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A Guide to Trauma Informed Pediatric Primary Care

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DOCUMENT PURPOSE

The purpose of this document is to serve as a practical guide to implementing trauma-informed care practices in Pediatric primary care clinics. It is designed to provide structure to the processes that are recommended to successfully, detect, treat and provide referral to families who have experienced trauma and to build capacity and competence for a busy primary care office.

BACKGROUND

ACES, TOXIC STRESS, AND RESILIENCE

Adverse Childhood Experiences (ACEs), including child abuse, neglect, and household dysfunction, have significant short- and long-term detrimental impacts on child health and well-being.[1] The Adverse Childhood Experiences study initially conducted by Kaiser Permanente and the CDC between 1995 and 1997 found that people who experienced childhood trauma had higher rates of negative physical and mental health outcomes.[1] ACEs are harmful for a child's development, stress response, and both pediatric and adult health outcomes.[2-5] ACEs can manifest into ill health and somatization during childhood. ACEs can lead to chronic disease, mental illness, and perpetuated cycles of violence in adults.[6] Additional studies have found that when children are exposed to adverse experiences (such as abuse or parental substance use or incarceration), a child's stress response system is activated. If this activation is prolonged and excessive, it can derail healthy development and is called **toxic stress**.[7] The constant experience of threats in their environment puts strain on physiological systems. Parental ACEs can also negatively affect child development and impacts may continue to show up decades later.[8-12, 18] Toxic stress can be buffered and returned to baseline if a child has an environment of supportive and responsive relationships.[7]

> In 2021, the American Academy of Pediatrics released a policy statement outlining the critical role of the medical home in partnering with families and communities to build family relational health to mitigate the effect of toxic stress and build resilience.[13]

Ways to Foster Resilience[19]

- Building Healthy Relationships
- Improving parent/child attachment
- Encouraging participation in activities to increase confidence and develop peer relationships
- Encouraging positive parenting practices
- Providing praise to increase confidence
- Encouraging connection to community
- Advocating for broader social change targeted at reducing resource disparity

Resilience is an individual's ability to manage their stressful environment and counteract some of the negative impacts that toxic stress may cause. Many people with multiple ACEs thrive in adulthood. It is possible for adverse experiences to be balanced out by protective factors.[14] The key elements of resilience include emotional regulation, strong achievement motivation, secure attachments, and social support.[15] Interventions that support resilience factors should be explored as tools to mitigate the negative impact of ACEs.[7, 16]

ORGANIZATIONAL ASSESSMENT

CURRENT STATE

Before undertaking a project to screen for and respond to ACEs, a practice should assess its current capacity to deliver trauma-informed care and prioritize steps to meet organizational gaps, such as leadership commitment, workforce development, data collection, and providing a safe environment. There are several options for tools to evaluate an organizations current state. Find that works with the values and goals of your team.

Leadership

Workforce Development

Data Colloection

Safe Environment

The National Council for Behavior Health developed an Organizational Self-Assessment for the Adoption of Trauma-Informed Care that can be found here:

Organizational Self-Assessment

More examples from the Trauma -Informed Care Implementation Resource Center can be found here:

Trauma-Informed Care Implementation Resource Center

Resources from SAMHSA's National Center for Trauma-Informed Care (NCTIC) to help teams learn more about the Guiding Principles to Trauma-Informed Approach can be found here:

SAMHSA's National Center for Trauma-Informed Care

SCREENING: WHAT TO LOOK FOR

Practices need to make three major decisions before their team implements a trauma and resilience screening process: who will be screened, when will screenings take place, and what screening tool(s) will be used.

WHO WILL BE SCREENED?

Screening for trauma and resilience can help clinicians identify and engage with caregivers about reducing risks and building strengths to promote the health and development of the child and family. A vital first step is reframing the questions from, "What is wrong with this patient?" and "How can I fix them?" to "What has happened to this patient?" and "How can I better understand this patient?".[20]

Screening efforts assess: 1) caregivers (adult providing the majority of the care for a child) for adversity they experienced as children 2) the child to identify cumulative adversity experienced thus far, or 3) both. The same questions arise with respect to screening for resilience. Below are some reasons and considerations for screening the caregivers and/or child.

> "If [a caregiver] experienced trauma, I think that regardless of whether [a clinician] talks about it or not in the office, that is a fear that's in the back of [their] head, that their experiences are going to affect or are already affecting their parenting skills. And so, having that out in the open and in a non-judgmental way where [the caregivers] feel supported and they feel like somebody gets it and is going to help them through it I think is really liberating for a lot of parents and really helps them to heal."
> -RJ Gillespie, Pediatrician, Children's Clinic, Portland, OR

Reasons to Screen Caregivers

- Identify risk for attachment/maladaptive parenting and caregiver mental or behavioral health concerns, including substance use
- Caregiver exposure to ACEs increases the risk of ACEs for their children[10]
- Caregiver ACEs can impact a child's physical health (e.g. higher chronic disease rates) and development in domains such as problem solving, communication, personal-social, and motor skills[21, 22]
- Adults who have experienced ACEs may not have had modeling experiences that showed stable and supportive relationships, which puts them at a disadvantage to have the skills needed to protect their own children from the damages of toxic stress[6]
- Screening can provide the "space" for a caregiver and clinician to have a larger conversation about concerns that otherwise may not have been shared

Reasons to Screen the Child

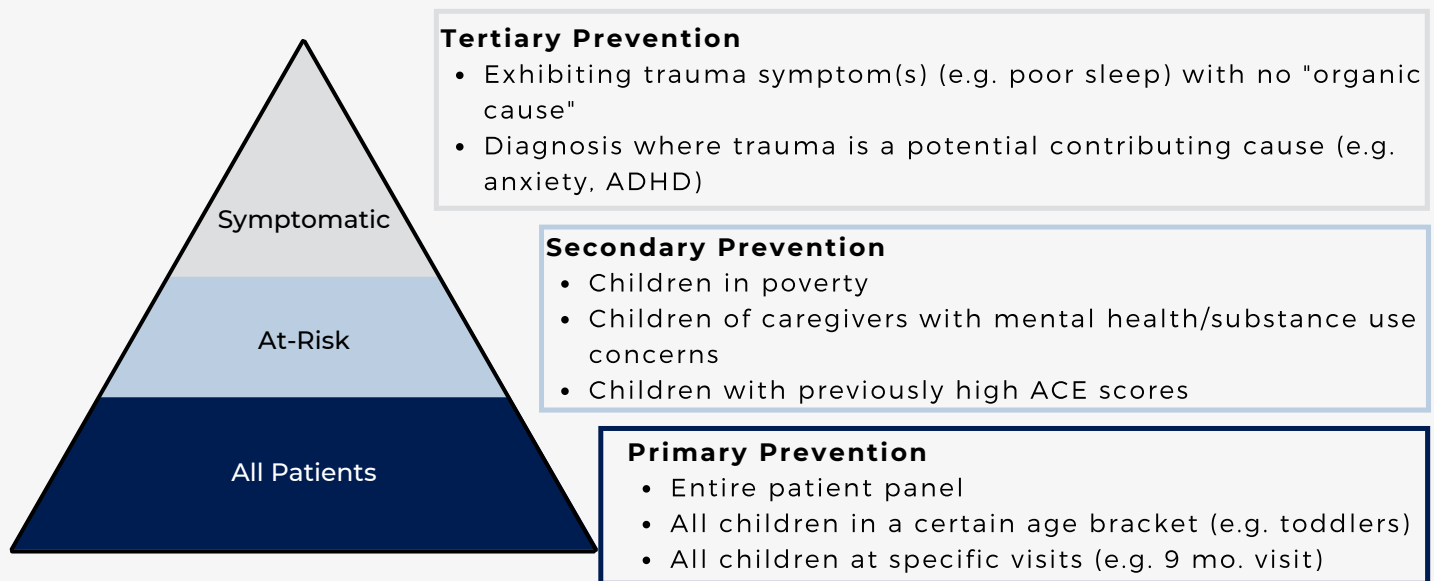- Identify issues contributing to physical and/or behavioral concerns conditions including developmental delays, asthma, somatic complaints, recurrent infections, and sleep disruptions have been associated with adversity.[4]
- Early identification (and evidence-based interventions such as home visiting programs and child parent psychotherapy), may lead to better outcomes for the child and family.

As the caregiver typically represents the "child's primary source of strength and support", acknowledging and building on caregiver strengths is paramount.[5] Screening for protective factors and resilience provides the opportunity to recognize positive behaviors and assets to buffer the effects of toxic stress. If at all feasible, screen for trauma and resilience simultaneously to help mitigate negative and strengthen positive factors.

WHEN TO SCREEN

After selecting the population to screen, the next step is to identify when to implement the screening process. For example, will screening take place at certain visits based on risk level or annually for all patients? A public health framework for potential screening approaches includes primary, secondary and tertiary prevention.

Tertiary Prevention
- Exhibiting trauma symptom(s) (e.g. poor sleep) with no "organic cause"
- Diagnosis where trauma is a potential contributing cause (e.g. anxiety, ADHD)

Symptomatic

Secondary Prevention
- Children in poverty
- Children of caregivers with mental health/substance use concerns
- Children with previously high ACE scores

At-Risk

Primary Prevention
- Entire patient panel
- All children in a certain age bracket (e.g. toddlers)
- All children at specific visits (e.g. 9 mo. visit)

All Patients

HELPFUL TIPS TO CONSIDER WHEN MAKING SCREENING SCHEDULE DECISIONS

- Choose a visit where few other screening tools or immunizations are due to lessen time constraints and staff burden. If your clinic is already screening for social determinants of health and/or maternal depression, consider how to coordinate these efforts with screening as they are often linked.
- Establish a relationship with the caregiver that is based on trust and understanding before screening for toxic stress.
- Universal delivery of trauma education is an evidence-based strategy for primary prevention.
- Start small and then spread. Consider starting with only one visit or at-risk population. Once a practice feels confident, expand screening to additional visits or to a larger population group.
- If a practice plans to screen a high-risk population, setting up and communicating very clearly to clinicians and staff who qualifies as "at risk" is critical to developing an effective workflow.
- Always consider the clinic's resources and capacity to address the results. Two key capacity considerations are care/case management and integrated behavioral health as both are frequently used to support families experiencing toxic stress.[23] Screening frequency factors into capacity considerations as well

Examples of screening schedules can be found in **Appendix 1**

WHAT SCREENING TOOL(S) TO USE

Having selected the population to screen, the next step is selecting a screening tool(s). In **Appendix 2** of this guide are three tables of available screening tools. One table focuses on tools for assessing toxic stress in children/adolescents, another for adults (i.e. caregivers), while the third includes tools to assess resilience/strengths.

Important Considerations for Screening Tool Selection

- What screening tools could optimize attachment between caregiver and child? For example, identifying current family social determinant needs, followed by screening to assess toxic stress and resilience opportunities.[18]
- Is the tool copyrighted? What are the copyright limitations? Can you photocopy? Enter on tablet?
- Are there costs to use the tool? Is it affordable?
- Is there research evaluating the reliability and validity of the tool? Results?
- How long does it take to complete the tool?
- Is the tool culturally relevant and available in the languages spoken by clinic families?
- Does the tool literacy level fit with that of families served by your clinic?
- Is the tool designed for the population you plan to screen?
- If an ACE screen is selected, how is screening approached? This decision impacts development of how the clinic will respond to screening results (the topic of Section 5). (see note below.)

Screening for Trauma: The Maine Building Resilience to Adverse Childhood Experiences (BRACES)[24]

Maine Medical Partners conducts universal trauma screening in pediatric well child visits at its Pediatric and Family Medicine practices. Their screening tool is a compilation of:
1) a two-question trauma screen to identify current trauma for either child or caregiver
2) an ACE screen to assess cumulative trauma exposure of the child
3) the abbreviated PTSD Reaction Index to identify post-traumatic symptomology in the child
4) two-question family food-security screen

Some clinics implement an ACE screen that tallies the number of ACEs experienced, thus the clinician sees only the cumulative ACE score. Based on this cumulative score, decisions about next steps are made. Other clinics implement a screen where ACEs experienced are checked off, thus the clinician can see both cumulative number and types of ACEs experienced. The former approach offers easier administration and may increase patient comfort. However, this approach assumes all ACEs have equivalent impact, a point of divergent opinion among experts. For example, an ACE score of "1", with the ACE being separation from caregiver is "weighted" the same as being sexually abused. It will be important to canvas clinicians and staff regarding which scoring method to use.

TOOL IMPLEMENTATION METHODS

Having selected the population, timing, and tool(s) for screening, the next step involves developing a workflow for how the screen will be implemented. Workflow steps will vary depending on screening population, timing, and practice staffing. Below is a sample in-office workflow for screening during a scheduled well-child visit.

Check-In	• Develop a process for how staff will know at which visits screening is needed. Example: Will a staff person review the next day's visits to identify those due for screening? How will they notify the care team?
Tool Distribution	• Will the screen be completed alone in the waiting room or in the exam room with staff or a clinician? See the table below. How will screenings of siblings be handled to not over burden the caregiver?
Screen Completed	• Determine if the screen will be administered by tablet or paper. See "Screening Admin" table below. If paper, who receives the completed screen? How will you ensure response confidentiality?
Screen(s) Scored	• Who will score the screen(s)? How will results be distributed to the clinician before the visits starts?
Review Results	• A clinician's response may influence the way the caregiver or child perceives the trauma, their hope for recovery, and their desire to seek further treatment. See Section 5.

Introducing Caregivers and Patients to the Screening Process

- Develop a way for caregivers/patients to learn about the screening prior to their appointment. For example, mail a letter or develop a script that a clinician could use to describe screening to be conducted at the next well-child visit. Affirm the goal is to support families, not shame or judge them.
- Develop a script for staff/clinicians to introduce families to the screening at the appointment including why the screen is being done and what will happen after it is completed. Consider developing a cover sheet for the screening tool that explains these points. Communicate that the goal is to support the family's health by recognizing strengths and addressing needs. Carefully and accurately inform the caregiver/patient of state child abuse and neglect reporting requirements.[25] (Sample scripts for staff, including medical assistants and the primary care clinician can be found at: **Center for Youth Wellness ACEQ & User Guide**)
- Assure that the staff distributing the survey (front-office, medical assistants, clinicians) are comfortable answering questions about why these questions are being asked.
- Train staff and clinicians to recognize trauma symptoms and what to do if they occur while caregiver/patients are completing the screen.

Considerations for Screening Administration Method*	
Electronic	**Paper**
Do clinic technology policies allow administration by electronic means? (e.g. tablet, mobile)? Can results be imported into the EHR? Does the screen developer only allow administration via a third-party system? What is the cost? Tablet administration may require IT department staff time to set up, thus funding and wait time may be factors.	Can begin to implement once screen is printed. Can be laminated and reused What will be done with completed screens?

Confidentiality Protocols
- Will results be stored in EHR/paper file system (if no EHR)?
- How will results be stored securely and NOT be included in after-visit summaries or patient records?
- Who will have access to the results? What in-office staff will be able to see results? Practices located in larger health systems will also need to determine if other departments (ED, Specialists) will have access.

*Some clinics may consider mailing the screening tool or making it available on a patient portal prior to the visit. Caution should be taken if utilizing either of these strategies because the clinic will not have an opportunity to answer questions right away or talk to families who may be uncomfortable with the questions.

Determine how screening of siblings will be completed. While each child has different experiences, attention should be given to ease the burden on caregivers if filling out screens for multiple children.

If a clinic is implementing a workflow that is initiated by presence of symptoms frequently associated with trauma (e.g. sleeplessness, sudden changes in eating) and/or a diagnosis with a potential trauma etiology (e.g. ADHD, depression, anxiety, substance misuse), existing workflows related to these conditions would need to be modified to include screening with the selected screening tool(s).

RESPONDING TO RESULTS: WHAT HAPPENS AFTER THE SCREEN?

WHAT TO DO WITH THE RESULTS

After developing the screening implementation process, the next step involves identifying a protocol for reviewing and responding to screening results. Practices should outline interventions for all possible results (not just very high concerns) to provide a comprehensive prevention and intervention response to traumatic experiences.[24] The full picture of caregiver and/or child experiences, protective factors, and symptoms should be integrated to determine appropriate follow-up care and referrals.[27] Training and role-playing to increase clinician comfort with engaging in trauma-informed discussions is critical as a clinician's response may influence the way the caregiver and/or patient perceive the trauma, their hope for recovery, and their desire to seek further support. To encourage consistency in clinician response to screening results, developing a risk stratification approach for follow up care is highly encouraged.

Below is an example of a response protocol to address results of a combined ACEs, resilience, and trauma symptom screen of the child. Of note, this approach assumes the clinician can see both the number and type(s) of ACEs experienced. (See Section 3 of this Guide)

> All conversations should begin with thanking the family for sharing and acknowledging the difficulty of disclosing this type of information followed by re-affirming its relevance to the health of the child.

Risk Category	Screening Assessment	Example of Screen Results Meeting This Classification	Follow-Up Action
Low	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 factors that are already being addressed effectively by the family.	**Primary Prevention**[1] strategies include: • Anticipatory guidance about toxic stress • Positive parenting techniques • Promoting family bonding
Moderate	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 activities PLUS **Secondary prevention**[2] strategies include: • Identifying and addressing barriers (e.g. social determinants) to families having safe, stable and nurturing relationships (e.g. linkages to food) • Augmenting family coping capacity and resilience (e.g. parenting classes)

			Above activities PLUS **Tertiary prevention**[3] strategies include:
High	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)	• Addressing trauma-related symptoms/conditions (e.g. Trauma-informed Cognitive-Behavioral Therapy) • Rebuilding unhealthy family relationships (e.g. Child-Parent Psychotherapy)

Universal

- Talk to family about building resilience skills.
- Discuss what trauma is and the effects of trauma on development.
- Consider referral to a Family Resource Center (all patient families) for continued resilience and parent skill-building.
- Offer anticipatory guidance about future developmental milestones that may present parenting challenges and how to address them.

Moderate and High Risk

- Determine if there is need to report to DCYF. Follow protocol for reporting.
- If caregiver has experienced trauma, discuss the impact of trauma, for example on parenting and bonding. Celebrate existing bonding activities and encourage additional bonding.
- Refer to appropriate in-office staff or community resources for further assessment and therapeutics for both caregiver and patient depending on experience of trauma, symptoms, and need. If immediate safety need for caregiver, refer immediately with their agreement and support.

High Risk

- Provide a warm handoff to appropriate in-office staff to prioritize and address immediate safety and basic needs as well as conduct additional mental/behavioral assessments for both the caregiver and patient depending on experience of trauma, symptoms, and need.

Determining and prioritizing appropriate next steps and referrals is critical. The below table offers a suggested prioritization scheme based on ecological, biological, and developmental determinants to promote healthy and resilient families.

Guidance on Developing Next Steps Based on Screening Results to Build Relationship Between Caregiver and Child/Adolescent[20]
1. Address any unmet social determinants (i.e. safety, housing, food, childcare) or support (i.e. behavioral, social, substance misuse) needs of the caregiver
2. Build capacity of caregiver to have a safe, stable, and nurturing relationship with the child(ren). (For example, home visiting, referral to parenting/child development classes, Child-Parent Psychotherapy, family playgroups, etc.)
3. Build capacity of child to engage in developmentally appropriate interactions with caregiver and others. (For example, referral to social-emotional growth opportunities and supports such as behavioral health counseling, Head Start, youth mentoring, mindfulness, etc.)

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INTERNAL REFERRAL RESOURCES

Identifying in-office referral resources prior to addressing child adversity is key. Inventorying and educating clinicians and staff about in-office services and supports and how/who to contact to access them may seem unnecessary, but it is critical to maximizing both service use and staff time. For example, if a practice has both an integrated behavioral health clinician and a case manager, clinicians need to know which person to contact about support with meeting unmet social determinant needs. If a clinic does not have an integrated behavioral health clinician but has identified a staff person with a specialization/advanced training in behavioral/mental health, then clinicians need to know about this internal resource. In addition to clinicians, some staff may also be able to provide positive parenting tips and serve as bridges to community-based parenting classes/support groups. Consider the cultural needs of your patient population. For example, the use of community health workers to connect families from different cultures, citizenship status, or underserved communities in bridging the gap to needed services has been shown effective.[27,28] Coordinating care delivery to mitigate the impact of childhood adversity and build resilience requires a team-based care model and integrated technology.[23] The table in **Appendix 3** provides guidance about each component to assist clinics in developing workflows and tools to optimize care delivery.

> **Importance of Team-Based Care**
> "If I'm the only one doing it [care provision], I definitely can't do it in 20 minutes. But if I have a team, then it becomes a whole different experience and so I feel like that I've been giving that family more time, and that's a good thing. And most providers are going to love that if that's possible.
> -Primary Care Clinician Practicing in a team-based care model (NHPIP Interview)

EXTERNAL REFERRAL RESOURCES

Community resources may include a wide variety of agencies and individuals who are equipped to address the social determinants of health as well as trauma-specific behavioral health care. A good first step is to review and update the clinic's existing list of community resources followed by identifying and inventorying any missing referral resources based on patient population needs.

Key Partners:
- Family Resource Centers
- Domestic Violence Crisis Centers
- Community Action Programs
- Community Mental Health Agencies

Developing relationships/rapport along with referral/communication processes with key community resources is highly advantageous. Identifying a specific contact person at the community agency/organization and determining if the diversity, quality, and capacity of services will meet family needs is critical. Understanding intake processes can help clinic staff prepare patients for what to expect when they access community resources. These relationship-building conversations can be ideal

opportunities to identify and review privacy regulations that govern sharing of information between the clinic and community agency/organization about shared patients. Becoming familiar with these rules and having conversations with community partners about information sharing can greatly enhance patient care.[26] The American Academy of Pediatrics outlines what can be shared in the normal course of treatment with and without written consent and can be accessed through the AAP website. State regulations also govern what can be shared in New Hampshire.[29] Always follow the most restrictive rule. Developing a joint release of information form to allow communication between a practice and a community service provider is an important strategy. Completed by the caregiver/patient, this form allows for the bi-directional sharing of information to facilitate care coordination among providers.

There are numerous provider and parent resources available to promote resilience and awareness of the impact of traumatic experiences. Please see **Appendix 4** for a list of helpful links to on-line resources.

Provider Quotes About Community Partnerships

Family Resource Center
"I wasn't even aware that all these virtual parenting classes were available. This has been really, really helpful."

"It has been really helpful getting to know our community partners"

"I didn't know you guys did all that stuff! I definitely have families I could have referred!"

"That is the number one eye open experience about this whole thing...we are learning about things in the community as resources that we've never know before. I have already started utilizing a lot of that. It's not just about counseling."

PILOTING SMALL TESTS OF CHANGE

After determining the population to be screened, the screening tool, the intended screening schedule and the response to results, a practice can begin drafting a workflow for adversity screening and response.

Tips for Creating a Draft Workflow		
Develop the workflow with a multidisciplinary team • If someone has a role in the workflow, they should be involved in the planning process	Use sticky notes and create the workflow on the wall so everyone can see and provide input • IMake sure to include a sticky note for every step, no matter how small	Assign roles to assure evryone is involved • Roles include writing steps, hanging notes on the wall, and taking notes to capture the conversation

To learn more about developing clinical workflows, see **Module 5 of the Agency for Healthcare Research and Quality's (AHRQ) Practice Facilitation Handbook**.[30]

MODEL FOR IMPROVEMNET

The Institute for Healthcare Improvement's *Model for Improvement* is an effective and simple tool to help guide a practice through the pilot phase.[31] As with the workflow, it is helpful to document each step taken and make it visible to all members of the team. Use the Quality Improvement Worksheet in **Appendix 5** of this guide as a tool to walk through each of these steps. Additional QI guidance can be found here.
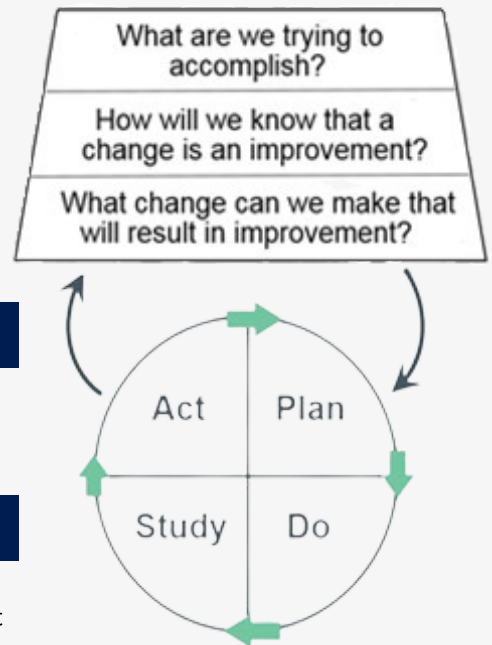
Sample Measures to Collect

- Percentage of eligible population screened
- Percent with a significant result
- Percent with significant result with a referral

Qualitative Data

- At the end of the first day, have a huddle with everyone that was involved. How did it go? What went well? What could have gone better? Then make the adjustments the following day.
- Feedback from patients/caregivers

Display Data Over Time

- Longitudinal data is critical for tracking progress and identifying trends and variations in the data. Try displaying the data in a run chart and hang it in a common staff area to get everyone engaged with the improvement activity

INCORPORATING PATIENT/CAREGIVER VOICE

Along with use of quality improvement science, incorporating family voice into workflow development and piloting is critical. Engaging with patients about their preferences for and concerns about trauma screening and response can inform framing for clinician staff conversation "scripts", screening tool selection, preferences for family support resources, etc. Gathering family input can be done via a variety of strategies. See the sidebar for family engagement strategies.

Strategies for Engaging Family Voice

- Invite family partners to join the clinic team developing the screening workflow

- If the practice has a patient-family advisory board, seek their preferences on screening tools/workflow

- Identify a "friendly family" in the practice to initially pilot and debrief about family experience with workflow

- Conduct a focus group of screened families to garner feedback on process improvements

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BUILDING A CLINIC CULTURE OF RESILIENCE

Provider burnout is a growing issue in the US health care system. It produces substantial economic costs and negatively impacts clinical outcomes and the lives of clinic providers and staff. Symptomatology of burnout includes exhaustion, reduced emotional energy, and lack of efficacy in work.[32] Burnout can effectively be reduced with moderate levels of investment in burnout reduction programs which provide substantial economic value to hospital systems.[33] In addition, previous research demonstrates that meaningful work can buffer against clinician burnout.[34, 35] Conceivably, building clinician competency to prevent and mitigate the effects of toxic stress for some clinicians may serve as a buffer to burnout by increasing meaningful work. Pediatric provider teams working with children and families experiencing trauma, may be at increased risk for secondary traumatic stress which may impact their own lives as well as their interactions with patients. Clinicians and staff may have or be experiencing trauma in their own lives. Therefore, recognizing and promoting self-care is important.[36]

INDIVIDUAL RESPONSE

In order to promote resilience and self-care among staff, the National Child Traumatic Stress Network (NCTS) and the American Academy of Pediatrics offer the following recommendation:[32, 36]

Method	Preventative Measures	Interventions for Burnout
Education and Training	• Definition and impact of secondary traumatic stress • Importance of self-care (e.g. exercise)	• Evaluating secondary traumatic stress • Mindfulness training
Supportive Human Resource Practices	• Clinical supervision • Balanced caseloads • Flextime	• Reflective supervision • Caseload adjustment • Change in job assignment or workgroup
Social Supports	• Workplace self-care groups (e.g. yoga) • Self-care accountability buddy system	• Informal gatherings following crisis events (to allow for voluntary, spontaneous discussion)
Behavioral Health Services	• Informal/formal self-report screening • Promote awareness of available supports (e.g. Employee Assistance Program)	• Cognitive behavioral interventions • Referrals to EAP or outside agencies

SYSTEM RESPONSES

In addition to methods for individuals to recognize and address secondary traumatic stress, the AAP recommends taking a systems approach to promoting wellbeing and awareness of the impact that trauma-informed work can have on the health care workforce. Creating an environment that recognizes and openly seeks to address the stress of working with traumatized children and families can improve provider satisfaction as well as patient interactions and outcomes.[33]

APPENDICES

APPENDIX 1: SCREENING SCHEDULE EXAMPLES

Timing Screening to Support Caregiver-Child Attachment
The Children's Clinic in Portland, Oregon, conducts caregiver screening for ACEs and resilience at the four-month well-child check. This screening approach provides the opportunity to promote awareness of ACEs, discern previous traumatic exposures that could impact attachment, and acknowledge caregiver strengths that lend to supportive parenting. The Clinic picked the four-month visit as it gives time for the providers and caregivers to build trust before screening, is not as packed with shots/screening, and to try to mitigate attachment issues as early as possible in the child's development.

Below are the chosen screening schedules from 5 clinic teams

A	4 mo
	3 yo
	7yo
	13 yo
B	4mo
	12mo
	Annually 3+
C	4 mo
	15mo
	3yo
	6yo
	9yo
	12yo
D	4 mo
	3 yo
	7yo
	13 yo
	When there is a positive depression screen
E	4mo
	3yo
	6yo
	9yo
	12yo
	15yo
	18yo

APPENDIX 2: SCREENING TOOL COMPARISON

Potential Screening Tools for Trauma Exposure, Symptomology, and Resilience

Note: When available, links to actual surveys/tools are provided in the "tools" column. Links in the "More Info" column go to websites containing more specifics about the tool.

NA = Not Applicable
NR = Not Recorded

Table 1: Child and Adolescent Trauma Exposure and/or Symptomology Screens[4]

Tool [4]	Tool Description	# Items	Admin Time	Who Completes	Tool Age Range	Use in Primary Care	Reliability/ Validity	Literacy Level	Language	Cost	More Info
Tools Assessing Trauma Exposure (including ACEs)											
Safe Environment for Every Kid (SEEK-PQ-R) (2019)	Screens for psychosocial problems (subset of ACEs) that increase likelihood for child maltreatment. Tool is part of SEEK Intervention Program.	16	2-4 min	Caregiver	0-5 yrs	Yes	Yes, extensive testing done.	4th-5th grade	English Spanish Italian	Copyrighted Licensing Fee for large practices or health systems	LINK
Pediatric ACEs and Related Life-event Screener (PEARLS) 2018	Assesses ACEs from original ACEs study (see row below) plus additional SDOHs that may increase risk for toxic stress	17	NR	Caregiver if child <12 Caregiver & teen (12-19 yrs)	Child:<12 Teen:12-19 yrs	Yes	No, but testing in progress	6th grade	English Spanish	Free	LINK
Whole Child Assessment (2019)	Tool combines screening for original ACEs, additional social determinants, and	32-50	NA	Caregiver if child <12 Child if between 12-	0-20 yrs, Different versions depending on age	Yes	No	NA	English Spanish	Free	LINK

Tool [4]	Tool Description	# Items	Admin Time	Who Completes	Tool Age Range	Use in Primary Care	Reliability/ Validity	Literacy Level	Language	Cost	More Info
	developmental health & safety issues			20 yr							
Child Trauma Screen (2017)	Assesses 4 common pediatric trauma exposures & 6 trauma symptoms	10	5 min	Child/Youth (7-17 yrs) And/or caregiver for child 6-17 yrs)	6-17 yrs	Yes	Initial psychometrics appear good	NR	English, Spanish	Free and in public domain	LINK
Tools Assessing Trauma Symptomology											
Trauma Symptom Checklist Screening Form for Children and for Young Children (2018)	Screens for posttraumatic symptomatology after a traumatic event	20	5 min	Caregiver Child/Youth	3-12 ys (Young Children Form) 8-17 yrs (Children Form	NR	Initial psychometrics appear good	NR	English, Spanish	Proprietary and copyrighted	Younger Children Children Form
Child Trauma Screening Questionnaire (2006)	Child version of the Trauma Screening Questionnaire (see table below) that assesses for risk of PTSD after a traumatic event	10	5-10 min	Child/Youth	7-16 yrs	NR	Initial psychometrics appear good	NR	English, Arabic, Croatian	Free, but copyrighted	LINK
Child Stress Disorders Checklist – Short Form V.3 (2010)	Assesses risk for Acute Stress Disorder (ASD) and/or Posttraumatic Stress Disorder (PTSD) after a traumatic event	4	5	Caregiver	2-18 yrs	No	Initial psychometrics appear good	NR	English	Free and in public domain	LINK
Child's Revised Impact of	Assess risk for PTSD after traumatic events	8	5 min.	Child/Youth	8-18	No	Yes, initial psychometrics appear good	NR	Available in 26 languages	Free. No tool changes w/o author approval	LINK

Tool [4]	Tool Description	# Items	Admin Time	Who Completes	Tool Age Range	Use in Primary Care	Reliability/ Validity	Literacy Level	Language	Cost	More Info
Events Scale											
Child Trauma Screen (2017)	Assesses 4 common child trauma exposures & 6 symptoms	10	5 min	Child/Youth	6-17 yrs	Yes	Initial psychometrics appear good	NR	English, Spanish	Free	LINK

Table 2[5]: Caregiver Trauma Exposure and/or Symptomology Screens

Tool	Tool Description	# Items	Admin time	Who Completes	Tool Age Range	Use in Primary Care	Reliability/ Validity	Literacy Level	Language	Cost	More Info
Tools Assessing Trauma Exposure (including ACEs)											
Original ACEs Questions (1998)	Questions used in original CDC-Kaiser study done by Anda and Felitti.	10	5 min	Caregiver	18+	Yes	No	NR	English	Free and in public domain	LINK
Children's Clinic ACE & Resilience Survey (2015)	Tools includes original ACEs question plus 4 additional ones and Connor-Davidson Resilience Survey 10Q	29	5-7 min	Caregiver	18+	Yes	ACEs: no Connor-Davidson yes	NR	English, Spanish	Fee for Connor-Davidson Resilience Survey	LINK
Life Events Checklist for DSMV (2018)	Assesses lifetime exposure to 17 traumatic experiences	17	NR	Caregiver	18+	NR	Minimal changes made from previous version exhibits good psychometric testing	NR	English	Free and in public domain	LINK

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[5] Helpful resources accessed to create Table 2 include: PTSD Screening Instrument Resource Page and the Trauma Exposure Screening Instrument Webpage.

Tool	Tool Description	# Items	Admin time	Who Completes	Tool Age Range	Use in Primary Care	Reliability/ Validity	Literacy Level	Language	Cost	More Info
Brief Trauma Questionnaire (1999)	Assesses lifetime exposure to 10 different traumatic experiences	10	NR	Caregiver	18+	NR	No	NR	English	Free and in public domain	LINK
Trauma History Screen (2005)	Assess lifetime exposure to 13 traumatic experiences	14	<8 min	Caregiver	18+	NR	Initial psychometrics appear good	NR (but tested w/ lower literacy pop)	English	Free and in public domain	LINK
Trauma Symptomology											
Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) (survey after article) (2001)	Assesses the core PTSD symptoms (intrusion, avoidance, numbing, arousal), somatic malaise, stress, and role/social functioning.	8	5-10 min	Caregiver	18+	NR	Initial psychometrics appear good	NR	English	Free, but copyrighted	LINK
Primary Care PTSD Screen for DSM 5 (survey after article) (2015)	Assesses trauma exposure and if yes, then assesses trauma symptoms	5	5 min	Caregiver	18+	Yes	Initial psychometrics appear good	NR	English	Free and in public domain	LINK
Abbreviated PTSD Checklist – Civilian (PCL-C) (2005)	Two or six question screen derived from the PTSD Checklist-Civilian Version that assess PTSD symptoms	2 6	1-3 min	Caregiver	18+	Yes	Initial psychometrics suggest Q6 version performs better	NR	English	Free and in public domain	LINK
Trauma Screening Questionnaire (2002)	Used after a traumatic event to assess two trauma symptom clusters of re-experiencing and	10	5 min	Caregiver	18+	No	Initial psychometrics appear good	NR	English	NR	LINK

Tool	Tool Description	# Items	Admin time	Who Completes	Tool Age Range	Use in Primary Care	Reliability/ Validity	Literacy Level	Language	Cost	More Info
	arousal										

Table 3: Tools for Assessing Resilience (Individual OR family)

Tool	Focus	# Items	Admin Time	Who Completes	Tool Age Range	Use in Primary Care	Reliability/ Validity	Literacy Level	Language	Cost	More Info
Connor-Davidson Resilience Scale 3 Versions 25Q (2003) 10Q (2009) 2Q (2008)	Can be used to screen for low, medium, and high resilience of an **individual**	25Q 10Q 2Q	10 min 1-5min 1-5min	Caregiver Teen	Teens and adults	Yes	Considerable research available to support	5th grade	77 languages see LINK	Proprietary & copyrighted	LINK
Devereux Early Childhood Assessment Versions Infants: 2007 Toddler: 2007 Preschool: 2012 Caregiver: 2013	Assesses key social & emotional strengths of an **individual**	33 36 38 23	5-10 min.	Caregiver	Inf:1-18 mo. Tod:18-36 mo. Pre:3-5yrs 18+	NR (Originally developed for child care and education)	Yes, research available	6th grade	English, Spanish	Copyrighted & proprietary	LINK
Child/Youth Resilience Measure (2018) Adult Resilience Measure	Assesses **individual** & **Caregiver/ relational resilience** (child/caregiver or caregiver relationship	17	5-10 min	Child Youth Caregiver	5-9 yrs 10-23 yrs 18+ yrs.	No	Significant research done	Standard & simplified versions by age available	LINK	Free, but copyrighted	LINK

Tool	Focus	# Items	Admin Time	Who Completes	Tool Age Range	Use in Primary Care	Reliability/ Validity	Literacy Level	Language	Cost	More Info
(2018)	with partner/family)										
Resilience Questionnaire (2014)	Assesses **individual** resilience as measured by positive supports and experiences available as a child	14	5-10 min	Caregiver	18+	Yes (Caregiver education purposes only)	NR	NR	English	Free	LINK
Protective Factors Survey[6] Original (2011) Version 2 (2014)	Assesses 5 **family** protective factors: functioning/ resilience, social &concrete supports, nurturing and attachment, and knowledge of Caregiving/child development (last item included in original survey only)	V1: 20 V2: 19	10 min	Caregiver	Caregivers of children/teens	No (Developed for use in child welfare agencies)	Original tool: psychometrics appear good PFS v2: Initial psychometric studies demonstrate tool reliability and validity	NR	PFS: English Spanish PFS2: English	Free	LINK

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[6] One helpful resource to locating surveys included in the resilience tables includes the ACEs Connection Website Resilience Survey Page.

APPENDIX 3: TEAM-BASED CARE MODEL AND INTEGRATED TECHNOLOGY

Use of Team-Based Care Delivery Model
1. Determine clinic team needs and capacity to provide integrated behavioral health and case management services. Of note, this does not mean that if a clinic does not have an integrated behavioral health clinician it does not preclude addressing trauma.
2. Define each team member's responsibilities to develop workflows that maximize staff use. For example, if a team includes a social worker, how is this person being deployed -- as an integrated behavioral health clinician or as a case manager focused on addressing social determinants and other referral needs?
3. Pilot ways to do just-in-time response to family needs. For example, if a family is coming in for an acute care visit, doing a real-time huddle of clinician and key staff to coordinate short "check-ins" of pertinent team member(s) about current family priorities (e.g. housing stability, stress response) can be beneficial.
4. Design physical space to support team communication and decision-making.
5. Brainstorm ways to support "relational continuity" between the family and the clinic team responsible for their care. This strategy is particularly important for clinics with frequent turnover, such as residency training sites. Strategies could include verifying each child is assigned a primary care clinician, scheduling as many visits as possible with this clinician. Introduce and encourage patients to communicate with other clinic team members if their clinician is not available.

Integrating Technology (EHRs, Registries, etc.) to Maximize Care Coordination
Maximizing Your EHR to Support: Consistent Implementation of the Screening Response Protocol   • Build in the functionality based on screening result category entered, prompting immediate display of next steps.   Informational Continuity   • Identify a mechanism to quickly find, summarize, and update the family's social history in the EHR. This facilitates informational continuity about current family circumstances among team members caring for the family and/or for visits with clinicians unfamiliar with the family.   • Determine if the EHR has a built-in field for current care priorities that can be easily found, read, and updated when needed   Referrals: • Explore potential for e-referral functionality being built-in for frequent referral resources (family resource centers, local community mental health center, etc.)   • Decide how team members will indicate referral related activities in the EHR (flags, etc.) including progress or status of referrals and communication with family via phone call, text, email, or during an appointment.

- Investigate EHR ability to support closed-loop referrals? To find out, look at other conditions that require frequent follow up. It may be difficult to replicate these processes for trauma follow up and referral. If so, developing a patient registry of families experiencing chronic toxic stress may be useful. (See below)

Other Useful Tools:
- A registry is an electronic tool that facilitates tracking of referrals and follow-up care for a specific patient population. Sometimes a registry functionality is built into an EHR. If it is not or is not robust enough, then most often it is built using a spreadsheet software program that can be easily categorized, sorted, and updated to support optimal care delivery
- HIPAA-compliant videoconferencing platforms like Zoom for Healthcare that can facilitate real-time coordination with clinic and community partners caring for the family.
- A family resource sheet of key local resources (family resource centers, community mental health center, etc.) that can be included in after-visit summary, accessible on clinic website, and built into a clinic's patient portal for easy, anytime accessing.

Designing Physical Space to Promote Team-Based Care

A pediatric care team at one NH primary care clinic promotes care coordination and shared decision-making by having team members (pediatric clinicians, case managers, integrated behavioral health, WIC/nutrition, community health workers, and others) sit in one office around a large oval table. All present have "permission" to "listen in" on other conversations about family/patient needs or ask questions/request guidance about care/service recommendations.

Universal Screening at Every Visit:
2 Questions
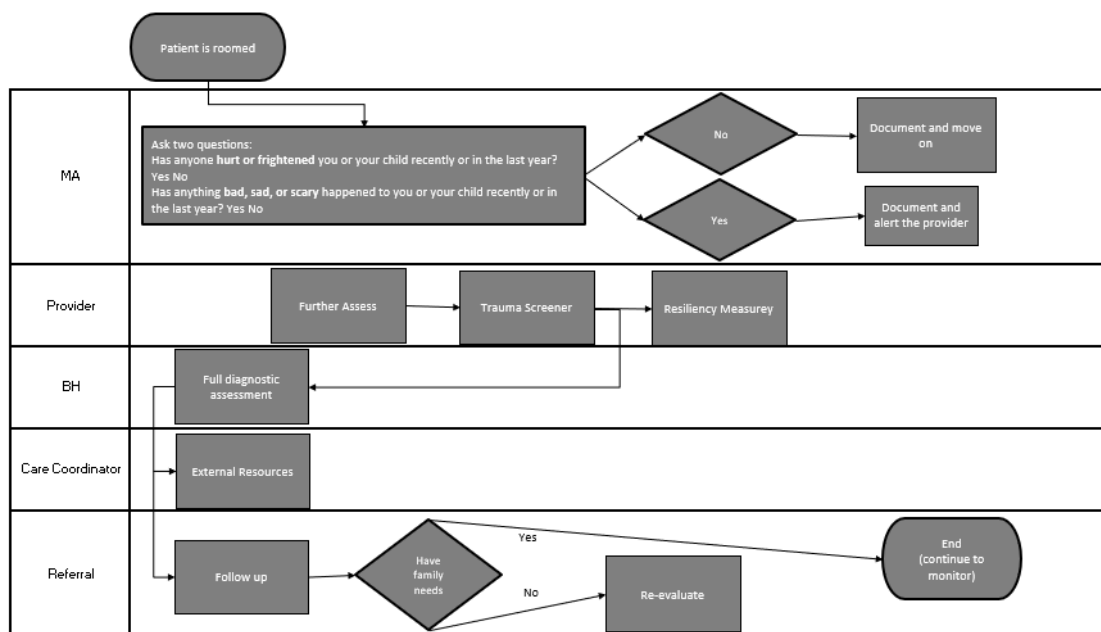
APPENDIX 4: PRACTICE AND PARENT RESOURCES

Practice Enhancement Resources:
- **Strengthening Families** is a research-based protective factors framework that provides a set of resources and tools for supporting parents, particularly those who seem to be overwhelmed by parenting, isolated, or struggling to understand and respond to their children's needs. More information can be found here: https://www.aap.org/en-us/Documents/resilience_messaging-at-the-intersections.pdf
- **Connected Kids** is used to increase awareness in the office among staff and patients, hang posters relaying positive messages about attachment and protective factors. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Connected-Kids.aspx
- ACEs Aware https://www.acesaware.org/implement-screening/about-the-guide/

Parent Resources:
Parent education and strengthening attachment promote healthy development and can mitigate the adverse effects of trauma. Here are some examples of resources to share with parents.
- When Things Aren't Perfect: Caring for Yourself and Your Children https://www.aap.org/en-us/Documents/ttb_caring_for_yourself.pdf
- Bring Out the Best in your Children https://www.aap.org/en-us/Documents/ttb_bring_out_best.pdf
- Positive Parenting Tip Sheets (CDC Resource) https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/index.html
- Stress Health Website: http://www.stresshealth.org
- NHPIP resources sheets developed for clincis – www.nhpip.org

Considerations for Special Populations:
LGBTQ: Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth experience trauma at higher rates than their straight peers. Learn more here: https://www.nctsn.org/what-is-child-trauma/populations-at-risk/lgbtq-youth
Race and Equity: Exposure to race-based discrimination/violence contribute to adverse childhood experiences. Learn more here: https://pediatrics.aappublications.org/content/144/2/e20191765
Refugees: Immigrant and refugee youth have higher rates of trauma than youth who are not transnational. Learn more here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6721394/
Homeless: As many as 2.5 million youth per year experience homelessness. Along with losing their homes, community, friends, and routines—as well as their sense of stability and safety—many homeless youth are also victims of violence or other traumatic events. Learn more here: https://www.nctsn.org/what-child-trauma-populations-risk/homeless-youth

APPENDIX 5: QUALITY IMPROVEMENT WORSHEET

Quality Improvement Worksheet

Practice Name: _____

Project Lead: _____

Project Name:	
Start Date:	
Team Members:	

Global Aim

Create an aim statement that will keep your focus clear and your work productive. What are we trying to accomplish? What is the overarching goal?

Specific Aim

Use numerical goals, specific dates, and specific measures. What is the area of focus?

Measures

How will we know that a change is an improvement? List measures to track for project.

PDSA

PLAN (How should we PLAN the pilot? Who? Does what? By when? What baseline data do we track?)

DO (What are we learning as we DO the pilot? What happened? Any obstacles, good/bad surprises?)

STUDY (As we STUDY what happened, what have we learned? What do the measures show?)

ACT (Based on our results, how will we ACT? 1) Re-test with a modified plan 2) expand to a wider test group 3) abandon altogether 4) adopt the new pilot and monitor? Make a PLAN for the next cycle of change.)

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