DEPARTMENT OF HEALTH CARE SERVICES
DEPARTMENT OF SOCIAL SERVICES
AB 340 TRAUMA SCREENING ADVISORY WORKGROUP
September 13, 2018 Meeting
9:30am – 3:00pm

MEETING SUMMARY

Attendance

Members Attending: Cori Allen, Tuolumne County Department of Social Services; Debbie Manners, Hathaway-Sycamores; Dianna Wagner, Shasta County Health & Human Services Agency; Dr. Ariane Marie-Mitchell, Loma Linda University; Dr. Chris Esguerra, Care1st Health Plan; Dr. Dayna Long, UCSF Benioff Children's Hospital; Dr. Robert Riewerts, Southern California Permanente Medical Group; Dr. Sara Marques, Center for Youth Wellness; Dr. Susan Coats, California Association of School Psychologists (CASP); 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); Laura Stillmunkes, Capital Adoptive Families Alliance; Lynn Thull, California Alliance for Children and Family Services; Maheen Ahmed, Assemblymember Arambula's Office; Terri Fields Hosler, Shasta County Health & Human Services Agency; and Lishaun Francis, Children Now

Members not Attending: Dr. Brent Crandal, Rady Children's Hospital in San Diego; Esther Franco, Fresno Council on Child Abuse Prevention (FCCAP); and Susan Holt, County of Fresno.

Members Attending by Phone: Dawan Utecht, County of Fresno, and Dr. Robert Pynoos, The National Child Traumatic Stress Network and UCLA School of Medicine

DHCS Staff: Jennifer Kent, Dr. Dionne Maxwell, Dr. John Griffith, Tara Zimonjic, and Angeli Lee

CDSS Staff: Will Lightbourne and Mary Sheppard

Public in Attendance: 12 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.

Review of Existing Tools and Application to AB 340
Dr. Ariane Marie-Mitchell, Loma Linda University; Dr. Brent Crandal, Rady Children's Hospital – San Diego; Dr. Dayna Long, UCSF Benioff Children's Hospital; Dr. Sara Marques, Center for Youth Wellness; Frank Mecca, County Welfare Directors Association; John Bauters, Californians for Safety and Justice; Lishaun Francis, Children Now

Director Kent provided an overview of the smaller sub-workgroup's work over the summer between our June meeting and our September meeting. The sub-workgroup reviewed a cadre of tools assessing them along the following criteria:

1) What are the data-driven elements of the tool?
2) Who is the target population the tool is addressing?
3) How long does it take to administer the tool?
4) Is the tool self-reported or not?
5) How much does the tool cost?
6) Are there additional screenings for symptoms?
7) What languages is the tool available in?
8) What is the reading level of the tool?

She then explained that each sub-workgroup member will have a chance to present on which of the tools they prefer and why.

Dr. Sara Marques, Center for Youth Wellness
Dr. Marques prefaced her presentation by saying it is important to note that there are a lot of different criterial and tools to consider even though she selected the Center for Youth Wellness (CYW) ACE Questionnaire and the Bay Area Results Consortium (BARC) to present on. The BARC is the updated version of the CYW ACE Questionnaire, and after it is finalized, it will be replacing the CYW questionnaire. The tool is built off of the ACE Study and used by primary care providers. It focuses on prevention by addressing both exposure to traumatic events and symptoms. It is currently going through a clinical trial and is being evaluated for both biometric and psychometric properties. The tool is free to use and is supposed to be conducted during every well-child visit.

The one con is that only the child (0-12 y/o) version is going through the clinical trial. The BARC does have a teen (13-19 y/o) self-report version; however that version is not going through the clinical trial. The age 12 cut-off is aligned with California's

confidentiality law for minimum age requirements. The scoring of the assessment is as follows:

Score of 0 = low risk
Score of 1-3 = intermediate risk
Score of 1-3 (with symptoms) or 4+ = high risk.

Lishaun Francis, Children Now
Lishaun noted that the field is still emerging and there are a lot of elements to consider. She recommended the Loma Linda Whole Child Assessment – Version 2 for the workgroup. To her the tool felt very holistic and asked questions that referenced the whole child's wellbeing. Lishaun discussed how screening 0-5 year olds can be challenging as children sometimes cannot verbalize their experiences, however when a child becomes 7 and is starting to externalize some of these behaviors it becomes more obvious. However, if we are trying to get interventions in as early as possible it is critical to address issues that are occurring in children's lives as early as possible. Lishaun also noted that the Whole Child Assessment asks questions directed at parents that could get to the root of how they parent, which may provide relevant clues as to whether the children may be experiencing trauma.

Dr. Ariane Marie-Mitchell, Loma Linda University
Dr. Marie-Mitchell also presented on the Loma Linda Whole Child Assessment – Version 2. She discussed how they chose to cluster trauma factors, as no 5 or 10 experiences are the ones that may have the highest risk for trauma. They include at minimum the 10 Adverse Childhood Experiences (ACEs) as ACEs have been proven to be a key indicator in whether or not people bounce back from trauma – which is also known as resilience. Areas that help improve resilience include healthy eating, sleeping better, and reducing stress levels. These are all incorporated in the Whole Child Assessment as lifestyle counseling type of questions so that primary care providers can provide lifestyle counseling, an area they are familiar and comfortable with – which can still improve trauma outcomes even though it is not a direct mental health service provision. The development of the tool also incorporated a stakeholder process where the tool was reviewed by users of the tool as well as other professionals in the field. The tool is a variation of the Staying Healthy Assessment (SHA), which DHCS currently uses.

Dr. Brent Crandal, Rady Children's Hospital
Dr. Crandal provided his input in writing, and he recommended two screening tools for the workgroup's consideration – the Screen for Child Anxiety Related Emotional Disorders (SCARED) and the Child & Adolescent Trauma Screen (CATS).

Frank Mecca, County Welfare Directors Association
Frank did not have any preference on a single tool, but was more concerned that the workgroup stays aligned with the intentions of the legislation as well as develop criteria for the tool, including that it assesses trauma exposure and not just symptoms. Frank also shared that the tool would have greater adoption if providers had an opportunity to

choose the tool(s) for their own use. Therefore as a workgroup we develop criteria the tools need to meet and provide opportunities for flexibility.

John Bauters, Californians for Safety and Justice
John also did not have a specific tool in mind, but he wanted to ensure that the tool is applicable for the purposes of this workgroup.

Group Discussion:

Dr. Sara Marques, Center for Youth Wellness, responded to John Bauter's concerns regarding tool usability. She reminded the workgroup that training support is an important element to consider in the workgroup's development of recommendations.

Dr. Chris Esguerra, Care1st Health Plan, discussed that whatever tool we choose needs to fit into the normal flow of the office visit, so that doctors can easily adapt and it does not feel like an additional burden. He also highlighted the importance of making this part of the normal discussion in promoting its success and

Terri Fields Hosler, Shasta County Health & Human Services Agency, noted that if we have too many options providers may be overwhelmed and not buy-in, in response to Frank's comments regarding providing flexibility. At the end of the day, it is not so much about the tool itself but about the conversation and the patient-provider relationship. If the tool allows for that conversation to happen, then it is a good tool.

Frank Mecca, County Welfare Directors Association, noted that it does not need to be 10 different tools, maybe just one tool. He also noted that it sounded like the group has agreed on two different tools – the BARC and the Loma Linda tool. Should the workgroup compare the two tools and see where there are overlaps?

Terri Fields Hosler, Shasta County Health & Human Services Agency, commented that we as a workgroup need to decide what we want to do next. Are we selecting a single tool, multiple tools, or providing criteria?

Jennifer Kent, DHCS, suggested that the workgroup could also amend the current SHA to add trauma questions since the state is already utilizing that tool. She also stressed the importance of engaging the health plans since the majority of the Medi-Cal population, especially children are in the managed care delivery system.

Frank Mecca, County Welfare Directors Association, raised if it would be possible to pull out trauma-specific elements from the Whole Child Assessment tool in order to gather data regardless of its holistic nature. Dr. Chris Esguerra clarified that the only way to do this is to create codes that doctors could use to represent social determinants, which could then be assessed.

Dr. Sara Marques, Center for Youth Wellness, discussed that it sounds like we have developed some criteria:

1) Feasibility in pediatric primary care
2) Acceptance by parents and caregivers
3) Categories of trauma experiences
    a. Household dysfunction
    b. Abuse
    c. Neglect
    d. Major stressful events
    e. Poverty
    f. Discrimination
    g. Community Violence
4) A way to document screening completion (“z” code)

Multiple workgroup members discussed not wanting to get too caught up with selecting the perfect criteria as these things change due to experiences happening. As part of the workgroup’s recommendations, it is important that this the document that gets updated and questions added or removed based on developments in the field, as it is all still so emerging.

Current Observations and Innovative Trends on Trauma Awareness/Supports in Schools
Dr. Susan Coats, California Association of School Psychologists

Presentation slides can be found here.

Education is guided by “Ed Code.” In education, the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of trauma is used, as well as reference to the DSM-5 criteria.

Significant behavioral changes have been observed over the last 15 years. Many students are also being frequently misdiagnosed with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactive Disorder (ADHD); in reality these behaviors could be linked to traumatic experiences, not necessarily ADD or ADHD.

Schools see long-term effects of trauma. Children who may have behaved appropriately when they were younger start to act out once the curriculum becomes more demanding. A main challenge is getting children the early interventions they need. It is not that kids are acting out to be malicious, but are instead dealing with unresolved traumatic issues.

In order to create change, we need to give teachers a new lens to look through and build relationships with parents to include them in the process. School staff and the

limited time available are both pain points, but many efforts are also driven by a lot of grants.

Schools can adopt the Multi-Tiered Systems of Support Model and the Positive Behavioral Interventions & Support framework to create trauma-informed and trauma-sensitive schools and to foster a safe environment for everyone. It is critical to change the culture of the school, starting with the school staff.

Debbie Manners, Hathaway-Sycamore, stated that there is now pressure for schools to adopt or explore trauma-informed care. Funding is a challenge and just pockets of people have embraced it throughout the state. If contracted mental health agencies are involved, invested, and have a good relationship, improvements can be achieved.

Collaboratively Addressing ACEs in a Rural Community
Terri Fields Hosler, Shasta County Health & Human Services Agency

Presentation slides can be found here.

In rural counties, it is critical to take a collaborative approach. Communities need to understand that this is not just people making bad choices, but there are historical and generational cycles of trauma, which have long-standing impacts. There are attributable risks data, which can be used to stop generational issues.

Shasta County's ACEs are nearly double what they are in California. In addition, approximately 40% of adults reported having four or more ACEs, and family substance abuse was the most prevalent type of ACE observed.

Public Comments
There were no public comments.

Closing and Next Steps
Jennifer Kent, DHCS Director

Maheen Ahmed, Assemblymember Arambula's Office, reminded the AB 340 workgroup of their requirement to provide recommendations to the Legislature by May 1, 2019. It would be ideal to finalize recommendations for the Legislature in February, in advance of the May Revise. She was wondering what our timeline looks like.

Workgroup members also discussed having provider training and implementation as a topic to be discussed at next workgroup meeting. The next meeting date and agenda will be set by agenda sub-workgroup within the next few weeks.