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GRANTEE

Peer-to-Peer Learning Sessions Proceedings Report

Funded in part by First 5 LA, a leading public grantmaking and child advocacy organization.

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Background

The ACEs Aware initiative seeks to change and save lives by helping Medi-Cal providers understand the importance of screening for Adverse Childhood Experiences (ACEs) and training them to respond with trauma-informed care. ACEs Aware offers Medi-Cal providers training, screening tools, clinical protocols, and payment for screening children and adults for ACEs. Screening for ACEs, assessing for toxic stress, and responding with evidence-based interventions can significantly improve the health and well-being of individuals and families. The ACEs Aware initiative is part of a statewide effort, led by the Office of the California Surgeon General (CA-OSG), to decrease ACEs and toxic stress by half in one generation. ACEs and toxic stress represent a public health crisis that has been, until recently, largely unrecognized by the health care system and society. By screening for ACEs, responding with evidence-based interventions, and implementing trauma-informed care, we can significantly improve the health and well-being of individuals and families.

In January 2020, CA-OSG and the California Department of Health Care Services (DHCS) released a Request for Proposals to fund organizations to help extend the reach and impact of this initiative to Medi-Cal providers and organizations that serve Medi-Cal beneficiaries. The ACEs Aware initiative seeks to support the training and engagement of a wide range of health providers and other professionals, as well as encourage collaboration among organizations to build networks of care through provider training, provider engagement, communications, and convenings.

First 5 LA and joint applicants, the American Academy of Pediatrics – California Chapter 2 (AAP-CA2) and the Los Angeles County Department of Mental Health (LACDMH)-UCLA Prevention Center of Excellence (COE), were awarded a Provider Engagement grant from CA-OSG and DHCS to promote the ACEs Aware initiative within the Medi-Cal provider community in Los Angeles (L.A.) County. Specifically, First 5 LA partnered with key stakeholders in L.A. County to implement three Provider Engagement activities:

1) Peer-to-Peer Learning sessions with primary care physicians and other health providers;

2) Network of Care activities for multiple types of providers, including organizations selected as ACEs Aware planning and implementation grantees; and

3) a Practice Paper to inform large scale systems change for incorporating ACEs screening alignment, treatment, and referrals/care coordination.

Peer-to-Peer Learning

First 5 LA has a long-standing relationship with AAP-CA2 and they have previously worked together to expand the implementation of developmental screenings in L.A. County. First 5 LA partnered with AAP-CA2 in 2017 to deliver a series of six countywide Town Hall sessions on Developmental Delay Screenings that educated 129 pediatricians across L.A. County. The Town Hall sessions focused on the importance of using an evidenced based developmental screening tool, resources available in the community, as well as the importance of systematizing the practice and using screening results for referrals. Additionally, in collaboration with AAP-CA2 and the Los Angeles County Department of Public Health, First 5 LA hosted a forum on May 29, 2019 titled "The Gray Zone: Strengthening Early Identification and Intervention for Children with Mild to Moderate Developmental and Behavioral Delays." Over 50 leaders across different sectors participated in this forum. Given these successful partnerships, the ACEs Aware Provider Engagement work provided another opportunity for First 5 LA and AAP-CA2 to come together and collaborate on important work to support L.A. County's youngest residents and their families.

As part of the ACEs Aware Provider Engagement work, First 5 LA and AAP-CA2 co-designed and implemented four Peer-to-Peer Learning sessions using AAP-CA2's existing Town Hall infrastructure. The four sessions focused on:

- Session 1 – ACEs Science: The Physiology of Toxic Stress
- Session 2 – Childhood Adversity and Health Systems Change
- Session 3 – After ACEs Screening: Early Intervention and Overcoming Barriers to Referrals
- Session 4 – Impact of Secondary Trauma and Burnout: A Blueprint for Wellness

The Peer-to-Peer Learning sessions targeted primary care providers serving children, including Pediatrics and Family Medicine. All Peer-to-Peer sessions were free of cost and took place on the Zoom virtual platform. AAP-CA2 ACEs Committee members (see callout box on next page), considered experts in the field, served as speakers and facilitators for all four sessions. Participants from AAP-CA2's member base were invited to attend these sessions through email campaigns. First 5 LA also partnered with their managed care partners to

advertise the Peer-to-Peer series to their partners. Continuing Medical Education (CME) credits were available to pediatricians and family medicine physicians who participated in the Peer-to-Peer Learning sessions. Recordings and meeting packets for all sessions can be found at https://aapca2.org/aces-aware/.

AAP-CA2 ACEs Committee

For years, the AAP has identified childhood adversity as a threat to child health, recommending pediatricians understand the ample science linking adversity to health outcomes, while also recommending pediatricians address adversity and its health risks through clinical practice and advocacy. With the alignment to Governor Newsom's budget introducing new Medi-Cal resources for health care systems to address ACEs and our state's first Surgeon General tackling ACEs as a health care priority in California, AAP-CA2 organized its first ACEs Committee in May 2019. The goal of the Committee is to educate pediatricians on a) the mechanisms by which childhood adversity impacts health, b) clinical approaches to identify and address ACEs, and c) the emerging policy and advocacy landscape. The committee meets monthly and, as of this report, 29 professionals participate in the committee (pediatricians, child psychologists, medical students, and school board representatives). Members are kept engaged and informed through Newsletter articles and resources, all of which can be found on the website: http://aapca2.org/aces.

The following report provides a summary of each Peer-to-Peer session, highlighting key themes, best practices, opportunities, and challenges by focus area.

ACEs Science – The Physiology of Toxic Stress

🔍 Session 1 Overview

The first Peer-to-Peer Learning session, hosted virtually on January 7, 2021, laid the foundation for the Peer-to-Peer Learning series. During the first session, Dr. Christine Thang, MD, FAAP (see sidebar on next page for bio) provided foundational information on the physiology of toxic stress and highlighted a pediatric approach to trauma, treatment, and resilience. [i] The objectives of this session were to (1) introduce the findings from the original Adverse Childhood Experiences (ACEs) Study, (2) describe how toxic stress impacts three physiological mechanisms, (3) identify variable response to toxic stress depending on age, and (4) examine how toxic stress physiology relates to a pediatric clinical case.

The session was conducted online and included a presentation followed by small group discussions and share outs among groups. Dr. Thang started the session by introducing the Landmark 1998 study by the [Centers for Disease Control and Prevention (CDC) and Kaiser Permanente](). The landmark ACE study included 17,000 adult patients from Southern California who completed confidential surveys regarding their childhood experiences and current health status and behaviors. According to Dr. Anda, co-principal investigator to the landmark ACE study:

- ACEs are common.
- ACEs tend to occur in clusters, rather than single experiences.
- 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.[ii]

Dr. Thang further explained the findings of the landmark ACE study as they relate to health outcomes. The findings suggest ACEs are [strongly associated](), in a dose-response fashion, with some of the most common, serious, and costly health conditions facing our society today. This includes at least nine of the 10 leading causes of death in the United States, as well as earlier mortality for those with four or more ACEs. Additionally, the landmark ACE study found that compared to people with zero ACEs, people with four or more ACEs are: 2 – 2.3 times as likely to have a stroke, cancer, or heart disease; 3.1 times as likely to have chronic lower respiratory disease; 11.2 times as likely to have Alzheimer's or dementia; 1.4 times as likely to have diabetes; and 37.5 times as likely to attempt suicide.[iii]

ACEs impact a child's development by negatively altering neurobiological and psychosocial processes which ultimately result in long-term health consequences including disease, disability, and social problems. The

Christine Thang, MD, FAAP

Dr. Christine Thang is an Assistant Clinical Professor in the Division of General Pediatrics at the David Geffen School of Medicine at UCLA. Dr. Thang is a board-certified pediatrician and member of the faculty practice at the UCLA Children's Health Center in Westwood, CA. She precepts medical students and resident physicians training in the UCLA Pediatrics Continuity Clinic. She is also one of the medical team providers for the UCLA Pediatrics Craniofacial Program. Dr. Thang's educational interest lies in training pediatric residents to be trauma aware and responsive clinicians with the adoption of a national evidence-informed curriculum, the Pediatric Approach to Trauma, Treatment, and Resilience (PATTeR) program. The curriculum was adapted and piloted with UCLA pediatric interns starting in January 2020. Dr. Thang currently holds AAP leadership positions in her local chapter and district, the Section on Early Career Physicians (SOECP), the Council on Foster Care, Adoption, and Kinship Care (COFCAKC), and the Community Access to Child Health (CATCH) Program. She is a graduate of the AAP Young Physicians Leadership Alliance (YPLA). Dr. Thang grew up in Los Angeles, CA. She is a spirited Bruin alumna.

mechanism underlying these potentially permanent shifts in the body is stress. Specifically, there are three different types of stress that children experience – positive stress, tolerable stress, and toxic stress. Positive stress is a normal and essential part of healthy development and includes brief increases in heart rate and blood pressure. Tolerable stress activates the body's alert system at a greater degree, but this activation is time-limited and can be buffered by caring adult relationships. Toxic stress occurs with strong, frequent, or prolonged adversity in the absence of protective relationships and disrupts the brain's architecture and other organ systems. It is now known that one important way in which ACEs increase risk of poor physical, mental and behavioral health is through prolonged activation of the biological stress response and associated changes to brain development, as well as immune, hormonal, and genetic regulation. These changes are known as the toxic stress response.[iv]

Toxic stress triggers potentially permanent biological changes through three mechanisms: neurobiology, immunology, and epigenetics. Repeated or prolonged activation of a child's stress response, without the buffering of trusted, nurturing caregivers and safe, stable environments, leads to long-term changes in the structure and functioning of the developing brain, metabolic, immune, and neuroendocrine responses, and even the way DNA is read and transcribed. Development of the toxic stress response is influenced by a combination of cumulative adversity, buffering or protective factors, and predisposed vulnerability.[v]

Bodily functions and behaviors may be maladaptive when children are removed from stressors. Thus, when not examined within the context of past traumas, a child's functions or behaviors may be misinterpreted as pathological. It is imperative that providers shift their perspective from "What is wrong with you?" to "What happened to you?" This shift will also support providers to identify the positive protective factors in a child's life that can buffer the harmful effects of toxic stress. Dr. Thang introduced two acronyms to the Peer-to-Peer Learning session participants that relate to toxic stress and resiliency in children – THREADS and FRAYED. THREADS is an acronym physicians can use to identify resiliency skills in children. THREADS stands for Thinking and learning, Hope, Regulation or self-control, Efficacy, Attachment, Developmental skill mastery, Social connectedness. These are resiliency factors that should be bolstered through childhood to promote positive physical and emotional development and mitigate the harmful effects of toxic stress. However, when a child experiences trauma, their resiliency skills shut down, and a provider may see FRAYED behaviors – Fits, frets, and fear, Restricted development, Attachment

concerns, Yelling and yawning, Educational delays, and Defeated/dissociation. Physicians can incorporate these two acronyms into their clinical encounters to better understand how trauma and resilience present in a child.

Thinking and learning brain

Hope

Regulation or self-control

Efficacy

Attachment

Developmental skill mastery

Social connectedness

Fits, frets, and fear

Restricted development

Attachment concerns

Yelling and yawning

Educational delays

Defeated/dissociation

Session Takeaways

Participants were invited to engage in small group discussions during a 20-minute breakout session. The objectives of the small group discussions were to: (1) examine how toxic stress physiology relates to pediatric clinical presentation, (2) use the FRAYED and THREAD acronyms to better understand the trauma presentation and resilience approach, and (3) identify practice changes that can lead to more trauma-informed care. To meet these objectives, a clinical case study (Exhibit 1) was presented to participants. Additionally, the physician who treated the patient in the case study was available during the session to further discuss the practices they applied to support the child. Participants noted it was helpful to have a real-world example to work from, as well as an opportunity for real-time follow up with the physician to learn more about how they proceeded.

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Exhibit 1. Session 1 Clinical Case Study

- 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."
- **Past Medical/Surgical History (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.
- **Social History (SHx):** Henry resides with his mother & maternal 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 an 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 2:00 a.m. 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.
- **Family History (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.
- **Review of Systems (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 two months ago.

Participants were asked to discuss: (1) Using the FRAYED acronym, what symptoms do you note among Henry and his mother? (2) Using the THREADS acronym, what buffering and protective factors do you note for Henry and his mother? and (3) How would you approach this well child visit today? What changes you would like to make? The following section provides key themes that emerged across small groups for these questions. Content of this section is informed by discussions and examples provided by Peer-to-Peer participants.

Applying THREADS and FRAYED

Following Dr. Thang's presentation, participants successfully identified THREADS and FRAYED behaviors in the case study about Henry. The following table highlights the various behaviors participants identified during their discussions.

THREADS
Thinking and learning brain: • He can stay focused on video games.   • Child is open to discussion. Using gaming and online activities to create social connections.
Hope: • He has plans for the future and hopes to study coding.
Regulation or self-control: • He did well verbalizing some of his emotions in the office.   • No alcohol/substance abuse.
Efficacy: • He could be enrolled in a coding class.   • Mother kept appointment   • Sharing personal information regarding his emotions and previous SI with pediatrician.
Attachment: • Not clear, but grandmother seems to provide nurturing relationship.   • Seems to relate readily to clinicians.   • Close relationships with mother and grandmother.
Developmental skill mastery: • Can stay focused on video games.
Social connectedness:

- Is connected to church.
- Has connectedness with parents but doesn't have a broader support system.
- Loves his mother and grandmother

FRAYED

Fits, Frets and Fear:

- Depressed, shows some fear. Has regulation issues (e.g., threatening to burn down house if video games taken away), which may be due to depression.
- Losing a parent, worry about mother's health, as she has several chronic health conditions.
- Henry fears that his Mom will die and he unfortunately witnessed his favorite uncle's violent assault resulting in his uncle's death.

Restricted development:

- Mother: stroke and memory problems including pseudo-seizures – can this disability impact ability to be provide nurturing attachment?
- Hasn't had social engagement sufficient to develop emotional intelligence.
- He has reported weight gain which means physically he is not developing normally (obese).

Attachment concerns:

- Given age should show some signs of emerging autonomy but still dependent on mother. No relationship with father.
- Threatens parent when screen time is taken away.
- Henry feels unloved by his biologic father who now has a new child with a different partner.
- An uncle who was his father figure passed away suddenly that he witnessed.
- His main adult role model, his mother, suffers from anxiety/insomnia/depression.

Yelling and yawning:

- Struggling to wake up in mornings.
- Not sleeping at night.
- He struggles to wake up to get to school.

Educational delays:

- Has educational delays – reading and mathematics; no interest in school or learning (but this may feed off of delays).
- Henry struggles with school. He has difficulties concentrating. He also stays up too late

> playing video games and not sleeping well so that could affect his ability to concentrate.
> - Dislikes school; doesn't like math or reading; currently at 3rd school.
> - He struggles with 6th grade schoolwork and paying attention, describes school as boring, and complains that other kids pick on him.

Defeated /dissociation:

- Dissociation, which may relate to educational delays.
- School disengagement.
- Escapes through video games; isolates self to avoid developing relationships; would benefit from daily routine.
- Henry states that there's "no point in being alive." He doesn't seem to find anything good about school finding it "boring" and doesn't describe any real friendships.

Managing Care with Available Resources

Overall, participants indicated that connecting with the child's support systems is an effective method to manage Henry's care. For instance, participants discussed how schools are a common source of support for a child. Through the school, physicians can connect with the school counselor, access or request IEP forms (if applicable), and develop plans for additional support with the school staff. This includes the possibility of conducting a psycho-educational assessment to understand any learning disability and establishing accommodations for the child, as needed.

Promising Practices

- Support children by collaborating with schools, providing referrals to services, offering parenting supports, providing linkages to mentoring programs, and encouraging healthy eating.

Participants also discussed how parenting support and education classes can help support Henry and his mother to mitigate the effects of ACEs. Participants shared it is important that these classes are advising parents to establish consistent routines, encourage their children to get plenty of outdoor exercise, and eat a nutrient-dense diet as these have been discussed as important in improving well-being. Additionally, support groups for parents could provide more information and resources should other barriers to well-being emerge, such as food and/or housing insecurity.

Understanding the Family and Community Context

Providers recognized the need to more fully understand the sources of support in Henry's life. This could include gaining a stronger understanding of the child's relationship with the father and further understanding the child's involvement in different groups (e.g., church, school groups, etc.). One participant shared,

"Recruiting some of those sources to ally themselves to your side…we could ask the dad if he realizes what Henry's going through…we could provide more help for mom…maybe grandmother is a resource…basically going back to his actual story and seeing if some of the characters would be willing to change his story." Further, participants discussed that physicians would need more time with the patient to discuss the social support network of the child and to discuss the socioemotional health of the child. Having more time for these discussions would allow for more time to build trust with the patient, provide referrals, and have discussions about additional resources.

Promising Practices

- Having discussions about a child's social support network builds trust and affords the opportunity to provide referrals and discuss additional resources.

Providers also recognized the need to better understand the mental/behavioral health resources and referral processes in the communities where their patients live. Physicians expressed that it is extremely difficult to find mental health providers that serve pediatric patients, which is further complicated by reimbursement and insurance barriers. During the group discussions, participants acknowledged that it is easy to identify needed resources for children and families, but getting families connected to those resources in practice is challenging due to the disconnection of systems.

Key Recommendations

- Take a comprehensive approach to a child's patient care. This includes looking past a patient's current physiological symptoms and considering what has happened to that child that may have contributed to their health status.
- Use the THREADS and FRAYED acronyms as a framework for understanding children's behaviors and identifying strengths and resiliency factors.
- Be creative and innovative about resources and supports to offer to children and families.

Session Participants

In total, 56 provider participants joined the virtual Peer-to-Peer Learning session. Twenty-eight (50%) participants completed the session's follow up survey that included questions about individual characteristics and roles. As illustrated in Exhibit 2, 39 percent identified as White, followed by 18 percent Asian Indian, 11 percent Filipino, and 11 percent Chinese. No participants identified as being from Hispanic, Latino/a, or Spanish origin. Participants were generally physicians (89%) with most physicians specializing in pediatrics (74%).[1] Lastly, 74 percent of participants indicated serving Medi-Cal patients.

Exhibit 2. Session 1 Participants' Race and Ethnicity
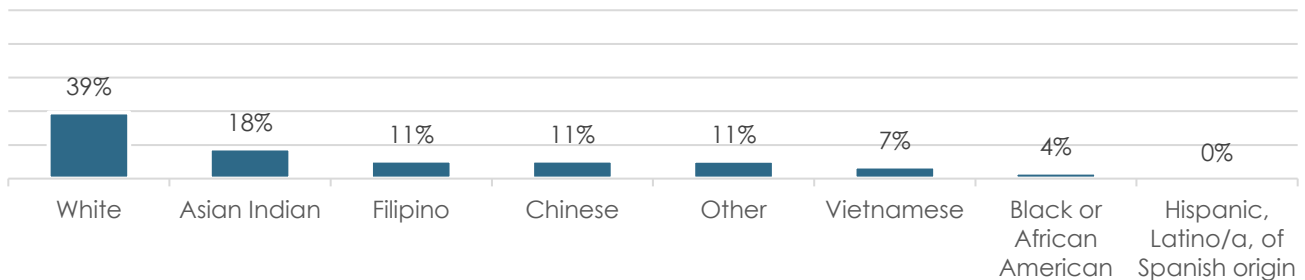
During the presentation portion of the session, participants seemed most comfortable asking questions in the chat box and during the Q&A session mid-way through the presentation. Topics that generated the most conversation surrounded developing care plans and identifying needed resources. Participants had less to contribute around implementing a trauma-informed approach into their practices as it has been challenging for participants to plan for implementation. Participant engagement during this Peer-to-Peer Learning session took place mostly during the breakout room discussions.
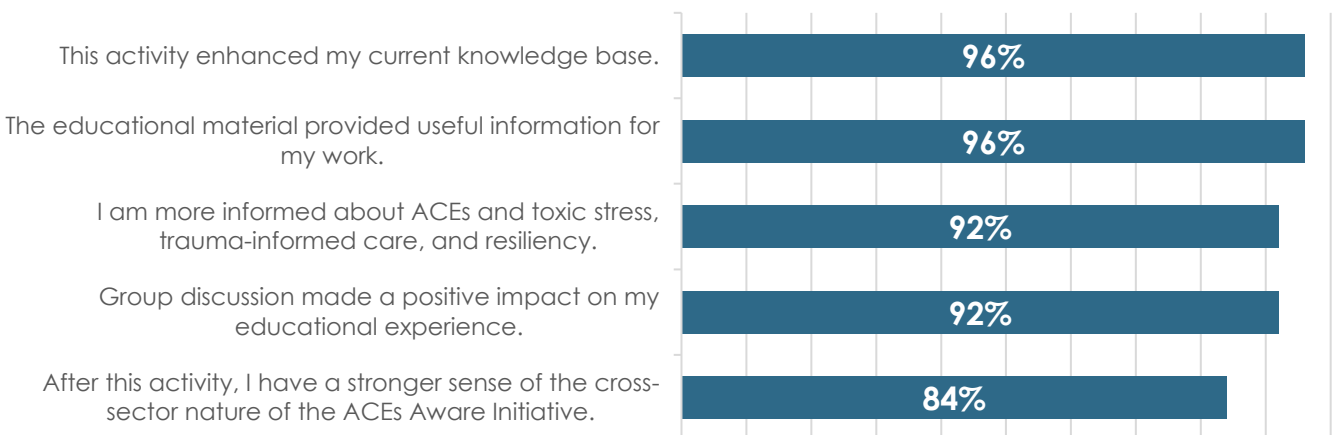
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[1] Additional occupation categories include Marriage and Family Therapist (4%) and Nurse Practitioner (4%). Additional specialization areas include behavioral health (4%), family medicine (7%) and other (7%).

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Follow Up Survey

Following the Peer-to-Peer Learning session, participants were asked to complete a short online survey and answer questions about their experience at the Peer-to-Peer Learning session. The results of the survey suggest participants had a positive experience and found the information and materials presented to be helpful (Exhibit 3). Nearly all participants (96%) agreed or strongly agreed that the educational material presented during the session provided useful information for their work and the same percentage of participants felt the Peer-to-Peer Learning session enhanced their current knowledge base.

Exhibit 3. Participants' experience at the Peer-to-Peer Learning session (n=28; percentage of participants who agree/strongly agree)

This activity enhanced my current knowledge base.	96%
The educational material provided useful information for my work.	96%
I am more informed about ACEs and toxic stress, trauma-informed care, and resiliency.	92%
Group discussion made a positive impact on my educational experience.	92%
After this activity, I have a stronger sense of the cross-sector nature of the ACEs Aware Initiative.	84%

Participants were also asked to indicate how they plan to incorporate what they learned into their practice. Just under 40 percent of participants (39%) plan to apply the clinical algorithm on ACEs and toxic stress to guide patient care and the same percentage intend to implement routine screening for ACEs in children. Following the session, one-quarter of participants reported plans to change their treatment or management approach based on ACEs score and toxic stress risk assessment (Exhibit 4). When asked how confident participants felt that they could implement their intended changes, 29 percent reported feeling very confident while 63 percent felt somewhat confident. The remaining

8 percent were not confident or unsure of their ability to make intended changes. The most common anticipated challenges to implementing changes were time constraints (40%), ability to refer patients to appropriate services and treatments (16%), and patient adherence/compliance (12%).

Exhibit 4. Percentage of participants planning to implement practice changes (n=28)

Apply the clinical algorithm on ACEs and toxic stress to guide patient care — 39%
Routine screening for ACEs in children — 39%
Change in treatment or management approach, based on ACEs score and toxic stress risk assessment — 25%
Change in interprofessional team communication or collaboration, within team in primary clinical setting — 18%
Change in interprofessional communication or collaboration, for referrals and off-site partners — 18%
Change in current practice for referrals or linkages to treatment and support services — 14%
Routine screening for ACEs in adults — 7%
Other — 4%

Childhood Adversity and Health Systems Change

Session 2 Overview

The second Peer-to-Peer Learning session was hosted virtually on February 11, 2021 and focused on educating and supporting clinicians to identify and address ACEs in their practice. The objectives of this session were to (1) describe common barriers to identifying and addressing adverse childhood experiences, (2) examine health system barriers to identifying and addressing adverse childhood experiences, and (3) assess readiness to deliver trauma-informed care in practice.

The session included an introduction, review of foundational content covered during the first Peer-to-Peer Learning session, a presentation from Dr. Adam Schickedanz (see sidebar on next page) on integrating ACEs screening into practice, and breakout groups to develop ideas for practice change based on a clinical case study. The presentation was supplemented with online polls accessible by browser or text where participants were able to engage with the lecturer.

During the presentation, Dr. Schickedanz framed the importance of screening for ACEs in the context of the health care system's shift to focusing on prevention efforts and upstream health care approaches. Root causes of poor health outcomes are often found at the systemic level and emanate from inequitable laws, policies, structures, and practices. Identifying and treating patients within the context of ACEs is part of a larger shift towards understanding social determinants of health to address individuals medical and social needs and contribute to large-scale population health improvements.[vi]

The presentation included discussion of several workflows to help attendees envision how they could incorporate and implement ACEs screening in their practice. The workflows demonstrated how the screening process is multifaceted and considers data or information from various sources when determining how to best support the patient. This includes utilizing a combination of scores obtained through screener tools but also considering the patient's symptoms and physician's concerns when determining how to best serve a patient (Exhibit 5). Examples of detailed workflows and other resources can be found at https://aapca2.org/aces-aware/.
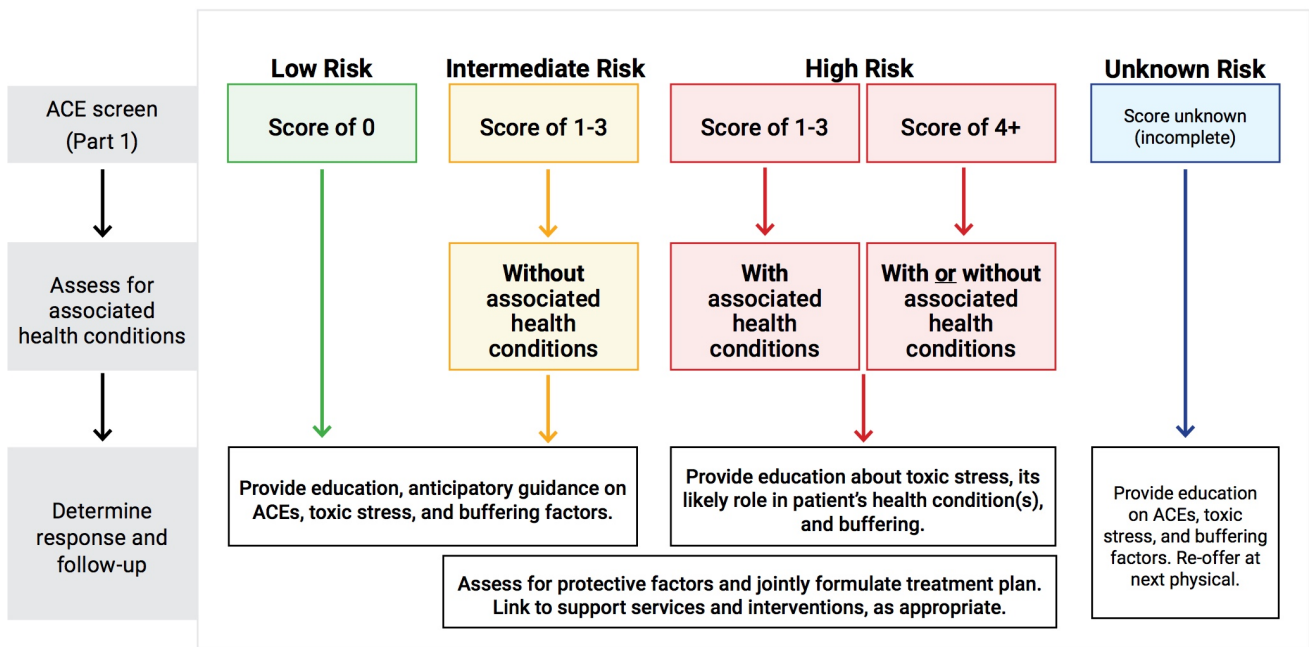
Adam Schickedanz, MD, PhD, FAAP

Adam Schickedanz is a general pediatrician and health services researcher at UCLA who works clinically within the Los Angeles County Department of Health Services at Olive View-UCLA Medical Center. His work focuses on developing new models of pediatric primary care to address families' social and economic determinants of health. He has helped large and small health systems and clinics implement assessment and evaluation programs to address patients' basic needs, including food, housing, and transportation. Dr. Schickedanz received his medical training at UCSF and came to Los Angeles as a Robert Wood Johnson Clinical Scholar at UCLA. He received his doctorate in Health Policy and Management at the UCLA Fielding School of Public Health, focusing on the relationships between Adverse Childhood Experiences (ACEs) in one generation and behavioral health problems in the next generation of children. Dr. Schickedanz is currently on faculty in the UCLA Department of Pediatrics in Westwood. He is also the Chair of the ACEs Committee of the Southern California American Academy of Pediatrics Chapter.

Exhibit 5. ACEs Aware Screening and Response Workflow

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

	Low Risk	Intermediate Risk	High Risk		Unknown Risk
ACE screen (Part 1)	Score of 0	Score of 1-3	Score of 1-3	Score of 4+	Score unknown (incomplete)
Assess for associated health conditions		Without associated health conditions	With associated health conditions	With or without associated health conditions	
Determine response and follow-up	Provide education, anticipatory guidance on ACEs, toxic stress, and buffering factors.		Provide education about toxic stress, its likely role in patient's health condition(s), and buffering.		Provide education on ACEs, toxic stress, and buffering factors. Re-offer at next physical.
		Assess for protective factors and jointly formulate treatment plan. Link to support services and interventions, as appropriate.			

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

Dr. Schickedanz reiterated the importance of starting small when it comes to practice change and adding one area of risk/need at a time. Moreover, it is important to focus on risks/needs that have established interventions so that families can be supported once ACEs are identified. Trauma-informed care is foundational and must be in place first to effectively address ACEs. This includes taking a family-centered approach to identifying and addressing ACEs and considering the patients' and families' biggest risk or needs when screening for ACEs – ideally from their perspective and with their input. Additionally, physicians should anticipate pushback both from patients and clinicians in their practice and it is important to design and change care experiences, not just care processes, to effectively identify and treat ACEs.

💡 Session Takeaways

As a starting point for the small group discussions, the same clinical case study from session 1 was shared to help participants apply the concepts discussed during the presentation to a real-world case. The case study discussion allowed participants the opportunity to examine barriers to identifying childhood adversity as a routine part of clinical cases and consider practice changes to routinize identification of and response to childhood adversity.

Participants were asked to discuss: (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?; and (3) What system/policy-level changes would facilitate these practice improvements? The following section provides key themes that emerged across small groups, related to the topics: clinical workflow design; addressing stigma; and system level policy changes. Content of this section is informed by discussions and examples provided by Peer-to-Peer participants.

Clinical Workflow Design

Clinical workflow design is an important factor to consider when incorporating ACEs screenings into clinical practice. Elements to consider when designing workflows include incorporating time for building trust and rapport, questionnaire fatigue, using telemedicine, staff roles, and patient experience. Clinical workflow designs need to consider the time needed (1-2 visits) to establish rapport with the patient as many are reluctant to disclose sensitive information, such as ACEs, right away. Some providers prioritize screenings depending on the timing of the visits with patients. For example, the first visit can be an orienting visit introducing the screening tool and asking the family to complete it at home, scheduling a follow up to bring back the tool. Successful workflow designs take into account questionnaire fatigue and may include completing all screening forms at the front end of a patient engagement. One person shared, "[We need to recognize] the form

Promising Practices

- Consider questionnaire fatigue when designing workflow.
- Clinical workflow designs should include time to establish rapport with the patient.
- Medical staff can conduct screenings over the phone if the family has trouble with computer-based screeners.
- Normalizing peer navigators throughout the workflow to support the screening process.

filling fatigue families experience. Maybe we can think about being trauma-informed and giving people time to fill out these forms." Medical staff can also consider doing screenings over the phone if the family has trouble with computer-based screeners. This allows physicians to use their limited time to focus on patient needs and the screening would still qualify for reimbursement by the state if conducted by medical staff. Similarly, paraprofessional staff (e.g., health promotoras) can be incorporated into the workflow to conduct ACEs screenings as well, however their services would not be reimbursable by the state. Lastly, normalizing the work of peer navigators throughout the workflow can support the screening process and would allow patients to feel more comfortable and informed.

Addressing Stigma

Peer-to-Peer Learning session participants acknowledged that many families face stigma when it comes to screening and treating ACEs. Some of the ways participants address the stigma of ACEs screenings include normalizing screenings in general, anonymizing screenings to help alleviate the distress families feel related to the sensitive questions, and giving parents resources prior to visits can allow families to prepare for the types of questions they will be asked.

> **Promising Practices**
> - Normalize screenings.
> - Anonymize screenings to reduce distress related to stigma.
> - Continuity in care is critical in establishing a quality relationship between the patient and the provider.
> - Trauma-informed care trainings for staff.

A key component of addressing screening stigma is continuity in care and establishing a quality relationship between the patient and the provider, which takes time. Given the hesitation with disclosing information during initial visits, participants have found it helpful to explore creative ways to get more information from the patient early on and potentially save time. For example, the patient may be encouraged to draw a picture of their family life and home as way to get insight. Participants also suggested providing incentivized trauma-informed care trainings for staff to learn how to use health concerns to explore underlying trauma.

Screen and Support Pregnant Women

Participants also discussed how it may be beneficial to look at ACEs during pregnancy and provide mental health support for mothers as needed. There is evidence to support consideration of toxic stress in utero and post-partum and that screening and treating ACEs should begin with the mother. This could potentially prevent the intergenerational transmission of ACEs for some children.

System Level Policy Changes

Participants discussed how schools have the potential to be a critical partner in screening for ACEs, however more funding is needed to support school-based mental health programs. Additionally, participant highlighted the need for established referral pathways that will prevent practitioners from conducting screenings that may surface needs they cannot address. For example, connections with mental health staff can help make immediate referrals but can be a barrier for a smaller practice that does not have this capacity. Lastly, participants identified how they could advocate for greater mental health resources by organizing fellow pediatricians in their area to write letters to their local Medi-Cal carrier to jointly advocate for investing in therapists and mental health resources for their patients.

Promising Practices

- More funding to support school-based mental health programs as parents tend to feel more comfortable with school-based services.
- Establish referral pathways that will prevent practitioners from conducting screenings without resources.

The following recommendations emerged from the small group discussions, to be considered by physicians when integrating ACEs screening into their practice and patient care.

Key Recommendations

- Train all medical staff (i.e., physicians, nurses, etc.) in ACEs, trauma-informed care, and social determinants of health to ensure continuity in a patient's experience.
- Alleviate patient-level time constraints by preparing parents of patients with materials or resources in advance and giving them options, such as completing screenings online, utilizing telemedicine, and designing creative ways (e.g., drawing, "agreements/contracts") to get more information early on about ACEs.
- Alleviate patient stigma by normalizing screenings. Ways to normalize screening include explaining that the ACEs screening is a standard protocol, the information will be used to inform patient care, referrals are available if the patient is interested, and doing so in an empathetic and nonjudgmental way.[vii]
- Providers should consider establishing connections with schools, community mental health providers, and collaborate with local Medi-Cal

representatives to increase resources available to children and their families.

- Consider engaging ancillary supports in the screening and treatment process to free up the amount of time providers are able to engage with patients.

Session Participants

In total, 38 participants joined the virtual Peer-to-Peer Learning session. Of the participants who completed the session's follow up survey (n=13, 34%), 54 percent identified as White, followed by 15 percent Asian Indian, and 15 percent who identified as another race (Exhibit 6). Additionally, 15 percent of participants identified as being from Hispanic, Latino/a, or Spanish origin. Participants were primarily physicians (85%), mostly specializing in pediatrics (85%).[2] Just under three-quarters of participants (73%) indicated serving Medi-Cal patients.

Exhibit 6. Session 2 Participants' Race and Ethnicity[3]
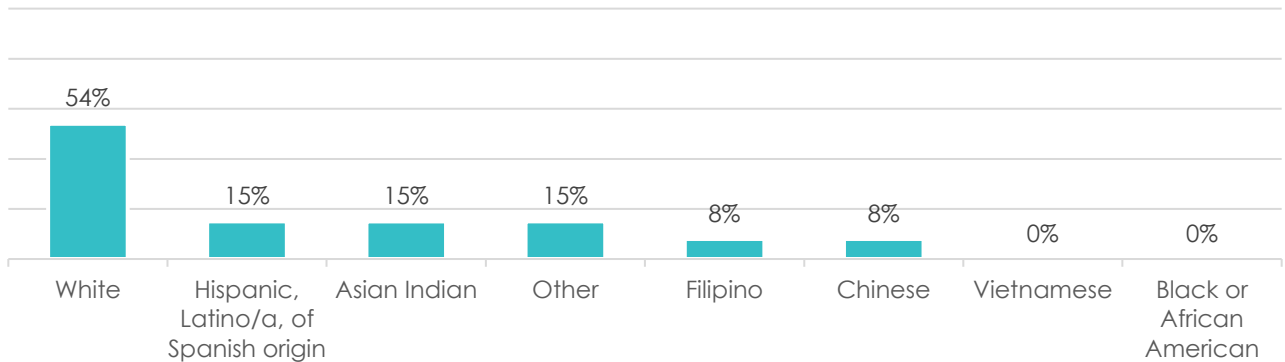
Participant engagement during this Peer-to-Peer Learning session took place mostly during the breakout room discussions. During the presentation portion of the session, polls were used to engage participants. Though the polls were

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[2] Additional occupation categories include non-profit/advocacy (8%), registered nurse/advanced practice nurse (8%). Additional specialization areas include family medicine (8%) and other (8%).
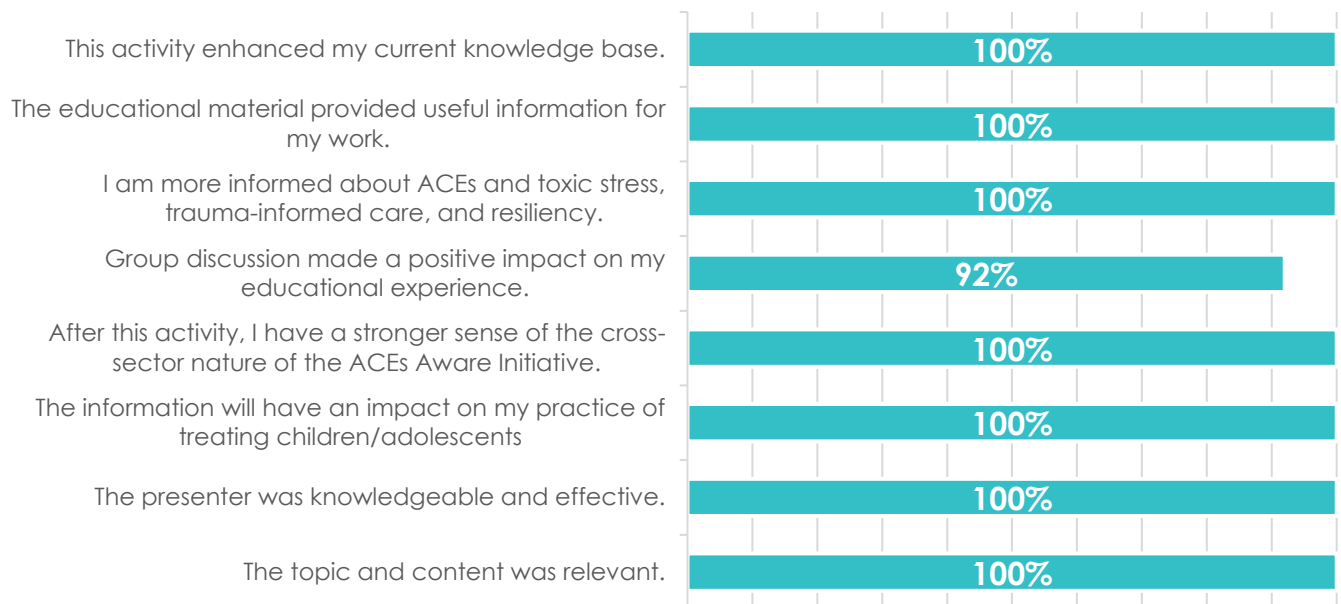
[3] Participants were asked to indicate their race and ethnicity. Percentages add up to more than 100%.

conducted outside the Zoom platform and required extra effort to join, which resulted in not all attendees participating, thoughtful insights emerged through these polls. It was noted that the breakout sessions and idea-sharing portions of the presentation provided the most opportunity for rich discussions and engagement between participants.

Follow Up Survey

Following the Peer-to-Peer Learning session, participants were asked to complete a short online survey and answer questions about their experience at the Peer-to-Peer Learning session. The results of the survey suggest participants had a positive experience and found the information and materials presented to be helpful (Exhibit 7). All participants indicated feeling more informed about ACEs and toxic stress, trauma-informed care, and resiliency. All participants also felt the information presented will have an impact on their practice of treating children and adolescents.
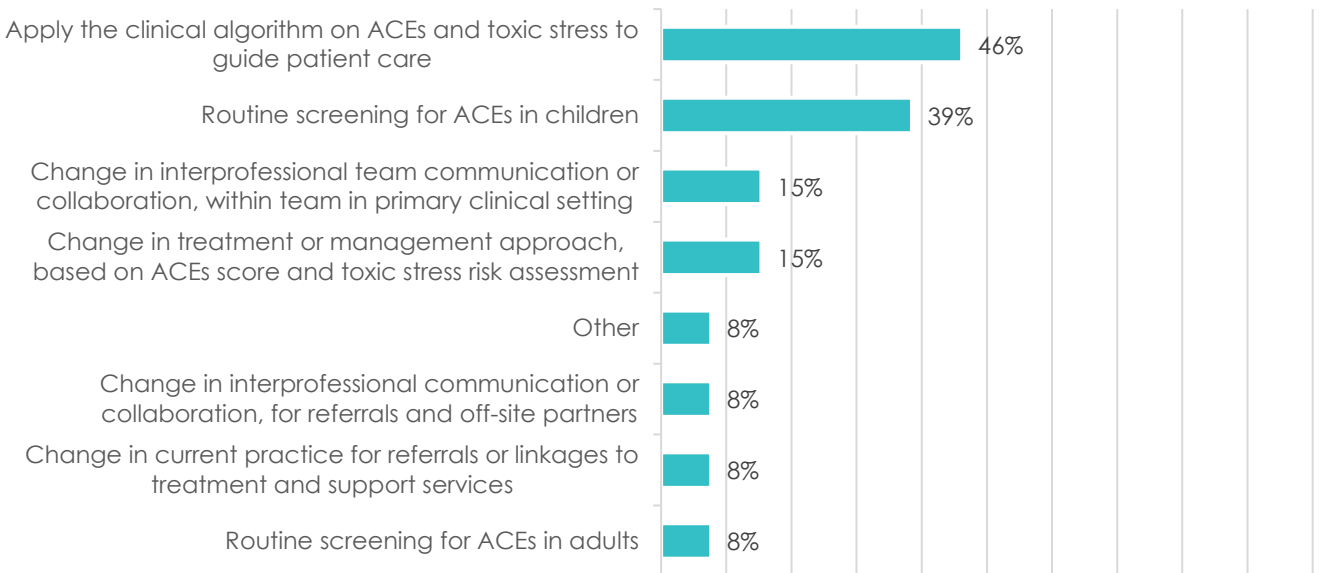
Exhibit 7. Participants' experience at the Peer-to-Peer Learning session (n=13; percentage of participants who agree/strongly agree)

| Statement	Percentage
This activity enhanced my current knowledge base.	100%
The educational material provided useful information for my work.	100%
I am more informed about ACEs and toxic stress, trauma-informed care, and resiliency.	100%
Group discussion made a positive impact on my educational experience.	92%
After this activity, I have a stronger sense of the cross-sector nature of the ACEs Aware Initiative.	100%
The information will have an impact on my practice of treating children/adolescents	100%
The presenter was knowledgeable and effective.	100%
The topic and content was relevant.	100%

Participants were also asked to indicate how they plan to incorporate what they learned into their practice. Nearly half of participants (46%) plan to apply the clinical algorithm on ACEs and toxic stress to guide patient care while 39 percent plan to implement routine screening for ACEs in children (Exhibit 8). When asked how confident participants were that they could implement their intended changes, 30 percent reported feeling very confident while 60 percent felt somewhat confident. The remaining 10 percent were unsure. The most common anticipated challenges to implementing changes were insurance/financial issues (25%) and time constraints (25%).

Exhibit 8. Percentage of participants planning to implement practice changes (n=13)

Apply the clinical algorithm on ACEs and toxic stress to guide patient care	46%
Routine screening for ACEs in children	39%
Change in interprofessional team communication or collaboration, within team in primary clinical setting	15%
Change in treatment or management approach, based on ACEs score and toxic stress risk assessment	15%
Other	8%
Change in interprofessional communication or collaboration, for referrals and off-site partners	8%
Change in current practice for referrals or linkages to treatment and support services	8%
Routine screening for ACEs in adults	8%

GRANTEE

After Screening: Building ACEs Response Interventions and Overcoming Barriers to Referrals
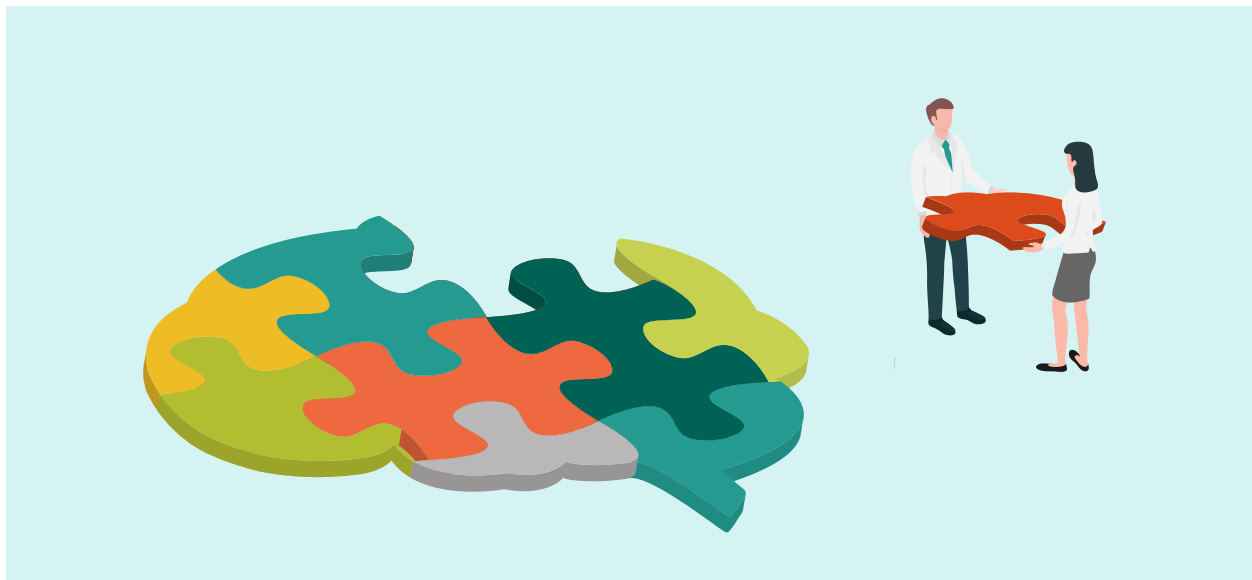
Session 3 Overview

The third Peer-to-Peer Learning session was hosted virtually on March 18, 2021. It highlighted the importance of aligning ACEs and developmental screenings and identifying solutions for common referral barriers that prevent children and families from accessing needed services. The objectives of this session were to: (1) Describe the AAP guidelines for developmental screenings, (2) Understand the relationship between ACEs screening and developmental screening, (3) Understand early intervention as an effective strategy for addressing ACEs in young children, (4) Understand referral guidelines for California Early Start services and Regional Centers, (5) Understand how the pandemic has impacted screening and referrals, and (6) Navigate common barriers to implementing screening and referrals in practice.

ACes aware

The session was led by Dr. Carlo DeAntonio, MD, FAAP (see sidebar) from the North Los Angeles County Regional Center. The session included an informative lecture on the relationship between ACEs and developmental screenings, a presentation on an early intervention service referral option to address ACEs in young children, and solutions-oriented small group discussions where providers had the opportunity to discuss common referral barriers and brainstorm solutions.

The session opened with a welcome and recap of the first two Peer-to-Peer Learning sessions

Carlo DeAntonio, MD, FAAP

Dr. Carlo DeAntonio is a pediatrician and the Director of Clinical Services at the North Los Angeles County Regional Center. He earned his Bachelor of Arts degree at Harvard University and his Medical Doctorate at UCLA. He completed his residency in pediatrics at Mattel Children's Hospital at UCLA. Dr. DeAntonio is a past Fellow of the California Health Care Foundation (CHCF) Health Care Leadership Program. Dr. DeAntonio's areas of interest include developmental disabilities, early intervention, and child advocacy.

which highlighted the neurological basis of toxic stress on young children, how toxic stress can relate to long-term health issues, and some of the barriers providers face when identifying and addressing adverse childhood experiences in their own practices.

Dr. DeAntonio's presentation explained the association between developmental delays and ACEs. Research shows that young children with an ACEs score of three or more are almost twice as likely to experience a developmental delay and children with an ACEs score of four or more are about 33 times more likely to have learning and/or behavior problems compared to children with no ACEs.[viii] While screening for developmental delays and ACEs are often done independent of one another, the results should be interpreted in relation to each other. The toxic stress associated with ACEs impacts a child's development and would likely be evident on a developmental screener. Conducting both ACEs and developmental screenings with young children are important components of comprehensive pediatric well-child care. Additionally, both types of screenings are reimbursed through Medi-Cal and provides physicians with an additional incentive to implement both types of screenings with patients.

Best practices associated with screening for developmental delays include:

- surveillance (no standardized tool) at every well-child check,
- screening (with a standardized tool) at any interval when a parent or provider has concerns,
- screening at regular intervals of 9, 18, and 24-30 months, when no concerns are present,

first 5 la
Giving kids the best start

- screening for autism at 18 and 24 months, and
- referral for developmental evaluation promptly if there are concerns from provider or a concern discovered through a screening.

Early intervention services play an important role in addressing ACEs in young children. Regional Centers across the state provide early intervention services that providers can refer patients to when a developmental concern has been identified. Regional Centers in California provide resources for developmental evaluation, early intervention services for children under three, diagnostic evaluation for Autism Spectrum Disorder or intellectual disabilities, and lifelong services for individuals diagnosed with handicapping developmental disabilities.

The Regional Center Early Start program is an early intervention resource that serves children who have been diagnosed with an established risk condition, are under 36 months of age with a 33 percent or greater delay in one developmental domain, or are at high risk of having a substantial developmental disability due to a combination of bio-medical risk factors. If determined eligible for Early Start, an individualized family service plan (IFSP) is developed based on the child's needs. Some examples of typical early intervention services may include child development, speech therapy, physical therapy, and occupational therapy. A child in Early Start may receive additional assessment such as a psychological evaluation and autism specific testing to determine if a developmental disability such as autism spectrum disorder or intellectual disability is present so that the child may qualify for continued Regional Center services after the age of 3.

Early Start through Regional Center is one example of an early intervention service that helps address developmental concerns in young children. A large portion of children under the age of five in California with, or at risk for, developmental or behavioral delays are not connected to early intervention services. Common barriers to connecting these children with services include fragmented services, complex eligibility criteria, unclear referral processes, and limited availability of early intervention services, among others.

Session Takeaways

During the third Peer-to-Peer Learning session, the small group discussions were focused on identifying solutions and resources to address common referral barriers. At the end of Dr. DeAntonio's presentation, he discussed common barriers to referring families to services. One important distinction was that barriers occur at multiple levels including the family level, practice or provider level and the resource level. In addition, the pandemic has created new challenges. Exhibit 9 details some of the common barriers experienced at each of these levels.

Exhibit 9. Common Referral Barriers

Level	Common Barriers
Family	• No follow through with referral due to hesitation or further education needed • Stigma associated with accessing services • Other priorities • Disagreement with need for services
Provider or Practice	• Hesitation to refer • Lack of or need for training • Staff capacity • Knowledge of resources
Resource	• No feedback from referring party • Information about resource is out of date (e.g., contact information, waitlists, eligibility criteria etc.) • Waiting lists or perception of waiting lists
Pandemic Challenges	• Missing well child visits and thus screenings • Added stress • Misinformation about the availability of referral parties

Focusing on developing solutions to the known barriers that exist at these various levels, the objectives of the small group discussions were to: (1) Engage in solution-oriented discussions, (2) Share information and ideas that may be useful

for peers, and (3) Share information and ideas to elevate to key decision makers. During the small group discussions, participants were asked to propose specific ideas or examples of ways to overcome the barriers that exist at the various levels (i.e., family, provider, resource, pandemic challenges) and identify additional supports and resources that would be needed to implement the solutions. During the small group discussions, participants noted that referral barriers at the various levels are not independent and one barrier may often compound another.

The following section highlights the solutions developed by participants to address common referral barriers at the family, provider, resource, and pandemic-related levels. The content of this section is informed by discussions and examples provided by Peer-to-Peer participants.

Family-Level

Communication

One of the most salient family-level referral barriers is communication between physicians and patients. Providers believe that parents often leave appointments unclear about what physicians are screening for in their children and why a child is being referred to services. One solution offered by participants to counter this barrier is to simplify the screening and referral process to a step-by-step break down so that parents understand the services their children will be receiving. Breaking down the referral process will promote transparency and help establish trust and shared expectations between providers and the family. To further support communication, providers may want to consider providing patients with guidelines and pamphlets outlining the referral process such as contact time, case management, and referral updates. Participants noted having a diverse patient population, thus all informational materials must be provided in a variety of languages and, if possible, provided by people of the same culture to further establish trust.

> **Promising Practices**
>
> - Provide patients with clear explanations and written information outlining the referral process such as contact time, case management, and referral updates.
> - Provide informational materials on referrals in a range of languages and by people of the same culture to further establish trust.

Vulnerable Populations

Peer-to-Peer participants noted that individuals from immigrant and low-income communities are more likely to face barriers in attending appointments or referrals due to additional challenges they face in their daily lives. For example, undocumented patients often experience fear and hesitation to share information with providers due to their status. To build trust with vulnerable populations, providers need to stay updated on current events within the immigrant community. Knowing more about the background, traditions, and values of the populations they serve can help inform appropriate adjustments in ACEs screening protocols or other factors that impact a patient's experience. One approach discussed by participants is to stay updated on immigrant news and connect with local immigrant or grassroots groups to support their undocumented patient population. Low-income populations may also have a challenging time attending services because the times in which services are typically offered fall within regular business hours and could potentially lead to a loss of income for families who have to take time off work to attend. Participants identified extending paid time-off benefits for taking children to doctor's appointments and related services and providing a stipend for families who would experience significant financial loss as potential solutions.

> **Promising Practices**
> - Extend paid time-off benefits for taking children to doctor's appointments and related services and provide a stipend for families who would experience significant financial loss as potential solutions.
> - Provide training for staff on talking with families about sensitive topics and how to administer ACEs screener in trauma-informed way.

Provider Level

Sensitivity of ACEs Screening

Peer-to-Peer participants discussed that some providers experience hesitation and resistance to conduct ACEs screening due to the sensitive nature of the questions. One proposed solution was to provide trainings for all staff on talking with families about sensitive topics and how to administer the screener in a trauma-informed way. Furthermore, parents can sometimes react negatively to screener questions, thus, it is helpful to familiarize parents with ACEs by going over the screening tool together and explaining the purpose and benefit of the tool. Relatedly, some patients may not feel comfortable fully answering the questions due to the sensitivity of the questions. This creates a challenge for service referrals, because if a patient is not responding candidly on the

screener, the provider is unable to identify areas in which a child or family may be needing support. This could be the case for vulnerable populations, or parents who do not feel comfortable revealing details about their child. Suggested solutions to encourage candid responses include using a de-identified screener or having a trained staff member explain the purpose and benefit of the questionnaire with the family during the screening process and prior to the provider's review. Additionally, conducting the developmental screening prior to the ACEs screening can help to build trust and rapport and help the family understand the importance of the ACEs screening.

Resource Level

Care Coordination

Lack of care coordination is one of the most prevalent barriers reported when it comes to connecting patients to services. Peer-to-Peer participants shared that the current referral system is "All fractured right now and needs to get better aligned." When asked what their experience with referrals has been like, one provider shared, "It is like dropping in a black hole – some kids are taken care of, some you hear about from the parent, some disappear. We do not get a lot of feedback." Another person shared, "It's difficult because everyone's in their own silo. We end up with miscommunication if any communication at all." Furthermore, participants discussed that families are often met with additional roadblocks such as long lines, no insurance coverage, or inability to secure an appointment when following up on service referrals. Lastly, there is currently no centralized referral system designed to refer patients to resources, house patient health information, and track the referral status.

Suggested solutions to address this challenge include developing a systematic approach for referrals and improved technology to allow for a referral portal that providers can use to refer patients to service providers or programs. This would allow for better integration and communication between medical home and developmental early intervention services. An additional solution suggests the presence of a social worker or referral coordinator within the practice to schedule and follow up with referrals. For example, if the Regional Center Early Intervention program had a funded liaison positions to coordinate referrals and provide feedback to health care providers that would be helpful. Lastly, participants discussed the need for better models of reimbursement. Currently,

there are not enough resources for providers to provide patient care and follow up on screenings and referrals. Better reimbursement for screening and referrals would allow primary care providers to have dedicated staff to help administer and follow up on screenings and referrals as well as allow providers to spend more time with patients and families to address ACEs and developmental concerns.

Pandemic-Related Challenges

In-person visits during COVID

The onset of COVID-19 has introduced numerous challenges for physicians to ensure the wellness of their patients. Existing challenges such as reduced patient-physician interactions were amplified during COVID, and telehealth did not fully alleviate this problem. As a result, there have been steep declines in the frequency of in-person visits, immunizations, and well-child checks. Additionally, practices have had to cut back on staffing by moving from full-time hours to part-time hours, and partial retirement for some. Being unable to see patients in-person has made it difficult to provide consistent and thorough care and physicians are ready to reestablish those elements with patients. One physician said, "I truly believe in-person care has a therapeutic effect. There are things you miss over the phone/video. I'm eager to get kids back into the office."

To encourage in-person visits, some practices have implemented creative methods to ensure that there is limited contact and COVID safety. For example, some practices have integrated a "one patient at a time" approach to minimize the number of patients inside the office at any given time. Additionally, some practices have eliminated the waiting room and typical waiting room items (e.g., toys). Some practices screen every patient prior to attending the appointment, either over the phone at the time of appointment confirmation, or at the door before entering the building. Some practices have moved their offices to the ground floor to avoid the need for close contact in elevators or stairwells. And lastly, some practices provide services outside or in the car to help families feel more comfortable coming for in-person visits.

Promising Practices

- Develop a systematic approach for referrals.
- Create a referral portal that providers can use to refer patients to services or programs.
- Establish better reimbursement models for screening and referrals.

Promising Practices

- Set the next in-person meeting with the patient before they leave the appointment.
- Contact patients before their appointment to confirm their attendance, or after to address why they did not attend.

Practices have also established outreach solutions to address the challenge of increased no-shows during COVID. For the few patients that have come into the office, establishing the next in-person meeting before leaving the appointment was suggested as a working solution. Agreeing to show up in a face-to-face setting provides a sense of accountability for patients, increasing the likelihood they return. Another form of accountability was to contact patients before their appointment to confirm their attendance, or after to address why they did not attend. Additionally, some practices have been charging patients for not showing up to their appointments, however, this is not the case for Medi-Cal patients. Understanding family dynamics may help practices develop a no-show protocol that can help families meet their appointments or provide additional resources to communities that need it (e.g., South Los Angeles).

The following recommendations emerged from the small group discussions, to be considered by physicians when referring patients to services.
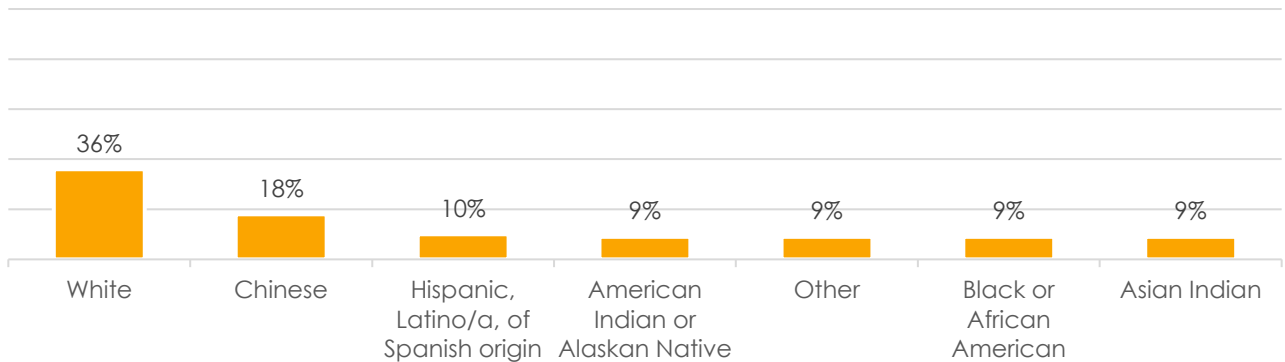
Key Recommendations

- Primary care providers should have transparent conversations with patients about developmental and ACEs screening processes, referrals, and how the two relate to one another. This could include providing informational materials in the patient's preferred language.

- Due to the sensitive nature of the questions, primary care providers and other medical staff should be trained on trauma-informed ways to conduct an ACEs screening. Additionally, the workflow should allow providers to build rapport with families prior to conducting the ACEs screening.

- Establishing referral coordinator or liaison positions within a practice or network who can schedule and follow up on referrals could be helpful for ensuring families are connected to needed services. Also consider developing a shared referral portal that uses technology to efficiently and consistently coordinate and communicate about a family's referral status.

- Continuously remind patients and communicate with families, through public service announcement campaigns or individual phone calls that attending well-child visits during the pandemic is necessary and critical for a child's health.

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Session Participants

In total, 35 participants joined the virtual Peer-to-Peer Learning session. Of the participants who completed the session's follow up survey (n=11, 31%), 36 percent identified as White, followed by 18 percent who identified as Chinese (Exhibit 10). Additionally, 10 percent of participants identified as being from Hispanic, Latino/a, or Spanish origin. Participants were generally physicians (73%) with most physicians specializing in pediatrics (64%).[4] A majority of participants (73%) indicated serving Medi-Cal patients.

Exhibit 10. Session 3 Participants' Race and Ethnicity[5]

White	Chinese	Hispanic, Latino/a, of Spanish origin	American Indian or Alaskan Native	Other	Black or African American	Asian Indian
36%	18%	10%	9%	9%	9%	9%

Participant engagement during this Peer-to-Peer Learning session took place mostly during the breakout room discussions, although participants also had the opportunity to ask questions at the end of the presentation. The breakout room discussions varied by topic and demonstrated a range of insights, mostly from physicians.

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[4] Additional occupation categories include registered nurse/advanced practice nurse (9%), license clinical social worker (9%), and physician assistant (9%). Additional specialization areas include family medicine (18%), behavioral health (9%), and other (9%).

[5] Participants were asked to indicate their race and ethnicity. Percentages may add up to more than 100%.
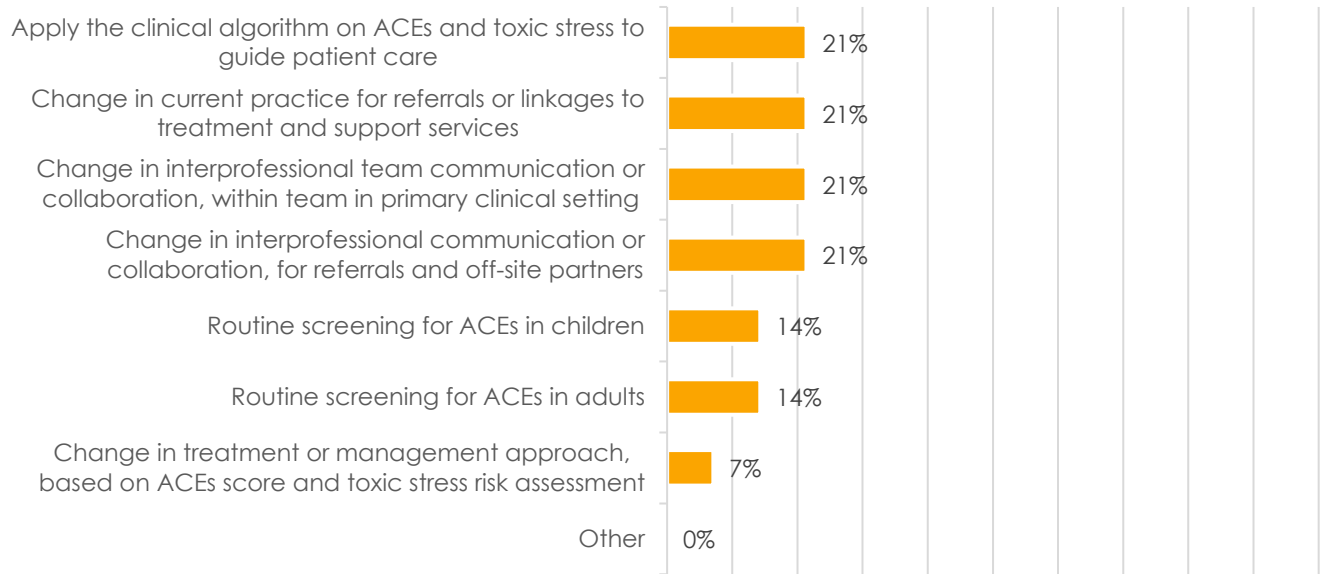
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Follow Up Survey

Following the Peer-to-Peer Learning session, participants were asked to complete a short online survey and answer questions about their experience at the Peer-to-Peer Learning session. The results of the survey suggest participants had a positive experience and found the information and materials presented to be helpful (Exhibit 11). Following the third Peer-to-Peer Learning session, all participants felt the educational material provided during the session was useful to their work and 91 percent felt more informed about ACEs and toxic stress.

Exhibit 11. Participants' experience at the Peer-to-Peer Learning session (n=11; percentage of participants who agree/strongly agree)

The educational material provided useful information for my work.	100%
I am more informed about ACEs and toxic stress, trauma-informed care, and resiliency.	91%
This activity enhanced my current knowledge base.	90%
Group discussion made a positive impact on my educational experience.	82%
After this activity, I have a stronger sense of the cross-sector nature of the ACEs Aware Initiative.	82%

Participants were also asked to indicate how they plan to incorporate what they learned into their practice. Nearly one-third of participants (21%) plan to apply the clinical algorithm on ACEs and toxic stress to guide patient care (Exhibit 12). The same number of participants (21%) indicating changing their current process for referrals or linkages to treatment and support services. When asked how confident participants were that they could implement their intended changes, 75 percent felt somewhat confident while the remaining 25 percent were unsure. The most common anticipated challenges to implementing changes were time constraints (33%), system constraints (33%), and insufficient interprofessional team support within primary clinical setting (17%).

Exhibit 12. Percentage of participants planning to implement practice changes (n=11)

Practice Change	Percentage
Apply the clinical algorithm on ACEs and toxic stress to guide patient care	21%
Change in current practice for referrals or linkages to treatment and support services	21%
Change in interprofessional team communication or collaboration, within team in primary clinical setting	21%
Change in interprofessional communication or collaboration, for referrals and off-site partners	21%
Routine screening for ACEs in children	14%
Routine screening for ACEs in adults	14%
Change in treatment or management approach, based on ACEs score and toxic stress risk assessment	7%
Other	0%

Impact of Secondary Trauma and Burnout: A Blueprint for Wellness

Session 4 Overview

The fourth and final Peer-to-Peer Learning session was hosted virtually on April 22, 2021. It focused on the impact of secondary trauma and burnout for providers, highlighting the importance of self-care and strategies to maintain provider wellness. The objectives of this session were to: (1) Identify medical and emotional features of secondary trauma, (2) Identify symptoms of burnout in clinicians, (3) Compare secondary trauma to burnout, (4) Compare different stress responses, (5) Identify self-care tools/strategies from PERMA theory of well-being, (6) Develop self-care tools for use in personal well-being, and (7) Demonstrate the use of music and movement as a self-care tool.

The session was led by Dr. Nirupama Madduri, MD, FAAP and Dr. Adwoa Osei, MD, FAAP (see sidebars). They were welcomed by Dr. Carlo DeAntonio who opened the session with an overview of ACEs Aware. Dr. Madduri then provided a recap of the first three Peer-to-Peer learning sessions, which were focused on patients and practice, before transitioning into an informative presentation on how to identify the symptoms and impacts of secondary trauma, responses to burnout, and how providers can support themselves and each other.

Secondary trauma is a consequence of providing care to patients who have experienced trauma. Also known as vicarious trauma or "compassion fatigue", providers experiencing secondary trauma bear the suffering of their patients, reliving their events and sharing their stories. Providers with a history of depression or anxiety tend to be at higher risk of secondary trauma.

There are four types of symptoms that indicate secondary trauma amongst providers:

1. Physical symptoms (e.g. increased heart rate, difficulty breathing)
2. Behavioral symptoms (e.g. withdrawal, difficulty sleeping, hypervigilance)
3. Emotional symptoms (e.g. guilt, anger, numbness, sadness, helplessness)
4. Cognitive symptoms (e.g. spiritual questions, questioning purpose)

When faced with a stressor or threat, most people will first freeze and then enact a fight or flight response as the hypothalamus activates and stress hormones and cortisol surge. When this cycle happens repeatedly, it results in

Nirupama Madduri, MD, FAAP

Dr. Madduri graduated from the University of Missouri-Kansas City School of Medicine and completed pediatric residency at Marshall University School of Medicine. She completed a fellowship in developmental-behavioral pediatrics at Baylor College of Medicine, and held faculty positions at Baylor College of Medicine, Vanderbilt University School of Medicine, and Children's Hospital Los Angeles. She has recently completed a fellowship in clinician wellness at the University of California Davis School of Medicine. She is currently in private practice in Arcadia, CA and is also a consultant for the California Department of Developmental Services.

Adwoa Osei, MD, FAAP

Dr. Adwoa Osei is a board-certified pediatrician, a fellow of the AAP and an Assistant Professor in UC Riverside School of Medicine. She received her medical degree from the University of Ghana Medical School and completed residency and Chief Residency in Pediatrics at Michigan State University. After residency, she practiced general pediatrics for several years with Indiana University Health. She then joined the Faculty at UCR Medical School as an Assistant Clinical Professor. Her administrative roles include Director of Undergraduate Pediatric Medical Education, and Health Equity, Social Justice and Anti-racism in the School of Medicine. She completed a fellowship at the University of California Leadership Education in Neurodevelopmental Disabilities (UC-LEND) program, subsequently founding a primary care based neurodevelopmental and behavioral clinic within the UC Riverside Health System, serving children and families with a wide range of neurodevelopmental disabilities and complex psychosocial factors of diverse backgrounds and cultures.

burnout, which can take the form of unbearable levels of exhaustion, increased depersonalization and decreased investment in the work, lower sense of accomplishment and feelings of helplessness. 35-54 percent of physicians and nurses experience burnout and 45-60 percent of resident physicians experience burnout.[ix]

The dangers of physician burnout include higher incidences of undesirable patient experiences, higher likelihood of medical errors, more likely to reduce clinical hours, more likely to leave their jobs, and more likely to leave medicine.[x]

Factors that contribute to secondary trauma and burnout include changes in healthcare delivery, increased workload demands with insufficient resources and support, system improvement processes, changes in professional expectations, implementation of technology, and increasing needs of patients.[xi] Additionally, this year providers are dealing with the additional stressors of the COVID-19 pandemic.

A healthy response to secondary trauma is to "tend and befriend". Tending includes nurturing and protecting yourself and your patients. Befriending includes developing and maintaining social supports to continue the process of healing. Both actions reduce reactivity to stress and increases oxytocin, endogenous opioids and dopamine, rewarding the body and reducing anxiety.

Dr. Madduri ended her presentation with a quote from Ram Dass: "Together we are all on a journey called life. We are a little broken and a little shattered inside. Each one of us is aspiring to make it to the end. Let us just help each other put all those pieces back together and make it to the end more beautifully. Let us help each other survive." She encouraged participants to help and support each other to heal after everything healthcare professionals have gone through in the past year. Participants were then asked to join a small group to discuss their own experiences with secondary trauma and share solutions and ideas.

After the small group discussions and share out, Dr. Osei shared self-care strategies using the PERMA theory of wellbeing. She shared descriptions of each element of PERMA, including an additional element of Health.

- **P**ositive emotions: cultivating joy, gratitude, kindness, forgiveness and satisfaction
- **E**ngagement: finding something nourishing or refreshing to experience in the moment
- positive **R**elationships: developing mutually supportive, stable, safe and nurturing relationships

- **M**eaning: knowing our lives matter and we are contributing to a bigger purpose
- **A**ccomplishment: feeling autonomy and competence in achieving or working towards personal goals
- **H**ealth: getting enough sleep, good nutrition, physical activity, and access to nature

Dr. Osei encouraged participants to make a list of actions and applications for each PERMAH letter for themselves and then implementing them throughout the day – using multiple tools a day or the same one every day for a month, whatever works best for each individual. The model can also be used with patients, such as reflective journaling, family picture books, identifying and building on strengths during visits, and using music and movement. The session closed with a self-care exercise where participants were invited to turn off their cameras, close their eyes, listen to a song being played, and let themselves move, starting and ending with deep healing breaths.

Session Takeaways

During the final Peer-to-Peer Learning session, the small group discussions were 30 minutes and focused on identifying solutions to reducing the secondary trauma and burnout experienced by providers administering ACEs screenings and working through the trauma their patients experience. The objectives of the small group discussions were to: (1) Engage in solution-oriented discussions, and (2) Share information and ideas that may be useful for peers. During the small group discussions, participants were asked to think about times they were challenged personally by clinical encounters and how they worked through it, how burnout has impacted their practice, how the culture of medical practice needs to change to address clinician stress and burnout, and how the system could be adjusted to make wellness of clinical professionals a priority.

The following section highlights the solutions developed by participants to address secondary trauma and physician burnout. The content of this section is informed by discussions and examples provided by Peer-to-Peer participants.

Tend and befriend strategies

Participants shared that, especially when busy, the additional stress of the pandemic, and the challenges of maintaining work-life boundaries when working from home, it is important to be committed to intentional "tend and befriend" strategies to care for themselves and their colleagues. Examples of "tending" self-care activities included meditation, faith-based activities, and leaving things at work. One participant shared a Pomodoro Timer time management model meant to eliminate burnout by engaging in 25 minutes of activity with a 5 minute break for four cycles, and then taking a 15 minute break before repeating. Examples of "befriending" activities included taking time at the beginning of Zoom meetings for silence or stretch breaks and setting aside time and space for connection and reflections, whether through the chat function or through breakout rooms specifically for social connections.

Promising Practices

- Be committed to intentional "tend and befriend" strategies to care for self and colleagues.
- Consider meeting with a group peers outside of the workplace to support each other, share resources, and discuss difficult encounters.

One participant shared about connecting virtually with a group of pediatricians outside of their workplace for one hour each week. They explained how these meetings bring together a community of pediatricians, parents, behavioral specialists and teachers to support each other, share resources, discuss difficult encounters, and make plans to meet when safe.

Healthcare culture shifts

In the workplace, potential solutions to reduce burnout include incorporating a team approach to care that works together and includes the support of ancillary providers. This includes teaming with scribes to help with charting and paperwork and social workers or referral coordinators to help with referral tracking and follow up. Additionally, improving technology and EMR systems to be streamlined and coordinated rather than an additional burden to the providers, which would support reducing physician burnout as many providers find they need to work in the evenings to catch up on charting in order to spend as much time as they can with their patients during the day.

Additionally, participants shared that physicians' voice and perspective is often overlooked when healthcare administrators are making decisions that impact them. One participant suggested developing a coalition of physicians with various specialties to come together with a united voice to amplify the provider

perspective and ensure healthcare culture changes are informed by the physicians who are working directly with patients.

Key Recommendations

- Utilize tend and befriend strategies to prioritize the well-being of providers administering ACEs screenings and reduce secondary trauma and burnout.
- Incorporate a team approach to care that includes scribes to help with charting and paperwork and social workers or referral coordinators to help with referral tracking and follow up.

Session Participants

In total, 16 participants joined the final Peer-to-Peer Learning session. Of the participants who completed the session's follow up survey (n=9, 56%), 44 percent identified as White, followed by 22 percent who identified as Black or African American (Exhibit 13). Additionally, 13 percent of participants identified as being from Hispanic, Latino/a, or Spanish origin. Participants were generally physicians (89%) with most physicians specializing in pediatrics (89%).[6] Two-thirds of participants (67%) indicated serving Medi-Cal patients.

Exhibit 13. Session 4 Participants' Race and Ethnicity[7]

44%	22%	13%	11%	11%	11%
White	Black or African American	Hispanic, Latino/a, of Spanish origin	Other	Chinese	Asian Indian

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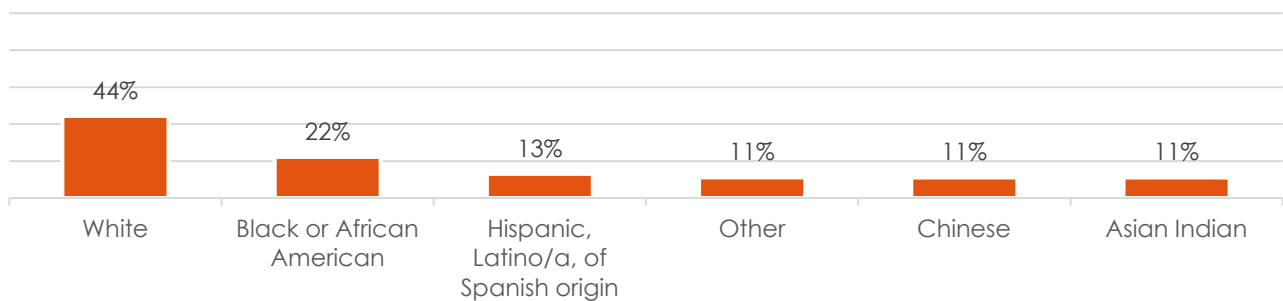
[6] Additional occupation categories include physician assistant (11%). Additional specialization areas include family medicine (11%).

[7] Participants were asked to indicate their race and ethnicity. Percentages add up to more than 100%.
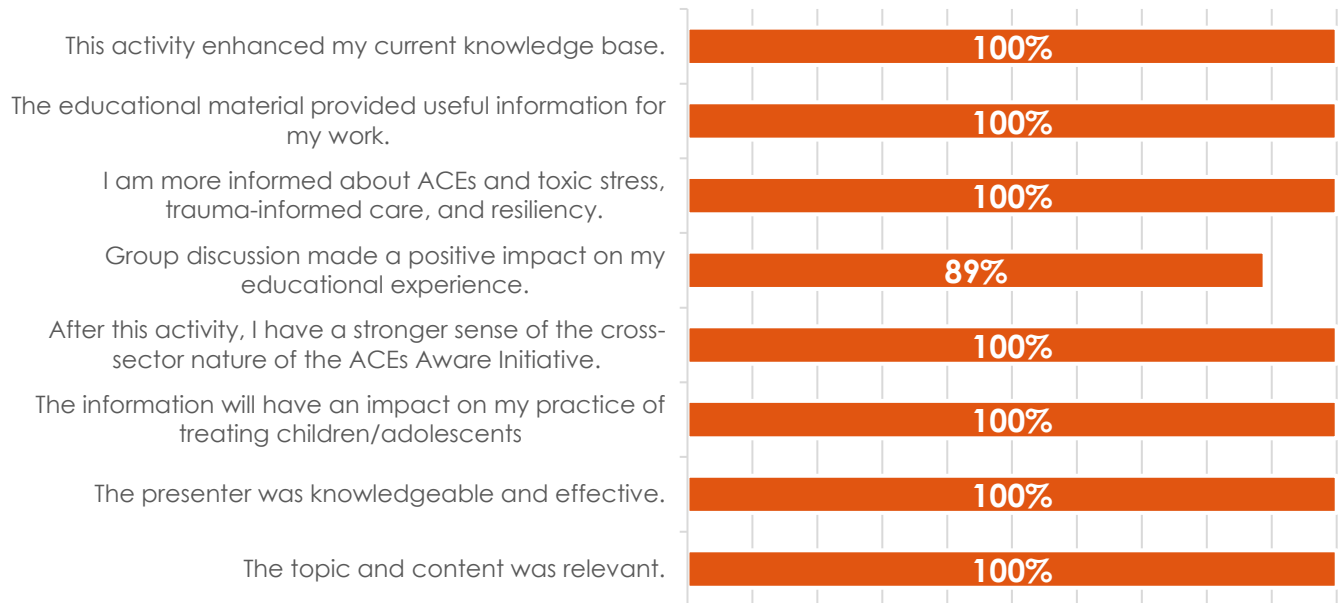
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Participant engagement during this Peer-to-Peer Learning session took place mostly during the breakout room discussions, although participants had the opportunity to ask questions at the end of the presentation portion of the session. The breakout room discussions varied by topic and demonstrated a range of insights, mostly from physicians. Additionally, participants engaged in the self-care exercise that closed the session.
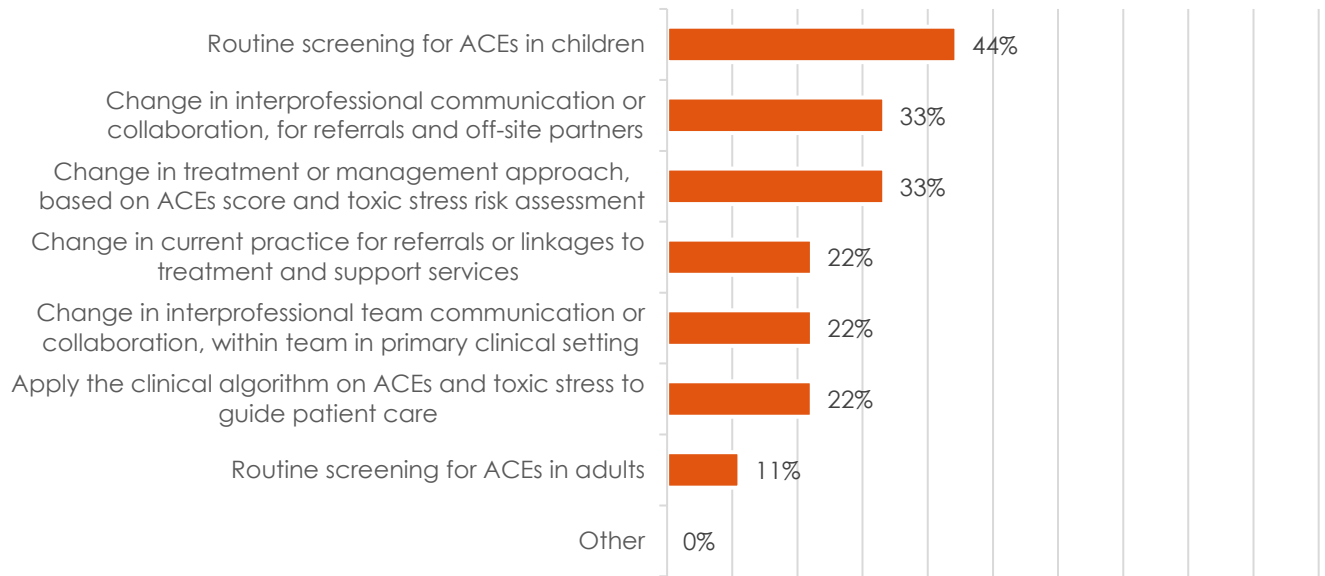
Follow Up Survey

Following the Peer-to-Peer Learning session, participants were asked to complete a short online survey and answer questions about their experience at the Peer-to-Peer Learning session. The results of the survey suggest participants had a positive experience and found the information and materials presented to be helpful (Exhibit 14). Following the final Peer-to-Peer Learning session, all participants had a stronger sense of the cross-sector nature of the ACEs Aware Initiative and percent felt the activities enhanced their current knowledge base. Additionally, all participants shared that the information provided during the session will have an impact on their practice of treating children and adolescents.

Exhibit 14. Participants' experience at the Peer-to-Peer Learning session (n=9; percentage of participants who agree/strongly agree)

Statement	Percentage
This activity enhanced my current knowledge base.	100%
The educational material provided useful information for my work.	100%
I am more informed about ACEs and toxic stress, trauma-informed care, and resiliency.	100%
Group discussion made a positive impact on my educational experience.	89%
After this activity, I have a stronger sense of the cross-sector nature of the ACEs Aware Initiative.	100%
The information will have an impact on my practice of treating children/adolescents	100%
The presenter was knowledgeable and effective.	100%
The topic and content was relevant.	100%

Participants were also asked to indicate how they plan to incorporate what they learned into their practice. Almost half (44%) plan to implement routine screening for ACEs in children whereas one third (33%) plan to change the interprofessional communication or collaboration for referrals and off-site partners. One third of participants also indicated changing their treatment or management approach based on ACEs score and toxic stress risk assessment (Exhibit 15). When asked how confident participants were that they could implement their intended changes, 22 percent reported feeling very confident while 78 percent felt somewhat confident. The most common anticipated challenges to implementing changes were time constraints (33%), ability to refer to appropriate services and treatments (22%), and insufficient interprofessional team support within primary clinical setting (22%).

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Exhibit 15. Percentage of participants planning to implement practice changes (n=9)

Practice Change	Percentage
Routine screening for ACEs in children	44%
Change in interprofessional communication or collaboration, for referrals and off-site partners	33%
Change in treatment or management approach, based on ACEs score and toxic stress risk assessment	33%
Change in current practice for referrals or linkages to treatment and support services	22%
Change in interprofessional team communication or collaboration, within team in primary clinical setting	22%
Apply the clinical algorithm on ACEs and toxic stress to guide patient care	22%
Routine screening for ACEs in adults	11%
Other	0%

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Conclusion and Recommendations

Overall, the Peer-to-Peer Learning sessions were effective at bringing together Medi-Cal providers across L.A. County to discuss the importance of screening for ACEs, assessing for toxic stress, managing workflows to include ACES screening, and responding with evidence-based interventions. Not only did the learning sessions bring together physicians to learn from one another, but participants walked away feeling more informed about ACEs and toxic stress, trauma-informed care, and resiliency. Participants also gained a stronger understanding of the cross-sector nature of the ACEs Aware Initiative as a result of the learning series. This is a critical first step to developing networks of care that support the children and families of L.A. County and ultimately decrease ACEs and toxic stress by half in one generation.

The recommendations that follow are intended to provide suggestions as L.A. County considers how to engage providers in conversations on practice change related to screening and treating ACEs.

Process Focused Recommendations

Consider a cohort model to increase collaboration and promote an ongoing culture of learning among providers.

The Peer-to-Peer Learning session format was effective in communicating important information about ACEs and toxic stress and promoting peer-to-peer engagement. However, notably deeper levels of engagement occurred among providers in small breakout discussions. In addition to large scale sessions, future efforts may benefit from a cohort model to training and learning. In this model a small group of providers stay together over time. This would allow a small group of providers to deeply engage in the topics together and create a more intimate learning community, likely continuing to support and learn from each other beyond the trainings. Cohort learning facilitates social interaction and collaboration, additional supports, an added level of accountability, expands perspectives, and offers opportunities for networking.[xii]

Incorporate time during learning sessions for participants to network and share information.

Participants clearly valued the opportunities to network and share information that naturally occurred during breakout components of the Peer-to-Peer Learning sessions. More intentionally creating space for networking and connection at the end of each session may sustain participation over time and help build a community of ACEs-informed providers. The opportunity to share information would help providers stay informed about what is happening around the county and also draw connections between their practice and what others are doing.

Consider organizing trainings or small group discussions by type of setting or geographic region so participants can connect with and learn from others working in similar contexts.

L.A. County is home to a variety of ethnic communities and populations, and each requires a unique approach to care that considers their cultural context. Research demonstrates ties between the racism and discrimination communities of color and other vulnerable populations experience and toxic stress. This points to the need for tailored approaches for screening and treating ACEs. L.A. County is also geographically vast, with each region experiencing different needs and challenges, which creates an added level of complexity when scaling efforts across the county. Organizers of future trainings may want to consider these nuances when planning peer learning efforts. Trainings may have more impact and value to participants if they were customized based on the needs of patient population and cultural context. This could include engaging patient populations in community listening sessions to identify needs and then holding separate trainings based on patient population, care setting type, or geographic region or organizing small group discussions by these factors. Physicians will likely be able to have more engaging and rich conversations with peers who are working in similar contexts.

Conduct targeted outreach to ensure Learning Session participants are racially and culturally representative of L.A. County's diverse patient population.

Research suggests culturally grounded health approaches that prioritize cultural values, practices, and community-based assets lead to sustainable and scalable interventions that improve health outcomes.[xiii] Demographic information shared by providers on the participant survey suggested that Latinx providers were underrepresented amongst Peer-to-Peer Learning session participants. In the future learning series organizers may want to consider conducting tailored outreach to ensure participants are racially and culturally representative of L.A. County's diverse populations.

Incorporate time and structured activities into sessions for individuals to make a commitment to action.

Establishing a shared understanding is a key objective of learning sessions, but without individual commitment to action, practice change is unlikely. Future efforts would benefit from a dedicated time at the end of each learning session, and supportive activities, to encourage individuals to make a public commitment to action. Alternatively, facilitators could offer suggested commitments during the lecture that participants could self-select. Commitments to action can be as simple or extensive as the participant chooses. For example, commitments can be sharing information from the learning session with three people in their organization or following up with a colleague on an idea. Additionally, if sessions are designed in a series like the Peer-to-Peer Learning series, each session could include dedicated time for participants to report back on the status of their commitments from the previous session, share what they have tried implementing, and challenges they encountered.

Provide resources to session participants so they can continue to strengthen their capacity around ACEs Aware topics.

Throughout the Peer-to-Peer Learning series, it was evident participants were energized by the session content, however little information was provided on additional opportunities to strengthen capacity around ACEs screening and treatment. Future efforts would benefit from providing participants with tangible tools during or after the session to aid in continued learning. Additionally, it would be useful to adopt a more systematic model for the diffusion of session learnings and promising practices. Diffusion of Excellence Initiative's Five-Step Process for Diffusing Promising Practices[xiv] highlights the importance of finding champions to communicate the importance of innovations and promising practices to their networks and beyond. As champions disseminate and promote promising practices, the practices are adapted and replicated within various settings, measured to assess real world impact, and eventually lead to scale and spread of best practices. Train the trainer models, communities of practice, or another iteration of the Peer-to-Peer Learning series are additional ways to continue engaging participants and spreading learnings.

Practice and System Level Recommendations

Each session surfaced valuable recommendations related to the specific topics discussed. The following recommendations have been previously highlighted in each section of the report and are provided in summary format in the tables below. The practice and system level recommendations that emerged from the Peer-to-Peer Learning sessions will contribute to the upcoming practice paper to inform large scale systems change for incorporating ACEs screening alignment, treatment, and referral/care coordination.

Toxic Stress Physiology Recommendations

- Take a comprehensive approach to a child's patient care. This includes looking past a patient's physiological symptoms and considering external factors that may contribute to their health status.

- Use the THREADS and FRAYED acronyms as a framework for understanding children's behaviors and identifying strengths and resiliency factors.

- Be creative and innovative about resources and supports offered to children and families

Screening Recommendations

- Train all medical staff (i.e., physicians, nurses, etc.) in ACEs, trauma-informed care, and social determinants of health to ensure continuity in a patient's experience.

- Alleviate patient-level time constraints by preparing parents of patients with materials or resources in advance and giving them options, such as completing screenings online, utilizing telemedicine, and designing creative ways (e.g., drawing, "agreements/contracts") to get more information early on about ACEs.

- Alleviate patient stigma by normalizing screenings. Ways to normalize screening include explaining that the ACEs screening is a standard protocol, the information will be used to inform patient care, referrals are available if the patient is interested, and doing so in an empathetic and nonjudgmental way.[xv]

- Providers should consider establishing connections with schools, community mental health providers, and collaborate with local Medi-Cal representatives to increase resources available to children and their families.

- Consider engaging ancillary supports in the screening and treatment process to free up the amount of time providers are able to engage with patients.

Referral Recommendations

- Primary care providers should have transparent conversations with patients about developmental and ACEs screening processes, referrals, and how the two relate to one another. This could include providing informational materials in the patient's preferred language.

- Due to the sensitive nature of the questions, primary care providers and other medical staff should be trained on trauma-informed ways to conduct an ACEs screening. Additionally, the workflow should allow providers to build rapport with families prior to conducting the ACEs screening.

- Establishing referral coordinator or liaison positions within a practice or network who can schedule and follow up on referrals could be helpful for ensuring families are connected to needed services. Also consider developing a shared referral portal that uses technology to efficiently and consistently coordinate and communicate about a family's referral status.

- Continuously remind patients and communicate with families, through public service announcement campaigns or individual phone calls that attending well-child visits during the pandemic is necessary and critical for a child's health.

Secondary Trauma and Burnout Recommendations

- Utilize tend and befriend strategies to prioritize the well-being of providers administering ACEs screenings and reduce secondary trauma and burnout.

- Incorporate a team approach to care that includes scribes to help with charting and paperwork and social workers or referral coordinators to help with referral tracking and follow up.

Next Steps

In January 2021, the Los Angeles County Department of Health Services was awarded an ACEs Aware Network of Care implementation grant, which First 5 LA is a convening partner on, to continue their work building and strengthening robust networks of care to effectively respond to ACEs and toxic stress. Additionally, various other L.A. based organizations received Network of Care planning grants that will contribute to the development of effective Networks of Care to support L.A.'s children and families. First 5 LA looks forward to supporting the alignment of similar collaboratives and networks such as the various ACEs Aware efforts and Help Me Grow in L.A. County.

Resources

- All recordings and meeting packets for the Peer-to-Peer Learning sessions can be found at https://aapca2.org/aces-aware/.

- The ACEs Aware initiative website offers various resources for screening and treating ACEs including a Provider Toolkit. Visit www.ACESAware.org for more information and resources.

- AAP-CA2 offers various resources related to ACEs including publications, AAP's official policy statement on childhood adversity, and links to additional trainings. For more information visit https://aapca2.org/aces/.

Report developed by Taylor Anderson, Ashlyn Dadkhah, Joelle Greene, Sophia Lee, and Madeline Rayon of Harder+Company Community Research.

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