Assessing Readiness & Building Resilience in the Clinical Workforce: A Foundation for ACE Screening Integration – Webinar Transcript

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Sam Mills: Hello, and welcome to today's ACEs Aware webinar, “Assessing Readiness and Building Resilience in the Clinical Workforce: A Foundation for ACE Screening Integration.”

Sam Mills: This is our eighth educational webinar in a series informed by the feedback we've received from your webinar evaluations, with the goal of creating responsive and practical information on screening for adverse childhood experiences, and providing trauma-informed care.

Sam Mills: My name is Sam Mills, and I'm with the Aurrera Health Group, and it's our great privilege to be supporting the ACEs Aware Initiative and introducing our speakers, who we will hear from later today.

Sam Mills: Before we get started, I want to cover a few updates we've made based on your feedback. First, I want to thank all of you who submitted questions in advance. Many of those questions were used to guide our conversation with Dr. Ihle and Dr. Bernard-Pearl, who we'll hear from later in today's presentation.

Sam Mills: Second, we've also made sure to include time at the end to answer additional questions-- many related to specific tips and strategies for providers looking to begin implementing ACE screenings in their clinical practice. While all attendees are muted during today's presentation, feel free to submit questions in the chat function found in the panel on the righthand side of your screen. Our ACEs Aware team will be with you shortly. In the chat, you'll also find a link to the slide deck for this presentation. If you have any issues accessing the slides, let us know in the chat, and we'll get them to you shortly. Lastly, if you run into any technical difficulties and get disconnected, we will be posting this video and transcripts on our website at acesaware.org later this afternoon. Now let's get started.

Sam Mills: The mission of ACEs aware is to change and save lives by helping providers understand the importance of screening for adverse childhood experiences, and by training providers to respond with evidence-based interventions and trauma-informed care to mitigate the health impacts of toxic stress. Today, we'll hear from three speakers joining us to discuss how to assess organizational readiness and build workforce resilience to implement ACE screening.

Sam Mills: Karen Johnson has spent more than two decades working in trauma-informed care, including as Director of Trauma Informed Services for the National Council for Behavioral Health, and currently serves as principal at Trauma-Informed Lens Consulting. Dr. Deirdre Bernard-Pearl is a pediatrician and the Medical Director for Santa Rosa Community Clinic. And, Dr. Eva Ihle is a psychiatrist and Health Sciences Clinical Professor at the Departments of Psychiatry and Pediatrics at University of California, San Francisco.

Sam Mills: During today's webinar, Karen will provide definitions for workforce resilience and trauma-informed principles, and will also share how to build a resilient workforce, and how ACE screenings and trauma-informed care can support providers and their patients. Then, we'll hear from Dr. Bernard-Pearl and Dr. Ihle, who will share some examples and strategies on building organizational readiness and resilience as providers begin screening for ACEs.

Sam Mills: After that, we'll ask our presenters to answer a few additional audience questions submitted in advance. Finally, I'll wrap up the webinar by sharing some resources and tools developed or identified by the ACEs Aware to support providers in responding to toxic stress. With that said, I'm excited to hand it over to Karen Johnson.

Karen Johnson: Thank you so much, Sam. I'm Karen Johnson, and I'm excited to be with you today to share an approach and work that I am passionate about. I've been privileged to work with trauma-informed approaches over the last 12 years, both on the provider side and at the national level with the National Council for Behavioral Health, and as an independent consultant.

Karen Johnson: The last six months have not been easy for primary care. Current events are making the goals that primary care settings are hungry to achieve, much more difficult. We know that the patients that receive Medicaid

and are served by the safety net, and many individuals from racial and ethnic minority groups are uniquely impacted by our current circumstances, and as a result, have increased needs to maintain their health. As our patient needs are heightened, so are the needs of staff who are also living in today's events.

Karen Johnson: Prior to mid-March, organizations were already experiencing challenges, such as burnout and vicarious trauma, high turnover, complex work that can be rewarding but also exhausting. And we also know most of our patients and many staff have experienced adversity and toxic stress. For those who are not familiar with the term adverse child experiences, or ACEs, comes from the landmark study by the Centers for Disease Control and Prevention, the CDC, and Kaiser Permanente. It describes 10 categories of adversities in three domains experienced by the age of 18. And, it informs our understanding of the connection between adversity and health across the lifespan.

Karen Johnson: We are currently grappling with the challenges of a new plague, which has changed how we work, interact with each other, how we serve. And in the past months, we have faced a reckoning with an old familiar age-old scourge, systemic racism. During these months, we have seen a lot of challenges and economic downturn, devastating environmental events, such as fires in California, and increase in stress, anxiety, grief, and loss, and the need for leaders to grapple with what we want to hold onto and what may need to change.

Karen Johnson: Today I am privileged to share, along with our panel, an approach that pre-COVID was a movement gaining tremendous speed, and is now more relevant than ever. Trauma-informed resilience-oriented approaches provides a pathway for building individual resilience, and organizational resilience, and responding to the wide scope of staff and patient needs we see right now. I want to thank ACEs Aware for leading the work to screen and treat for ACEs in California, and for providing education on this and a promising approach that supports that work.

Karen Johnson: So why trauma-informed primary care? First of all, we know it lays the foundation for successfully implementing screening for ACEs and toxic stress. When staff understand the prevalence and impact of childhood adversity and toxic stress, and the urgent need to address it, they are more ready to take on this type of initiative, and ensure that they are doing screening in a compassionate person-centered way.

Karen Johnson: Trauma-informed primary care is also good patient-centered care, that can improve the health and well-being of our patients and their families. It improves clinical decision-making by incorporating knowledge of the health impacts of toxic stress and trauma into our responses and treatment planning. And, it supports the building of collaborative care networks focused on prevention, integration of behavioral health, case management and care coordination services. Finally, it creates environments in which providers and staff experience compassionate resilience, so they can stay healthy and do this fulfilling and challenging work.

Karen Johnson: Before diving into the trauma-informed approach. I want to talk a little more about stress. For many of you, this will be a review, but it can help us all get on the same page.

Karen Johnson: Our stress response falls along a spectrum of three different types of stress response, of which toxic stress is one. The first type of stress on this continuum is positive stress, which is a brief activation of the stress response, brief elevations in heart rates, blood pressure and hormonal levels. Through the buffering effect of a caring relationship and other interventions, we can bounce back and recover from positive stress. An example of positive stress for a child is a test, first day of school, a big speech. This is all healthy stress, and it builds resilience, and we don't need to be afraid of it.

Karen Johnson: Tolerable stress is a time-limited stress response that results in a short-term activation of stress response. Examples of this could include a big move, or the death of a grandparent for a child.

Karen Johnson: Toxic stress, the type of stress that we need to be most concerned about, is the constant activation of the stress response in the absence of caring, stable relationships, especially during sensitive periods of early development. It can be toxic to brain architecture and other developing organ systems-- resulting in long-term changes in the brain and body. Thus, of course, it is very important that we help our patients and families manage their levels of stress, and that as staff and leaders, we do the same.

Karen Johnson: There's much we can do about stress. That's the good news. Regulation is one set of strategies that can help us mitigate toxic stress and move to a calmer state when we are agitated, frustrated, anxious or upset.

Regulation helps us to quiet our lower brain, where the complex networks of the stress response system are located. It's really critical that we practice regulation and teach and model it for our staff and patients right now.

Karen Johnson: There are many ways we can self-regulate or quiet down our lower brain. We can use our cortex or thinking brain, with strategies such as mindfulness, journaling, and gratitude practices. We can also use some added sensory strategies to regulate, or those strategies that involve our body and senses, such as focused breathing, taking a walk or listening to music. These are really important, especially now, because thinking brain regulation strategies are not always available to us if we are experiencing unpredictable and extreme stress. So really right now, we need to regulate all day.

Karen Johnson: Our past practices that perhaps made us feel well, may not be enough right now. So, we need to try to build an activity such as taking a break every hour to do some focused breathing, taking a brief walk, maybe two to three minutes whenever we can throughout the day.

Karen Johnson: And, the third way we regulate is through relationships. We know that emotions are contagious. A calm friend or adult can help our emotions decrease in intensity and allow us to move towards a state of calm. The good news is that this type of connection doesn't need to involve a long-involved conversation. One simple text, such as, "Hope your day is going well. Thinking of you," can help us feel more regulated.

Karen Johnson: We can bring regulation practices into the organization and create environments in which it is expected that staff will practice these strategies throughout the day. And here are six stress-busting strategies for stress regulation, from ACEs Aware, that are also incredibly important to share with our patients and to use for ourselves. For supportive relationships, again, that connection in which we include our caregivers, other family members and peers, to help us stay in a state of health. Regular physical activity, high quality sufficient sleep, balanced nutrition, mental healthcare, including psychotherapy or psychiatric care, and substance use disorder treatment when indicated, and of course, mindfulness and meditation practices.

Karen Johnson: We can't talk about toxic stress and ACEs without talking about resilience. Resilience is the ability to withstand or recover from stressors. And it

results from a combination of both intrinsic and extrinsic factors, like safe, stable, and nurturing relationships with family members and others, as well as predisposing biological susceptibility. It's really important to note that with our advances in science, in the understanding of the impact of stress on neuro-endocrine immune and genetic regulatory health, we must consider resilience within that context also.

Karen Johnson: In a resilient organization, we work to create both individual and organizational resilience for the individual. That means we create environments and relationships in which staff can achieve compassion resilience, or the ability to maintain our physical, emotional, and mental wellbeing while responding compassionately to people who are suffering.

Karen Johnson: We know that the demands and pressures of working in primary health care can affect our ability to remain compassionate. And, it is the responsibility of both the individual and the organization to understand the influences that drive burnout and compassion fatigue, and to respond appropriately.

Karen Johnson: Organizations can also experience trauma and adversity. And, we have seen the impact of this year's events on our organizations. Primary care clinics have been impacted by changing workflows, by learning new billing, coding, and documentation practices, and implementing platforms for telemedicine, all while trying to support staff who are experiencing their own increased stress and fear of exposure to COVID.

Karen Johnson: So as a resilient organization, we strive to strengthen the ability for the organization to anticipate, prepare for, respond to, and adapt incremental change and sudden disruptions. The essence of being resilient as an organization means that you can fail well and recover, and take key learnings to strengthen future work. A resilient organization includes leaders and staff who have language and skills to have difficult conversations, to offer feedback, to hold each other accountable, and to create trust. Trauma-informed approaches builds both individual and organizational resilience.

Karen Johnson: So, what is this approach? Well, it is an organizational intervention that recognizes and responds to signs and symptoms and risks of trauma to better support the health needs of patients who've experienced ACEs and toxic stress. It creates safe environments for patients and staff that

promote healing and recovery by always prioritizing people's dignity, voice, and self-empowerment.

Karen Johnson: So here are the components of this framework. First, we understand the prevalence of trauma and adversity and their impacts on health and behavior. We recognize the effects of trauma adversity on health and behavior. We train all staff on trauma-informed care best practices, and this means everyone from the chief medical officer, to everyone who provides direct service, to the people who partner with us to keep our buildings clean. We integrate knowledge about trauma adversity into all of our policies, practices, and procedures and treatment planning. And always, we resist re-traumatization by approaching patients and staff with non-judgmental support.

Karen Johnson: So, what is it that we need to know in order to make this profound shift in our service delivery? First, we need to embrace two important tenets of a trauma-informed approach. I think this first one you are probably familiar with. We changed the question from what is wrong with you to what happened to you. This paradigm shift requires us to honor strengths in an individual, and we always move away from believing someone is broken or weak. We embrace the belief that an individual's health is impacted by the events in their lives, and healing and recovery is absolutely possible.

Karen Johnson: Secondly, we assume everyone is doing the best they can. This is important in our work with patients and staff, but maybe most impactful in our work with staff. It doesn't mean we don't hold ourselves and others accountable.

Karen Johnson: It means that as we strive for excellence, we bring grace, compassion, and empathy into the workplace, all of which are critical for combating burnout and building individual and organizational resilience. Both of these paradigm shifts require us to see and honor a person's resilience and strength. The effectiveness and sustainability of this approach really depends on a foundation of core principles that inform the clinic's physical setting, activities, and relationships. An organization entering in this process, or one that is well along in the journey, needs to always commit to honoring these principles. There are lots of parallel processes in our work of becoming trauma-informed and these principles impact how staff partner with patients, how leaders partner with staff, how we

work with our community partners, and how we interact with our colleagues.

Karen Johnson: Ultimately this work is about being human with each other. So perhaps, the most critical principle, especially now, is establishing physical and emotional safety for patients and staff. When we're doing this, we're creating calm physical spaces, waiting areas in exam rooms. We are also considering questions such as what are the messages on the walls, and how do we arrange the furniture. And of course, we're always ensuring that our spaces honor privacy and confidentiality. We are curious about what patients need to feel safe. We ask them what they need and listen to their response and use the information to adapt as possible, and as leaders working with staff, we create psychological safety, which is the belief that the work environment is safe for interpersonal risk taking. We create spaces in which people can be candid with each other. They can make mistakes, they can ask for help and share critical feedback.

Karen Johnson: Next, we'd build trust between providers and patients, which is again, very imperative right now during these times of uncertainty and fear. It is built through practice and intentional relationship building. And when we're doing this, we use reflective listening and motivational interviewing skills with our patients and our staff, ensuring that we are listening to understand not only to respond, and we always strive to share as much information as possible in our ACEs screening process and in every intervention with our patients and in our partnerships with staff.

Karen Johnson: We recognize the signs and symptoms of trauma exposure on physical and mental health and use that information to promote patient centered evidence-based care. We ensure provider and patient collaboration by bringing patients into the treatment process and discussing mutually agreed upon goals for treatment. When we're working to collaborate, we always focus on the patient's positive assets and resilience and ways to build strengths. We include peer support and health navigators into our health systems when we can. We seek patient and staff input and partner with patients and staff to consider solutions. And when collaborating with staff, we check in with them often, asking how they're doing and what they need. These check-ins can look very different. We can check-in at the beginning of our team meetings, we can check-in in our meetings with individual people we supervise, we can send a team wide email or a chat, and we can schedule a team lunch or coffee break. And I want to

pause here, to note that as leaders, you also need to be sure someone is checking in on you.

Karen Johnson: Again, furthering collaboration we create a staff buddy system in which no one is outside of the protective culture, and we can bring a curriculum such as “Mental Health First Aid at Work” to our workforce. It's pretty concerning, as the US census data from March to July indicates a tripling in the number of Americans who have experienced symptoms of depression and anxiety. This is especially concerning for our Black, Latino, and Asian communities. And there is a concern about a rise in suicide and overdoses. We need to eliminate stigma around mental health in our workforce and create environments in which people ask for help and receive it with no judgment.

Karen Johnson: And finally, we need to provide care that is sensitive to the patient's racial, ethnic, and cultural background and gender identity. So when we're becoming trauma-informed, we practice cultural humility, which requires us to embrace every person's individual culture and focus on self-reflection and our own lifelong learning in our work. And, we ensure policies, practices, and procedures are responsive to diverse needs. We always need to be curious about how people across all sectors and groups are impacted by current events and ensure everyone is invited to contribute to the solutions.

Karen Johnson: So what are the steps, tools, and resources needed to make this profound shift? The National Council for Behavioral Health and partnership with Kaiser Permanente created this change package over a three-year period to attempt to answer this question. It was developed by a practice transformation team of national experts and tested in a learning community of primary care clinics over 14 months. I share it as one tool available to organizations who are embarking on this change journey or who are already on it. This resource is in the public domain.

Karen Johnson: Implementing change in any organization is challenging, especially in a fast paced primary care setting. The first step that's outlined in this resource is the critical need to create the optimal conditions for moving an organization's trauma-informed initiative forward. It's complex work and we need to provide structure and support to hold it. The change package strongly recommends that an organization embrace this first step, so your work will gain traction throughout the organization. The action steps in this first change management process include developing

a core implementation team, which involves bringing people from all disciplines and levels in your organization to the team, educating them about the process and supporting them as they are the change agents in the work.

Karen Johnson: We always ensure continued support from leadership. This change will not happen if leaders at the top are not fully on board. We conduct an organizational self-assessment, align trauma-informed initiative with existing organizational initiatives, making sure it's not happening in a silo, and we communicate for buy-in to our stakeholders, our patients, our staff, our community partners, and our board members, to ensure that they understand the work and are supporting it. We develop a plan and act on that plan. And then of course we always monitor our progress.

Karen Johnson: After creating the conditions for change, we move to focusing on the areas of concrete action. The change package has five chapters, five change concepts that outline what we need to do to make this happen, the concrete action steps we need to take. The chapters include lots of resources and guidance on how to do this. First we help all individuals feel safety, security, and trust. We look at things such as the environment and how people interact with each other.

Karen Johnson: The next concept is developing a trauma-informed workforce. We train all the staff in this approach, and we build a culture of diversity equity, and inclusion, provide trauma-informed supervision and support, and ensure our HR practices are also trauma-informed.

Karen Johnson: The third chapter is about building compassion resilience in the workforce. When doing this, we educate staff on the symptoms of burnout and compassion fatigue, encourage our wellness practices and regulation, implement self-care plans, and create a positive culture through developing health and boundaries, clear and reasonable expectations, and again, the capacity for people to experience psychological safety.

Karen Johnson: The fourth chapter is about identifying and responding to trauma among patients. This is the area of focus around screening for ACEs. This chapter provides information on how we educate patients about the links between ACEs and toxic stress and health, how we train staff, how we ensure provider responses to disclosure are empathic and supportive, how we educate patients on ways that they can remain healthy and

regulate their stress response and how we can use the ACEs and toxic stress risk assessment and algorithms to inform our responses to disclosure.

Karen Johnson: Finally, the fifth chapter is on financing and sustaining trauma-informed initiatives. So here we measure the impact, identity, identify financial and non-financial resources for support, and advocate for an impact policy.

Karen Johnson: And in the fifth chapter, we focus on financing and sustaining trauma-informed initiatives. Measuring impact, identifying financial and non-financial resources for support, advocating for and impacting policies. These steps are not necessarily done in a linear fashion, but are implemented based on the current needs of the organization.

Karen Johnson: As I come to the end of my section, I leave you with a few final thoughts. Trauma-informed care can appear overwhelming at first, that is for sure, but please know, there are lots of people doing this work and lots of information available from organizations across the country, such as ACEs Aware, and from resources such as the change package I shared in other resources at the end of this webinar, that can help you understand how to take this step by step. Remember, it's an evolutionary process, so you don't have to do everything in the first year or even in the first few years, it takes place over time.

Karen Johnson: You have been moving mountains to meet the needs of your patients, families, and staff, and organizations and your own families. And there remains storms ahead. There's no question about it, but you have demonstrated incredible resilience in these past months and will continue to do so. The trauma-informed approach can strengthen your capacity at all levels to be resilient. I encourage you to keep at it if you were on this journey and to actively explore what you can do, if you are just starting your journey. And as you move forward, please remember to practice self compassion. Please remember that you are doing the best you can, and it is enough. Thank you very much.

Sam Mills: Thank you, Karen. Now we invite Dr. Bernard-Pearl and Dr. Ihle for a discussion on successfully implementing ACE screenings by assessing and building organizational resilience. But first, let’s start with some introductions. Dr. Bernard- Pearl, if you’d be willing to go first and also share how long you’ve been conducting ACE screenings.

Dr. Deirdre Bernard Pearl: My name is Deirdre Bernard-Pearl. I'm the Pediatric Medical Director at Santa Rosa Community Health, which is a federally qualified health center in Sonoma County, California. We started ACE screening here about six years ago when we were able to get some grant funding and started our project then.

Sam Mills: Thank you, Dr. Bernard-Pearl. Let's go to Dr. Ihle.

Dr. Eva Ihle: My name is Eva Ihle, and I'm a Health Sciences Clinical Professor of Psychiatry and Pediatrics at the University of California, San Francisco. I'm an embedded psychiatrist in pediatrics clinics at the San Francisco General Hospital, as well as The Center for Youth Wellness. And I've been involved in ACE screening for several years at The Center for Youth Wellness. And more recently, we are just starting to adopt ACE screening here at San Francisco General Hospital.

Sam Mills: Now let's start with our first question for Dr. Bernard-Pearl. Before you started ACE screening, what were some strategies or steps that you took to implement? And, what were some of the lessons you learned from this process?

Dr. Deirdre Bernard Pearl: Before we started ACE screening here at pediatrics, we decided to do a pretty extensive training of all of our staff. We definitely wanted to train our medical providers and our nurses, but we also felt it was really important that the whole clinic understand this initiative because the way we thought about it from the beginning is that the ACE screening it's really not like other screening questionnaires, it's kind of unique and it asks such personal information. We thought it would make a lot of sense if everyone understood why we were asking all of these very personal questions, and kind of get everybody on the same page. We looked at it as a shift in our culture because we were really shifting the way we were approaching primary care.

Dr. Deirdre Bernard Pearl: The training involved everybody, and a really important part of the training, what worked really well was that we introduced the science of ACEs so everybody could understand how extremely important someone's adverse childhood experiences are in terms of their health in their future. And then, we distributed the questionnaire itself to everyone. We didn't ask everyone to complete it or share their personal information, but we did want everybody to experience thinking about all

of those questions and what it might be like to answer that as a patient here in the clinic.

Dr. Deirdre Bernard Pearl: One of the lessons learned was that ACEs effect everyone. We kind of knew this to be true, but then when it actually happened this way, it was kind of a lesson that ACEs are very common and many of our staff members have experienced significant childhood trauma. So that was a lesson in the sense that it helped us to be more sensitive, thinking about our own traumatic past that we may have had, helped us feel more sensitive to our patients' experiences, too.

Sam Mills: To follow up to that question. What have been some strategies or lessons you learned that helped in gaining buy-in?

Dr. Deirdre Bernard Pearl: So before we started the ACE screening here at the clinic, we thought it'd be really important to ask our parent advisory committee on how they felt about it, if it seemed like a reasonable thing to do, and not too intrusive. So we brought the questionnaire to one of our meetings and we explained why we wanted to ask these questions, that we're learning that ACEs have a really important impact on health and we want to help to prevent a lot of bad health outcomes by addressing ACEs early in our patients and families. And when we explained it that way, they seemed to totally get it. And they were very much in favor of it.

Dr. Deirdre Bernard Pearl: They did say when we ask some more specific questions about exactly what it would look like and how we would ask, it was very important to them that we ask them in a confidential setting. So we tried to have them imagine what it would be like to be handed a paper questionnaire as they checked in for their appointment, and that seemed like it wouldn't be private enough to answer this questionnaire in the waiting room. And so they asked us, if we could make it more confidential somehow, so we decided to not give the questionnaire in the waiting room, but wait until the patient was actually roomed by the medical assistant.

Sam Mills: Thank you. Now to Dr. Ihle. As a provider embedded into clinics that implemented, or are considering implementing ACE screening, what are some strategies or lessons you have seen or learned from that helped to gain buy-in?

Dr. Eva Ihle: I think what's most important is to allow people to understand it. Meaning the staff of the clinic where we'll be implementing the

screening, to understand that we'll be implementing the screening to understand that this process can actually be mutually beneficial. Meaning that the patients can benefit from being able to share their stories and the pediatricians will be able to benefit from learning more about their patients in terms of the larger context in which the patients are presenting themselves to the clinic. I think it's also important to establish a foundation of trauma-informed care before starting any screening in terms of adverse experiences. I think it's important for the staff who is going to be doing the screening as well as the pediatricians who will be working with those patients once they're screened to understand the impact of trauma on the patients, but also for everyone to understand the fact that trauma can have an impact on their work and that having a foundation in trauma-informed clinical practice can be helpful in working with patients who have experienced trauma themselves.

Sam Mills: Our next question is for Dr. Bernard-Pearl. How do you take care of your colleagues and staff in trauma-informed way to reduce stress and burnout? If you have any examples, please be sure to share what this looks like.

Dr. Deirdre Bernard Pearl: It's a really important priority to me as a Medical Director to take care of all of the clinical staff and the frontline staff here as well. I feel like the work we do is really important and it's challenging, and sometimes it's really hard and sad and upsetting, especially when we hear about trauma and ACEs. I have worked really hard to cultivate a work environment that's very trusting where people feel safe to talk about things. People know that they can take a short break if they get overwhelmed. They know that we are here to support them. Specifically with the all-staff training, we always take time to get feedback and hear how things are going for people. If anything's been hard, we want to know about it.

Dr. Deirdre Bernard Pearl: For the medical staff, we have a monthly meeting where we know that one full hour of that meeting is dedicated to really supporting each other, finding out what's been happening, which often turns into what's been hard work-wise. And not too surprisingly a lot of the hardest cases are those where there's a trauma component. And so I think it's helped a lot over the years for everybody to know that there's that meeting every month and it's confidential sharing and support.

Sam Mills: Dr. Ihle, in what ways has conducting ACE screenings changed the relationship with patients and their families?

Dr. Eva Ihle: I think most importantly, doing ACE screening or having a questionnaire that reviews a patient's experience of their adversity or their exposure to trauma, provides tangible evidence of their being understood by the providers who are working with them, or at least to have the opportunity to share their story in a way that might not occur in a routine pediatrics visit. I think that it boils down to having an opportunity for people to be heard about their experiences.

Sam Mills: This next question is for Dr. Bernard-Pearl. How do you incorporate ACE screening and trauma-informed care into staff onboarding? Please share an example.

Dr. Deirdre Bernard Pearl: We make sure to do an ACEs training every year at an all-staff meeting. And then in addition, when new staff onboard at different times through the year, we make sure to work with them individually so they can understand why this ACEs questionnaire that is often new to them is part of what we do in pediatric primary care here. Another part of the onboarding that I think is helpful about trauma-informed care, is for the organization where I work, we do use a patient video where I have the mother of one of my patients explains what her experience of bringing her son to the pediatric clinic here is like. And it has a lot to do with the trauma-informed environment here, the experience she has of not being judged for her, maybe, mistakes in her past and the experience that she has, where her son who's a teenager now really opens up to me when he comes in.

Dr. Deirdre Bernard Pearl: He knows that he's also not being judged and he can trust me. And she's told me that I'm really the only person that he can talk to. I wish he would open-up to other people, but I don't know that he gets that kind of response because he kind of a troublemaker of a kid. But it's really made the work much better for me, more meaningful and the relationships better. It's really important as staff onboards that they understand why we're doing this ACEs screening as part of our routine primary care. Like we would introduce them to developmental screening, how to properly weigh and measure a baby, we make sure that they understand why we're doing the ACEs screening. We give them kind of a one-on-one about that and then we do the annual training. If they missed it the last year, they'll get it the next time.

Sam Mills: Dr. Bernard-Pearl, what advice would you give to providers or clinics beginning to introduce ACE screening and trauma-informed care to their patients and staff?

Dr. Deirdre Bernard Pearl: A lot of people I talk to about ACEs tell me they're worried if they start asking these questions that it's just going to take so much time, and it'll kind of take over the whole medical visit and they'll never get through their day. It'll be like opening Pandora's box. We really didn't find that to be the case at all. I mean, there have been studies now where adding ACEs screening to a visit adds no more than three to five minutes. I mean, that's important if you do it multiple times through the day, but it's worth it. And it turns out to be not as time consuming as most people think it will be. That's the first thing I would say. It's not as time consuming. The second thing is that it's extremely rewarding to be able to be that person in the medical visit who can hear this information and let the person know that whatever happened to them, it's not their fault.

Dr. Deirdre Bernard Pearl: And that there are a lot of ways to get over these kinds of traumas, and here are some things that help other patients, and here are some resources available. It's actually a really great thing to do because every time this comes up, I know that I'm doing really important prevention work. What I would say, if you're just contemplating, “should I really do this or not?” and, “I've done the ACEs Aware training and should I actually implement the screening now?” I would say, just try it. I mean, when we tried it, we didn't try it across the whole clinic. We tried it for a few ways just two of the clinicians for a few days, put it in place to see what it would feel like, how much time it would take, got feedback from the medical assistants and the patients and kind of built it from there. So it's not an all or none. You can start small. And I think you'll find like we did that it really leads to meaningful and a lot of great opportunities to help people.

Sam Mills: Last question. What advice would you give to providers or clinics beginning to introduce ACE screening and trauma-informed care to their patients and staff?

Dr. Eva Ihle: When introducing the concept and then the practice of ACEs screening and trauma-informed care, I think it's important to recognize that the trainings and the implementation don't necessarily happen all at once and shouldn't happen for both the staff and the patients all together at the same time. I think it's important to build the foundation of trauma-

informed care and training around ACEs screening for staff and providers first, so that the staff and the providers can be comfortable with this process. And then following that training and that opportunity to develop an understanding and a sense of comfort around the process, then introducing the screening to the patient population.

Dr. Eva Ihle: So I think it's important to separate the training for the staff from the implementation in terms of patient care. And that, actually facilitates the adoption of ACEs screening. I think it's important also to have it be a shared decision. That it shouldn't feel imposed on the clinic that they're being told that they're going to adopt trauma-informed care practices as well as ACEs screening. I think that the clinics should be given the opportunity to discuss the merits, as well as the drawbacks, of doing the screening and have the process feel more like a shared decision and a mutually beneficial process as opposed to something that's being imposed on the clinic.

Sam Mills: Thank you both for those informative responses. Now we'll move to more questions submitted by audience members. Our next question comes from Grace. Grace wants to know what barriers you've seen or experienced related to ACE screening and how you overcame them. Dr. Bernard-Pearl, let's start with you.

Dr. Deirdre Bernard Pearl: That's a great question. The main barrier that I experienced in implementing ACEs screening came from some of the clinics in my organization where they're really busy, really overwhelmed, and just too many different priorities and initiatives and they just felt like they weren't quite ready. So what I did to overcome that is since we had a number of clinics that were implementing, I asked which ones would be ready first and not everybody had to do it all at the same time. So there was one of the family medicine clinics in Santa Rosa who was ready to go and stepped up and did a pilot. That was a great way to get things started. They did a pilot, we collected some data, shared the data, and now some of the other clinics are getting closer to being ready.

Sam Mills: Thank you, Dr. Bernard-Pearl. And now to Karen. What would you say are the biggest barriers related to getting buy-in to implement ACE screening and trauma-informed care and how have you seen people successfully overcome them?

Karen Johnson: Thanks, Sam. I think barriers include a lack of understanding of; one, the prevalence and impact of how adversity and toxic stress impacts us across the lifespan. So, educating staff around that, raising the awareness, knowledge and skills around that can move people forward in creating buy-in for this work. Training and helping people understand what it is and creating the urgency for the work. We also know that time and resources get in the way. So it's challenging for people to carve out time right now to be able to put a team together, to be planful around this process. So again, that is ensuring that barriers can be addressed by ensuring that we have buy-in at all levels but most importantly, at the leadership level. That the leaders of an organization are making room for this, are removing barriers, are sorting out how to make it a top priority.

Karen Johnson: And then we integrate it across the other initiatives that are happening. Again, making sure that it's not happening in a silo. We bring that trauma-informed lens and those principles to all the work that we're doing.

Sam Mills: Our next question is for Dr. Ihle. April wanted to know how do we protect staff from secondary trauma they may experience as a result of doing the ACE screening?

Dr. Eva Ihle: April raises a really important point about the experience of another person's trauma. Secondary trauma is the immediate experience of recognizing a traumatic experience that happened for another person and having a reaction to that, that could feel traumatic. Another example is vicarious trauma, which is a more cumulative effect of being exposed to other people's adversity through hearing their stories.

Dr. Eva Ihle: Both of these types of trauma need to be recognized as potentially occurring for the staff who are working with patients as they're being screened with the ACEs questionnaire. Again, having resilience and restorative approaches to managing well-being, I think is important in providing that protection. Again, these ideas are based in the principles of trauma-informed care. So working in a clinic where these principles have been reviewed and staff have been trained in these principles is important to providing this protection.

Dr. Eva Ihle: Then again, working in a setting that encourages individuals to engage in their own self-care practices. So whatever opportunities that staff have to refresh and recharge, so again, to enhance their resilience. Also to

know that they work in a setting that provides a safe environment for them. This is both the structure or the functionality of the clinic, setting everything in terms of how patients get checked in, the location where the questionnaires are administered, to the opportunity to debrief when they may feel overwhelmed by the information that they've learned from a patient. Not just to debrief after the fact, but also to have the opportunity to anticipate that a patient might have a story that could be triggering for them.

Dr. Eva Ihle: It's important that there are huddles prior to the clinic days so that the patients who are scheduled to come in and who will be scheduled to have ACEs screening done can have their charts reviewed by the staff who are going to be providing the screening, so that the staff can anticipate the possibility that a story might be triggering. So again, preparing beforehand and then processing afterwards are strategies that can be implemented by the clinic to ensure that staff are helped to feel safe in this process.

Sam Mills: Now, Dr. Bernard-Pearl, how do we protect staff from secondary trauma they experience as they do the screening?

Dr. Deirdre Bernard Pearl: That's a great question. Everyone who works in health care is at risk for secondary trauma. We hear about things that are upsetting. And, when we do ACEs screening, we may be more likely to hear about some really upsetting trauma histories. It's really crucial that everyone involved knows what their options are for getting help and finding someone to talk to when they need to so we made sure everybody's aware of the employee assistance program, and I think some people have taken advantage of that. In addition, we try to really be supportive of each other. Some of the clinicians I work with really do help each other. So, if we have a troubling case, we'll just take a few minutes and say, “can I tell you about this tough case?” We'll just say it basically what happened, I know that my colleagues will listen and then in just saying it and sharing it, I will feel a little better and I can move on.

Dr. Deirdre Bernard Pearl: The other thing, actually, that we have done is when we first implemented... the other way that we tried to prevent burnout is by measuring it. So before we started the project and then each year for the first two years, we did a burnout questionnaire for all of the staff, including the clinical staff. What we found was that over time there was no increase or decrease in burnout, it was the same. So doing ACEs

screening really did not affect burnout or secondary traumatic stress for us.

Dr. Deirdre Bernard Pearl: Protecting staff from secondary trauma really has everything to do with creating a safe and supportive environment for them. So if you ask yourself, do I think my staff feel safe at work, emotionally safe? If the answer's yes, then that's fine. If the answer is no, maybe it's not such a safe environment then maybe the workplace is not really ready for ACEs screening that might need some work before you go ahead with this.

Sam Mills: Dr. Bernard-Pearl, another question for you. How do you make it a priority for providers and caregivers to complete this tool?

Dr. Deirdre Bernard Pearl: That's a really good question. We do make it a priority for providers and caregivers to complete the ACEs questionnaire because we distribute it at our annual training. So that's an opportunity to complete it and to become really sensitized to what that feels like.

Sam Mills: Thank you, Dr. Bernard-Pearl, Dr. Ihle, what else would you say to make using the ACE screening a priority for providers and caregivers?

Dr. Eva Ihle: That's an interesting question. So it sounds like it's a question around maybe incentivization, but I don't think that's really what the question is getting at. I think really the point of this screening tool is to have a better understanding of who the patients are and what they bring to their clinic appointment. I think that that principle or that concept that underlies the ACEs screening really means that the pediatrician will have greater insight into who their patient is and who they are as a person, not just a patient. I think this principle also can equally apply to the patient themselves when they are filling out questionnaire, then it does also give them the opportunity to share with the pediatrician more of their backstory, or more of the context within which this pediatric appointment is occurring so that their provider has a richer sense of the larger context for this individual. And, that the patient isn't just coming in for a well-child check, whatever that means for the particular pediatrician or pediatric clinic, but instead, this is a patient who is a person and has had a wealth of experiences as an individual person and it's all of those things that are coming into clinic. Even for something as straightforward or routine as a well-child check. I think this idea of understanding who the person is, is really how I would encourage people to think about the ACEs questionnaire.

Sam Mills: Dr. Bernard-Pearl, what specific strategies do you have for increasing staff capacity for screening and response to ACEs?

Dr. Deirdre Bernard Pearl: Thanks so much for that question. Increasing staff capacity to respond to ACEs screenings has a lot to do with training everyone on what the resources are available for our patients and families. So when we started the program, we decided to devote maybe 10 minutes of each of our monthly meetings to inviting a community based organization into the clinic to share with us what they do, how we refer to them, so that we can understand more about the resources available because ACEs screening is really all about finding ways to support people and get help when they need it and when they want it. Every community has a lot of resources, so understanding what those are in your community will make the program much more effective.

Sam Mills: Thank you for those great responses. That concludes our question and answer time. Thank you to our speakers, and thank you to all of you who submitted questions in advance.

Sam Mills: As we start to wrap up today, I want to highlight some resources and tools developed by ACEs Aware and other organizations to help providers screen and respond to ACEs and toxic stress.

Sam Mills: First, ACEs Aware developed a free, comprehensive training for providers that offers Continuing Medical Education credit, and Maintenance of Certification credit. The training covers the science of ACEs and toxic stress, how to screen for ACEs, and how to implement trauma-informed care. Also, after Medi-Cal providers take the training and self-attest, providers are eligible to receive a $29 payment for conducting an ACE screening for children and adults covered by Medi-Cal. More information, links to our training site, and the self-attestation form are available at ACEsAware.org. We also continue to use your feedback to inform future webinar topics. Our next webinar will be held on October 28th at noon. Please stay tuned for more information.

Sam Mills: As we end today's webinar, I want to thank our great speakers for sharing their expertise, time, and experience. I also want to thank all of you for attending. Later today you'll receive a webinar evaluation via email. Please be sure to fill it out and share your feedback. This will help inform our future webinar topics and materials. Lastly, a recording of the webinar will be emailed to all attendees and posted on the ACEs Aware

website later today. Please be sure to check it out and share with any colleagues or others in your network who may be interested. Thank you again, and take good care.