



Fundamentals of ACE Screening and Response in Adult Medicine – Webinar Transcript

July 29, 2020

Tanya Schwartz: Hello, and thank you for joining today's ACEs Aware webinar. My name is Tanya Schwartz and I'm with Aurrera Health Group, and we're very proud to be supporting the ACEs Aware initiative. Today's webinar is on the "Fundamentals of ACE Screening and Response in Adult Medicine." And this is the sixth in a series of educational webinars that offer practical information on screening for adverse childhood experiences, and providing trauma informed care.

Tanya Schwartz: I'll start with some very quick housekeeping items. If we run into any technical difficulties and get disconnected, please dial back into the webinar using the same link and we'll be with you as soon as we can. And everyone, all the participants are muted, but you can submit questions at any time during the presentation using the chat feature on the panel, on the very right hand side of your screen. And then finally, this webinar is being recorded. So a recording, a transcript, and the slides will all be available on ACEsAware.org early next week. Next slide please.

Tanya Schwartz: So the ACEs Aware mission is to change and save lives by helping providers understand the importance of screening for adverse experiences, and training providers to respond with evidence based interventions and trauma informed care to mitigate the health impacts of toxic stress. Next slide. So today we're very pleased to welcome five healthcare providers who have extensive experience screening and responding to ACEs. Dr. Nadine Burke Harris, the California Surgeon General, will kick us off today. And then Brent Sugimoto is a family medicine physician and new physician director at the American Academy of Family Physicians. And then we will have a cross disciplinary panel of three speakers from North County Health Services, which is a Federally Qualified Health Center in San Diego County that serves 70,000 unique patients per year across 11 different sites, and it has a patient population that is at higher risk for ACEs and toxic stress.

Tanya Schwartz: So we have Mimi Mateo, who is a Certified Nurse Midwife, Dr. Denise Gomez, who's an internal medicine physician and the Associate Medical



Director, and Dr. Leon Altamirano who's the Director of Integrated Behavioral Health, and he's also a member of the ACEs Aware Clinical Implementation Subcommittee. Next slide, please. So Dr. Burke Harris will provide some introductory remarks, Dr. Sugimoto will talk about the value of ACEs screening and clinical response in family and adult medicine. And then our panel of providers from North County Health Services, will walk through four case studies of ACEs in primary care.

Tanya Schwartz: Dr. Sugimoto is going to provide some final remarks and then we'll take questions from the audience. And we have received a lot of questions in advance of today's webinar, so thank you to many of you for submitting those. We also welcome questions submitted via chat throughout today's webinar, and we'll get to as many as we can, but any that we cannot get to we'll incorporate into our future activities. And we know that folks have a lot of questions and we're working really hard to get out the answers on them. So then I will wrap up the webinar by sharing some resources and tools that ACEs Aware has developed or identified to support providers in implementing ACE screening and response in your practices. And so with that, I'm going to hand it over to Dr. Burke Harris.

Nadine Burke Harris: Thank you so much. I am so thrilled about today's webinar. And it brings me back to when I first met Dr. Vincent Felitti, which I think was about a decade ago now. And the reason for that is because I'm reminded that although the term is adverse childhood experiences, this work really originated in adult medicine with Dr. Felitti being an internist and really recognizing how much his patients experiences of childhood ultimately impacted their health and the conditions that he was caring for. And in speaking to him and hearing from him how much the the identification and response to adverse childhood experiences not only improved his clinical practice and the quality of his clinical care, but also his experience as a practitioner. How much more meaningful and effective he felt as a practitioner in doing this work.

Nadine Burke Harris: So I'm thrilled that we are having this conversation around really hearing from our experts about how the advances of how to screen for ACEs and respond with trauma informed care in the adult medicine population. And I want to start by just saying a few things that I hope that you'll take away from this webinar. Number one, a recognition that, oftentimes, we don't know, we can't tell by just looking which of our patients may have experienced significant adverse childhood experiences. And with the



recognition that 62% of Californians have experienced at least one ACE, and almost 17% of Californians have experienced four or more adverse childhood experiences, we recognize that it's really important to ask all of our patients about adverse childhood experiences so that we can identify when it may be playing a role in our patients health outcomes.

Nadine Burke Harris: And I think that based on my clinical experience, as a pediatrician, I will say, not as an internist, but one of the things that we recognized is that the impacts of adverse childhood experiences, oftentimes we recognize it when a patient has a mental health or behavioral or a neuro-psychiatric outcome, right? That connection between, for example, a patient's depression or anxiety and their ACEs, for most of us, it's not hard to make. But what I think is really equally as important is understanding the role that ACEs play in the development of diabetes, or heart disease, or stroke, when we look at the fact that an individual with four or more ACEs is twice as likely to develop heart disease, two and a half times as likely to have a stroke, et cetera.

Nadine Burke Harris: So supplementing this work as a regular part of primary care is critically important. Finally, a few things that I want to touch on, particularly in terms of the role of racism as a risk factor for toxic stress. We know that when we look at the ACE criteria, it's really important for us to be able to compare apples to apples in terms of using the criteria that were in the original ACE study, when we're comparing relative risk of health outcomes. And so you'll see in the ACEs Aware materials that our researchers and scientists who helped to develop and inform those materials were very rigorous about using the original criteria and comparing them to odds ratios for health outcomes. But we also recognize the very strong science, that racial discrimination and institutional racism are also risk factors for developing the toxic stress response, which we recognize is the biological way in which ACEs get under our skin and increase our risk for negative health outcomes. And then from that standpoint are just as important in terms of a risk factor for health. So just because the name of the initiative is ACEs Aware, doesn't mean that other social determinants of health, like discrimination, like poverty, like other social determinants of health, are not as important when it comes to assessing our patients' risk.

Nadine Burke Harris: And finally, I want to highlight that you all as adult medicine clinicians have such an important role, not only improving patient outcomes and



improving quality of care, but also breaking the intergenerational cycle of adversity. Because we recognize that untreated ACEs are handed down from generation to generation. So it's such a critically important role that adult clinicians have to play in reducing our population burden of ACEs and toxic stress include doing this screening and trauma informed care so that we can break that intergenerational cycle. I want to thank all of our panelists today for their excellent work, and particularly Dr. Brent Sugimoto, who with the California Academy of Family Physicians, who has been such an incredible partner and advocate in this important work. And so I will leave it there and pass the baton.

Brent Sugimoto: Thank you Dr. Burke Harris for that really nice introduction. Good afternoon, everyone. My name is Brent Sugimoto. I am a family physician. I have had a lot of my experience working with ACEs in my HIV practice, where I saw how ACEs contributed to the health disparities I saw with my patients, not least of all, was living with an HIV infection. Working with ACEs has been a very important part of both my clinical practice as well as my advocacy and very proudly serve representing the California Academy of Family Physicians on the Surgeon General's Trauma Informed Primary Care group, as well as serving on the board of directors that we've mentioned, working nationally on issues of health equity.

Brent Sugimoto: But today, my role is to talk to you about ACEs as a family physician, and the role that primary care providers can serve in helping to improve the health of our patients and the health of Californians. Next slide, please. So, family physicians and primary care physicians have a very unique opportunity to have a very positive impact on ACEs. And if I can start with the story, early on in my career, I had a young girl come in with very severe debilitating abdominal pain, who came in with also a very worried mother. And what came out in terms of screening from ACEs was actually a very impactful story, was this was a eight year old girl who actually had immigrated to California over the border being snuck over by a coyote and actually been separated by this coyote in the journey over and was living with that. Then in addition to that, learned that this patient was also being physically abused by a teacher at school.

Brent Sugimoto: And It was only in thinking about these issues, thinking about adverse childhood experiences that we actually got to the root of her abdominal pain, as well as having addressing the ACEs that her own mother experienced as a child living in Mexico. And just the importance of how

this women have been caught, right? All these all these health effects, right? The downstream effects, the potential chronic disease that this eight year old girl could live with, had we not intervened at an early stage. So primary care has a very important role in this and just highlighting that, how important this is that you integrate this into your practice. I liken it to my work in HIV. For a long time the medical community was very resistant to Universal HIV screening, feeling that we should only screen people who we thought to be at risk.

Brent Sugimoto: But as Dr. Burke Harris mentioned, you can't tell who is at risk just by looking at them. And that is the same parallel that we see here with adverse childhood experiences. We're only going to find them if we actually screened the patients. And so this is why this groundbreaking initiative that Dr. Burke Harris is spearheading is so crucial to actually getting at the health issues that are going on in this state. Next slide, please. So, an adverse childhood experience is a traumatic experience that falls into one of three domains: abuse, neglect, and household dysfunction. And there are many other sources of toxic stress, but as Dr. Burke Harris said, we focused on these because this is where the evidence is best. And this is the evidence that shows that what we had the most was robust evidence in terms of evaluating what is going to have the most impact on their health.

Brent Sugimoto: So when we talk about adverse childhood experiences and screening, we focus on these 10 that you see here in front of you. Next slide, please. So ACEs have a very high impact on health of Californians, as Dr. Burke Harris said, about 63%-64% of Californians to have been exposed to at least one ACE, 17% have been exposed to four. And the ACEs have had an impact of maybe about \$10.5 billion in personal healthcare spending, with also an impact of 434,000 disability adjusted life years, valued at \$102 billion in just the state of California alone.

Brent Sugimoto: But what I also want to point out is that this has become even more relevant now, in the age of COVID, where now we have a lot of stresses from being sheltered in place by a lot of family dynamics that are being altered by the stress of not being able to leave your house, by the economic stress of maybe not having enough money and how this might impact the rates of abuse, the rates of a stressful environment in a home. And so when we think about what's going on now, with COVID, I would just like to highlight that this becomes even a more important thing that

we do. I'm also happy that ... I'm really happy that Dr. Burke Harris brought up the effects of racism as a form of toxic stress as another part of the nouveau that is affecting what's going on for Californians today. Next slide, please.

Brent Sugimoto: So, as Dr. Burke Harris mentioned, it's very intuitive that the adversity or toxic stress that someone goes through as a child can impact their mental health. But what the study has showed and what makes this so impactful is the fact that this impacts not just our mental health, but it also impacts our physiologic functioning. And what studies have shown is how chronic toxic stress impacts the endocrine function of the body, particularly the hypothalamic pituitary adrenal axis, and the effect on stress hormones, as well as our catecholamines, right behind the autonomic nervous center, the effects that this has on our immune system, and as well as the neuro development, for example, the ability to form memories, the impact of ACEs on the hippocampus, as well as on the amygdala. Toxic stress and ACEs actually affect how our body functions. And this has a direct association with the formation of chronic diseases like diabetes, like cardiovascular disease, like asthma.

Brent Sugimoto: There's a direct pathway that is independent of behavioral pathways. This is not just related to the diet that the person's eating, or the fact that they might smoke more or they might drink more, adverse childhood experiences actually make someone more predisposed on independent basis to so many of the chronic diseases that we deal with so frequently in primary care. Next slide, please. This slide shows an example of that. And there's a long list you can find this down the ACEs Aware website, but things that we think of as lifestyle issues, right? As I mentioned before, diabetes as being a function of diet, COPD as being a function of just smoking alone, cardiovascular disease. All of these have been shown to be independently affected by adverse childhood experiences, which shows why it is even more important that we are screening for these in primary care. Next slide.

Brent Sugimoto: So, what you see before you here is the ACEs questionnaire, which asks patients about the 10 ACEs that we study. One thing I'd like to point out about this is that this is what we call a de-identified questionnaire. Meaning that you do not ask the patient to list off the types of ACEs they have, but only to list the total number of responses. And the reason for this is comes from the trauma informed perspective of we don't want

to retraumatize the patient, we only want to be able to identify the patients that might need an intervention. And so in terms of integrating this into your own practice using a de-identified questionnaire is something to consider. Next slide, please.

Brent Sugimoto: And so once you do identify a patient who does have a high ACE score, what do you do about this? Right? And the reason why we do this is not to identify the ACEs that the patients have, but the fact that the evidence shows that having a high number of ACEs predisposes someone to having risk for all these chronic health conditions, as well as impacts on mental health. And so what you can see here is based on the ACE score, right? Zero to three, one to three, and four plus, how you might act on this. And with a high ACE risk score especially, is getting the patients the services they need, as well as educating the patient on what they can do to help make their health better, including things like nutrition, sleep, fostering healthy relationships, concentrating on exercise and mindfulness. Next slide, please.

Brent Sugimoto: Now, family physicians, see adult patients for sure. But we also see patients across the life spectrum from providing prenatal care to seeing children all the way throughout life. And so we will see children as well. And so just to let you know that children actually follow a different workflow. What you see here is the PEARLS questionnaire. Next slide, please. And if you want to learn more about this, I actually encourage you to check out the ACEs Aware website which has a lot of great information. There's also an archived webinar that was done last month, including with Dr. Burke Harris that talked about the fundamentals of ACE screening in the pediatric population.

Brent Sugimoto: And so for those who also see pediatric patients, I do encourage you to go to check this out. So, a question I get a lot when I talked to physicians and other providers about how do we fit ACE screening into our practice? Primary care is already so busy, and how's this something that we fit in? And my answer to that is that ACEs are already in our practice, already. When you have Californians were about 64% of Californians have already had an exposure to an ACE, Then you're dealing with adverse childhood experiences. What screening provides you is a workflow to be able to manage and deal with those ACEs for your patients. My background is actually in public health before I got into medicine, and in public health, we're very interested in what are the upstream effects? Right? What are

the most upstream thing we can do to have the most profound impact on health down the line? And ACEs is one of the most profound, I think, upstream effects that we can think about.

Brent Sugimoto: When you think about your patient who has ... how many of you have patients that have diabetes, and cardiovascular disease and COPD, and depression? There's a good chance that ACEs could have been part of the development of all these in your patients. And then addressing these in your patients can actually help you manage all these conditions better. And so I encourage you to do that. The other thing I'd like to say about this is that it might seem overwhelming to deal with ACEs, for your patient with the screening, but you have a longitudinal relationship with your patient, and this doesn't all have to be done in a single visit.

Brent Sugimoto: In fact, the most powerful thing you have with your patient is your relationship. And when you see them time and time again, you can provide that support, you can provide them the services that they need, so that adverse childhood experiences have less and less impact on their health as they go on. One thing I like about this slide that I'd like to say is, it's just that you see the many generations here, right? You see the children, the parents, you see the grandparents, and this is one of the things that I think family physicians have a unique opportunity. Is that very often we see multiple generations in the single room. I think many of you have seen both a child and a parent at the same time. Sometimes I see a child and their grandpa at the same time. Sometimes when I've screened a child, it gets the grandparent to reflect on their own experiences. Bringing this up in the conversation is a way for us to impact not just the single generation but all the generations.

Brent Sugimoto: And even more profoundly when all physicians deal with this and all practitioners deal with this with their adult patients. It is a way of impacting a life in a positive way, in a positive trajectory for someone who may not have even been born. Because when a patient is aware of the impact of ACEs on their own life, this is an opportunity for preventing them from transmitting it to the next generation. So with that, I would like to ... I'm very delighted to introduce the next speaker from North County Health Services. This is a health center that has a long experience of ACE screening intervention, with over 70,000 unique patients at 11 sites. And we have three practice experts in ACEs who are going to show you the value of screening in primary care. And so I'm very happy to

introduce Mimi Mateo, Certified Nurse and Midwife, who's going to talk to you about her case. Thank you, Mimi.

Mimi Mateo: Thank you so much, Dr. Sugimoto. I'm really happy to be here, and I think part of why I'm being included, those of us on the front line, really know that pregnancy is often the gateway for women into primary health care. And as far as the ACE based approach goes, we also know that pregnancy is kind of a physiologic stress test for a woman. And often conditions that may have been seated by adverse childhood experiences will emerge for the first time in pregnancy, things like diabetes and hypertension. And as both Dr. Burke Harris and Dr. Sugimoto mentioned, if we can bring an approach in pregnancy that addresses and incorporate ACE, maybe we have a chance to interrupt that intergenerational passage of some of these conditions.

Mimi Mateo: So I just wanted to share a very simple, typical patient that I might deal with and I'm thinking about somebody who had her first visit with me about a month ago, a 30 year old having her first baby and her first OB visit with a provider was at 23 weeks. Next slide, please. So when I reviewed her chart before going in to meet her, I identified significant medical and family history that included her own obesity, her history of smoking, her mother's hypertension, and when I reviewed some of the psychosocial history, it was documented that this pregnancy was in fact unplanned and that the father of her baby was incarcerated.

Mimi Mateo: In another section of the history, I could also see that she was employed full time and that she had strong family support. Next slide. So in our setting at NCHS, the ACE screening is done at the intake visit for our OB patients. And that visit is done by one of our perinatal coordinators or a health educator. And this is when a comprehensive history taking occurs and women get their basic prenatal labs. We have a robust depression screening program in women's health, and especially in our obstetric program, so women complete a baseline depression scale at their second prenatal visit, that is revisited in the third trimester, and then revisited at least twice in the postpartum period.

Mimi Mateo: So when I saw her for the first time, I did have this ACE score of three, which put her in that intermediate risk category that Dr. Sugimoto mentioned. Her physical exam and her lab work were essentially unremarkable. And at the end of her physical exam, we sat down and

talked about risks and opportunities that we identified together. So I brought up the fact that her smoking increased her risk for some issues, her weight increased her risk of gestational diabetes, and also her current situation made her a little more vulnerable to mood disorder in pregnancy and postpartum. I think it's really important to underline here that we also addressed some of the buffering, stabilizing our strengths that she was bringing, and that was that she had long term job that she really loved. She was incredibly motivated to do the best for herself, and her baby in this pregnancy.

Mimi Mateo: In fact, in this visit, she shared with me that she left a previous care provider because she felt like she was not getting the attention and support she needed to do the best for her own health in this pregnancy. And she found that being asked to complete the ACE screening at her intake visit actually suggested that we really cared about her as a whole person. Next slide. So my basic plan as a prenatal care provider, from the outset, I want to educate in broad strokes about the connection between early adverse experiences, and the potential they have to impact her health. And of course in pregnancy, we're also talking about the potential impact on her baby's health.

Mimi Mateo: I always take the opportunity to validate what she's bringing to the table. And I mentioned she had made a choice to change care providers. She had also by the time she had her first visit with me, been tobacco free for two weeks. So that really gives me a structured way to validate the choices that she's making. It also gives me an opportunity because women are so motivated in pregnancy to learn about their own health, and to make changes. Changes that they might not make for themselves like quitting smoking they will make for their unborn child. So this gives me an opportunity to introduce all kinds of support services that exists.

Mimi Mateo: And within that we have a variety of support services, nutrition, counseling, health education, childbirth education, and of course, our behavioral health program. Next slide. So I guess the real takeaways I want for anyone doing prenatal care to have is that some women are not going to choose to engage with behavioral health treatment, even if they present with past mental health diagnoses. However, the prenatal care provider still has a perfect inroad to address and create a treatment plan that is ACE formed. Pregnancy is a time when all of the pillars of self care are impacted. A woman's body is changing. This disrupts her sleep, her

appetite, and choices around nutrition. It impacts her relationships and her mental health. It may be the first time she chooses to exercise because she's worried about how she's going to have the strength to get through labor. So at each visit, the prenatal care provider the midwife or other provider has an opportunity to drop a few pearls of health education.

Mimi Mateo: Women who expressed interest and are engaged can go on and meet with a registered dietician, set a weight gain goal that will keep her healthy and make a diet that is going to optimize nutrition for her and her baby. Our childbirth education has undergone a tremendous amount of change. It is no longer a download about the physiology of pregnancy, labor and birth. There are all kinds of apps that exists for that, and women Google the information they need. Our childbirth education is founded in a program of mindfulness. We do some basic yoga and movement. We work with visualization that includes art and music. So women who want to make use of those resources have them available. And finally, I do just want to say That with every single woman, it is very easy to introduce the concept of behavioral health. And that's because all you have to say is, "Wow, pregnancy is really a roller coaster of emotions, isn't it?"

Mimi Mateo: Every woman will nod in assent if you bring that up. And so just a gentle suggestion, we have incorporated behavioral health in our OB Program. Even if your mood is stable and you feel great through the whole pregnancy. It's nice to meet one of our behavioral health consultants, one of our therapists, when everything is going well, just in case later in the pregnancy or postpartum you start to feel yourself getting into trouble with depression or anxiety. And that's a little seed we plant. Next slide. So really my dream in participating with this is that everyone will recognize the opportunity that exists in prenatal care. First and foremost, to just normalize the inquiry. In prenatal care it's easy to talk about what might have happened to you as a child that is impacting you now, and what might you want to do differently for your baby. And we just draw that through line and help women make the association between their current health status and what they experienced.

Mimi Mateo: By having our whole team involved in this ACE informed approach, we're really trying to create a partnership between team members, and most importantly, with the woman herself, because the dream is to move

beyond trauma informed care, and really promote healing engagement for this woman with the healthcare system. Healing engagement for herself and her family. And now I'm going to pass it off to Dr. Gomez, who does an amazing job with some of our patients who have much more chronic conditions and are not just here for the exciting episode of pregnancy.

Denise Gomez: Thank you Mimi, I appreciate that. So I'm going to go through a couple of cases that many of you will probably recognize from your own practice. These are very common scenarios that you might see, and how we use ACE screening and interventions to help our patients. So the first case is a 49 year old woman who's been in our clinic for the past eight years, my patient. Next slide. So this is a patient who initially was screened for ACE and she had a fairly high ACE score. She also had depression and anxiety but it was controlled, and the patient had a new diagnosis of cancer.

Denise Gomez: So during the visit, we briefly discussed ACEs and toxic stress. We discussed stress hormones and the relationship between stress and the development of chronic illnesses such as cardiovascular disease. We reviewed different options for care including self care, she actually had a very nice social network that helps support her as far as helping her with her anxiety and her new diagnosis. And so I basically offered the behavioral health referral, which she declined at the time. So on further assessment, a couple years later, of course her ACE score didn't change, but then I started to notice since she had more cancer related symptoms that she was starting to become overwhelmed. She now had mild depression and moderate anxiety. And we again discussed her ACE score and how her neurochemical development as a child and throughout her life was affecting her coping skills and her ability to reduce her stress because of her new related symptoms.

Denise Gomez: So at that time, she actually did agree to see a behavioral health specialists to discuss some of the interventions that would help with not only her anxiety and depression but also with more self care interventions. Next slide. So my plan with this patient was to educate on ACEs and toxic stress, just reviews simple interventions to reduce her toxic stress. Also, to validate the patient's strengths and those protective factors. She had a really nice social network in place and that helped her a lot, and that's really positive, so we validated that and we supported that.

- Denise Gomez: We also reassessed her interest in behavioral health as she started to have more symptoms of depression and anxiety. So at that time, we actually were able to do a warm handoff to the behavioral health person and the follow up was basically recognizing that a patient's situation can change, they might do well, okay, when they're not under a secondary stress such as cancer, but then as things worsen or their chronic illnesses worsen that they might need additional intervention and just to revisit the ACE and the coping skills and their ability to self care, and identify when they might need additional help. So next slide.
- Denise Gomez: So on the ... this is basically an example of a self care tool that is on the ACEs Aware website. It does help in setting goals and this can be done with the primary care provider, or it can be done with the behavioral health specialists, and setting goals, and it includes healthy relationships, exercise, nutrition, sleep mindfulness, and mental health, and basically gives a list of additional goals that they can set for themselves. So the next slide.
- Denise Gomez: So the takeaway is, many ACE informed treatment plans can be managed by the primary care provider, we don't necessarily always need to have a health provider intervention. Sometimes patients aren't ready or they don't need behavioral intervention at the time, but you also have to be aware of when situations can change with patients, when they have a different level of readiness, and obviously different stages of change that occur when somebody has a diagnosis of cancer. And also emphasizes the importance of continuity of care to support that readiness and additional treatment when appropriate. And next case.
- Denise Gomez: So our next case is much more complex. Again, probably familiar to many of you. So this is a 55 year old woman, in adult primary care. She has multiple uncontrolled chronic conditions. She has frequent emergency room visits. She has diabetes, hypertension, uncontrolled rheumatoid arthritis, severe depression and anxiety. So in evaluation, she's got a high ACE score. She has high depression and anxiety scores. She has uncontrolled diabetes, high blood pressure, rheumatoid arthritis, and she's non-adherent, she's very complex, kind of a very difficult patient from an internal medicine standpoint as well as from her underlying anxiety depression issues.

Denise Gomez: So the patient had been seen in our clinic for about three or four years, her ACE score was done in 2018. Her primary care provider had just left the clinic. She kind of bounced around to different providers over time and ended up after an ER visit in my clinic. So, I was like, "Wow." When you see a patient like this, you're like, "What do I do?" And I'll just kind of tell you my first approach is to find out why the patient is having the barriers to controlling her care. And so it turned out that the patient had multiple social determinants of health which impaired her ability to comply with her treatment, including transportation issues, financial childcare, et cetera, and this patient was just overwhelmed by the shared number of medical issues she had in her conditions. She had a low health literacy. So I didn't really understand a lot of her conditions. I basically sat the patient down reassured her that our primary care team is going to take care of her. We're going to have her see the resource specialist, the health educator, the dietitian, we're going to get her transportation to where she needs to go to see the rheumatologist. And I brought her back actually, for a just one visit just to talk about her ACEs and toxic stress.

Denise Gomez: And her rheumatoid arthritis isn't going to go away in a day, her diabetes isn't going to go away in a day, those are things that you take care of over time. So it's worth really focusing even entire visit on, what is ... what are your barriers? How can we help? What is toxic stress? How does this really kind of add to your already high risk of cardio vascular events? And how can we help you reduce this physiologic stress that you're having? So we did provide her with a warm handoff for her behavioral health consultant to do therapy. She was diagnosed with PTSD and so I started her on treatment for that. She was sleeping better, she saw the rheumatologist, her ACE is under control, she's doing better with her blood pressure and diabetes, and we follow her up very frequently. So next slide.

Denise Gomez: So I'm not going to read through this slide, you can read some of it, but I did want to focus on the treatment strategy, because I think it's really important to recognize that the treatment strategy really consists of education to help patients recognize and respond to the role that past or present stressors in their ... The role of stressors that they play in their current health conditions, and addressing that toxic stress physiology as a core component of treating ACE associated health conditions. So for both children and adults addressing current stressors like increasing the total dose of buffering and protective factors such as nurturing relationships

and having safe environments, are actually associated with decreased metabolic inflammatory and inflammatory dysregulation, and they actually have improved physiologic and psychological health.

Denise Gomez: So most important for adult medicine is the fact that even when the treatment comes later in life, it is known that for individuals with ACEs addressing the resulting toxic stress physiology is important in improving their health conditions, as well as for averting future consequences. Next slide. So the takeaways are, of course, the mantra of primary care as always establish that relationship with your patient, spend time if you need to, to focus on ACEs and toxic stress because their chronic medical conditions aren't necessarily going to go away, but it can certainly be helped if you can treat that toxic stress, and then emphasize what they are doing well already, and I think it's really important to reassure the patient that that team, the primary care team is going to be there for her and help her and make sure that she knows that somebody is actually there to help her.

Denise Gomez: I think one of the differences for this patient, and she said to me, "I finally feel like somebody actually cares about what happens to me, and cares about my medical conditions, but also just kind of somebody here to help me get through this, and to make my life better." So it's really nice to hear patients say that. So that completes my part and I would like to pass the baton on to our Director of Integrated Behavioral Health Dr. Altamirano. He is our illustrious leader who initiated trauma informed care and ACE screening in both our adult and pediatric populations.

Leon Altamirano: Everybody, so I'm going to go through a quick case for you. Let's see. We're talking about a 42 year old man who was suffering from chronic pain, and he was referred over for anxiety, depression that we identified after doing a depression screening and GAD-7 anxiety screener. Slide please. So this is a guy who was for him in a previous life trial attorney, worked in a couple of different states, he was at the time unofficially disabled, he had been suffering with degenerative disk disease and pretty severe pain from that for more than 10 years. Developed some anxiety and depression, really, the end of high school into college, and he was raised in a very strict family, his father was a general in the Air Force. They moved around frequently. So, he had ... he kind of knew at all.

Leon Altamirano: And so, I took the time to explain the impact of toxic stress on the brain during book development and for relevance, I also added the high prevalence of PTSD and people that suffer from Chronic pain. So he kind of took that and was a little bit more forthcoming. And on the second round, he actually admitted that his ACE score was actually a seven. At that time, he also admitted that he had been thinking about suicide. I think it is important to stress how critical it is to screen for suicide. It's there. And so as much as in primary care, we don't want to address some of these things, it's important to consider that 50% of folks who die by suicide, have seen someone in primary care within a month of actually doing it. So we really want to pay attention to all of these things and the ACE screening is a beautiful way to get into that type of a conversation.

Leon Altamirano: An important takeaway here is all patients really need a brief explanation that's relatable about ACEs prior to their screen. We see a tendency for under-reporting, in primary care, and then as the behavioral health consultants come in, we get a little bit more information out of them. Some of our more skilled primary care providers are spot on with the responses that they're getting from patients, because of the way that they are just calmly explaining why they're asking the questions and then gathering the information.

Leon Altamirano: So with this guy, he did a lot of relief seeking. Dr. Felliti from the ACE study once said, "It's hard to give up something that almost works." And this was in reference to essentially addiction as more of a relief seeking behavior and so this particular patient started using alcohol and marijuana early on in high school, no relief. Then as his pain started to ramp up, he started using opiates and other drugs, no relief. Eventually had to go through detox and rehab, continual, no relief. Finally ended up getting a spinal fusion L4-S1 joined and really didn't get much relief from that. It just was a downward spiral, and he ended up having to close his practice. Slide please.

Leon Altamirano: I'd seen him for or I saw him ... This was about four or five years after he had closed his practice, and he was functionally disabled. So as a behavioral health consultant process, we want to educate our people about toxic stress what it does to brain development when it happens especially early on birth to about age 24, of ACE study was birth age 18, and then the long term impact of these things. When appropriate, especially with pregnant folks, as Mimi was saying, we want to be able to

discuss the epigenetic or intergenerational impact of stress. And then jump into the ACE screening, so you've established some relevance as to why you're asking the questions.

Leon Altamirano: We also asked about associated symptoms, like sleep disturbance, concentration, anxiety, work challenges, as we move forward asking those questions about other traumatic events, race, immigration, these kinds of things, and then the survival skills, how they survived those traumas, those stressors, and what were their relief seeking behaviors. All of this, as with this patient, we kind of look at offering additional appointments to get people to come back and see if not only they can improve with pain or sleep or other things, but we really are seeking to promote constant relief instead of the standard relief seeking behaviors that we find in addiction, violence, and other things. Slide.

Leon Altamirano: So overview of treatment, again, we're enhancing the understanding, making it easier to talk about what happened to people. We educate them about the impact of toxic stress, self care strategies, stress management, looking at improving identification of symptoms, so that we can really figure out what's contributing to reactivity or HPA activation or toxic stress response. We want to look at helping them develop healthier coping skills through that symptom identification and then management of those symptoms. Identifying behavioral changes, and here really it's more looking at what changes are consistent with the patient's long term vision of their life after working through stress and trauma.

Leon Altamirano: Patients will tell you about what their ideal health and wellness picture looks like 5, 10, years down the road. It takes a few seconds, but it really carries a ton of weight because it provides that picture of hope. Ultimately, we're promoting resilience. We look to enhance natural strengths, those strengths that helped people survive their adverse childhood experiences, their traumas, and then increase additional supports. One important message for our patients is that behavioral health isn't about the diagnosis, it's not about being mentally ill, it's really more about accepting that they and many of us have had a hard life. And we want to instill hope and help people recognize that they can live a better life, and they can live more effectively. Slide.



Leon Altamirano: So, in talking about the integrated behavioral health, it's really an issue of coordinating care. We want trauma informed ACE informed behavioral health treatment within routine primary care. I feel like it works better than your traditional therapy. I kind of feel like we're in the midst of a paradigm shift where we're focusing on the masses and when we're looking at whole person health and wellness long term this is really I think the premier public health approach. We want to make sure that patients are ready to engage. Sometimes they're not, you'll hear a lot of presenters and primary care providers or physicians in particular, say that they may not be ready for behavioral health and that's okay, but provide education and really focus on stigma reduction.

Leon Altamirano: As a psychologist I have to add, if anybody's prescribing medications, it's really important to make a referral and get them connected, the fastest way to improve and really get through some of the symptoms of trauma and other conditions as medication and therapy together. Even brief interventions by behavioral providers can promote self care. So in the clinic, we may just see patient one time, but it opens the door for future therapeutic support. Oftentimes, especially folks with higher ACEs, either they come back or they may refer a family member when they really start to struggle.

Leon Altamirano: And then finally, patients treated in integrated behavioral health are more likely to understand and follow primary care treatment recommendations. We see reductions in no-shows, and really overall whole person improvement. I could go on, I probably should, but I'm not going to. I'm going to pass the mic over back to Dr. Gomez, and see if she can provide us with a few takeaways. Dr. Gomez.

Denise Gomez: Yeah, so I'm just going to review kind of an overview of what we all kind of just talked about. So key takeaways are routine screening for ACEs can help build stronger therapeutic relationships with patients. They can develop better treatment plans, improved outcomes, and really focus on healing engagement. It also, ACE screening and treatment helps us to understand that overactive stress response may be contributing to the pathophysiologic mechanism precipitating or exacerbating chronic health conditions. Providers can use ACE information to obtain more effective treatment for chronic conditions when they are recognized. Many ACE treatment plans can be managed with a routine care, they don't necessarily need direct intervention from a behavioral health provider,

but just a few brief moments with a primary care provider can sometimes make a huge difference. And addressing ACEs as part of adult primary care, including obstetrics provides an opportunity for prevention and most importantly, to interrupt that intergenerational transmission of ACEs.

Brent Sugimoto: Well, thank you, Mimi, Dr. Gomez, and Dr. Altamirano. For those very insightful cases. I know that we are running close to the hour, there is a question though that has come up from many of you that I think might be good if one of you guys could maybe respond to it. And North County Health Services has been doing routine ACEs screening for several years, and we have received many questions about how to integrate ACE screening and response into practice and into culture practices. Can one of you say a few words about how do you build a clinic culture that supports trauma informed care and routine ACE screening? Would one of you like to answer that for us?

Mimi Mateo: Go ahead. Dr. Altamirano.

Leon Altamirano: I'm just-

Denise Gomez: I was going to say doctor-

Leon Altamirano: ... Sure. So really developing the culture is more practice of ... Gosh, it's so dragged out, it seems easy, but it was bringing on the board of directors, making sure that all of our leaders or everybody in the C-suite understood why? Why are we doing this? What's the long term, big picture of this one particular screening? And then we brought in all of our providers from every discipline. Made sure that everybody participated in planning, how are we going to do this? How is this going to work? What are we going to do with the information? So everybody had input. I think the larger piece of it is also we have been doing trainings for everyone from our receptionists, to people who take the phones, all of our providers, nursing staff, medical assistants, you name it, on trauma informed care, suicide prevention, social determinants of health, is a large piece of it.

Leon Altamirano: We talk a lot about health literacy, and then what I like to call assertive customer service, which is more crisis intervention, and dealing with folks who have trauma histories, and really can't find the words to say what

they want. They're either angry or they're withdrawn, and recognizing this is trauma. And rather than engaging and having them push our own buttons, taking a deep breath and helping them with what they need in the moment, it has changed the way that we practice from top to bottom. We get referrals from behavioral health from all around the organization, including our receptionists. So it's a really ... it's a team approach. And everybody is focused on the community at large and making sure that all of our patients are getting better somehow, some way.

Denise Gomez: ... I just like to add on to that. Many years before we started doing ACE screening, providers recognized that we were having issues with ACE where they come in for their diabetes...We need help. We need a lot of help here because we can't really do our job without having some additional resources for us to help our patients and the issues that they're having that have to do with social determinants of health and just family issues et cetera. And so we actually started having integrated behavioral health before the ACE screening because we're like, "We need this." And then when ACE screening came on board, it all made sense of why our patients were having these issues. And kind of the underlying pathophysiology behind what was happening in the clinics was directly related to ACE and high ACE score.

Denise Gomez: So it kind of just fit in together. And we were fortunate to have a board of directors and our administration that supported us, and helped us to do our job. And so for people who don't have those resources, I think that's where I would start is basically trying to get your administration on board. Ultimately, this is a money saver, because you actually can take care of patients better when you have a behavioral health resource there for you to help your patients.

Brent Sugimoto: Funny, how doing the right thing always saves money. Right?

Tanya Schwartz: Right. Well, thank you all so much for your presentation. We are very grateful to have had you today, and thank you for sharing your experience and wisdom with us. I know we're over time, I'm going to say a few final words. We still have hundreds of people on. So some people have stuck with us. So thank you. And I want to thank everyone for submitting questions. We received a ton of questions, both in advance



and during today's presentation. And so we'll take those back and work very hard to respond to them on our website.

Tanya Schwartz: So before we wrap up, I'm going to highlight some key resources and tools that have been developed by ACEs Aware and other organizations to help providers as you screen and respond to ACEs and toxic stress. So first ACEs Aware has developed a free comprehensive training for providers that offers continuing medical education and maintenance of certification credit. It covers the science of ACEs and toxic stress, how to screen for ACEs, how to implement trauma informed care, as well as the medical billing policies.

Tanya Schwartz: As of July 1st 2020, qualifying providers must take this core training and self attest to completing it, in order to continue to receive medical payment for ACE screenings. Next slide, please. We have many other resources posted on our website that we encourage you to check out. We have clinical resources for adult and pediatric providers, patient and family handouts, research briefs, there are resources on all sorts of topics including the science of ACEs and toxic stress, screening, clinical response, resilience building interventions, so please check those out.

Tanya Schwartz: Next slide, please. And one of the resources that was mentioned earlier by Dr. Gomez that I just want to highlight is the ACEs Aware patient self care tool, which addresses the six pillars that can help patients decreased stress hormones and improve their health. So that support of relationships, high quality and sufficient sleep, balanced nutrition, regular physical activity, mindfulness and meditation, and mental health care when indicated. And providers can use the self care tool with their patients to collaboratively plan and set goals in each of those domains, and they can follow up on this treatment plan as they go forward with the patient's care. Next slide.

Tanya Schwartz: We have developed a provider toolkit that has comprehensive information about the initiative on all of the topics that you can see on your screen. And so that's a great resource for learning more about the initiative and all of the elements we've talking about today. Next slide. And we'll also continue to hold webinars on a range of topics. So our next webinar will be on regulating the stress response for kids practical tips for primary care providers. So stay tuned for more information about that. Next slide.



Tanya Schwartz:

And again, as we come to a close I just want to thank all of our wonderful speakers today for sharing your experience and your expertise. And thank you all for attending today, and later today, we'll send out a survey and would appreciate your feedback on the webinar. And we look at those very seriously as we plan for our future webinars. And just finally, a recording will be emailed out to all of the attendees today and posted on the ACES Aware website, so please share it with your colleagues who might be interested. So thank you all. Have a great rest of your day. Take care.