

Practical Approaches in the Primary Care Setting with Patients Exposed to Multiple Types of Violence



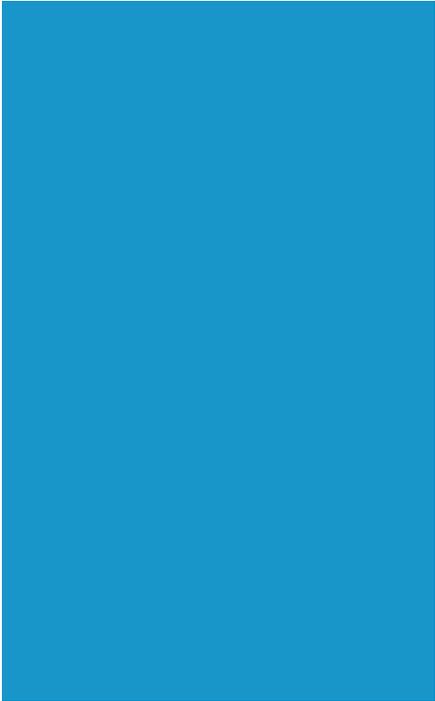
**Medical Home for Children
Exposed to Violence**

A Program of the American Academy of Pediatrics

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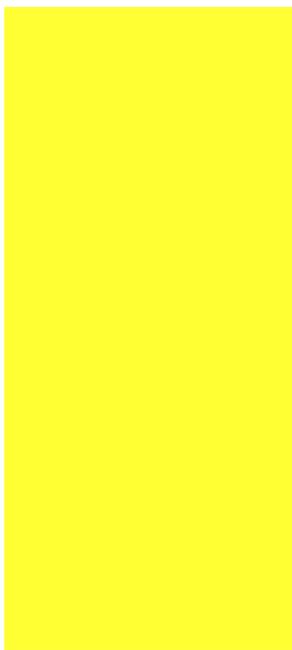
**DEFENDING
CHILDHOOD**
PROTECT HEAL THRIVE



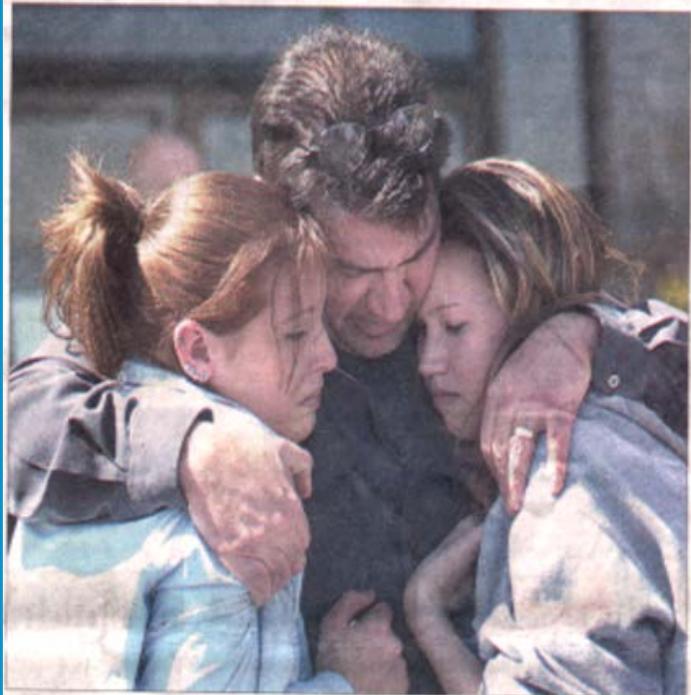
TODAY'S OBJECTIVES

- 1. Understand how polyvictimization relates to health across the lifespan.**
- 2. Understand how childhood exposure to violence shapes a child's development.**
- 3. Discuss practices for identifying and intervening in childhood exposure to violence**
- 4. Understand the role of the medical home for children exposed to violence**





SCHOOL RAMPAGE LEAVES TWO DEAD



After Monday's shooting at Santana High School, parents struggled through the aftermath to search for their children. Joe Lynch found his daughters Cora Beeder (left) and Tiffany Lynch safe across the street from the school in Santee, Calif., about 10 miles from San Diego.



How and Why I got Started

Pediatric Firearm Injuries, Kansas City, 1992: A Population-Based Study

M. Denise Dowd, MD, FAAP*; Jane F. Knapp, MD, FAAP‡; and Laura S. Fitzmaurice, MD, FAAP‡

Who were these kids with GSW's?

The baby evaluated for bruises and called CPS,
became...

The toddler who missed well child care appointments,
became...

The 6 year old with ADHD and “behavior issues,”
became...

The 9 year old with oppositional defiant disorder,
became..

The 12 year old with a boxer's fracture,
became..

The 14 year old with a mandibular fracture,
became....

The 16 year old shot in a drive by,
Became..

The homicide story on the back page.

THESE ARE CHILDREN YOU KNOW



NATional Survey of Children's Exposure to Violence (NATSCEV)

- Survey conducted January 2008- May 2008
- National RDD sample of 4549 children age 0-17
- Interviews with 2454 caregivers of children age 0-9
- Interviews with 2095 youth age 10-17
- Oversample of minorities and low income
- Interviews completed with 71% of eligible respondents contacted (63% with oversample of minorities and low income)



NATional Survey of Children's Exposure to Violence (NATSCEV)

- 
- Conventional Crime
 - Child Maltreatment
 - Peer & Sibling Victimization
 - Sexual Victimization
 - Witnessing & Indirect Victimization
 - Community Crime Exposure
 - Family Abuse Exposure
 - School Violence Threat
 - Internet Victimization

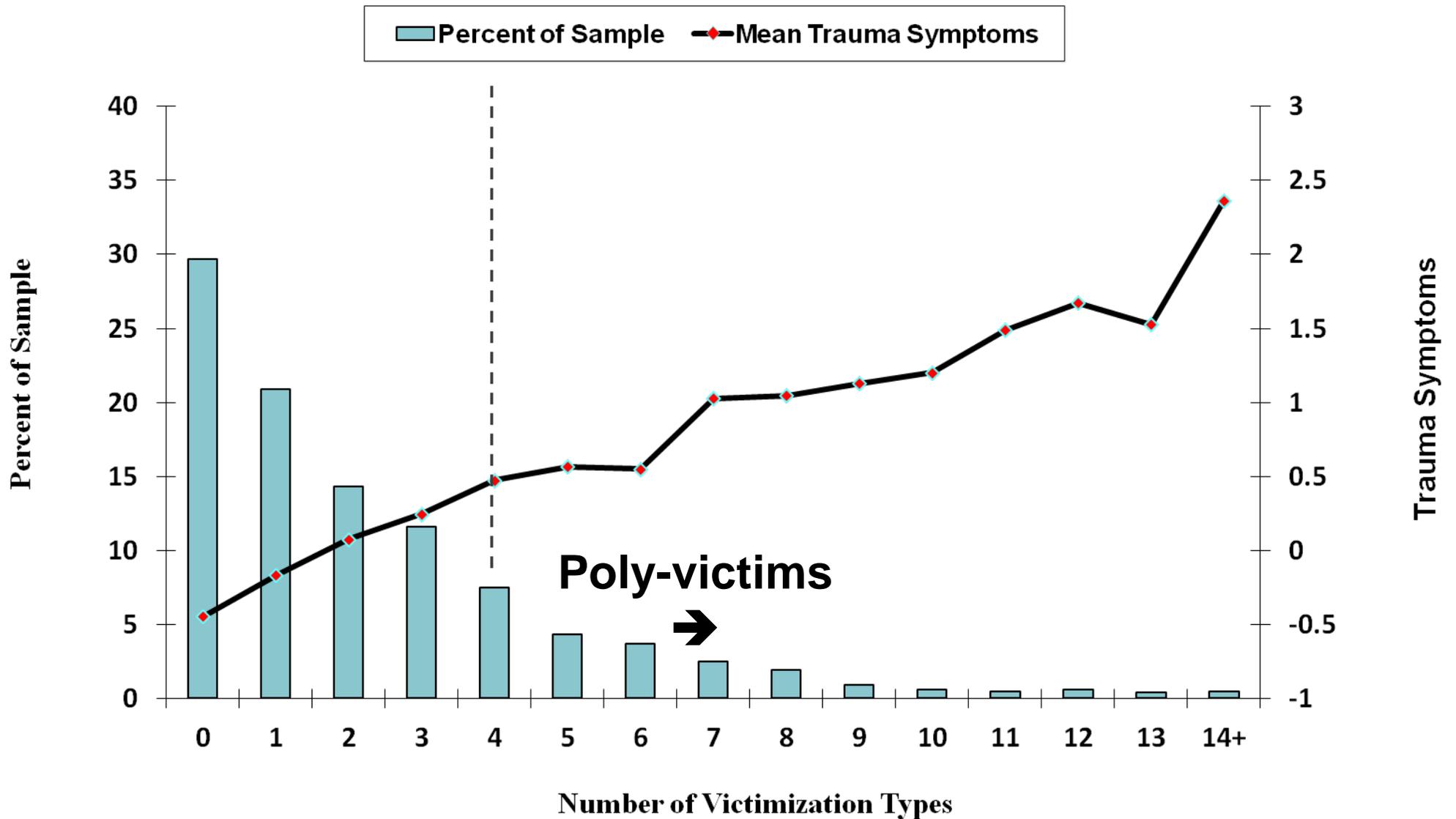
Exposure to Violence (NATSCEV)

60% of children are exposed to violence in a year*

- Nearly half (46%) experienced a physical assault
- 6% experienced sexual victimization
- 20% witnessed an assault in their family
- 30% witnessed an assault in their community
- 38.7% were victimized two or more times.
- 10.9% were victimized five or more times.

**Finkelhor , et al. Pediatrics 2009;124:1411-1423*

Past Year Victimizations and Trauma Symptoms



NATSCEV PY weighted
ANOVA includes sex, age, race/ethnicity, family structure and SES.

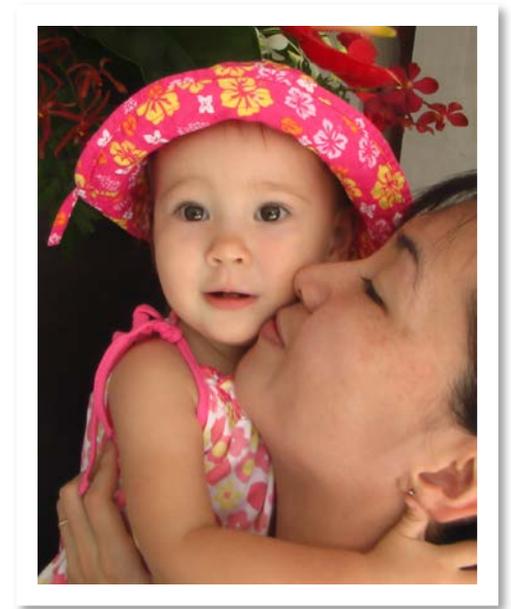
The Adverse Child Experiences (ACE) Study



- Vincent J. Felitti, MD and Robert J. Anda, MD, MS
- Asked 26,000 adults at Kaiser, San Diego's Dept of Preventive Medicine.
- 17,421 participated in the study.
- Participants completed a questionnaire.

ACE CRITERIA

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Contact sexual abuse
4. An alcohol or drug abuser in the household
5. An incarcerated household member
6. Someone who was chronically depressed, institutionalized, or suicidal in home
7. Mother treated violently
8. One or no parents, or parents divorced.
9. Emotional or physical neglect

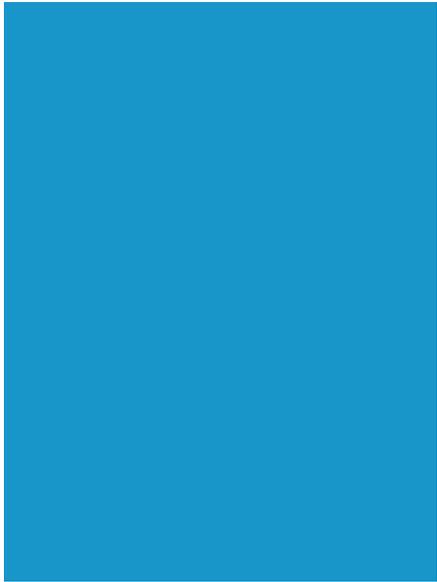


ACE SCORES

NUMBER OF CATEGORIES OF ADVERSE CHILDHOOD EXPERIENCES ARE SUMMED...

ACE SCORE	PREVALENCE
0	36%
1	26%
2	16%
3	9.5%
4 OR MORE	12.5%

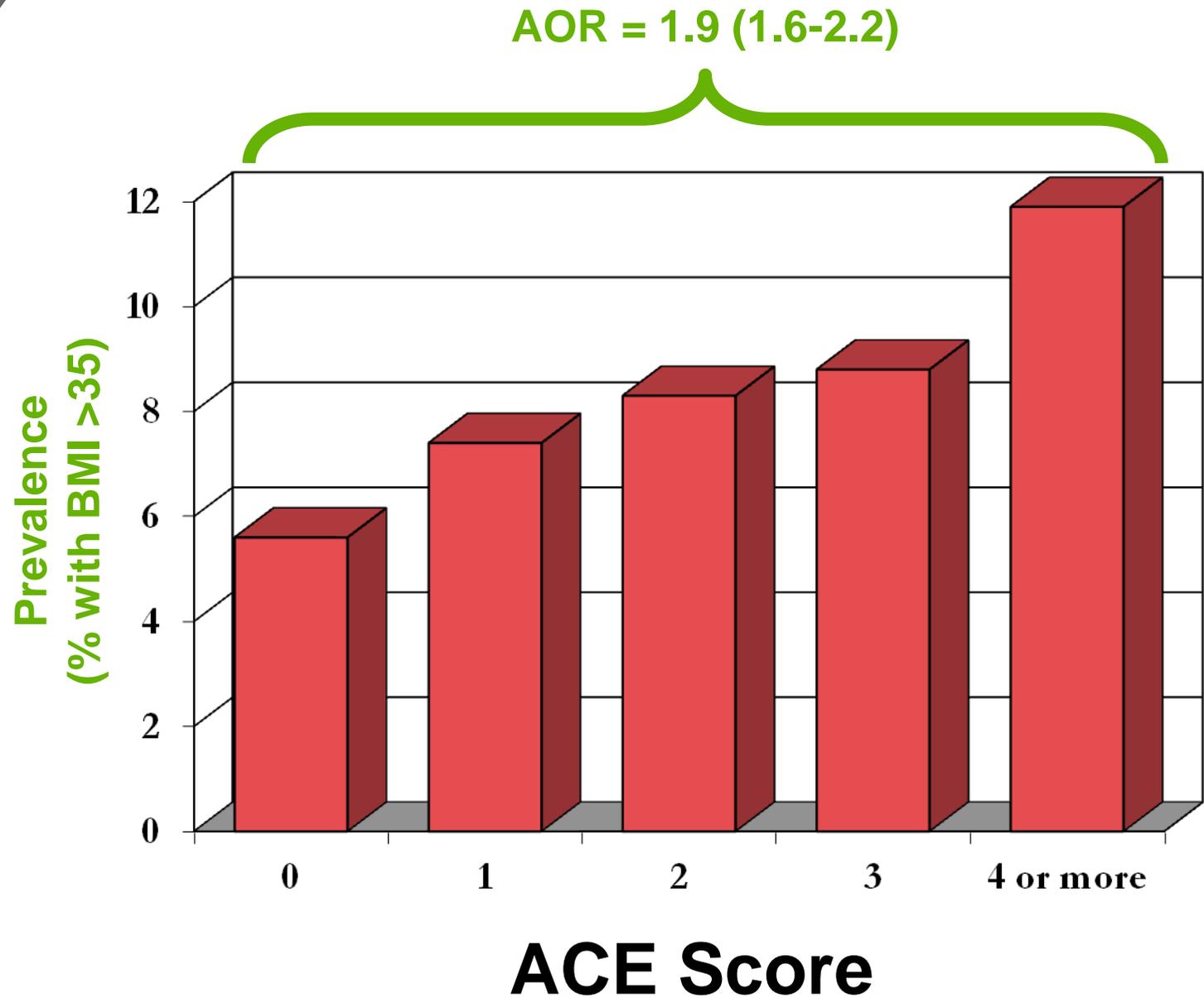
- More than half (almost 2/3) had at least one ACE
- 1 in 8 have 4 or more ACEs
- Average pediatrician will see 2-4 children with an ACE score of 4 or more each day



Relative Risk of disease for ACEs ≥ 4

- 
- Hepatitis 240%
 - STI 250%
 - COPD 260%
 - Depression 460%
 - Suicidal Behavior 1,220%

ACE AND OBESITY



Adapted from Anda RF et al., 2006. *Eur Arch Psychiatry Clin Neurosci* 256: 174-186.

Childhood Adversity has Lifelong Consequences.

Significant adversity in childhood is strongly associated with unhealthy lifestyles and poor health decades later.



STRESS RESPONSE

- Activation of the HPA Axis - release of ACTH, adrenaline and cortisol
- Increase in centrally controlled peripheral sympathetic nervous system activity
- Activation of nor-adrenaline throughout the midbrain and forebrain including the cortex





NO = NO

MOM

Dad



Dad hit Mom

Positive Stress

- Normal and essential part of healthy development
- Brief increases in heart rate and blood pressure
- Mild elevations in hormonal levels
- Example: tough test at school. Playoff game.

Tolerable Stress

- Body's alert systems activated to a greater degree
- Activation is time-limited and buffered by caring adult relationships
- Brain and organs recover
- Example: death of a loved one, divorce, natural disaster

Toxic Stress

- Occurs with strong, frequent or prolonged adversity.
- Disrupts brain architecture and other organ systems.
- Increased risk of stress-related disease and cognitive impairment.
- Example: abuse, neglect, caregiver substance abuse

Intense, prolong, repeated, unaddressed

**Social-Emotional buffering, Parental Resilience,
Early Detection, Effective Intervention**

MULTI-SYSTEM IMPACTS

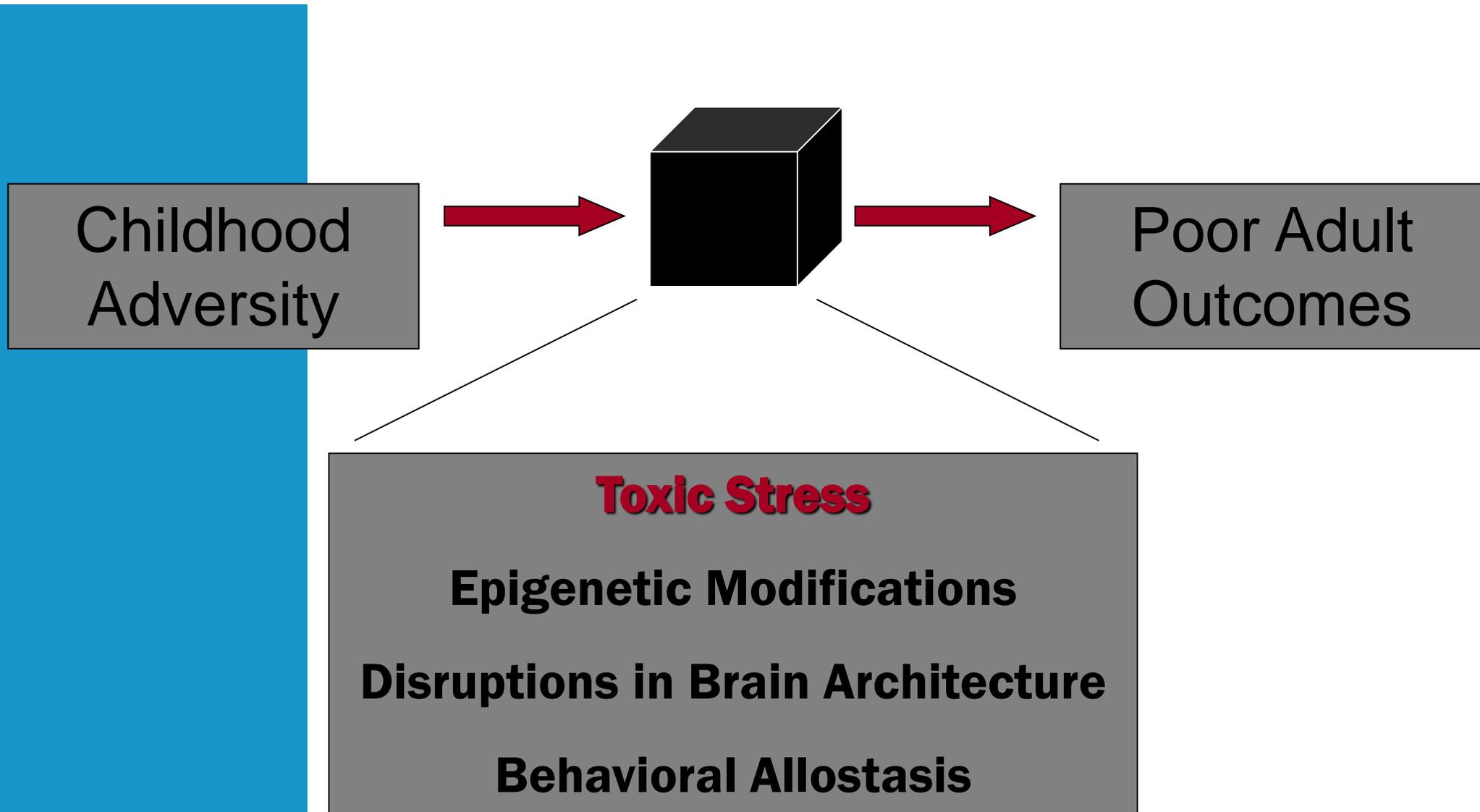
Neurologic

- HPA Axis Dysregulation
- Reward center dysregulation
- Hippocampal neurotoxicity
- Neurotransmitter and receptor dysregulation

Immunologic

- Increased inflammatory mediators and markers of inflammation such as interleukins, TNF alpha, IFN- γ

Linking Childhood Experiences and Adult Outcomes



Childhood
Adversity

Poor Adult
Outcomes

Toxic Stress

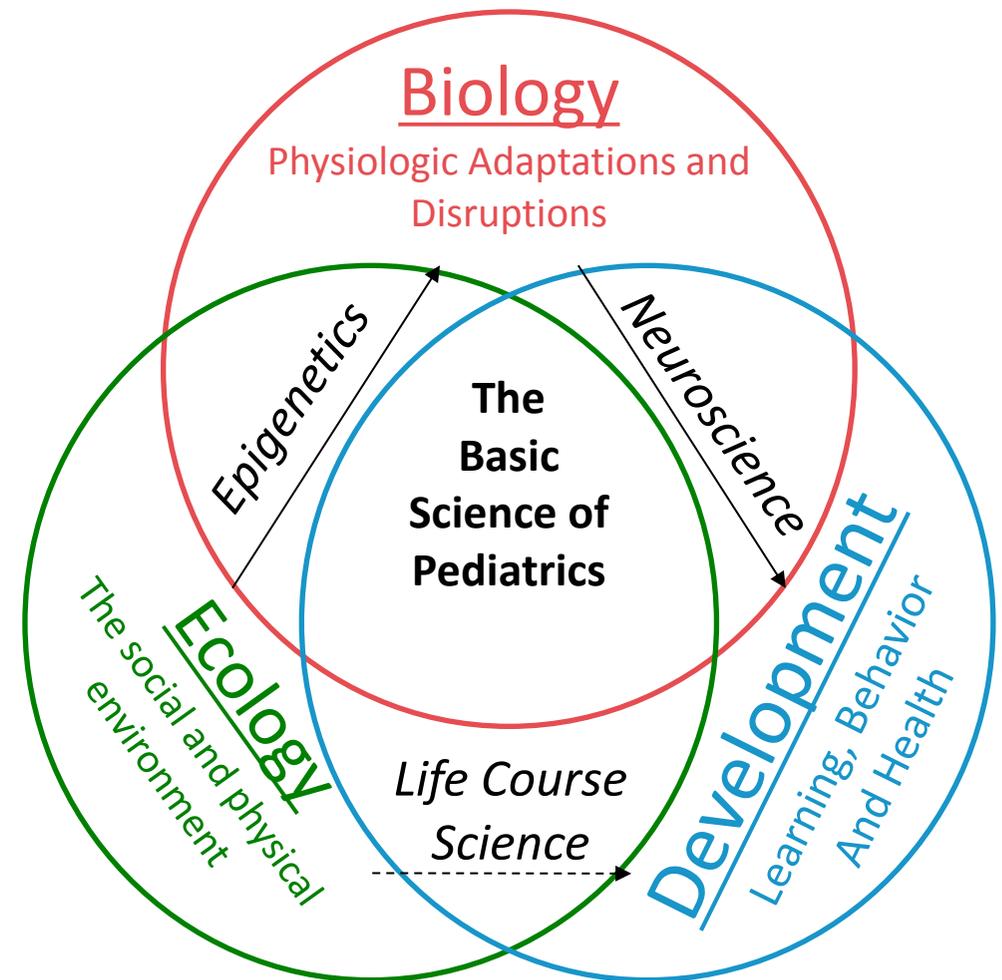
Epigenetic Modifications

Disruptions in Brain Architecture

Behavioral Allostasis

Eco-Bio-Developmental Model of Human Health and Disease

ECOLOGY
becomes
BIOLOGY,
and together they drive
DEVELOPMENT
across the lifespan





TOXIC STRESS: TREATMENT

- Trauma Focused Cognitive Behavioral Therapy
- Parent Child Interactive Therapy

Challenges:

Reactive

Costly

Insufficient numbers of providers

Limited reimbursement

Stigma

Intake process is daunting for those most at risk

TOXIC STRESS: SECONDARY PREVENTION

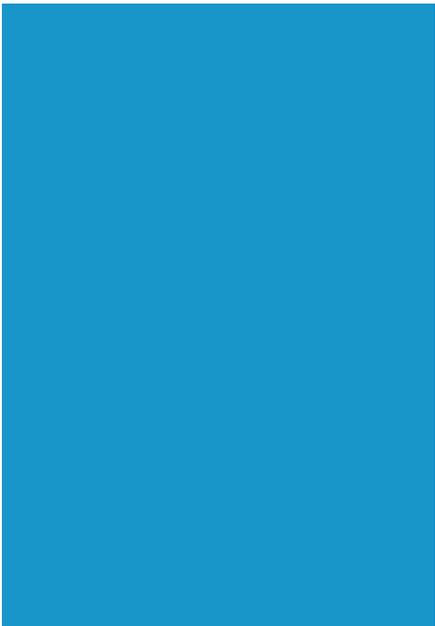
Focus on HIGH RISK populations

- Home visitation programs
- Nurse Family Partnership,
- Parenting Programs (Triple-P, Nurturing Parent.)
- Early childhood education (Early HeadStart, HeadStart)
- Pregnancy Planning

Challenges:

- More likely to be effective; minimize “damage”
- Requires screening
- Still issues with stigma, numbers of/access to providers

TOXIC STRESS: PRIMARY PREVENTION



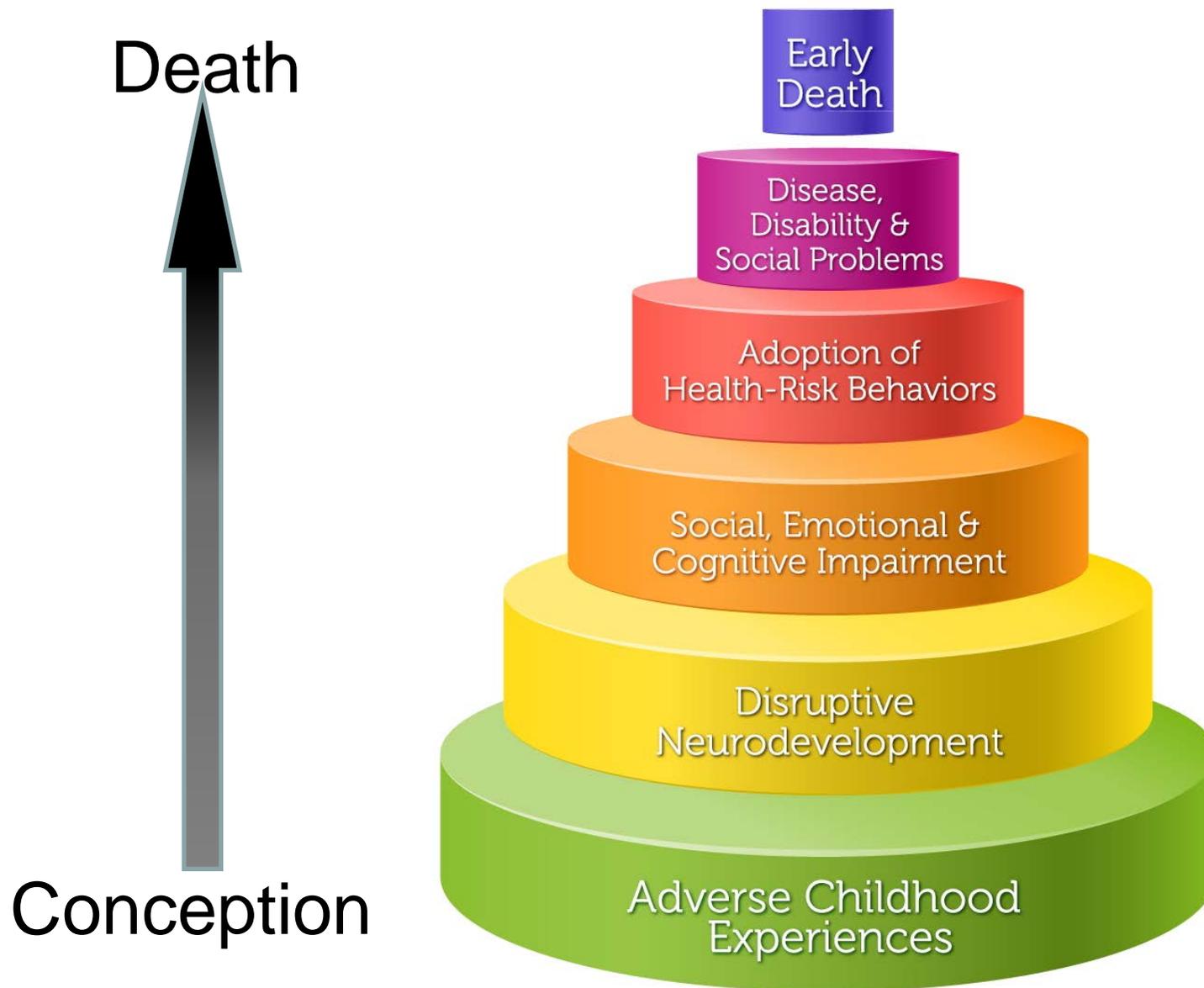
- Screening for ACEs in practice (child and parent)
- Parent's Toxic Stress must be addressed
- **Actively building resiliency** (“immunizing” through positive parenting, 7C’s, promoting optimism, formalized social-emotional learning)
- **Social Emotional Buffers** allow the physiologic stress response to return to baseline
- **Parenting/Care giving skills**
- **SEL skills for older children** (www.casel.org)
- Mindfulness

Parent/caregiver support is critical

- Addresses physiologic and safety needs
- Promotes healthy relationships and attachment
- Emphasis on the “serve and return” function of parenting
- Encourages foundational coping skills as they emerge

We can:

- Promote this sort of “Purposeful” Parenting
- Advocate / participate public health approach to address toxic stress



Mechanisms By Which Adverse Childhood Experiences Influence Adult Health Status



POLICY STATEMENT

Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health

abstract

FREE

Advances in a wide range of biological, behavioral, and social sciences are expanding our understanding of how early environmental influences (the ecology) and genetic predispositions (the biologic program) affect learning capacities, adaptive behaviors, lifelong physical and mental health, and adult productivity. A supporting technical report from the American Academy of Pediatrics (AAP) presents an integrated ecobiodevelopmental framework to assist in translating these dramatic advances in developmental science into improved health across the life span. Pediatricians are now armed with new information about the adverse effects of toxic stress on brain development, as well as a deeper understanding of the early life origins of many adult diseases. As trusted authorities in child health and development, pediatric providers must now complement the early identification of developmental concerns with a greater focus on those interventions and community investments that reduce external threats to healthy brain growth. To this end, AAP endorses a developing leadership role for the entire pediatric community—one that mobilizes the scientific expertise of both basic and clinical researchers, the family-centered care of the pediatric medical home, and the public influence of AAP and its state chapters—to catalyze fundamental change in early childhood policy and services. AAP is committed to leveraging science to inform the development of innovative strategies to reduce the precipitants of toxic stress in young children and to mitigate their negative effects on the course of development and health across the life span. *Pediatrics* 2012;129:e224–e231

INTRODUCTION

"It is easier to build strong children than to repair broken men."

Frederick Douglass (1817–1895)

From the time of its inception as a recognized specialty of medicine, the field of pediatrics has attached great significance to both the process of child development and the social/environmental context in which it unfolds. When the American Academy of Pediatrics (AAP) was founded in 1930, the acute health care needs of children were largely infectious in nature.¹ Over the ensuing 80 years, as increasingly effective vaccines, hygiene, and other public health initiatives produced dramatic gains, astute observers began to note that many noninfectious disease entities, such as developmental, behavioral, educational, and

COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COMMITTEE ON EARLY CHILDHOOD, ADOPTION, AND DEPENDENT CARE, AND SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

KEY WORDS

advocacy, brain development, ecobiodevelopmental framework, family pediatrics, health promotion, human capital investments, new morbidity, toxic stress, resilience

ABBREVIATIONS

AAP—American Academy of Pediatrics

EBD—ecobiodevelopmental

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Moving it into practice



Medical Home for Children Exposed to Violence

A Program of the American Academy of Pediatrics

About the Project

- Funded by the Department of Justice
- Began June 2011
- Areas of focus
 - Educate and equip the medical home team
 - Raise awareness on a national level
- Builds on expertise of leading experts
- Advisory of leaders in the field



The Goal

- Over 60% of children have experienced some kind of violence. This means that it IS happening in every practice and it can have incredibly negative impacts on the child's health.
- Ask about exposure to violence
- Consider toxic stress when making a diagnosis
- Talk to families about building resiliency

What We Have So Far – Web Site

The screenshot shows the AAP website's navigation bar with links for Professional Resources, Continuing Medical Education, Advocacy & Policy, AAP Store, and About the AAP. A search bar is located in the top right corner. Below the navigation bar, the breadcrumb trail reads: AAP.org > Advocacy & Policy > AAP Health Initiatives > Medical Home for Children and Adolescents Exposed to Violence. An Advanced Search link is also present.

Medical Home for Children and Adolescents Exposed to Violence

About

Putting It Into Practice

Improving Practice

Tools and Resources

Medical Home for Children Exposed to Violence

This website provides pediatricians and all medical home teams with the resources they need to modify practice operations to more effectively identify, treat, and refer children and youth who have been exposed to or victimized by violence.

Learn all you can

Current Events

View current events in the news related to children exposed to violence

DISCLAIMER

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What We Have So Far – Web Site

About

Putting It Into Practice

Overview

Bullying and
Cyberbullying

Community Violence

Child Abuse and
Neglect

Domestic & Intimate
Partner Violence

Sexual Abuse

Teen Dating Violence

Improving Practice

Tools and Resources

Community Violence

The information below is meant only as a starting place for pediatric medical home teams to begin addressing community violence. In no way are these resources exhaustive. An overall statement that can be used to start the discussion is "We have a better understanding today of the negative effects that exposure to violence has on children and adolescents, such that I now talk to all of my families about exposure to violence." For more background on using the materials below, go to the [Overview](#).

Framing the Question

- Has the child had stomach pains, headaches, and other somatic complaints that seem to have no source?
- Has the child's behavior changed dramatically, seemingly without cause (eg, difficulty sleeping, avoiding people, performance in school)?
- Has anything violence-related or frightening happened in the child's school or neighborhood since the last time you saw

What We Have So Far - Webinars

Professional Resources | Continuing Medical Education | Advocacy & Policy | AAP Store | About t

AAP.org > Advocacy & Policy > AAP Health Initiatives > Medical Home for Children and Adolescent Practice > Educational Opportunities

Medical Home for Children and Adolescents Exposed to Violence

 Medical Home for Children Exposed to Violence

a a

Educational Opportunities

There are a number of valuable Webinars and presentation materials that medical home teams can access to increase their knowledge related to exposure to violence and its potentially lifelong impact on children and youth. This is a growing list and if



A Shake-up to the Medical Model

- Acute care → Wellness care
- Using relationships as a vital sign
- ACEs are part of the medical home (both parent and child)
- Building parental and child resiliency
- Integration with early childhood education and social services



THE MEDICAL HOME RESPONSE

The Framework: AAP-defined Medical Home

Accessible

Continuous

Family-Centered

Comprehensive

Coordinated

Compassionate

Culturally Effective

Recognizing that families play a vital role in ensuring health and well-being of the patient. Acknowledging that emotional, social and developmental support are integral components of health care.



Simultaneously addressing medical, behavioral, and social issues. Treating the whole individual and ALL of his or her needs.

MEDICAL HOME FERVOR



WHAT'S ACTUALLY HAPPENING...



MCHB Definition of CYSHN

- *Children with special health care needs are those who have or are at-risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.*

Considering CEV as CYSHN

- Medical home model originally developed for CYSHN
- CEV meet the definition of CYSHN as they...
 - Are at risk for poor health outcomes
 - Should be connected to additional services compared to other children
 - Deserve tracking and follow up
- “CEV need developmental promotion times ten.”

Applying Medical Home Principles to ACE Screening

- Identify the population through screening or surveillance, and track them
- Assess the family and patient strengths / assets, and needs for specific services
- Make referrals
- Provide self-management tools (developmental promotion)
- Follow up on referrals / close communication loops

Case Study: The Children's Clinic

- 27 providers in two practice sites
- Strong interest in early childhood development / developmental promotion
- Since 2008 have implemented multiple standardized universal screening protocols
 - Developmental delay
 - Autism
 - Maternal Depression
 - Adolescent Depression
 - Adolescent Substance Abuse
- Adolescent questionnaire has always included questions about dating violence; many providers ask about bullying in their history for school aged children.



Four Starting Questions:

- Why am I looking?
- What am I looking for?
- How do I find it?
- What do I do once I've found it?



What Others Have Done

- Formal screening protocols in primary care practices are pretty rare
- Public health?
 - Incorporating ACE questions into Behavioral Risk Factor Surveillance System (BRFSS)
- Home Visiting?
- Nadine Burke Harris, MD – San Francisco
 - Inner city practice – screening all children for ACEs, developed a multidisciplinary team approach to trauma-informed care
- Christopher Blodgett, PhD – Spokane, WA
 - Screening in elementary school settings, interventions included changes in disciplinary process. Found ACEs are the second highest predictor of academic failure (after being in special education classes).
 - If 3 or more ACEs: Academic failure 3x
 - Attendance problems 5x
 - School behavior problems 6x
 - ***A single ACE more than doubled the risk of attendance and school problems***

Why am I looking? Building the Case

- Important to understand the impact
 - Educating other providers
 - Educating patients
 - Educating office staff
- Helps to drive QI change if there are practice champions (provider and office staff)
- After reading policy statement on toxic stress, several providers were left with a “now what?” feeling.



Addressing Every Provider's Greatest Fear...



- Listening is therapeutic.
 - “When something becomes speakable, it becomes tolerable”.
 - Drawing the connection between the emotional brain and the thinking brain is the first step toward healing and integration.
- Principles of Motivational Interviewing 101.
 - Abandon the “righting reflex”.
 - Solutions to patients’ problems often can be found within the patients themselves.
- Put your own oxygen mask on first.
- Key message: “you aren’t alone, it’s not your fault, and I will help.”

What am I looking for?

Our Starting Questions

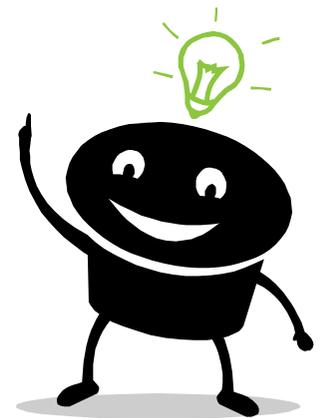
- Who should we screen?
 - Are we targeting the incidence of ACEs within our patients themselves? If so, when do we screen?
 - Everyone during the toddler years?
 - Children who present with apparent somatic complaints?
 - Children experiencing school problems / failure?
 - Teens with mental health concerns?
- Do we look at parents' experiences?
- What do we screen them with?
- When should we screen them?



What am I Looking for?

Screening Parents for ACEs

- If the majority of what we learn about being a parent comes from our own experiences...
 - How do ACEs impact parenting choices?
 - Is it possible to counsel and support parents in making different decisions about parenting (that is, build resiliency)?
 - What resources do our parents want?
- Decided that focusing on parents' experiences in childhood was a good starting point.



How do I find it?

Deciding on an Office Workflow

- Which visits will I begin to ask screening questions?
- How will I ask the questions? Pre-visit questionnaire versus direct interview?
 - If questionnaire, who will distribute, explain to patients, and get it to the provider? How do I ensure patient privacy as they answer the questions?
 - If direct interview, what decision supports will help me remember the questions?
- How do I document the results?



How do I Find it? Our First Small Step

- Eight providers piloting screening
- At the four month visit, parents are given the ACE screener, along with a questionnaire about resilience and a list of potential resources.
- Cover letter explaining the rationale for the screening tool, and what we plan to do with the information
- Created a confidential field in the EMR that does not print into notes, but perpetuates into visits to document results while minimizing risk to families.



Overall Results of ACE Screening

ACE Score	Total (% of total)	Public Insurance (% of total Public Insurance)	Private Insurance (% of total Private Insurance)	Unknown Insurance Status
0	155 (47.5%)	54 (40.2%)	89 (53.6%)	12
1	107 (32.8%)	53 (39.6%)	44 (26.5%)	10
2	21 (6.4%)	7 (5.2%)	10 (6%)	4
3	18 (5.5%)	8 (6%)	10 (6%)	0
>4	25 (7.8%)	12 (9%)	13 (7.8%)	0
Total	326	134	166	26

Comparing TCC to Oregon

ACE Score	TCC Average	State of Oregon
0	48%	38%
1	33%	23%
2	6%	13%
3	6%	10%
>4	8%	17%

Resiliency Scores

ACE SCORE	Resilience (Range)	
	Public Insurance	Private Insurance
0	56 (36-60)	57 (38-60)
1	53 (43-60)	57 (46-60)
2	51 (41-60)	54 (47-60)
3	51 (42-60)	50 (36-60)
>4	43 (32-55)	45 (37-58)

What Parents Want...

Type of Support	Number of responses
Support Groups	20
Parenting Classes	18
Website Information	13
Twitter Feeds	10
Home Visiting Nurse	8
Relief Nursery	3
Other (Childcare assistance, Fathers' Support Group, Mom and Baby Groups, Job Assistance)	4

Our Results?

- Prevalence rate of ACEs ≥ 4 in our practice was around 8%.
- Only recently translated materials for screening into Spanish, so missing a critical population
- Lower than overall prevalence for the state
- Parents received the screening tools well, and were receptive to conversations about their experiences when presented in the context of offering support and guidance.
- Connected Kids materials and exercises used as part of the follow up; most parents were interested in parenting classes and parent groups.

Parent Comments...

I would like to have counseling because me and my boyfriend [daughter's father] are getting into a lot of arguments and fights, also there's a lot going on and I feel like having someone to come into the situation will really help better our relationship with each other and also raising [our daughter].

Ace Score: 8

Resiliency Score: 32



What do I do Once I've Found It?

Meaningful Conversations and Follow Up

- Selected Connected Kids resources stocked in exam rooms.
- Used guidance from Connected Kids to supplement conversation during subsequent exams.
- Care Coordinator tracked down community resources (parenting classes, resources for home visitation, support groups, etc.).

Infancy and Early Childhood: Prenatal to 5-Year-Old Visits

Visit	Introduce	Reinforce	Brochures
2 Days to 4 Weeks	<ul style="list-style-type: none"> • What Babies Do • Parental Frustration • Parent Mental Health • Parent Support 		1. <i>Welcome to the World of Parenting!</i>
2 and 4 Months	<ul style="list-style-type: none"> • Child Care • Family • Safe Environment • Parenting Style • Bonding and Attachment 	<ul style="list-style-type: none"> • Parent Mental Health • Parent Support 	2. <i>Parenting Your Infant</i>
6 and 9 Months	<ul style="list-style-type: none"> • Establishing Routines • Discipline = Teaching • Firearms • Modeling Behavior 	<ul style="list-style-type: none"> • Parent Support • Child Care • Safe Environment • Bonding and Attachment 	3. <i>How Do Infants Learn?</i> 4. <i>Your Child Is On the Move: Reduce the Risk of Gun Injury</i>
12 and 15 Months	<ul style="list-style-type: none"> • Child Development and Behavior 	<ul style="list-style-type: none"> • Safe Environment • Parenting Style • Firearms • Modeling Behavior 	5. <i>Teaching Good Behavior: Tips on How to Discipline</i>
18 Months and 2 Years	<ul style="list-style-type: none"> • Child's Assets • Guided Participation • Media 	<ul style="list-style-type: none"> • Parent Support • Establishing Routines • Firearms • Child Development and Behavior 	6. <i>Playing Is How Toddlers Learn</i> 7. <i>Pulling the Plug on TV Violence</i>
3 and 4 Years	<ul style="list-style-type: none"> • Peer Playing • Safety in Others' Homes • Talking About Emotions • Promoting Independence 	<ul style="list-style-type: none"> • Modeling Behavior • Guided Participation 	8. <i>Young Children Learn a Lot When They Play</i>



Examples of Response Algorithm: Selected Topics From Connected Kids

- At 4 months:
 - How are you and your partner getting along?
 - What are you doing to take care of yourself?
 - Handout: Parenting your infant
- At 6 months:
 - Modeling behavior: How do you and your partner handle conflict?
 - How did your parents handle conflict with each other and with you?
 - Handout: How do Infants Learn?
 - Social connections exercise
- At 9 months:
 - When your child is doing something good, how do you encourage him / her?
 - Does your child hit or bite? If so, how do you handle this?
 - Handout: ASQ Activities handouts of parents' choice

How we Found our Resources

- **Don't reinvent the wheel!**
- Local Public Health Department / Defending Childhood Initiative
- CARES NW (our local child abuse hotline / clinic / resource)
- Child Care Resource & Referral
- Local Title V Division / CYSHN Program
 - Family2Family Networks

Now what?



- Our first pilot was really to answer the questions:
 - Is it feasible? Will our patients complete it? Will our providers accept it? Can we tailor a response to the screening results?
- Now what we want to know:
 - How do we spread screening?
 - What are the outcomes we are looking for?
 - How does the resiliency score form or tailor our response to ACEs?
 - What additional ACEs should we screen for?
 - Should we do universal screening?

What's next for TCC?

Continuing to Focus on Simple Steps

- How do we improve detection rates?
 - Culture change in the patient-provider relationship...how is this facilitated?
 - Are we asking the right questions?
 - Are response rates different if asked as an interview (instead of paper)?
- What other times do we need to be asking these questions?
 - Universal screening: what ACEs are our patients experiencing...toddler years? School years? Teen years?
 - Targeted screening: screening at mental health visits? Screening when unexplained somatic complaints arise? Screening in the context of school failure?

What's next for TCC?

Continuing to Focus on Simple Steps

- Some providers have added ACEs into the standard history for adolescents with mental health complaints.
- Adding additional questions...more ACEs to ponder:
 - Parental death
 - Food Insecurity
 - Racism / prejudice
 - Community violence
- Considering screening universally for childhood ACEs to understand prevalence in our patient population.
 - What is the right set of screening questions?
 - What is the right time to ask?

And getting into the weeds of statistics...

- Resiliency screener looks at three domains of resilience – individual, family, community.
- Are there correlations with types of ACEs and types of resilience (either present or lacking)? If so, how does this inform our response?
- Are there differences in ACE rates based on race / culture / language?
- If there are no clear differences in public versus private insurance in terms of the number of ACEs, are there differences based on other patient / parent characteristics?
- Which ones should we be looking for?

Other Ways to Get Your Feet Wet

- Some providers choose to work on a specific type of violence first, rather than the entirety of ACEs
- Specific surveillance questions for exposure can be found at www.aap.org/medhomecev
- Universal surveillance question:

“Since the last time I saw your child, has anything really scary or upsetting happened to your child or anyone in your family?”

(Cohen, Kelleher, & Mannarino, 2008),

What if I'm not ready to start asking?

- Set the tone – let your parents know that the issues are important, impact the child, and are ok to talk about.
“You’re not alone, it’s not your fault, and I can help”
- Other modalities for opening the door to conversation.
 - Exam room posters, resource lists and website links, “Did you know” statements on clipboards used to fill out office paperwork.
- Continue to encourage developmental promotion.

Summary

- Screening for ACEs can and should be integrated into medical home model of practice.
- When considering screening for ACEs, remember to start small but think big
- From Bright Futures:
 - Prevention works
 - Families matter
 - Health is everyone's business



For More Information

- Project Web site: www.aap.org/medhomecev
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Medical Home for Children
Exposed to Violence

A Program of the American Academy of Pediatrics