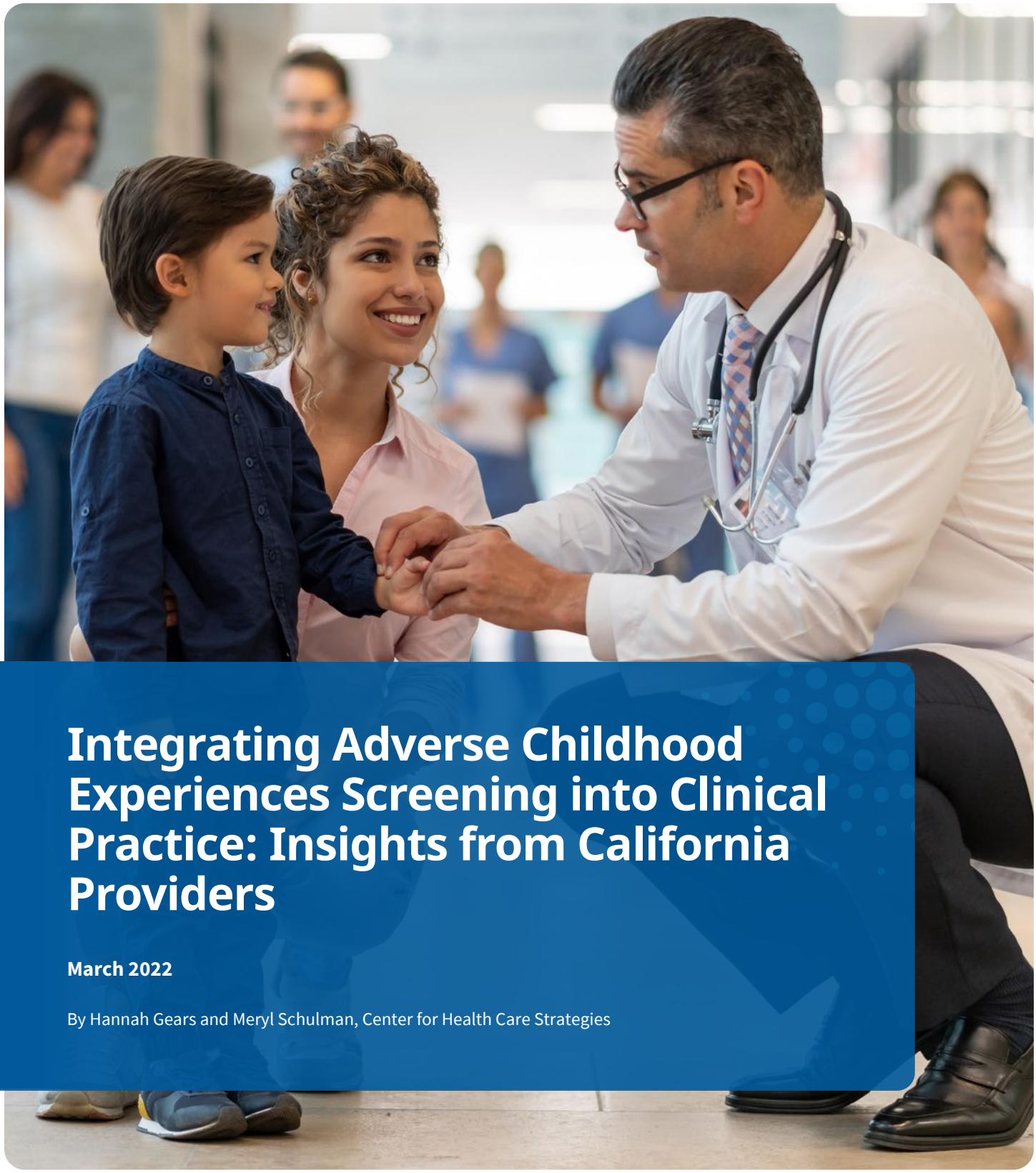
Center for Health Care Strategies

aces aware GRANTEE



Integrating Adverse Childhood Experiences Screening into Clinical Practice: Insights from California Providers

March 2022

By Hannah Gears and Meryl Schulman, Center for Health Care Strategies

Acknowledgments

The Center for Health Care Strategies (CHCS) is grateful for the generous contributions of the following individuals who shared their time, expertise, and insights to inform the development of this paper, including:

- Alfonso Apu, Director of Behavioral Health, Community Medical Centers
- Andria Ruth, MD, Pediatrician, Santa Barbara Neighborhood Clinics
- Ariane Marie-Mitchell, MD, PhD, MPH, Associate Professor, Departments of Preventive Medicine and Pediatrics, Loma Linda University
- Dayna Long, MD, FAAP, Professor of Clinical Pediatrics, University of California, San Francisco (UCSF), and Pediatrician and Director, Community Health and Engagement, UCSF Benioff Children's Hospital Oakland
- Deirdre Bernard-Pearl, MD, Medical Director, Pediatric and Elsie Allen Campuses, Santa Rosa Community Health
- Elisa Nicholas, MD, Chief Executive Officer, TCC Family Health
- Gloria Sanchez, MD, Medical Director, SAGE/Drug Medical Waiver Clinic, and Faculty, Department of Family Medicine, Harbor UCLA Medical Center, University of California, Los Angeles
- Heyman Oo, MD, MPH, Novato South Associate Site Medical Director, Marin Community Clinics
- Leon Altamirano, PsyD, Director of Integrated Behavioral Health, TrueCare
- Linda Zane, MSN-FNP, Hill Country Health and Wellness Center
- Mimi Mateo, CNM, MSN, CD, Clinical Director of Midwifery, TrueCare
- Pamela Roper, MD, MPH, Pediatrician and Site Lead, Los Angeles Christian Health Centers
- Simone Ippoliti, PNP, Site Director, Bayview Child Health Center
- Susie Foster, MSN, FNP-BC, Chief Medical Officer, Hill Country Health and Wellness Center

The authors also thank Aurrera Health Group for its ongoing support throughout this project and the development of this report, as well as their colleagues at CHCS, including Rachel Davis, Allison Hamblin, Lorie Martin, and Emma Opthof for their guidance on this project and contributions to the paper.

This paper was produced with funding from the California ACEs Aware initiative, a first-in-the-nation effort to screen children and adults for Adverse Childhood Experiences (ACEs) in primary care, and to treat the impacts of toxic stress with trauma-informed care. The bold goal of this initiative is to reduce ACEs and toxic stress by half in one generation. For more information, visit **www.acesaware.org**.

aces aware
GRANTEE

Contents

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

Glossary

- **Adverse Childhood Experiences (ACEs):** Potentially traumatic events that occur in childhood (up to age 18). The term comes from the landmark 1998 study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente that examined the impact of early adversity on health outcomes. The study outlined 10 categories of ACEs that fall into three domains:
  - **Abuse:** Physical, emotional, and sexual abuse.
  - **Neglect:** Physical and emotional.
  - **Household Challenges:** Growing up in a household with incarceration, mental illness, substance misuse or dependence, absence due to parental separation or divorce, and/or intimate partner violence.[1]
- **Cultural Humility:** The ability to maintain an interpersonal stance that is open to the perspectives of other people in relation to aspects of cultural identity that are most important to the individual.[2]
- **Protective Factors:** Intrinsic or extrinsic conditions or attributes that mitigate risk for toxic stress. Intrinsic factors include: (1) neuro, endocrine, metabolic, immune, genetic, and epigenetic factors; (2) curiosity; (3) ability to pay attention; and (4) ability to regulate emotions. Extrinsic factors include: (1) buffering relationships; (2) supportive environments; and (3) community resources.[3]
- **Toxic Stress Response:** Repeated or prolonged activation of a child's stress response, without the buffering of trusted, nurturing caregivers and safe, stable environments, leading to long-term changes in the structure and functioning of the developing brain, metabolic, immune, and neuroendocrine responses, and even the way DNA is read and transcribed.[4]
- **Resilience:** The ability to withstand or recover from stressors, and results from a combination of intrinsic factors and extrinsic factors (like safe, stable, and nurturing relationships with family members and others) as well as pre-disposing biological susceptibility.[5]
- **Trauma-Informed Care:** A framework for approaching care delivery and organizational policy and practice. It involves:
  - Understanding the prevalence of trauma and adversity and their impacts on health and behavior;
  - Recognizing the effects of trauma and adversity on health and behavior;
  - Training leadership, providers, and staff on responding to patients with best practices for trauma-informed care;
  - Integrating knowledge about trauma and adversity into policies, procedures, practices, and treatment planning; and
  - Resisting re-traumatization by approaching patients who have experienced ACEs or other adversities with non-judgmental support.[6]
- **Vicarious trauma:** Secondary emotional duress resulting from hearing about another's trauma.[7]

Background

In recent years, states have sought to support providers and communities in addressing Adverse Childhood Experiences (ACEs), which are potentially traumatic events such as abuse, violence, and neglect that occur prior to age 18. California is among this group of innovators. The Office of the California Surgeon General and the California Department of Health Care Services launched ACEs Aware, a statewide initiative that assists Medi-Cal (Medicaid) providers through training, clinical protocols, and payment for screening children, adolescents, and adults under 65 for ACEs.[8] Universal ACE screening can help clinical care teams provide more effective health care by supporting more targeted clinical interventions and an opportunity for relational healing.[9] ACEs Aware outlines a three-step approach to ACE screening, which includes: (1) identifying a patient's exposure to adversity through screening; (2) determining any clinical manifestation of toxic stress (i.e., ACE-Associated Health Conditions); and (3) understanding protective factors (e.g., stable environments, nurturing caregiver) that may be a present in a patient's life.[10]

TAKEAWAYS

- Many states have created campaigns to address Adverse Childhood Experiences (ACEs), which are potentially traumatic events that occur before the age of 18.
- In December 2019 California's Office of the Surgeon General and the California Department of Health Care Services launched ACEs Aware, a statewide initiative focused on supporting Medi-Cal (Medicaid) providers in adopting ACE screening.
- This report shares perspectives from Medi-Cal providers on effectively integrating ACE screening into clinical practice for pediatric and adult populations in a trauma-informed manner.
- While insights were gleaned from California-based providers, they are applicable to health care organizations and providers working across the country to adopt ACE screening.

To support providers in adopting ACE screening, the Center for Health Care Strategies (CHCS) conducted interviews with 14 Medi-Cal providers, including pediatricians, family medicine providers, behavioral health clinicians, and a certified nurse midwife, from 12 clinics in regions in California (see Appendix I). The interviews sought to understand providers' approaches to ACE screening in pediatric and adult populations and how they employ the principles of trauma-informed care (TIC) to guide these efforts. Interviews included questions related to ACE screening and response, staff support and training, data collection and analysis, and general recommendations for providers interested in ACE screening (see Appendix II). This report draws from these interviews to inform providers seeking to incorporate ACE screening into clinical practice in a trauma-informed manner. Although the report focuses on California perspectives, the insights can inform health care organizations and providers across the country seeking to adopt an effective ACE screening approach.

Insights on ACE Screening Implementation

Following are key insights from California Medi-Cal providers that can inform other providers looking to integrate ACE screening into their own clinical practice. The findings focus on assisting health care providers and their organizations in adopting a screening approach that aligns with the principles of TIC, which includes supporting staff in administering the ACE screening tool and the patients and families completing it.

Provider insights are organized into the following areas:

1. Selecting the Screening Tool and Approach for Your Patient Population

Based on feedback from interviewees, one of the most important steps to integrating ACE screening into clinical practice is the selection of the screening tool itself, as well as the approach that will be taken to implement the screener. Interviewees offered the following considerations:

- **Choose the right tool for your patient population and clinical practice.** There are a variety of tools that providers can select when adopting ACE screening in pediatric and adult care settings, such as the Pediatric ACEs and Related Life-events Screener[11] (PEARLS) for children ages zero to 21, ACE Questionnaire[12] for Adults, Whole Child Assessment[13] for children ages zero to 20, homegrown screening tools, among others. PEARLS includes an adolescent self-report tool for patients ages 12 to 19 and a caregiver reporting tool.[14] In California, Medi-Cal payment is only available for two types of screening tools – PEARLS and the ACE Questionnaire for Adults (or an

alternative that contains questions on the 10 ACEs from the original 1998 study[15]). Both ACEs Aware-approved tools are available in 17 languages and can be translated into additional languages.[16] Many interviewees chose to screen using the ACEs Aware recommended tools or are transitioning to these tools due to the associated payment and a desire to support statewide efforts to improve child, adult, and family well-being through the prevention and treatment of ACEs. Out of the 14 providers interviewed, all but two noted that they use the PEARLS tool for their child and adolescent patients and the ACE Questionnaire for Adults for their adult patients. Of the clinics that do not use the PEARLS and ACE Questionnaire for Adults, one uses a modified version of the PEARLS and the other uses the Whole Child Assessment to collect ACE-related data at many of their clinics.[17]

- **Determine whether to use an identified or de-identified version of a screening tool.** An identified screener allows providers to view the types of ACEs a patient has experienced as indicated on the screener. The de-identified screener provides only the overall ACE score. As Medi-Cal provides payment for both versions of screening tools, providers can select the type of tool they prefer. Interviewed providers noted the merits of using both identified and de-identified ACE screening tools. Some providers believe that knowing the specific ACEs a person has experienced allows for more tailored treatment to support their needs. Other providers feel the ACE score is sufficient to determine the treatment plan and make appropriate referrals. For example, providers at TrueCare screening perinatal patients for ACEs noted it can be helpful to have the identified version so the care team is aware of specific ACEs a patient may have had to best support them during labor — a time when past traumas can be triggered. Conversely, providers at both Hill Country Health and Wellness Center and Marin Community Clinics choose to use the de-identified screening tool with their pediatric patients, as they feel it honors the patient's autonomy in deciding to disclose or not. Also, some patients may feel more comfortable giving a score rather than specifying the types of adversity they experienced. Providers at Marin Community Clinics specifically tell patients that they do not have to disclose ACEs, but it is okay if they wish to do so.

- **Consider whether to present the screener on paper, laminated paper, an electronic device, or verbally.** In one interviewed clinic, it became clear that patients and families were more open to completing the ACE screener when it was offered on a laminated piece of paper with a dry-erase marker. Clinicians from this practice believe that the impermanence of the record made patients feel more comfortable to answer. Many interviewed providers chose to administer the screener using a paper copy that was assembled alongside other types of screeners in a packet of well-visit materials. Interviewees at two other clinics explicitly stated that they encourage their staff to tactfully introduce the screener as part of a conversation, then provide the patient or family with the screener via paper copy.

- **Consider if other screenings will be offered alongside the ACE screening.** Some clinics have chosen to couple ACE screening tools with other types of screening tools. These include tools that assess for strengths or protective factors of an individual or family, health-related social needs, and other routine screenings. For example, Marin Community Clinics offers a three-question resilience

screening alongside PEARLS to capture the two main factors that contribute to resilience: a personal sense that one has the ability to manage stress and cope, and a sense that one has a system of social support in times of need. In TrueCare's obstetrics department, a perinatal coordinator conducts the ACE screening alongside a comprehensive assessment during intake visits. The medical team at SAGE/Drug Medical Waiver Clinic gathers a pain history and screens for health-related social needs in conjunction with the ACE screening tool. At the Bayview Child Health Center, some providers use the Self-Care Tool for Pediatrics to frame the well visit and the PEARLS tool for screening.[18]

- **Establish when to introduce ACE screening to patients.** In pediatrics, some interviewed providers begin screening as early as four months old, while others wait until the child's first birthday. Santa Barbara Neighborhood Clinics, for example, begins screening pediatric patients at the four-month visit, since this is the earliest visit with the lowest number of required screenings and providers want to be able to focus solely on the ACE screener. Other providers screen at new patients' initial appointments, regardless of their age. Although ACEs Aware recommends screening universally without selection bias,[19] California-based clinics that are just beginning their screening process or that currently lack bandwidth to roll out universal annual screening may provide the screening tool to a small subset of patients through a pilot project or on a patient-by-patient basis depending on symptoms and presentation. Most provider interviewees in both adult and pediatric care indicated a desire to expand screening to all patients once resources allow.

- **Decide how frequently to offer ACE screening.** Under Medi-Cal, providers can seek payment for screening patients annually through age 20 and once in the adult lifetime between ages 21 and 65. Most interviewed pediatric providers with consistent screening procedures chose to screen pediatric patients annually at well-child visits. Some interviewed providers noted that they offered ACE screening above and beyond the annual screening based on specific patient presentation despite the limitations of payment because the ACE screening may inform plans to support patient and family well-being. For example, if a child has had difficulty concentrating in school or is experiencing frequent stomachaches or headaches, the provider may choose to ask the child's caregiver to fill out an ACE screener. Providers often find that complaints of chronic, mild pain, and behavioral changes in children indicate a form of trauma.[20] In perinatal care, providers may choose to screen each time a person becomes pregnant, as they also value the information from ACE screening to support the patient's general wellness.

- **Determine what staff member(s) should offer ACE screening.** A variety of factors affect decision-making around which staff members are most appropriate to administer screening, including workflow, knowledge of ACEs, and who has flexible schedules to meaningfully engage with patients around ACEs and toxic stress. Benioff Children's Hospital at University of California, San Francisco (UCSF) leverages its care navigators and nursing staff when screening for ACEs. They receive training on how to administer the ACE screener, as well as how to refer children and families to appropriate follow-up care and resources to ensure their needs are met. At Harbor UCLA Medical Center, Department of Family Medicine, at the University of California, Los Angeles, medical

providers with extensive knowledge of ACEs, social workers, and psychiatrists administer ACE screening. These providers are also responsible for delivering appropriate psychoeducation around ACEs and toxic stress and offering referrals to patients and families based on their specific needs. Bayview Child Health Center screens annually for ACEs at well-visits. Front-desk staff provide the PEARLS screener alongside a variety of other annual screeners to patients and their families, and providers conduct any necessary follow-up during the visit. Other clinics interviewed noted that medical assistants are responsible for presenting the screener while they are rooming patients and families. Medical assistants at these clinics have enough knowledge to explain the purpose of the screener and offer it in a trauma-informed manner, and the provider is responsible for addressing any concerns based on the responses to the screener.

- **Remain open to refining screening processes over time.** Clinics often try multiple screening options before they feel confident in their approach and most continue to refine their approach over time. Interviewees encouraged organizations to evaluate their screening processes, using both staff and patient and family input, to ensure that screening is performed effectively and with respect for the patients. Interviewees also suggested that gathering anonymous feedback from patients who have undergone ACE screening can support patients in having their voices heard and help inform screening processes and implementation.

Tools to Support Providers in Screening for ACEs

Through the ACEs Aware initiative, the following tools have been created to assist providers in adopting ACE screening and building a network of care to support their patients and staff after a screening. Although these tools were created for California-based providers, they can help inform providers in other states that are implementing ACE screening. California providers should look to the ACEs Aware website, **acesaware.org**, for new and the most up-to-date resources.

- **Clinical Team Toolkit: Preventing, Screening, and Responding to the Impact of ACEs and Toxic Stress:** This tool includes a series of fact sheets for providers on integrating screening into clinical practice, providing TIC, using ACE and toxic stress risk assessment algorithms, educating patients on evidence-based interventions, and supporting patients in healing from the impact of toxic stress.
- **ACE Screening Implementation How-To Guide:** These resources support clinical teams in adopting ACE screening through four stages: (1) prepare the foundation; (2) select your approach; (3) implement the program; and (4) build sustainability.
- **Trauma-Informed Network of Care Roadmap:** This resource offers practical steps for clinical care teams, community-based organizations, and social service agencies to grow networks of care that work to prevent and address the impact of ACEs and toxic stress on health.

2. Building Staff and Organizational Capacity

Providers interviewed underscored the importance of building staff and organizational capacity to screen for ACEs prior to rolling out screening to patients. This includes familiarizing staff with the screening tool that will be used, as well as providing training on the science of early adversity, toxic stress, trauma, and resilience, and other core competencies like TIC. Following are considerations to help provider organizations build internal capacity to screen for ACEs:

- **Educate staff on ACEs, toxic stress, and resilience.** Providing comprehensive training to all staff – from executive leadership to front-desk staff – on the science of ACEs, toxic stress, and resilience is a best practice when integrating screening into the clinical experience. Ensuring that all staff who may interact with patients understand the connection between early adversity and health outcomes is important so they can proactively explain ACEs, answer any questions that patients and families might have related to screening, and articulate the reason for screening to patients and families. Pediatric medical providers should understand the effects of toxic stress since physical signs — including failure to thrive, growth delay, sleep disruption, and/or developmental delay — can begin as early as infancy.[21] For patients of all ages, there is a significant correlation between ACE scores and mental health disorders and individuals with ACEs are more likely to have serious health consequences, such as chronic respiratory disease, heart disease, and diabetes.[22] For many California practices, building an understanding of ACEs and toxic stress begins with taking the "Becoming ACEs Aware in California" training, which is required to receive Medi-Cal supplemental payment for screening.[23] Medical teams can then use this knowledge to provide psychoeducation to patients around ACEs and toxic stress as appropriate.

> **Staff want to do a good job and learn. As long as they are supported, they are able to do wonderfully.**
>
> - Heyman Oo, MD, MPH, Marin Community Clinics

- **Establish clinic-wide understanding of TIC.** To supplement the training offered by ACEs Aware, many interviewees cited the importance of establishing a clinic-wide understanding of TIC specifically. While some providers interviewed were only able to offer training on TIC to staff who present the ACE screening, most had resources to train all clinical staff. A small number of interviewees noted they had the resources to train staff across the organization from front-desk workers to clinical staff to security. These interviewees expressed the importance of all staff being aware of the principles of TIC to create and

> **Not everyone needs intensive therapy, but everyone needs someone non-judgmental and accepting telling them they're not alone, that it's not their fault and that many other people have gone through this, and that we can give you support and help if you want it.**
>
> - Elisa Nicholas, MD, MSPH, Pediatrician, TCC Family Health

maintain a trauma-informed environment and prevent incurring harm, as even non-verbal cues can impact patients and families.

- **Encourage staff to anonymously complete the ACE screener themselves in a supportive, trauma-informed manner.** Several interviewed providers shared that they encourage staff to complete the ACE screener as part of broader TIC capacity-building efforts. Answering the screening questions can help staff better understand how the patient or family feels when completing the screener. It also helps to normalize talking about trauma and in turn reduce stigma, as staff may recognize that they share many of the same experiences of their patients. Prior to providing staff with the option to complete the ACE screener, there should be adequate resources (e.g., access to a behavioral health provider) in place to support staff who may be triggered by completing the screening tool.

- **Train providers to listen and convey empathy to patients when engaging in conversation about traumatic experiences.** While providing resources, referrals, and behavioral health consults can be helpful, many interviewees stated that patients expressed appreciation for the clinician providing adequate time and space for discussion. Research shows that being treated with empathy from a medical provider is a strong predictor of positive health outcomes. As a result of empathy in a patient-provider relationship, patients often disclose more information (health-related and otherwise) to their provider, have more success in following a treatment plan, and file fewer malpractice complaints, while providers experience increased health, well-being, and professional satisfaction.[24]

> **Having the courage to engage in [a conversation about ACEs] up front is going to pay so many dividends, not just for the patient, which is of course the most important, but your life as a provider is easier and a lot more satisfying because the patient is going to trust you and you can really enter a partnership.**
>
> - Mimi Mateo, CNM, MSN, CDE, Director of Wellness and Diversity, TrueCare

- **Acknowledge and address staff concerns related to ACE screening**, such as:

  - **Fear of not having a solution to the patient's or family's trauma.** Many providers noted apprehension when screening for ACEs, as they feared they might uncover a patient's trauma they may not be able to address immediately. Medical providers are trained to identify problems and respond with solutions, and when presented with situations with no clear solution, some worry they have not done their job effectively. It is important to remind providers, however, that they may be more uncomfortable having conversations about adversity and trauma than their patients, who have been living with the pain of their experience(s). By initiating conversations about trauma in an empathetic way, even without a prescribed solution, providers can help patients to destigmatize trauma and better understand the connection between psychological and physiological pathology.[25] It is also important to remind providers that they are not alone in solving their patient's problems. They can and should build a network of support services to connect patients and families to if needed.[26]

- **Hesitancy about integrating an additional requirement to an already busy workflow.** Primary care providers, including both pediatricians and adult medicine providers, often have limited time with patients. Adding another screening tool, even if conducted annually or on a one-time basis, can raise concerns among clinicians who already feel the pressure of time constraints. To ease concerns, it is important to think through how best to integrate screening into the clinical workflow and ensure that providers have the tools, trainings, and resources they need to effectively screen for ACEs and provide appropriate follow-up care and referrals. Interviewed providers also noted that taking the time to talk about trauma and provide the screening can facilitate a deeper connection between patients and providers, which can increase both effectiveness and efficiency of visits over time. Though the ACE screening is an additional element in the busy workflow at TrueCare's obstetrics department, the ACE screener is viewed by patients and providers as a pathway to additional services and resources, such as nutritional counseling from registered dietitians, recommendations around daily activity from childbirth educators, and stress management and coping practices from the behavioral health providers. It is also an opportunity to discuss the impact of toxic stress on the body.
- **Uncertainty regarding presenting the screener appropriately.** To address nervousness about presenting the ACE screener appropriately, staff in several interviewed practices use a script with guidance[27] on how to talk to patients about ACE screening. This helps providers feel more confident in talking to patients about ACEs and can help streamline the screening process until they feel more secure in their abilities to implement the new tool. At Bayview Child Health Center, new providers are often trained by watching other providers model screening practices if the patient and family consent. Oftentimes, new providers will go into exam rooms with established providers who demonstrate how to best incorporate ACEs education in regular check-ups.

- **Select a group of patients with whom you want to pilot the ACE screener, if needed.** ACEs Aware recommends that clinics with adequate staffing and time should roll out ACE screening universally. Interviewees noted that in order to start, it can sometimes be more effective in the long run to start small, as many noted that they did not feel prepared to roll out universal screening immediately. If this is the case, interviewed providers recommended screening within a subset of the patient population and expanding ACE screening over time. For example, at Communty Medical Centers, they first chose to screen patients in their adult diabetes clinic based on high Patient Health Questionniare-9 (PHQ- 9) and Generalized Anxiety Disorder Assessment-7 (GAD-7) scores. Over time, they trained staff and established workflows necessary to expand screening for both adults and children across the majority of their 23 sites.

Case Examples of Training Protocols

Providers interviewed used a variety of resources to help staff effectively screen for ACEs and embrace TIC principles. The below details how three health centers prepared staff for the adoption of ACE screening.

- **Bayview Child Health Center:** At Bayview Child Health Center, where providers have been screening for ACEs since 2013, all staff are required to complete the ACEs Aware Core training.[28] Upon being hired, staff are required to watch Nadine Burke Harris' TED Talk on ACEs;[29] attend trainings on resilience, structural racism, and TIC; and often complete the ACE screening tool themselves. To maintain a trauma-informed environment for staff, two minutes of every staff meeting are dedicated to mindfulness and meditation with a focus on supporting each other and mitigating vicarious traumatization.
- **Los Angeles Christian Health Centers:** At Los Angeles Christian Health Centers, where select departments have incorporated ACE screening, maintaining a trauma-informed environment involves hosting monthly staff trainings for all staff on the basics of TIC, the state's and Centers' goals for this work, the specifics of different ACE screening tools, and staff burnout and vicarious trauma. The clinics initially hosted the trainings with external support from a local initiative, the California ACEs Learning and Quality Improvement Collaborative. Now, internal staff host all trainings. Looking ahead, the Centers may implement opportunities for staff decompression to improve the trauma-informed environment they are working to create.
- **TrueCare:** At TrueCare, which has long-term familiarity with ACEs and creating a trauma-informed environment, each new employee regardless of position must complete TIC training as part of the onboarding process. To further build their understanding of TIC and better support patients in the clinic, staff also complete suicide prevention, crisis intervention, and health literacy trainings. Their training program aligns with the ACEs Aware guidelines but was developed by internal staff who have expertise in TIC.

3. Promoting Cultural Humility

Screening for ACEs can be beneficial, but it also has the potential to be harmful if not conducted with cultural humility. When screening for ACEs, it is important that providers are consistently evaluating their own biases, which can inadvertently harm patients and families. Following are considerations from interviewees on centering cultural humility when adopting ACE screening:

- **Educate staff on historical harm and trauma inflicted upon communities of color at the hands of the medical system.** Understanding this historical context reinforces the critical nature of establishing trust with patients and families prior to asking them to fill out an ACE screener of any kind. Interviewees noted that providers should take their patient population into consideration when establishing screening procedures, as families from different cultures may be more hesitant to share their trauma history. One provider noted that the reported ACE score may increase over time, not only because additional ACEs occur, but also as patients and families slowly begin to trust the provider more and have confidence that they will not be punished for disclosing the experience of a traumatic event.

- **Mitigate potential harms associated with ACE screening for patients and families of color.** Interviewees acknowledged the importance of ensuring that staff take time to understand each patient and family's cultural and ethnic background and how they might be impacted by ACE screening. For families that have newly immigrated to the U.S. or people without documentation, filling out the ACE screening tool can incite fear of being separated from their family or deportation. Similarly, families of color, that have historically been and continue to be disproportionately represented in the child welfare system, may be fearful of disclosing information that could be used against them.[30] Studies show that medical professionals' racial biases directly impact rates of reporting suspected maltreatment to child protective services in children of color, even when controlling for income.[31] As such, it is a best practice to train providers on the effects of racial biases and when it is appropriate to report child abuse or neglect.[32] Providers should also be encouraged to solicit input from peers when making decisions about reporting information to child protective services.

- **Screen for ACEs in a patient's native language.** If a clinic has staff who speak the patient's native language, interviewees recommend that the screener should be introduced in a patient's native language and the written screener should be offered in their language. If a screener has not yet been translated into the patient/family's language, interviewees suggest providing appropriate translation services for introducing the screening tool as well as asking each of the questions verbally via telephone/on-screen translation.

Resources to Support ACE Screening with Cultural Humility

There are many resources that can support provider practices in understanding the impact of racial trauma on health and well-being, and how best to integrate cultural and racial humility into ACE screening and trauma-informed clinical practice. Select resources include:

- **Racial Equity Tools**, made available by the Center for Assessment and Policy Development, World Trust, and MP Associates, includes tools, research, tips, and curricula aimed at supporting people working toward racial justice in systems, organizations, and communities.
- **Racism and Discrimination as Risk Factors for Toxic Stress**, hosted by ACEs Aware, is a webinar that examined the impact of racism and discrimination on health and how ACE screening and a trauma-informed approach to care can promote health equity and overall well-being.
- **Incorporating Racial Equity into Trauma-Informed Care**, a brief from the Center for Health Care Strategies, outlines considerations for health care practices looking to integrate a focus on racial equity to enhance trauma-informed approaches and promote racial justice.

4. Supporting Staff Wellness

In adopting ACE screening, interviewees underscored the importance of supporting the mental and emotional health of staff given the sensitive nature of screening for early adversity, the potential for incurring vicarious trauma — the secondary emotional duress resulting from hearing about another's trauma[33] — and the fact that talking about ACEs may re-traumatize staff with their own trauma histories. Interviewees noted that when staff felt supported, they not only experienced more job satisfaction, but also were able to provide better care for the patients and families they served. Following are considerations for providers organizations for supporting staff wellness when screening for ACEs:

- **Create spaces for healing.** The clinics interviewed offered a range of staff wellness activities related to TIC and ACEs. Among the more well-resourced clinics, each staff member has open-door access to a provider trained in ACEs and TIC who could provide one-on-one opportunities to process what they have experienced when working with patients with toxic stress. At Bayview Child Health Center, for example, there are quarterly team bonding activities to build trust among care team members. On a more regular basis, staff can join wellness-related activities such as yoga and resilience workshops to build staff resilience. Many clinics do not have the bandwidth to provide this level of staff support, but instead include dedicated time for staff to check in about their experiences during monthly staff meetings. By having the space to collectively process and heal, providers can normalize talking about their own trauma, better manage the effects, and decrease potential burnout.

- **Provide opportunities for staff reflection around how engaging in conversations about early adversity and trauma affects them personally and how it impacts patients.** Maintaining a trauma-informed environment requires frequent opportunities for all staff to reengage in conversations, trainings, and reflection. Interviewed providers gave universal feedback that more time and resources dedicated to training and maintaining a trauma-informed environment would likely improve patient care and decrease provider burnout overall. They also noted the benefits of encouraging staff to decompress following difficult conversations with patients about trauma. This might look like creating opportunities for discussion with peers or providing resources with external mental health providers.
- **Encourage providers to schedule follow-up visits with patients for further dialogue on ACEs.** At Bayview Child Health Center, this is a best practice to avoid providers feeling as though they are required to introduce the concept of ACEs and provide a fully realized treatment plan in the same visit.
- **Respect staff who are not comfortable presenting the ACE screener to families.** Some staff may not feel comfortable presenting the ACE screening to patients and families for various reasons, including personal trauma. Honoring this decision may avoid potential re-traumatization and aligns with the principles of TIC.

Creating a Trauma-Informed Environment

There are several resources that can support provider practices in creating a culture that aligns with the principles of TIC, such as:

- **Fostering Resilience and Recovery: A Change Package**, a toolkit from the National Council for Mental Wellbeing, that provides information, action steps, and tools to guide implementation of TIC in primary care settings.
- **Trauma-Informed Care Implementation Resource Center**, a resource center from the Center for Health Care Strategies, curates resources from experts to support TIC implementation in health care settings.
- **Trauma-Informed Organizational Change Manual**, a tool from The Institute on Trauma and Trauma-Informed Care and the University of Buffalo's Buffalo Center for Social Research, is a guide for organizations and systems interested in implementing and sustaining trauma-informed organizational change.

5. Developing Trust with Patients and Families

Regardless of the specifics of the screening process – such as what member of the medical care team offers the screening, when is the screening offered during the visit, at what age do they begin screening, and who is responsible for making referrals – providers underscored the importance of screening for ACEs within the context of a trusting relationship. They agreed universally on the need to build and maintain trust throughout the entirety of the screening and referral process. Following are considerations for providers seeking to develop trust with patients and families to support ACE screening:

- **Find opportunities to build trust.** For some providers, this includes incorporating ACE screening questions into a conversation rather than presenting as a formal screener. Other clinicians work to build trust before offering the screener by either reading the questions or providing the patient and/or family with a paper screener to complete.

- **Focus on strengths.** Providers can build trust by incorporating strengths-based language into their practice. Because ACEs are inherently stressful and potentially traumatic events, it is essential to validate a patient or family's strength and resilience in the face of trauma. By focusing on strengths, families may feel more empowered. Providers at Bayview Child Health Center also recommend taking time to assess who in the family has what responsibilities to encourage caregivers to share responsibilities more equitably. Through such discussions, providers may help families to identify other family members who have strengths that may offset caregiving responsibilities.

> **As we move forward, organizations will find that it's not just about the ACE screening, but about whole person health and comprehensive screenings that will piggyback on each other and will lead to overall better health.**
>
> - Leon Altamirano, PsyD,
> Director of Integrated Behavioral Health, TrueCare

- **View ACE screening as an opportunity to deepen patient-provider relationships.** While ACE screening does not prevent ACEs that have already occurred, it is possible that ACE screening can help prevent future ACEs and/or mitigate the impact of ACEs on toxic stress. Interviewees perceived ACE screening as an opportunity to provide education around risky behavior and toxic stress so that if something does come up, patients and families feel comfortable bringing their concerns to their medical provider. Others have acknowledged that screening for ACEs and providing appropriate follow-up care may help prevent additional adversity and trauma from occurring as the individual and/or family may be more supported and better able to meet their health and social needs. It may also help prevent the intergenerational transmission of ACEs and toxic stress.

- **Honor patient and family autonomy.** Interviewees underscored the importance of providers respecting patient and family preferences regarding screening for ACEs, including refusing to complete a screening, which also contributes to a trusting relationship.

6. Determining How Data Will Be Tracked

After an ACE screener is administered, providers need to decide how to handle the sensitive patient information gleaned during the screening process. Interviewed provider practices use different ways to track data. ACE scores or specific ACEs, if using the identified screener, and referral pathways are key pieces of information for clinics to record, as these data will inform next steps in treatment for patients and families and can help providers monitor a patient or family's care. Following are considerations from interviewed practices on determining how data will be tracked following an ACE screening:

- **Embed the screener into the electronic health record.** Understanding that staff are incredibly busy and adding another screener to document can be overwhelming, some clinics embed the screener into the electronic health record (EHR) to simplify the process. Others are still scanning a paper copy of the completed screener into the chart, though these interviewees noted an interest in developing the capacity to seamlessly add the ACE score into the EHR. Prior to embedding a screener into the EHR, providers should obtain permission from the creators of the particular screener(s) they wish to include.

- **Prioritize protecting patient privacy when recording ACE scores.** Having the screener embedded in the EHR can also help care teams understand patients' potential trauma history or triggers (if identified details are embedded), whereas others choose to not record the score and/or specific reported ACEs at all. For example, a clinic may choose to include the patient's ACE score/responses because they want their providers to refer to the score at the next visit to provide context or to follow up on concerns that the patient/family raised during the previous visit. At Community Medical Centers, they developed a shared template embedded in the EHR with all screening tools a patient has completed that can be seen by any other specialty. However, if a patient prefers that their score is kept confidential, the provider who has administered the screening can ensure that it remains accessible only to that one provider. To maintain patients' privacy, providers at Community Medical Centers frequently send out communications to patients to remind them that providers are working within an integrated system that shares information.

- **Consider how to track referrals to community resources.** Only a few of the clinics interviewed have robust referral tracking databases. An extensive referral database (e.g., Aunt Bertha, 1degree, FINDConnect, and Unite Us) can be helpful when tracking the utility of ACE screening and ensuring that families follow-up based on recommendations related to their trauma history. Clinics that do not have access to a referral tracking database rely heavily on community health workers, promotores, and social workers to monitor referral follow-through and manually document in the medical record. For example, at Santa Barbara Neighborhood Clinics, wellness navigators currently track referrals for health insurance enrollment, supportive services, and community resources through a custom template in the EHR that allows tracking referrals by category and agency. At Los Angeles Christian Health Centers, case managers track all referrals in a template embedded in the EHR representing the following categories: substance abuse, employment, food, education, and mental health. TrueCare's obstetrics clinic tracks every prenatal patient's ACE score by including it on a list that can be easily accessed by providers of all specialties. This variation among clinics is largely dependent on resources and staffing.

7. Establishing a Referral Network and Process

Robust, integrated physical and behavioral health care services can help ensure more comprehensive supports for providers who are seeking to adopt a trauma-informed ACE screening and referral process. At Bayview Child Health Center, the network of community providers across all domains meets for weekly check-ins via Zoom and shares important resources to better coordinate care. In speaking with providers from across California, it was apparent that providers preferred to have integrated services on site but recognized that it is not always possible due to financial or space constraints. Others indicated the importance of addressing needs with the patient's perspective in mind. For example, a provider at Harbor UCLA Medical Center, Department of Family Medicine noted that patients typically need to address concerns related to housing or food insecurity before they can directly address the effects of trauma. For clinics with integrated behavioral health or extensive social work support, following are considerations for providing appropriate follow-up care and referrals:

- **Work closely with behavioral health staff to support patients following ACE screening.** In clinics with integrated behavioral health, providers expressed greater confidence in screening because they know that they are able to call in a trained mental health professional if a patient requires additional support.
- **Create workflows where patients with an ACE score of four or more automatically receive a behavioral health consult.** These visits may serve as an opportunity to provide one-time support to patients but also can be the first opportunity to discuss ongoing therapy options. Clinics that do not have integrated behavioral health support can also successfully screen for ACEs. When clinics do not have integrated behavioral health staff, developing relationships with community-based organizations is incredibly important so that clinicians have places to refer patients and families.[34]
- **Partner with social work, community health workers, wellness/health navigators, and promotores to help patients navigate follow-up care and connections to resources.** Interviewees noted that having the support of these care team members can help patients access resources. They also shared that patients and families often feel most comfortable approaching these care team members to ask for assistance. At Santa Barbara Neighborhood Clinics, wellness navigators develop trusting relationships with patients, assess for needs, and make referrals to needed resources, which often relate to support in accessing health insurance, childcare, and housing.

> **Get to know your community-based organizations. There are often people in your community who are doing the work and have services they can provide, and if you get a virtual cup of coffee with them or send an email to get to know them, you tend to create a more rich and beneficial referral process.**
>
> - Simone Ippoliti, NP, Pediatrician, Bayview Child Health Center

- **Develop relationships with community-based organizations.** Many interviewed providers have established relationships with community agencies to better support their patients. Interviewed providers suggest looking for community-based organizations that have existing networks. These networks of community-based organizations often host monthly or quarterly meetings that providers can attend to learn more about local resources. The most common community-based resources referred to by interviewed providers include parenting resources, behavioral health services, Medical-Legal Partnership, and food security supports. Interviewed providers also suggest spending time determining the most accessible local resources, what the availability is, and how to contact them.

Looking Ahead

The interviews with Medi-Cal providers who have experience screening for ACEs unveiled numerous insights that provider organizations can keep in mind when adopting ACE screening in a trauma-informed manner in both pediatric and adult settings. In California, the ACEs Aware initiative offers a unique opportunity to understand how best to support and incentivize ACE screening.

As the state's work continues and more providers incorporate ACE screening into clinical practice, additional insights are likely to emerge and will inform future state and provider ACE screening practices in California and in states nationally.

Appendix A. Interviewee Approaches to ACE Screening

SITE NAME AND LOCATION	PRACTICE AND POPULATION DETAILS	TYPE OF SCREENING TOOL	STAFF INVOLVED	FREQUENCY OF SCREENING	ADDITIONAL DETAILS ON SCREENING APPROACH
Bayview Child Health Center	**Type:** Federally Qualified Health Center (FQHC) **Population Screened:** Predominantly pediatrics	• PEARLS deidentified	• Front-desk staff administers along with other screenings	• Annually at well visits and then on as needed basis	• Front-desk staff have a script to help introduce the ACE screener, then primary care providers review screener with patients
Community Medical Centers	**Type:** FQHC **Population Screened:** Pediatrics and adults	• PEARLS deidentified for ages 0-20 • ACE Questionnaire for adults ages 20+	• Case managers connect with patients via phone the day before scheduled visits with providers; provider follows up on responses to questionnaire during visit	• Currently screening a subset of patients, but goal is to screen all pediatric patients annually	• Case managers use a script when introducing ACE screener to patients and families
Hill Country Health and Wellness Center	**Type:** FQHC **Population Screened:** Pediatrics and adults	• PEARLS deidentified for ages 0-20 • ACE Questionnaire deidentified for adults ages 20+	• Provider administers for both pediatrics and adults	• Goal is to screen annually for pediatrics	• Providers seek to incorporate screening into conversation as part of patient history
Loma Linda University Center for Health Promotion	**Type:** FQHC resident clinic **Population Screened:** predominantly pediatrics	• Whole Child Assessment; PEARLS deidentified (at one location)	• Provider integrates questions into the history taking as part of a well-child visit	• Annually at well-child visit	• When administering the Whole Child Assessment, ACE questions are integrated into the history taking, and worded in a way that allows providers to assess for safety, substance use, mental health, and lifestyle
Los Angeles Christian Health Centers	**Type:** FQHC **Population Screened:** Pediatrics and adult and pediatric patients specifically seeking mental health services	• PEARLS deidentified • ACE Questionnaire deidentified	• Pediatric patients receive screening tool in a packet with other screenings and complete in waiting room; provider follows up in visit • For mental health department, providers currently screen verbally during visits as most visits are currently done via telehealth	• For pediatrics: Providers screen annually at well-child visits • Within the mental health department: Providers incorporate screening at every initial assessment visit	• Script is provided, but staff are encouraged to put into their own words to engage with patients/families.

SITE NAME AND LOCATION	PRACTICE AND POPULATION DETAILS	TYPE OF SCREENING TOOL	STAFF INVOLVED	FREQUENCY OF SCREENING	ADDITIONAL DETAILS ON SCREENING APPROACH
Marin Community Clinics	**Type:** FQHC **Population Screened:** Pediatrics, obstetrics, and adults	• PEARLS deidentified for ages 0-19 • ACE Questionnaire deidentified for ages 20+	• Medical assistant (MA) administers; provider reviews screen and address concerns, patient care navigator connects to resources as needed	• Annual screening for pediatrics at well visits starting at 12 months • Screening once in pregnancy during the 2nd trimester • Screening adults once in a lifetime by primary care provider at a chronic disease follow-up visit	• Score of one or more warrants a follow-up conversation with provider. A score of zero gets universal education around toxic stress and health
Santa Barbara Neighborhood Clinics	**Type:** FQHC **Population Screened:** Pediatrics and adults	• PEARLS deidentified for ages 0-19 • ACE Questionnaire deidentified for ages 20+	• MA administers	• First screening at the four-month visit, annual screening at all well child visits and adults screened once at their preventive health visit	• Script is provided, but staff are encouraged to put into their own words to engage with patients/families.
Santa Rosa Community Health	**Type:** FQHC **Population Screened:** Pediatrics and adult parents/caregivers	• PEARLS deidentified for ages 0-19 • ACE Questionnaire deidentified for ages 20+	• MA administers	• All new patient visits and annual visits for pediatrics • Once per lifetime for adults	• Teens 12-18 years old receive separate screening • Script is provided, but staff are encouraged to put into their own words to engage with patients/families.
TCC Family Health	**Type: FQHC** **Population Screened:** Pediatrics and adults	• PEARLS (adapted version) for ages 0-19	• MA administers (but currently considering expanding to social workers, and health educators)	• New patients and wellness visits • Annually for children	• Scripts are written on questionnaire and given to staff. Educational updates are given to staff quarterly, at staff meetings, including what not to do, such as comparing your story with the patients'.

SITE NAME AND LOCATION	PRACTICE AND POPULATION DETAILS	TYPE OF SCREENING TOOL	STAFF INVOLVED	FREQUENCY OF SCREENING	ADDITIONAL DETAILS ON SCREENING APPROACH
TrueCare	**Type:** FQHC **Population:** Entire lifecycle	• PEARLS identified for ages 0-19 • ACE Questionnaire identified for ages 20+	• In family medicine clinic: MAs and trained behavioral health consultants administer, provider reviews with patient • In OBGYN clinic: Perinatal coordinator administers, provider reviews with patient	• Annually for children 0-20 • In OBGYN clinic: every new patient at intake visit	• Score of four or more, depending on presentation, warrants connection with a behavioral health provider for a warm handoff • In OBGYN clinic, ACE score is added to a list of issues in patients' electronic health record • Perinatal coordinator introduces screener conversationally and why it is important for promoting health of mother and baby
Harbor UCLA Medical Center, Department of Family Medicine and Chronic Pain Clinic	**Type:** Academic, publicly funded clinic **Population Screened:** Pediatrics in family medicine clinic; adults in chronic pain clinic	• PEARLS identified for ages 0-19 • ACE Questionnaire identified for ages 20+	• In family medicine clinic: provider or social worker administers • In chronic pain clinic: provider administers	• In family medicine clinic: only screen patients deemed at-risk by provider (defined as patients with a history of depression, anxiety, PTSD, out of control chronic conditions, and recurring emergency department or hospital admissions) • In chronic pain clinic: providers strive to screen every new patient but do not screen if patient appears overwhelmed	• ACE Questionnaire is embedded into the EHR for easy access; patients fill out the ACE screeners on paper that is then shredded
University of California San Francisco Benioff Children's Hospital – Oakland	**Type:** FQHC affiliated with large hospital system **Population Screened:** Pediatrics	• PEARLS for ages 0-19	• Nurses administer screening	• Begin at six-month visit then annually thereafter	• Care navigators manage referrals related to ACE screening and facilitate necessary follow-up care.

Appendix B. Interview Questions

The following details questions asked of providers who participated in interviews. Questions are grouped by topic area, including: (1) practice overview; (2) screening and response; (3) staff support and training; (4) data collection and analysis; and (5) reflections and recommendations. Given the limited time with interviewees, CHCS staff did not ask all the questions listed during interviews and asked additional questions during the conversation as warranted.

Practice Overview

- Can you provide a broad overview of the practice where you work? For example:
  - What type of practice is it?
  - Can you describe your patient population?
  - How many providers and what type of providers practice there?
  - Which types of services do you offer on-site?

Screening and Response

- Can you describe your organization's approach to screening for ACEs, including:
  - The tool(s) used;
  - How the tool(s) is administered;
  - Which types of staff members administer the screening;
  - Who receives screening (which patients and the % of your patient population); and
  - How frequently is screening conducted and when in the context of a patient visit?
- How do you talk with patients and/or families about ACE screening? What works and what doesn't work when doing so?
- How do you take a strengths-based approach to administering a questionnaire about childhood adversity?
- What types of support, services, resources, and/or information are given (if any) following any indication of ACEs on the screening?
- What kind of feedback have you received from both providers and patients about the screening? Do you have a channel through which patients can provide such feedback?
- Can you share a story that articulates the benefit of ACEs screening? Similarly, do you have any stories that highlight challenges related to ACE screening or that generated insights that led to process changes when screening for ACEs?
- How did you get leadership buy-in for screening for ACEs and what has been needed to sustain it?

Staff Support and Training

- Can you describe how the principles of trauma-informed care guide or inform your approach to screening?
- What training, tools, resources, etc. are provided to staff prior to administering the screening, and which of these have been most helpful?
- Where do staff need the most guidance/support when it comes to screening for ACEs?

Data Collection and Analysis

- How do you use the information obtained from the screening process?
- Did you have to update any data platforms, EHRs, etc. when adopting ACE screening?
- Do you track referrals (such as those to behavioral health providers or community-based organizations) following a positive screening for ACEs and if those connections are actually made?

Reflections and Recommendations

- In general, what has worked well when screening for ACEs? What has not worked well?
- What have been your biggest lessons learned around how to successfully integrate ACE screening into clinical practice?
- Are there any additional resources/supports that would help make screening for ACEs more effective?
- What recommendations would you give other providers, those in your specialty or otherwise, looking to incorporate ACE screening into their clinical workflow?
  Is there anything additional that would be helpful for us to know as we continue to develop this white paper?

ENDNOTES

[1] D. Bhushan, K. Kotz, J. McCall, S. Wirtz, R. Gilgoff, S.R. Dube, et al. Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health. Office of the California Surgeon General, 2020. DOI: 10.48019/PEAM8812. p. 36-52; 94-130. Available at: https://osg.ca.gov/wp-content/uploads/sites/266/2020/12/Roadmap-For-Resilience_CA-Surgeon-Generals-Report-on-ACEs-Toxic-Stress-and-Health_12092020.pdf.

[2] J.N. Hook, D.E. Davis, J. Owen, E.L. Worthington Jr., and S.O. Utsey. "Cultural Humility: Measuring Openness to Culturally Diverse Clients." Journal of Counseling Psychology, 60, no. 3 (2013): 353-366. Available at: https://psycnet.apa.org/record/2013-15106-001.

[3] D. Bhushan, et al., op. cit.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] For more information on California's efforts related to ACE screening and response, see: ACEs Aware. Available at: www.ACEsAware.org.

[9] ACEs Aware. "Benefits of Screening for ACEs." Available at: https://www.acesaware.org/learn-about-screening/benefits-of-ace-screening/.

[10] ACEs Aware. "Learn About Screening." Available at: https://www.acesaware.org/learn-about-screening/.

[11] For more information on the Pediatric ACEs and Related Life-events Screener tool, see: ACEs Aware. Available at www.acesaware.org/learn-about-screening/screening-tools/.

[12] For more information on the ACE Questionnaire for Adults, see: ACEs Aware. Available at: https://www.acesaware.org/learn-about-screening/screening-tools/.

[13] For more information on the Whole Child Assessment, see: Loma Linda University Children's Health. Available at: https://lluch.org/health-professionals/whole-child-assessment-wca.

[14] For more information on the adolescent self-report and caregiver reporting tool, see: ACEs Aware. Available at: https://www.acesaware.org/learn-about-screening/screening-tools/.

[15] V.J. Felitti, R.F. Anda, D. Nordenberg, D.F. Williamson, A.M. Spitz, V. Edwards, et al. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine, 14, no. 4 (1998): 245-58. Available at: https://pubmed.ncbi.nlm.nih.gov/9635069/

[16] For more information on the adolescent self-report and caregiver reporting tool, see: ACEs Aware. Available at: https://www.acesaware.org/learn-about-screening/screening-tools/.

[17] For more information on the Whole Child Assessment, see: Loma Linda University Children's Health. Available at: https://lluch.org/health-professionals/whole-child-assessment-wca.

[18] ACEs Aware. "Aces Aware Self-Care Tool for Pediatrics." Available at: https://www.acesaware.org/wp-content/uploads/2019/12/Self-Care-Tool-for-Pediatrics.pdf.

[19] For more information on the benefits of ACEs screening, see: ACEs Aware. Available at: https://www.acesaware.org/learn-about-screening/benefits-of-ace-screening/.

[20] Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series 57. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014, 59-89. Available at: https://www.ncbi.nlm.nih.gov/books/NBK207191/.

[21] ACEs Aware. "ACEs Aware: The Science of Trauma and Toxic Stress." Available at: https://www.acesaware.org/wp-content/uploads/2019/11/ACEs-Aware-Science-of-Trauma-Fact-Sheet-2-25-20-FINAL.pdf.

[22] Ibid.

[23] For more information on how to get started with ACE screening in California, see: ACE Screening Implementation How-To Guide. Available at: https://www.acesaware.org/implement-screening/stage-1-prepare-foundation/step-1-get-informed/.

[24] J. Decety and A. Fotopoulou. "Why Empathy Has a Beneficial Impact on Others in Medicine: Unifying Theories." Frontiers in Behavioral Neuroscience, 8, no.457 (2015). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4294163/.

[25] For tools on how to talk with patients about ACE screening, see: ACEs Aware. Available at: https://www.acesaware.org/wp-content/uploads/2021/09/ACEs-Aware-Sample-Scripts-for-Pediatric-Clinical-Teams.pdf.

[26] For more information on how to build a network of support services for patient and family referrals, see: ACEs Aware Trauma-Informed Network of Care Roadmap. Available at: https://www.acesaware.org/wp-content/uploads/2021/06/Aces-Aware-Network-of-Care-Roadmap.pdf.

[27] For tools on how to talk with patients about ACE screening, see: ACEs Aware. Available at: https://www.acesaware.org/wp-content/uploads/2021/09/ACEs-Aware-Sample-Scripts-for-Pediatric-Clinical-Teams.pdf.

[28] For more information on the ACEs Aware core training, see: ACEs Aware. Available at https://training.acesaware.org/.

[29] N. Burke Harris. "How Childhood Trauma Affects Health Across a Lifetime." TEDMED presentation, 2014. Available at: https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en.

[30] A.J. Dettlaff and R. Boyd. "Racial Disproportionality and Disparities in the Child Welfare System: Why Do They Exist, and What Can Be Done to Address Them?" The Annals of the American Academy of Political and Social Science, 692, no.1 (2021): 253-274. Available at: https://journals.sagepub.com/doi/abs/10.1177/0002716220980329?journalCode=anna.

[31] W. Lane, D. Rubin, R. Monteith, and C. Christian. "Racial Differences in the Evaluation of Pediatric Fractures for Physical Abuse." Journal of the American Medical Association, 288, no.13 (2002): 1603-9. Available at: https://pubmed.ncbi.nlm.nih.gov/12350191/.

[32] J. Schnierle, N. Christian-Brathwaite, and M. Louisias. "Implicit Bias: What Every Pediatrician Should Know About the Effect of Bias on Health and Future Directions." Current Problems in Pediatric and Adolescent Health Care, 49, no.2 (2019): 34-44. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6652181/.

[33] D. Bhushan, et al., op. cit.

[34] For more information on how to build a network of support services for patient and family referrals, see: ACEs Aware Trauma-Informed Network of Care Roadmap. Available at: https://www.acesaware.org/wp-content/uploads/2021/06/Aces-Aware-Network-of-Care-Roadmap.pdf.