Understanding the Effects of Toxic Stress in Childhood

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Project Background

- Funded by Department of Justice
- Focus on polyvictimization
  
  *Children who have directly experienced multiple types of violence (eg, bullying; child abuse, sexual abuse, and neglect; domestic violence; community violence)*

- 2 primary objectives
  - Educate pediatricians, medical home teams, and community partners
  - Raise awareness of the medical home as a key support for families whose children have experienced polyvictimization
Building on Previous Work

• Medical home for children exposed to violence project
  – Also funded by DOJ
  – Web portal (www.aap.org/medhomecev)
  – Webinar series (www.aap.org/medhomecev/education)
  – Online training toolkit

• Additional AAP projects
  – Practicing Safety
  – Connected Kids
  – Preventing Sexual Violence toolkit
  – EBCD work group
Roadmap

• Recognize the short- and long-term biological impact of exposure to toxic stress in childhood
• Understand the role of the pediatrician and medical home team in identifying children who have experienced toxic stress

• What is toxic stress?
• How big is the problem of violence exposure?
• What are some potential first steps in the Medical Home’s response?
WHAT IS TOXIC STRESS?
Adverse Childhood Events

“*We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.*”

- **Abuse**
  - Emotional
  - Physical
  - Sexual

- **Neglect**
  - Emotional
  - Physical

- **Household dysfunction**
  - Domestic violence
  - Household substance abuse
  - Household mental illness
  - Parental separation / divorce
  - Incarcerated family member


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The effects of ACEs

• ACE scores range from 0 (none) to 10 (all). One in five study participants reported 3 or more ACEs.

• Compared to persons with an ACE score of 0, those with an ACE score of 4 or more were:
  – twice as likely to be smokers
  – 12 times more likely to have attempted suicide
  – 7 times more likely to be alcoholic
  – and 10 times more likely to have injected street drugs.

• Also more likely to have COPD, ischemic heart disease, liver disease, STDs, early / unintended pregnancies, autoimmune diseases, obesity.
Premature Mortality with ACEs

- People with 6 or more ACEs died nearly 20 years earlier on average than those without ACEs.
- Average Years of Life Lost (YLL) was three times greater among people with six or more ACEs than those without.
- Increase in risk was only partly explained by documented ACE-related health and social problems.

“Adverse Childhood Experiences have created a chronic public health disaster.”

– Robert Anda
Adverse Childhood Experiences → ??? → Adult Health Risks
Toxic stress & the biological impact

- Maladapted neural connections in the brain
- Over-stimulated stress response
- Ongoing issues managing stress response and decision-making
- Particularly vulnerable early in life (<2 years)

Eco-Bio-Developmental (EBD) model of human health and disease

And together they drive development across the lifespan

Biology
Physiologic Adaptations and Disruptions

Ecology
The social and physical environment

Development
Learning, Behavior And Health

Life Course Science

The Basic Science of Pediatrics

Epigenetics

Neuroscience

Ecology Becomes biology, development

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What we learn from the EBD Framework

- Though grounded in developmental science, the simplicity of the EBD framework may promote understanding as well as support for translation.

- Psychosocial stressors and other salient features of the ecology are every bit as biological as nutrition or lead (no distinction between mental and physical health, just healthy vs. unhealthy development).

- Emphasizes the dimension of time – to reflect the on-going, cumulative nature of benefits and threats to health and wellness.
What we learn from the EBD Framework

• Underscores the need to improve the early childhood ecology in order to:
  – Mitigate the biological underpinnings for educational, health and economic disparities
  – Improve developmental/life-course trajectories

• Highlights the pivotal role of toxic stress
  – Not just “step on the gas” or enrichment
  – But “take off the brake” by treating, mitigating or immunizing against toxic stress
The **BIG** Questions

If **TOXIC STRESS** is the missing link between **ACE exposure** and the **unhealthy lifestyles** and **poor outcomes** seen as adults, it raises the following **BIG** questions:

1) Are there ways to **treat, mitigate, and/or immunize** against the effects of toxic stress?

2) What are the **long term costs** due to toxic stress **versus** the up-front costs to treat, mitigate or immunize?
How ACEs impact health

- Death
- Disease, Disability and Social Problems
- Adoption of high Risk Behaviors
- Social, Emotional & Cognitive Impairment
- Disrupted Neurodevelopment
- Adverse Childhood Experiences

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Impact of Violence on Outcomes

Violence Exposure

- Aggression
- Substance abuse
- Academic problems
- PTSD
- Anxiety
- Depression
- Social problems
- Delinquent Behavior

Healthy Development
Risk factors are cumulative

<table>
<thead>
<tr>
<th>Social/Community</th>
<th>Family</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poverty</td>
<td>• Poor parenting</td>
<td>• Poor coping skills</td>
</tr>
<tr>
<td>• Discrimination</td>
<td>• Parental mental health problems</td>
<td>• Learning problems</td>
</tr>
<tr>
<td>• Low quality schools</td>
<td>• Housing instability</td>
<td>• Impulsivity</td>
</tr>
<tr>
<td>• Availability of drugs &amp; guns</td>
<td>• Family conflict</td>
<td>• Difficult temperament</td>
</tr>
<tr>
<td>• High crime</td>
<td>• Neglect</td>
<td>• School failure</td>
</tr>
<tr>
<td>• Gangs</td>
<td></td>
<td>• Poor work skills</td>
</tr>
<tr>
<td>• Delinquent peers</td>
<td></td>
<td>• Substance use</td>
</tr>
</tbody>
</table>
Multiple Influences on Outcomes

Risk factors: increase likelihood of poor outcome

Protective factors: increase resilience

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### Resiliency and a Child’s Basic Needs

#### Models

<table>
<thead>
<tr>
<th>Needs</th>
<th>Maslow’s Hierarchy of Needs (Theoretical - 1943)</th>
<th>America’s Promise Alliance (Evidence-based)</th>
<th>ASCD’s Whole Child Education (Implementation)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Actualization</strong></td>
<td>Need to know, explore and understand</td>
<td>An effective education</td>
<td>Each student is actively engaged in learning</td>
</tr>
<tr>
<td><strong>Esteem</strong></td>
<td>Need to achieve and be recognized</td>
<td>Opportunities to contribute</td>
<td>Each student has numerous opportunities</td>
</tr>
<tr>
<td><strong>Love/Belonging</strong></td>
<td>Need for friends</td>
<td>Caring adults and family</td>
<td>to demonstrate achievement</td>
</tr>
<tr>
<td><strong>Safety/Security</strong></td>
<td>Need to feel secure and safe from danger</td>
<td>Safe places</td>
<td>Each student has access to qualified, caring adults</td>
</tr>
<tr>
<td><strong>Physiological</strong></td>
<td>Need to satisfy hunger, thirst, sleep</td>
<td>A healthy start</td>
<td>Each student learns in a physically and emotionally safe environment</td>
</tr>
</tbody>
</table>

Unmet needs are potential sources of **STRESS**
Prevention through Building Resilience

• For young children, parent/caregiver support is critical:
  • Turns off physiologic stress response by addressing physiologic and safety needs (Maslow levels 1+2 – PROTECT)
  • Turns off the physiologic stress response by promoting healthy relationships and attachment (Maslow level 3 - RELATE)
  • Notes and encourages foundational coping skills as they emerge (Maslow levels 4+5 - NURTURE)
Key protective factors

- Safe, cohesive neighborhood
- Parental warmth and monitoring
- Connection with a caring adult
- Parent without trauma symptoms
HOW BIG IS THE PROBLEM?
ACEs are Common

- 62% of adults have at least one ACE.
- One in four reports three or more.
- 5% of adults have 6 or more ACEs.
  - Since ACEs are interrelated, the occurrence of one ACE should precipitate a search for others.
- There is a dose-response relationship between ACEs and adoption of high risk behaviors, and between ACEs and lifetime health risks.
National Survey of Children’s Exposure to Violence

- Telephone survey conducted January – May 2008
- National representative sample of 4549 children age 1 month-17 years
  - 2454 caregivers of children age 0-9
  - 2095 youth age 10-17
- More than 40 types of victimization assessed

NatSCEV, Finkelhor, Turner, Ormrod, & Hamby, 2009
Victimization in Last Year

Key Findings from the National Survey of Children’s Exposure to Violence and Implications for Assessment, Sherry Hamblin, Sewanee, University of the South.
Why focus on polyvictimization?

- The National Survey of Children Exposed to Violence (NatSCEV) indicates over 60% of children are exposed to violence in a year
  - 38.7% were victimized two or more times
  - 10.9% were victimized five or more times
- Children directly victimized by any number of violent events are at significantly higher risk for additional direct victimization

Why focus on polyvictimization?

- 8% of children have experienced or been exposed to 7 or more types of violence, crime or abuse
- This group represents a disproportionate number of the children who have experienced other serious types of violence
- The victimization often starts in grade school and continues throughout high school
- Increased association with higher levels of lifetime adversity

Dose effect of ACEs

The ACE Score... Alcohol Use and Abuse

ACE Score
0 1 2 3 4 or more

Percent with alcohol related problem

Early initiation of use (by age 14)
Problem with alcohol use
Alcoholic
Married an Alcoholic

RF Anda, DW Brown. Adverse Childhood Experiences & Population Health in Washington. 2010. Do not cite or reproduce content without appropriate citation.
Dose Effect of ACEs

The ACE Score, Smoking, and Lung Disease

ACE Score
- 0
- 1
- 2
- 3
- 4 or more

Percent With Health Problem (%)

Early smoking initiation

Current smoking

COPD


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Exposure to Violence, Traumatic Stress, and PTSD in Preschoolers

• Children aged 2–5, more than half (52.5%) had experienced a severe stressor in their lifetime

Egger & Angold, 2004

PTSD in Pre-school Children:

• Proposed addition to the DSM V
  – Disturbance causes distress or impairment in relationships with parents, siblings, peers, or in school behavior
  – Associated features: new fears, anxieties, aggression, constriction in play, loss of developmentally acquired skills

Scheeringa, Zeanah, & Cohen, 2011
Exposure to Violence → Traumatic Stress → PTSD

PTSD

• “Exposure to an extreme traumatic stressor.........”
  • The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response may involve disorganized or agitated behavior)
• Symptoms related to re-experiencing the event
• Symptoms associated with avoidance of trauma reminders and numbing of general responsiveness
• Symptoms of arousal
• Duration of symptoms > 1 month
Behaviors Associated with Early Childhood Trauma

<table>
<thead>
<tr>
<th>Ages: 0-2</th>
<th>Ages: 3-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Irregular eating, sleeping patterns</td>
<td>• Increased aggression</td>
</tr>
<tr>
<td>• Developmental regression</td>
<td>• Somatic symptoms</td>
</tr>
<tr>
<td>• Irritability, sadness, anger</td>
<td>• Sleep difficulties/nightmares</td>
</tr>
<tr>
<td>• Poor appetite; low weight</td>
<td>• Increased separation anxiety</td>
</tr>
<tr>
<td>• <strong>Increased separation anxiety; clinginess</strong></td>
<td>• New fears</td>
</tr>
<tr>
<td></td>
<td>• Increased distractibility/high activity level</td>
</tr>
<tr>
<td></td>
<td>• Increased withdrawal/apathy</td>
</tr>
<tr>
<td></td>
<td>• Developmental regression</td>
</tr>
<tr>
<td></td>
<td>• Repetitive talk/play about the event</td>
</tr>
<tr>
<td></td>
<td>• Intrusive thoughts, memories, worries</td>
</tr>
</tbody>
</table>

NCTSN.org/earlychildhoodtrauma

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THE MEDICAL HOME RESPONSE
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.
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 CEV

• 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
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?
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)
What am I looking for?
Deciding on an Office Workflow

• What types of violence am I prepared to start asking about? What is the prevalence in my particular community?
• 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?
Range of Childhood Violence Exposure

- Physical abuse
- Sexual abuse
- Domestic violence
- Community violence
- Bullying
- School violence
- Gang activity
- Sexual exploitation
- Terrorism
- War, Genocide

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How do I find it?

Screening and Surveillance

Universal inquiry about exposure to violence in the child’s life:

“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),
Specific Screening Questions

- Depending on your community’s prevalence, you may choose to tailor for specific types of violence.
- Guidance from Bright Futures, Medical Home for Children Exposed to Violence Website.
What do I do once I’ve found it?
Assessing Family Strengths

• Assess the child and parent’s immediate safety
  – Assets
  – Resources
  – Resiliencies

• The role of promotion and prevention can’t be underestimated...
## Counseling Schedule

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

<table>
<thead>
<tr>
<th>Visit</th>
<th>Introduce</th>
<th>Reinforce</th>
<th>Brochures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Days to 4 Weeks</td>
<td>- What Babies Do&lt;br&gt;- Parental Frustration&lt;br&gt;- Parent Mental Health&lt;br&gt;- Parent Support</td>
<td></td>
<td>1. Welcome to the World of Parenting!</td>
</tr>
<tr>
<td>2 and 4 Months</td>
<td>- Child Care&lt;br&gt;- Family&lt;br&gt;- Safe Environment&lt;br&gt;- Parenting Style&lt;br&gt;- Bonding and Attachment</td>
<td>- Parent Mental Health&lt;br&gt;- Parent Support</td>
<td>2. Parenting Your Infant</td>
</tr>
<tr>
<td>6 and 9 Months</td>
<td>- Establishing Routines&lt;br&gt;- Discipline = Teaching&lt;br&gt;- Firearms&lt;br&gt;- Modeling Behavior</td>
<td>- Parent Support&lt;br&gt;- Child Care&lt;br&gt;- Safe Environment&lt;br&gt;- Bonding and Attachment</td>
<td>3. How Do Infants Learn?&lt;br&gt;4. Your Child Is On the Move: Reduce the Risk of Gun Injury</td>
</tr>
<tr>
<td>12 and 15 Months</td>
<td>- Child Development and Behavior</td>
<td>- Safe Environment&lt;br&gt;- Parenting Style&lt;br&gt;- Firearms&lt;br&gt;- Modeling Behavior</td>
<td>5. Teaching Good Behavior: Tips on How to Discipline</td>
</tr>
<tr>
<td>18 Months and 2 Years</td>
<td>- Child’s Assets&lt;br&gt;- Guided Participation&lt;br&gt;- Media</td>
<td>- Parent Support&lt;br&gt;- Establishing Routines&lt;br&gt;- Firearms&lt;br&gt;- Child Development and Behavior</td>
<td>6. Playing Is How Toddlers Learn&lt;br&gt;7. Pulling the Plug on TV Violence</td>
</tr>
<tr>
<td>3 and 4 Years</td>
<td>- Peer Playing&lt;br&gt;- Safety in Others’ Homes&lt;br&gt;- Talking About Emotions&lt;br&gt;- Promoting Independence</td>
<td>- Modeling Behavior&lt;br&gt;- Guided Participation</td>
<td>8. Young Children Learn a Lot When They Play</td>
</tr>
</tbody>
</table>
What do I do once I’ve found it?
Specific Follow-up Screening Tools

• Pediatric Symptom Checklist (PSC)
• Emotional Distress Screening (used to assess traumatic stress when an event is known, in children 2-10 years)
• UCLA PTDS Reaction Index (0-8 years, adolescent version available. 6 items)
• Screening Tool for Early Predictors of PTSD (12 questions developed for use during acute trauma care)
• Depression and anxiety diagnostic tools (PHQ9, SCARED)
When to refer for mental health treatment

- Chronic vs. single incident trauma
- When the symptoms persist for more than one month
- When the parents are unable to ensure safety, be supportive or attuned to the needs of the child
- When the parent is highly distressed and symptomatic
- When the trauma involves the sudden or violent loss of a caregiver or family member
What do I do once I’ve found it? Making Community Connections

• Child abuse hotline
  – Can be a resource for community agencies
• Hospital or health plan social workers
• Family to Family Network (www.familytofamilynetwork.org)
• Public Health Department – Futures without Violence, Defending Childhood
• Mental Health Organizations
• 211Info – operated out of United Way in MO, KS
Finding Community Resources

• Usually don’t need to reinvent the wheel…who in your community keeps resources lists like these?

Domestic Violence Resources

RESTRAINING ORDERS & STALKING ORDERS
Multnomah County Courts ………….. 503-988-3022
Clackamas Women’s Services ………… 503-655-6816
Washington County RO Advocate ……….. 503-846-3850
Clark County (Washington Court) ……… 1-888-397-2424
Legal Aid’s Domestic Violence Project ……….. 503-224-4080
(Please call for legal representation as low-income petitioners with court ordered restraining order hearings in Multnomah County. Call Tuesdays from 12-1pm)
Volunteers of America Court Liaison ……….. 503-988-4334
(For child care at Multnomah County courthouses while parents conduct Court business. Only for children ages 6 weeks to 7 years)

LAW ENFORCEMENT AGENCIES

EMERGENCIES (911)
Non-emergency Police Response in Mult. Co. ……….. 503-823-3333
Multnomah County Jail Release Info ……….. 503-988-3589
VME (Jail/Prison/Corrections Info) ……….. 1-877-84-VME
DVERT (Domestic Violence Enhanced Response) ……….. 503-988-6449
Portland Police DV Reduction Unit ……….. 503-823-0090
Gresham Police ………….. 503-618-3219
Multnomah County Sheriff’s Office ……….. 503-255-3600
Multnomah Co. Probation DV Unit ……….. 503-988-5056

MULTNOMAH COUNTY DISTRICT ATTORNEY’S OFFICE

Domestic Violence Prosecutor’s Office ……….. 503-988-3873
Victims’ Assistance Office ……….. 503-988-3222
Outreach for Under served Populations ……….. 503-988-5149
Child Support Enforcement ……….. 503-988-9104

CIVIL LEGAL ASSISTANCE

Child Support HelpLine ………….. 1-800-383-1222
(Legal Aid & Oregon Legal Center are here for help with child support information. Call Mondays 1-4:00 or Thursdays 9-noon)
Legal Aid’s Family Law Hotline ………….. 1-800-399-6101
(Phone advice about family law issues for low-income domestic violence survivors in Mult. Co. Call Thursdays between 9am-noon)
Hope For Families (Christian) ………….. 503-651-4444 x 556
Insights Teen Parent Program ………….. 503-239-6996
IRCO ………….. 503-234-1541
IRCO Refugee & Immigrant Family Strengthening ………….. 503-445-1446
L.A.Z.O.S. (Español) (NWIC/Washington Co.) ………….. 503-640-5322 x 311
MAYA Family Healing Center ………….. 503-288-8177
Ruskin Oregon Society ………….. 503-777-2437
SAWERA (South Asian) ………….. 503-778-7386
Self Enhancement Inc Domestic Violence Program ………….. 503-285-0493

FREE SUPPORT GROUPS* ………….. (Call groups and children’s groups)

Battered Women’s Services ………….. 503-654-2805
Clackamas Women’s Services ………….. 503-654-2805
Domestic Violence Resource Center ………….. 503-640-5352
El Programa Hispano Project UNICA ………….. 503-669-8350
Human Solutions ………….. 503-548-0021
Volunteers of America Home Free ………….. 503-771-5505

OTHER SERVICES

211 info (information & referral for community services) ……….. 2-1-1 Multnomah Childcare Resource & Referral ………….. 503-948-4400
SafeKids (state wide health referrals) ………….. 1-800-SAF-KID Oregon Crime Victim’s Compensation ………….. 503-700-7663
Oregon Health Helpline ………….. 1-800-359-9595
DHS Self-Sufficiency Services (Food Stamps, TANF, OHP, JOBS, etc.) ………….. 1-800-359-9595
TAX Program Information ………….. 971-673-2748
Alberta Branch ………….. 971-673-6900
SE Branch ………….. 971-673-2500
St. John’s ………….. 971-673-5500
East Self-Serve ………….. 971-673-0909
New Market ………….. 971-673-1400
Gresham ………….. 503-451-1979
East JBS ………….. 971-673-5566
North JBS ………….. 503-771-3331
Teen Parent ………….. 971-673-2502

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National Resources

• Family Violence Prevention Fund website www.futureswithoutviolence.org
• www.thatsnotcool.com – website for teens about dealing with cyber bullying
• www.stopbullying.gov
• Big Brother / Big Sister
Case Study: The Children’s Clinic

• 28 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.
Screening Parents for ACEs

• After reading policy statement on toxic stress, several providers were left with a “now what?” feeling.
• 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.
Our First Small Step

• 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.
• Connected Kids resources stocked in exam rooms.
Our Results?

• Prevalence rate of ACEs ≥ 4 in our practice was around 10%.
  – Only recently translated materials for screening into Spanish, so missing a critical population

• 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.
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.
• 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?
Summary

• CEV can and should be integrated into medical home model of practice
• When considering screening for CEV, remember to start small but think big
• From Bright Futures:
  – Prevention works
  – Families matter
  – Health is everyone’s business
How to Cite this Presentation: