2015).
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Thank you so much!

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