Webinar Name	
Keep It Real: How One Pediatrician Makes Medical Home Work for Children Exposed to Violence	
Date	
30-Nov-12	

Session Details

Questions Asked by Attendee	Response Provided
Q: Are you able to use community health workers in your clinic?	We have not used community health workers to date, but that was mostly because it was very difficult to get sustainable funding for it under our previous model. I spoke briefly about the Center for Youth Wellness(CYW) as the new wellness center that we created to expand this model. CYW will be using community health workers.
Q: are you screening mothers of new borns for their exposure to adverse childhood events? if so, what interventions do you provide for those with high ACE scores?	We have not explicitly screened mothers of newborns for ACEs, though we have screened them for depression and exposure to domestic violence. That being said, based on the histories that many mom's disclose to us, I can say that many of them have high ACE scores. We have found that child-parent psychotherapy, in which the therapist works with the young child and the parent at the same time, is a very effective intervention.
Q: How do you handle "mother treated violently" in chart is father is abuser and has access to chart?	Answer provided during Webinar.
Q: Hi, this is so interesting - I'm wondering if these practices have been used in refugee clinics to address trauma in these populations where a medical home is so important	Great question. I have no idea! I know that mindfulness has been used in war-ravaged areas like Kosovo to help youth with PTSD and that it has been demostrated to be effective, but I can't speak specifically about refugee clinics.
Q: Can you re-explain bio-chemically why the adverse experiences childfen experience created the high risk behavior down the road: a week later, a year ater, etc…	Answer provided during Webinar. Resource all provided: Harvard's Center on the Developing Child (http://developingchild.harvard.edu/)
Q: I like the multidisciplinary team approach, but are there ways to work directly with the schools to help these kids, especially since the rate of problems in school are so high? Is there a feedback loop with school counselors?	I mentioned in the webinar that we have an educational advocate who works with school counselors and what they call here in SF the "student success team" or SST. What we have found over the years is that it sometimes takes a lot of follow up to make sure that the child is receiving the right support from school. Many districts are really under-resourced and it often takes persistence to get them plugged in to the appropriate servicees. That's why we specifically created the educational adovocate role for one of our case managers, because it was tough for the providers to do that level of follow-up.

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Q: At what age do you start asking children to participate in mindfulness-based awareness? Q: What are the specifics of your mindfulness program?	We did a mindfulness pilot for our teenage girls. Most of the girls were 14-17. What we found was that it really depends on the developmental stage of the youth. Some kids with a high ACE score, may have some developmental regression and mindfulness may not be that well suited for them. What seemed most important was the ability to be reflective and observe what was going on their minds and bodies. We had a grant and brought in a mindfulness professional. I know that there are folks that specialize in mindfulness work for kids
Q: What data do you have that your new clinical approach has truly resulted in improved outcomes?	Answer provided during Webinar
Q: What has been your experience when dealing with insurance companies reguarding coverage for mindful based awareness/biofeedback therapy?	Most of our population is covered by medi-caid which does not pay for mindfulness or biofeedback. Our kids who have had biofeedback are the ones who were covered by private insurance. Our mindfulness pilot was payed for with grant funding.
Q: What level of interaction does your center have with CPS?	We have a fair amount of interaction with CPS. We work incredibly hard to provide resources for parents and families and we are clear that CPS referral is a last resort. Often times we will do a contract for safety of the child if there is a case of medical neglect or an issue with parental mental illness or substance dependence. That contract clearly outlines our concerns and what the parent needs to do to alleviate our concerns and under what circumstance CPS will be called. Usually, by the time we have to make that referral, there is a fair amount of documentation in the chart that we have offered parents/caregivers quite a bit of resources and they have not followed through on the plan.
Q: Which symptoms do you assess for along with the occurence of an ACE. Do you assess for physical symptom or PTSD symptoms or both?	We assess for both physical symptoms and mental health symptoms. I usually do a fairly standard review of systems with particular attention to bowel and bladder function, any chronic issues that are impacting school attendance such as headaches and abdominal pain, and chronic disease management like asthma or diabetes management. In addition, I assess mood, school functioning and high-risk behavior. It's also helpful to do a strengths assessment as well in terms of family resources, church, school resources, etc which can be leveraged in plans for health and safety.