DEPARTMENT OF HEALTH CARE SERVICES
DEPARTMENT OF SOCIAL SERVICES
AB 340 TRAUMA SCREENING ADVISORY WORKGROUP
June 21, 2018 Meeting
9:30am – 3:30pm

MEETING SUMMARY

Attendance

Members Attending: Dawan Utecht, County of Fresno; Debbie Manners, Hathaway-Sycamores; Dianna Wagner, Shasta County Health & Human Services Agency; Dr. Ariane Marie-Mitchell, Loma Linda University; Dr. Brent Crandal, Rady Children's Hospital in San Diego; Dr. Chris Esguerra, Care1st Health Plan; Dr. Dayna Long, UCSF Benioff Children's Hospital; Dr. Robert Pynoos, The National Child Traumatic Stress Network and UCLA School of Medicine; Dr. Robert Riewerts, Southern California Permanente Medical Group; Dr. Sara Marques, Center for Youth Wellness (CYW); Dr. Susan Coats, California Association of School Psychologists (CASP); Esther Franco, Fresno Council on Child Abuse Prevention (FCCAP); John Bauters, Californians for Safety and Justice; Frank Mecca, County Welfare Directors Association (CWDA); Kimberly Lewis, National Health Law Program; Linnea Koopmans, County Behavioral Health Directors Association of California (CBHDA); Terri Fields Hosler, Shasta County Health & Human Services Agency, Lishaun Francis, Children Now; and Susan Holt, County of Fresno.

Members not Attending: Cori Allen, Tuolumne County Department of Social Services; Dr. Charlie Sophy, Los Angeles County Department of Children and Family Services; Lynn Thull, California Alliance for Children and Family Services; Shronda Givens, Tessie Cleveland Community Services Corp.

Members Attending by Phone: Maheen Ahmed, Assemblymember Arambula's Office

DHCS Staff: Jennifer Kent, Erika Cristo, Dr. John Griffith, Tara Zimonjic, and Angeli Lee

CDSS Staff: Greg Rose

Public in Attendance: 6 members of the public attended.

Welcome and Introductions
Jennifer Kent, DHCS Director
Director Kent welcomed workgroup members, state representatives, and the public, and she facilitated introductions. She then introduced the parent and youth representative who would be presenting their stories as they relate to trauma, screenings and provision of services.

Setting the Context: Parent and Child Panel
Ms. Laura Stillmunkes, Parent, and Ms. Christina Parker, Youth Representative

Ms. Stillmunkes is an adoptive parent of two children, both of whom had experienced trauma earlier in life and had various psychological and behavioral repercussions of the trauma. In particular, her son was challenging to diagnose, and they tried different services for him such as therapy, occupational therapy, Wraparound, and Building Blocks. She is also the Executive Director at the non-profit organization *Capital Adoptive Families Alliance*. While trying to get her children the services they needed, she encountered the following barriers:

- Difficulty in finding supportive services and trained providers, particularly those trained to work with grief and loss.
- Difficulty finding therapists with the appropriate trainings and expertise who accept Medi-Cal.
- Finding “innovative” or uncommon services such as respite program and other forms of therapy, including occupational and play therapy.

Ms. Stillmunkes also provided some suggestion for screenings including:

- Ensuring providers are educated on how pervasive trauma is.
- Providing screenings that prevent the misdiagnoses of the effects of trauma as autism or ADHD.

Ms. Parker spoke about how the traumatic experiences that she had as a child negatively impacted her life and how challenging it was for her to get the services she needed. Some of the negative effects that her trauma has caused include: suicidal thoughts, anxiety, academic struggles, and depression. The first time that she was provided services was when she tried to commit suicide at age 14. In trying to get the services she needed, she discussed the following barriers:

- Cultural barriers
- Lack of access to highly trained professionals
- The services that were provided were not adequate for her needs and there was a lack of follow-ups for continuation of services

Group Discussion:

Dr. Anne Marie-Mitchell, Loma Linda University, commented on the importance of staff training specific to grief loss.

Dawan Utecht, County of Fresno, asked Ms. Stillmunkes if she received training in regards to caring for her children. They discussed that she took initiative to get herself educated because she needed to for the sake of her kids. Ms. Stillmunkes also commented on how adoption services need to be more transparent with what children may have experienced in order for parents to know the services that they may need to seek out for their children.

Frank Mecca, Child Welfare Directors Association, reflected on how long it took Ms. Parker to get the services she needed. Her first traumatic experience happened at 1 year old but she did not receive services until she was 14 and it only happened then because she had tried to commit suicide. Frank also mentioned that though there were systems that failed Ms. Stillmunkes and her children as well as Ms. Parker, we cannot forget about the people who are living outside of the system who also do not have the resources they need.

John Bauters, Californians for Safety and Justice, inquired about where Ms. Stillmunkes was referred to for services. She referenced that she worked with Access team as well as the Academy of American Pediatrics (AAP). Parent Child Interaction Therapy (PCIT) was offered to her family, but it was not sufficient to meet her children's needs. As a parent, she had to find the services she needed and then figure out how to pay for it.

Dr. Bob Pynoos, The National Child Traumatic Stress Network and UCLA School of Medicine, suggested a resource from his organization that provides some helpful educational resources on trauma.

Dr. Dayna Long, UCSF Benioff Children's Hospital, reemphasized Ms. Parker's comment regarding cultural barriers. Trauma is normalized by populations of color. It also has biological ramifications that need to be addressed.

Dr. Susan Coats, California Association of School Psychologists, inquired more about Ms. Stillmunkes' experiences in working with the schools. Ms. Stillmunkes commented that it things improved once she hired a lawyer, who helped her get services for her son. She also discussed how as a parent she did not feel on par with other professionals and that her opinions were not taken as seriously.

Kimberly Lewis, National Health Law Program, noted that it was important to hear about the lack of treatment specialists being one of the main barriers to accessing services. Additionally, she commented on the challenge that parents can experience when trying to navigate and learn the system

Jennifer Kent, DHCS Director, thanked both Ms. Stillmunkes and Ms. Parker for taking the time to share their personal stories and experiences with the group.

AB 340 Definitions and Goals
John Bauters, Californians for Safety and Justice, and Maheen Ahmed, Assemblymember Arambula's Office

Link to AB 340 Legislation:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB340

The bill language has a definition of trauma that was developed in consultation with CBHDA and DHCS. The bill is a statutory framework and is designed to be broad enough to provide flexibility. The group may make recommendations regarding assessments, screenings, behaviors, as well as possibly expanding the context of the workgroup to include the impact of adult trauma on children and the scope of this group.

Kimberly Lewis, National Health Law Program, reminded the group that the bill does address the Early and Periodic Screening, Detection, and Treatment (EPSDT) benefit, which does focus on screenings and application to children under age of 21. Parents may be a proxy and could be screened if they are caring for children, and we would still be within the requirements of the bill.

Dr. Chris Esguerra, Care1st Health Plan, noted that there is a prevention element in EPSDT and that we should be mindful of intergenerational trauma. Additionally, he noted that there are some updates that could be incorporated into the Staying Healthy Assessment (SHA) to better address the recommendations of the group. He also commented that having a lengthy assessment that is checked off and then does not lead to anything is not helpful. Doctors need to know how to normalize the pathway of treatment based on what is found in the screening.

Dr. Brent Crandall, Rady Children's Hospital, commented that it is important to recognize resilience and that the definition of trauma is both the event as well as the response to the event. He also noted that there is a poor distribution of available services, particularly in underserved communities.

Dr. Ariane Marie-Mitchell, Loma Linda University, reminded us that it is important to look at the biological implications.

Dr. Robert Pynoos, UCLA and National Child Traumatic Stress Network, noted that screenings should also consider the common experience of violence among family members in discussing intergenerational issues.

Terri Fields Hosler, Shasta County Health & Human Services Agency, highlighted the importance of capturing community initiatives in the development of the workgroup's recommendations.

Frank Mecca, County Welfare Directors Association, noted that we should be working toward improving our diagnosis using evidence-informed ways to treat trauma, as well as think about how Medi-Cal can authorize these treatments.

Lishaun Francis, Children Now, discussed the importance of also thinking about who should administer the screenings, what is the appropriate setting or settings for these screenings to be administered.

Background on Screenings vs. Assessments
Dr. Dayna Long, UCSF Benioff Children's Hospital, and Dr. Ariane Marie-Mitchell, Loma Linda University

Presentation slides:
http://www.dhcs.ca.gov/Documents/ScreeningandAssessments6.12.18_ADACompliant.pdf

Screenings and assessments have very specific definitions depending on which part of the disease progression cycle we are. The natural history of the disease starts at the pre-clinical stage, when there is a biological onset of the disease. It then moves to the Acute Clinical stage when symptoms first appear. Finally, the disease moves into the chronic clinical stage. There are three different levels of prevention in relation to the natural course of the disease. The primary level of prevention is action that is taken to prevent the development of a disease in a person who is not yet ill. The secondary level of prevention is happens during the pre-clinical stage. This secondary level of prevention is a screening, which is an examination of asymptomatic patients to identify those likely to get the disease in order to avoid or postpone poor outcomes prior to the symptoms actually starting. The tertiary level of prevention is the treatment process.

Some criteria for screening tools include that it is a common disease, there is a prevalence of preclinical disease is high among the populations, there are accurate and reliable screening tests available, and they are easy to implement and inexpensive.

An assessment is an identification of a disease, illness or problem based upon history of symptoms and examination of signs. It occurs once symptoms are present during the acute clinical stage.

Dr. Mitchell also provided an example of how we could map Adverse Childhood Experiences (ACEs) along this spectrum of natural disease history. There was some discussion if it makes sense to map trauma on this type of spectrum as depending on the type of traumatic experience it a person may not go through the pre-clinical stage and go straight to clinical. She also explained what primary and secondary prevention might look like for ACEs. She also noted that there are a few gaps in whether or not screening for ACEs is effective due to the following points:

1) Are there accurate and reliable screening tests for exposure to ACEs in children?

2) Are interventions efficacious and effective when given before symptoms develop?

AB 340 Workgroup Goals/Objectives
Frank Mecca, County Welfare Directors Association

Frank reviewed how workgroup members had voted on proposed workgroup goal areas:

1) Create common language and understanding of trauma and screenings: 9 votes
2) Review existing screening tools and protocols: 9 votes
3) Design new screening tool and protocol: 5 votes
4) Assess how services are currently being delivered: 1 vote
5) Develop recommendations for implementation of screening tools: 8 votes
6) Develop recommendations for implementation of screening tools specifically focusing on workforce: 2 votes
7) Develop recommendations for policy changes needed to implement screening tools: 2 votes
8) Other Goals: 3 votes

The group realized that not everyone had a chance to vote and the goal areas were not developed well enough for the creation of sub-workgroups.

Dr. Arian Marie-Mitchell, Loma Linda University, presented on a slightly modified group of goals that were aligned to the US Preventative Task Services Force recommendations, which breaks down the goal areas between symptomatic versus asymptomatic children. There was some conversation about whether it is possible to divide kids who have experienced trauma by symptomatic and asymptomatic as symptoms are self-reported.

The group discussed that it would be helpful to use the afternoon to try to flush out the goals and have members share what their ideal trauma screening tool would look like.

Public Comments

Heather Little, First 5 Association, commented on how everyone has different experiences and outcomes in relation to traumatic experiences. Having a proper screening is important as it may bring to light issues that may not have been recognized as problematic and can provide early identification of risk factors. She also discussed the importance of recognizing the role of resiliency. In terms of what this group should be focusing on, she commented that it is important to assess the pathways of different interventions, based on the needs. It may not be just one screening tool that is all encompassing. Finally, she encouraged the group to explore the barriers that exist in getting access to services, as Ms. Stillmunkes pointed out during her presentation.

Sub-Workgroup Activities
Jennifer Kent, DHCS Director

Director Kent facilitated an opportunity for group members to share out what they feel an ideal trauma screening tool would look like. The first presenter was Dr. Dayna Long who presented on the screening used by UCSF Benioff Children's Hospital Oakland. Dr. Long commented on wanting to provide a perspective that may help contextualize some of the biggest concerns of the Medicaid population. Dr. Long pointed out that for her patients the top three issues that exists are: 1) concerns about running out of food, 2) concerns about child's safety at school and/or in the their neighborhood and 3) concerns about housing. The screening her organization administers is based on ACEs and social determinants of health. Their list of measures includes:

1) Community violence
2) Family Mental Illness
3) Family/Domestic Violence
4) Family Substance Use
5) Food Insecurity
6) Separation from Caregiver
7) Low family cohesion
8) Housing insecurity
9) Discrimination
10) Family Medical Illness
11) Child Physical Abuse
12) Child Emotional Neglect
13) Child Verbal Abuse
14) Child Sexual Abuse

Dr. Long also discussed how the screening is administered by navigators, who are able to facilitate a trusted relationship while simultaneously not affecting the limited time doctors have with their patients to administer a screening.

Director Kent then solicited responses from other workgroup members, or what their ideal trauma screening tool would encompass. The responses included:

- A universal screening to improve health outcomes for children
- Prevention of child abuse and neglect
- Better and earlier identification
- Appropriate training for providers
- Adoption and recognition of trauma-informed care and services.
- Promoting resilience
- Improve pediatric interventions to prevent mental health conditions
- Keep child in context of family
- Age appropriate screenings (including prenatal exposure)
- Screening that has multiple touchpoints

The workgroup then began discussing what events a trauma screening should screen for. In addition to those events listed in Dr. Long's screening, workgroup members suggested the following:

- Life threatening illness of a child
- Natural disasters
- School violence
- Incarceration (adult and juvenile justice)
- Law enforcement encounters

The group closed the discussion by addressing next steps, which include:

- Create a matrix of existing screenings, looking at events screened for and how the tool is implemented, key considerations, and elements that are inclusive of AB 340 statute.
- Do a literature review of trauma events to see which research shows the most indicative events for screening in relation to adverse effects of trauma.
- The next workgroup meeting will be scheduled in late August.