2018 Innovation Café: Strategies for Improving Children's Health

June 12, 2018

Salem, Oregon

TRANSFORMATION CENTER
Health Policy & Analytics Division

2018 Innovation Café: Strategies for Improving Children's Health

- This forum will engage health system champions in peer-to-peer learning and networking to spread innovation with the aim of improving children's health (prenatal to age 17), including a special emphasis on CCO early childhood incentive measures and cross-sector collaboration.
  - 2018 CCO challenge pool metrics:
    - Childhood immunization status
    - Developmental screening in the first 36 months of life (and follow-up to screening)
    - Assessments within 60 days for children in DHS custody
    - Prenatal and postpartum care: Timeliness of prenatal care
  - Cross-sector partnerships for early childhood health (ages birth to five), including social determinants of health
  - Oral health integration for improved child outcomes

Today's Agenda

7:30 – 8:30 a.m.	Registration & Breakfast
8:30 – 8:45 a.m.	Opening remarks
8:45 – 9:45 a.m.	Opening plenary
9:45 – 10:05 a.m.	Café instructions/Transition time
10:05-11:35 a.m.	Café session 1
11:35 -12:00 p.m.	Transition time/Lunch buffet
12:00- 1:15 p.m.	Lunch plenary
1:15 – 1:30 p.m.	Transition time
1:30 – 3:00 p.m.	Café session 2
3:00 – 3:45 p.m.	Networking & Refreshments

Opening Remarks

Chris DeMars, MPH, Director, Oregon Health Authority

Opening Remarks

Dana Hargunani, MD, MPH, Chief Medical Officer, Oregon Health Authority

Adverse Childhood Experiences in Children and Families: Understanding Primary Care's Role in Prevention

R.J. Gillespie, MD, MHPE
The Children's Clinic – Portland, OR

Innovation Café: Strategies for Improving Children's Health
June 12, 2018, Salem Convention Center

Disclosures

I have no personal financial relationships in any commercial interest related to this presentation.

I do not plan to reference off-label/unapproved uses of drugs or devices.

Objectives

- Provide an overview of ACEs and why ACEs / toxic stress matter to primary care, early education, and other providers who work with children and families.
- Discuss a framework for implementing screening in primary care practice, along with a clinical example of how this works in practice.
- Review potential areas for collaboration and cross-sector partnerships for addressing ACEs at a system level.

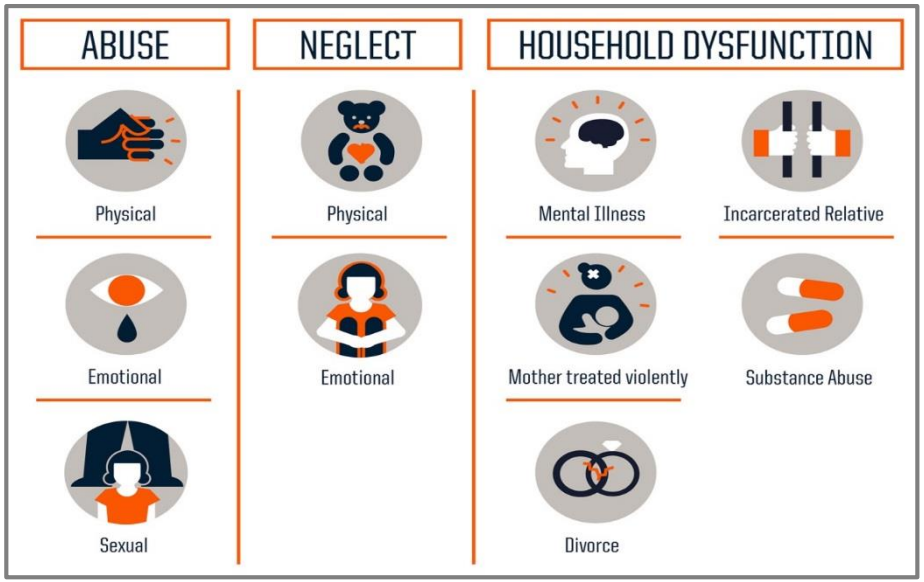
Background

What are Adverse Childhood Experiences and Toxic Stress?

Adverse Childhood Experiences (ACEs)

"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."

Felitti, et al. Am J Prev Med 1998;14:245–258

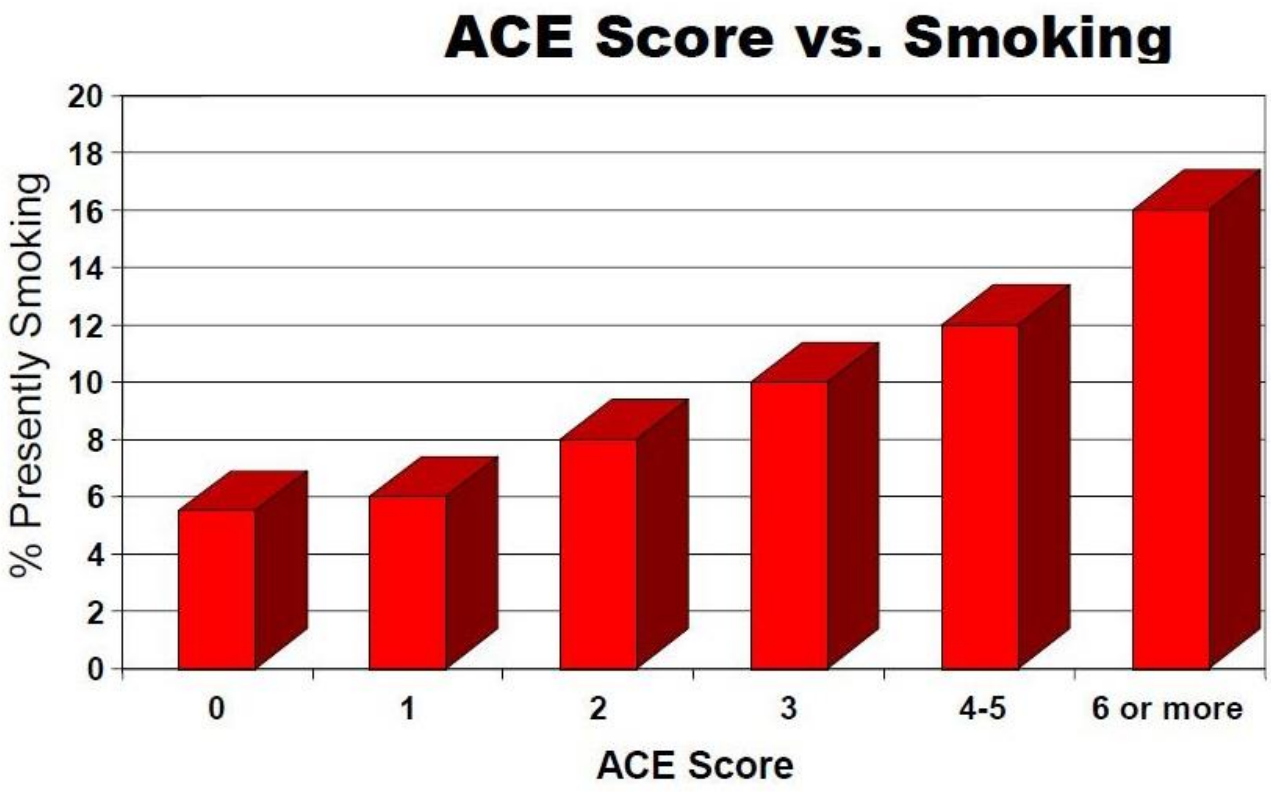


Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

ACEs are Common

- About 2/3 report at least one ACE
- 40% reported 2 or more ACEs
- 12.5% reported 4 or more ACEs

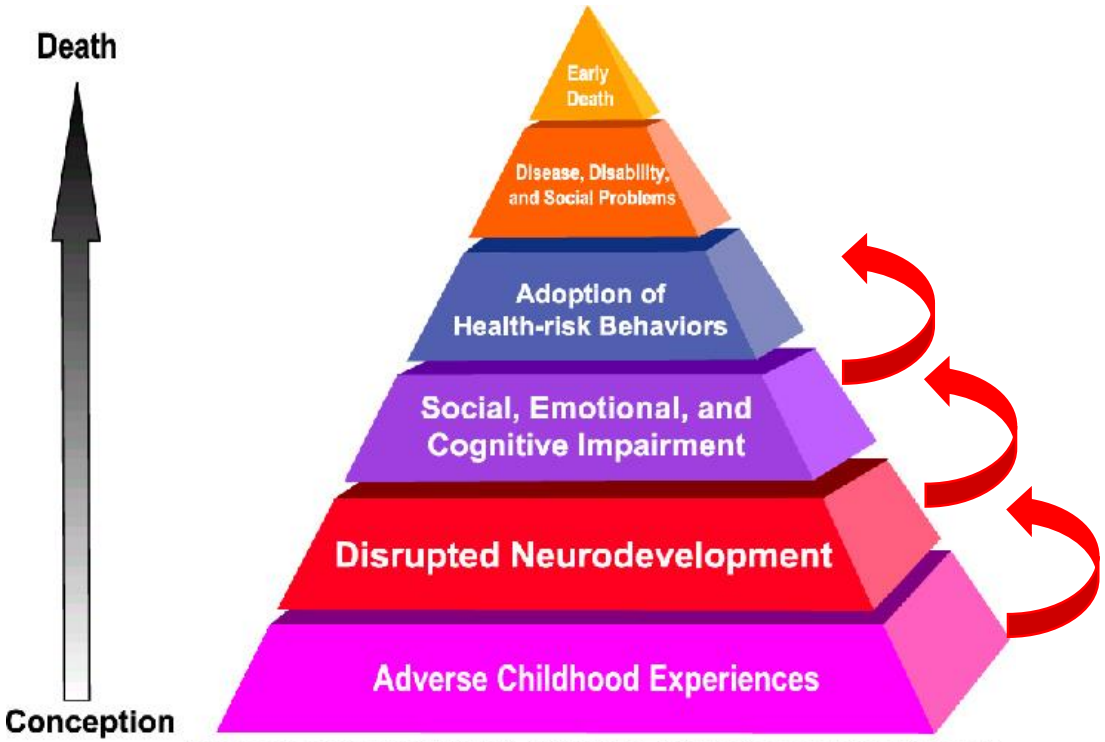
- If a patient has disclosed one ACE, there is approximately an 87% chance that they have experienced another.


ACE Score vs. Smoking
% Presently Smoking
20
18
16
14
12
10
8
6
4
2
0
0
1
2
3
4-5
6 or more
ACE Score

Premature Morbidity and Mortality with ACEs

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
- Autoimmune diseases
- ER visits
- Medical office visits
- Fractures
- Psychotropic medications prescribed
- Early death from myocardial infarction

ACE Pyramid



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

“We are the only living species that regularly and predictably maims and destroys its own young.”

Sandra L. Bloom
Creating Sanctuary

National Survey of Children's Health 2016

- **ACEs are a factor in a lot of the common problems that we see on a daily basis.**
  - 69% of kids with behavioral problems have ACEs
  - 45.7% of kids at risk for development have ACEs
  - About two-thirds of children ages 6-17 who bully, pick on, or exclude other children—or are themselves bullied, picked on, or excluded—have ACEs.

More NSCH Facts…

- **ACEs impact a child's social emotional development and chances of school success.**
  - Children ages 3-5 who have had two or more ACEs are over four times more likely to have three out of six social and emotional challenges, for example, have trouble calming themselves down, be easily distracted, and have a hard time making and keeping friends.
  - More than three out of four children ages 3-5 who have been expelled from preschool also had ACEs.
  - Children ages 6-17 who have had two or more ACEs are twice as likely to be disengaged from school than are peers who have had no ACEs.

Beyond ACEs… Stress and Toxic Stress

- Normal stress: Everyday pressure that pushes us to perform. Usually temporary and has an activating effect.

- Tolerable stress: Negative events (usually temporary or one-time) that are well-buffered by coping strategies and support of those around us.

- Toxic stress: Chronic, repeated stresses – often committed by those who are supposed to support us – and which overwhelm our capacity for coping.

Cumulative Burden of Recurrent or Persistent Exposure to Trauma

- Alterations in brain architecture
- Changes in gene expression
- Endocrine and immune imbalance
- Decreased executive function and affect regulation
- **Interference with relational health**
- Behavioral allostasis
- Chronic illness, health disparities, decreased quality and length of life

A Word from the American Academy of Pediatrics…

- Pediatric medical homes should:
  1. Strengthen their provision of anticipatory guidance to support children's emerging social-emotional-linguistic skills and to encourage the adoption of positive parenting techniques;
  2. Actively screen for precipitants of toxic stress that are common in their particular practices;
  3. Develop, help secure funding, and participate in innovative service-delivery adaptations that expand the ability of the medical home to support children at risk; and
  4. Identify (or advocate for the development of) local resources that address those risks for toxic stress that are prevalent in their communities.

Smoking Prevention

Drug Abuse Prevention

Alcohol Abuse Prevention

Teen Pregnancy Prevention

Prevention of Early Death From Heart Attacks

Stories from the Literature – Why Parent Trauma Matters

1. Correlations exist between parent ACE scores and child's ACE score… the more ACEs a parent experiences, the more ACEs the child is likely to experience.
2. Parenting styles are at least in part inherited: if a parent experienced harsh parenting, they are more likely to engage in harsh parenting styles themselves.
3. Parents have new brain growth in the first six months after their child's birth – in both the amygdala (emotional center) and frontal cortex (logical center) UNLESS they are experiencing stress, which impairs frontal cortex development.
4. Children who have experienced three or more ACEs before entering kindergarten have lower readiness scores: literacy, language and math skills are lower – and rates of behavioral problems are higher.

Kindergarten Readiness

The Role of Primary Care

Or, isn’t this a job for mental health providers?

Considering Children Who Have Been Exposed to Violence as CYSHN

- Medical home model originally developed for Children and Youth with Special Health Needs (CYSHN)
- Children exposed to violence (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 ACEs

- 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 (promoting resilience, healthy parenting, and developmental promotion)
- Follow up on referrals / close communication loops

Parallel Process

- Children learn more from what they see than from what they hear… so do parents…
- Parallel process is about using your own example to benefit the parent or patient.
- In other words, use the clinical visit to model what we want parents to do / say / feel when interacting with their child.

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 Do I Do Once I've Found It?

- Ethical question: why screen if you don't know what you're going to do with the information?

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."**

Our Starting Questions: What Am I Looking For?

- 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?

Types of Childhood Violence Exposure

Endemic

- Abuse – physical, emotional, sexual
- Domestic violence
- Bullying
- Dating violence
- Community violence / gang activity
- Sexual exploitation / trafficking

Episodic

- School violence
- Natural disasters
- Terrorism
- War / genocide

A Clinical Example: The Children's Clinic

How my clinic has addressed ACEs and toxic stress using a two-generation approach

Case Study: The Children's Clinic

- 30 providers in three 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- age children.

The Assumption

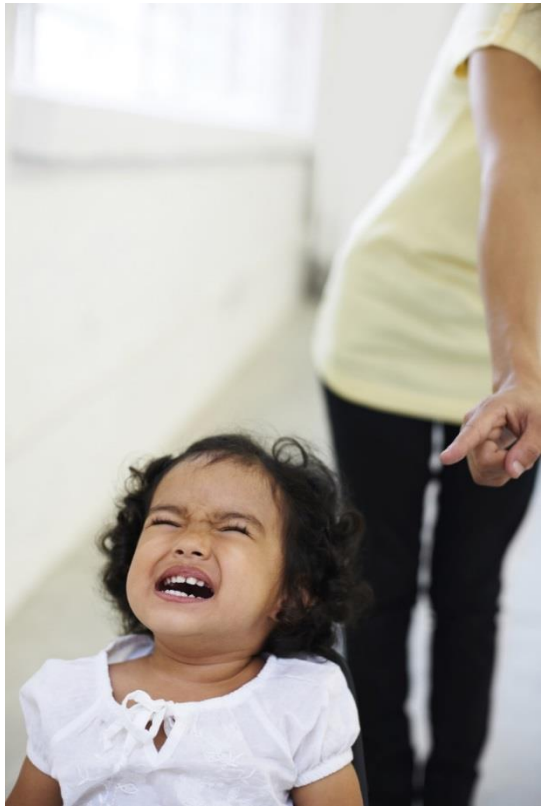
If…

- we can identify parents who are at greatest risk
- bring their trauma histories out of the closet
- agree to support them when they feel most challenged in a non-judgmental way

…we will be able to create a new cycle of healthier parenting.

The Theory

- Certain moments in the life of an infant or toddler will be stressful
  - Tantrums, colic, toilet training, hitting / biting, sleep problems are examples
- What happens to a parent who has experienced trauma? Will their response be:
  - Fight?
  - Flight?
  - Freeze?
  - Can it be something else?
- How can we better prepare at-risk parents for these inevitable moments?



And Thinking Further…

- If a parent experienced trauma, do they have appropriate skills / ideas for:
  - Taking care of themselves?
  - Identifying when they need help?
  - Modeling appropriate conflict resolution?
  - Discipline that is developmentally appropriate?
  - Playing with their child?
- In other words, can we teach parents and children to be more resilient?

How Do I Find it? Our First Step

- Eight providers piloted 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.

What Do I Do Once I've Found It? Meaningful Conversations and Follow-Up

- Selected Connected Kids resources stocked in exam rooms. Offered Zero to Three resources to providers to use selectively.
- 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.).

What Do I Do Once I've Found It?

- Assessment of child and family safety
- Assets, resources and resiliencies in the family
- Follow-up tools for assessing mental health in patients as needed (or referring parents if needed)
- Connecting with appropriate resources

Initiating the Conversation to Help Families Understand their own Experiences

- Thank parents for opening up about their experiences, validate the importance of the conversation.
- Are there any of these experiences that still bother you now?
- Of those that no longer bother you, how did you get to the point that they don't bother you?
- How do you think these experiences affect your parenting now?

Research Question #1

- How do we best assess parental ACEs in primary care?
- (Is it feasible to assess parental ACEs in the course of a primary care visit?)

Overall Results:
First Generation Assessment Tool

Number of ACEs	Percent	Average Resiliency	Resiliency Range
0	53.1	56.1	17-60
1	26.0	55.3	22-60
2	7.7	52.7	31-60
3	5.1	50.5	36-60
4 or more	8.1	47.6	23-60

↑ Oregon BRFSS: 17%

Insurance, Gender Differences

Number of ACEs	Total (n=1021)	Private Insurance (n=557)	Public Insurance (n=374)	Mothers (n=679)	Fathers (n=277)
0	53.1	56.6	48.7	51.3	57.0
1	26.0	25.1	27.0	25.5	25.6
2	7.7	7.7	7.2	8.1	7.6
3	5.1	3.9	6.4	5.7	4.3
4 or more	8.1	6.6	10.7	9.4	5.4

Mid-course Correction

- Given there were parents with relatively low ACE scores but also low resilience, two theories emerged…
  - They weren't comfortable telling us about their ACEs
  - We weren't asking about the right ACEs

Our Next Generation Assessment Tool

- Changed format from item-level responses to aggregate (parents just count instead of tell us what they experienced).
- Added four additional questions about “enhanced ACEs”: bullying, racism / prejudice, community violence, foster care exposure.
- Changed our resilience survey to the CD-RISC
  - Allows for better assessment of current function, rather than past history of resilience factors.

Comparing Assessment Tools

Measures		Item-Level Response Group	Aggregate Response Group	p value
All [a]		(n=1308)	(n=975)	
≥ 4 items endorsed	n (%)	109 (8.1)	109 (11.2)	0.013*
Mothers [b]		(n=880)	(n=693)	
≥ 4 items endorsed	n (%)	78 (8.9)	85 (12.3)	0.028*
Fathers [b]		(n=340)	(n=250)	
≥ 4 items endorsed	n (%)	21 (6.2)	23 (9.2)	0.167
Private Insurance [c]		(n=796)	(n=732)	
≥ 4 items endorsed	n (%)	47 (5.9)	65 (8.9)	0.026*
Public Insurance [c]		(n=467)	(n=223)	
≥ 4 items endorsed	n (%)	57 (12.2)	44 (19.7)	0.009*

What Parents Want

- Parenting classes ✓✓✓
- Parenting support groups ✓✓
- Information on the website ✓✓
- Twitter feeds (helpful hints on parenting) ✓
- Visiting Home Nurse Programs ×
- Relief Nursery Services ×

Research Question #2

- What are the outcomes for the kids whose parents experienced ACEs?
- In other words, why should we continue to look?

Adjusted Risk for Suspected Developmental Delay

	Relative Risk (95% CI)	
	[a]Maternal (n=311)	[b]Paternal (n=122)
[c]ACE		
≥ 1	1.25 (0.77, 2.00)	2.47 (1.09, 5.57)**
< 1 (Ref)	-	-
≥ 2	1.78 (1.11, 2.91)**	3.96 (1.45, 10.83)***
< 2 (Ref)	-	-
≥ 3	2.23 (1.37, 3.63)***	0.82 (0.12, 5.72)
< 3 (Ref)	-	-
Payer source		
Public	1.67 (1.05, 2.67)**	0.87 (0.37, 2.03)
Private (Ref)	-	-
Gestational age at birth		
< 37 weeks	1.70 (0.89, 3.24)	7.76 (3.12, 19.33)***
≥ 37 weeks (Ref)	-	-

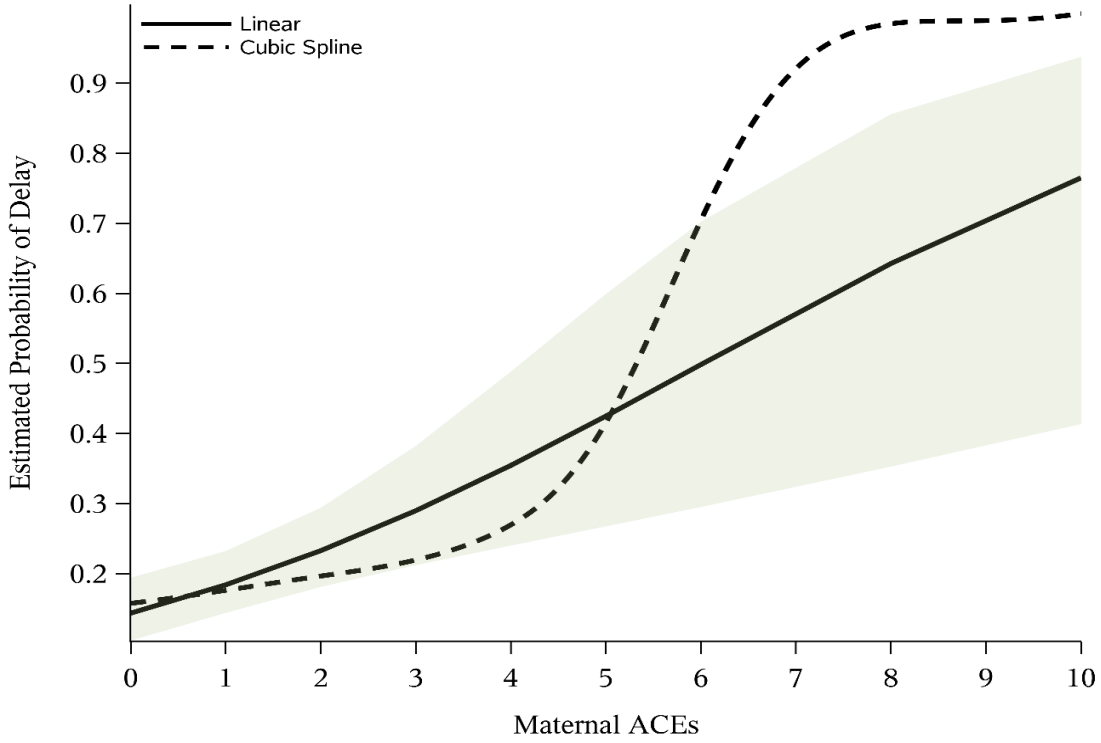
* = p <0.1, ** = p <0.05, *** = p <0.01

Domain-specific Developmental Risk by Maternal ACE Exposure

	Maternal ACEs		Relative Risk (95% CI)
	≥ 1 (*n*=149)	<1 (*n*=162)	
Communication, *n* (%)	24 (16.3)	18 (11.1)	1.47 (0.83, 2.60)
Gross Motor, *n* (%)	20 (13.5)	17 (10.6)	1.28 (0.70, 2.35)
Fine Motor, *n* (%)	18 (12.1)	16 (9.9)	1.22 (0.65, 2.31)
Problem Solving, *n* (%)	17 (11.6)	8 (5.0)	2.31 (1.03, 5.20)**
Personal-Social, *n* (%)	19 (12.9)	17 (10.6)	1.22 (0.66, 2.26)
	≥ 2 (*n*=60)	<2 (*n*=251)	
Communication, *n* (%)	12 (20.3)	30 (12.0)	1.69 (0.92, 3.11)*
Gross Motor, *n* (%)	12 (20.0)	25 (10.0)	1.99 (1.06, 3.73)**
Fine Motor, *n* (%)	9 (15.0)	25 (10.0)	1.51 (0.74, 3.06)
Problem Solving, *n* (%)	11 (18.3)	14 (5.7)	3.23 (1.55, 6.76)***
Personal-Social, *n* (%)	9 (15.0)	27 (10.9)	1.38 (0.68, 2.77)
	≥ 3 (*n*=39)	<3 (*n*=272)	
Communication, *n* (%)	10 (26.3)	32 (11.8)	2.23 (1.19, 4.16)**
Gross Motor, *n* (%)	9 (23.1)	28 (10.4)	2.23 (1.14, 4.36)**
Fine Motor, *n* (%)	8 (20.5)	26 (9.6)	2.15 (1.05, 4.40)**
Problem Solving, *n* (%)	6 (15.4)	19 (7.1)	2.17 (0.92, 5.10)*
Personal-Social, *n* (%)	8 (20.5)	28 (10.4)	1.97 (0.97, 4.01)*

* = p <0.1
** = p <0.05
*** = p <0.01

Dose Response Relationship between Maternal ACE and Risk for Suspected Developmental Delay



Corroborating Evidence

- Mothers of children being seen in the ED were given ACE questions and PEDS.

Maternal ACEs	Risk of single concern on PEDS	Risk of 2+ concerns on PEDS
1-3 ACEs	**1.86** (CI 1.16-3.00)	**1.7** (CI 1.26-3.87)
4+ ACEs	**2.21** (CI 1.07-2.72)	**1.76** (CI 1.02-3.05)

- Highest correlations found for specific maternal ACEs of household substance abuse, mental health, and parental incarceration.
- "Mothers' ACEs are significantly associated with their children's developmental risk. If replicated, findings suggest that addressing intergenerational trauma through focus on childhood adversity among young children's caregivers may promote child development."

Sun et al. Am J Prev Med 2017;53(6):882–891.

Corroborating Evidence

- Retrospective cohort study of 1172 maternal-child dyads in early childhood home visiting program – examining relationship of maternal interpersonal trauma and ASQ:SE results.
- Interpersonal trauma associated with a 3.6 point higher ASQ:SE score, indicating higher developmental risk.
- Conclusion: maternal interpersonal trauma can negatively impact child social emotional development (but we still need to study why).

Folger, et al. Paediatric and Perinatal Epidemiology. 2017.

Stories from the Literature – Why Parent Trauma Matters

5

There is a correlation between parental ACEs and their child's developmental risk.

Stories that Still Need to Be Told… Our Next Research Questions:

1. What role does parental resilience play in buffering their child's developmental risk?
2. Does the conversation about trauma (and the process of assessing parental ACEs) mediate developmental risk?
3. Can a primary care provider intervene? Specifically, can a PCP teach attachment / attunement interventions in the course of a well-visit to reduce developmental risk and improve parental resilience?
4. How does the conversation about toxic stress change the relationship between parents and their pediatrician?

Stories that Still Need to Be Told…

5

Can primary care interventions prevent (at least some) ACEs?

Next Steps

Or, what can you do by next Tuesday?

Practical Steps

- Implement trauma-informed care in your practice or system
  - Oregon Pediatric Society
  - Trauma-Informed Oregon
- Understand the role of your conversation with patients and families
  - What services are you offering already that can address some of the needs of patients and families? What tweaks can you make to make these services trauma-informed?
- Understand modifiable resilience factors
- Pick a screening tool or surveillance question and implement on a small scale
- Get connected with other practices screening for ACEs

Trauma-Informed Care: A Definition

Trauma-informed care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma-informed care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

More about Trauma-Informed Care

Becoming "trauma-informed" means recognizing that people often have many different types of trauma in their lives. People who have been traumatized need support and understanding from those around them. Often, trauma survivors can be re-traumatized by well-meaning caregivers and community service providers.

- Trauma Informed Care Project (traumainformedcareproject.org)

Steps in Trauma-Informed Care

- Individual: Can I take care of myself while addressing the trauma of others?
- Interpersonal: Can I listen effectively to the trauma history of my patients and families?
- Organizational: Is my clinic a safe place to reveal trauma and address it?
- Environmental: Are there community resources that I can connect with to help patients and families who have experienced trauma?

Listening is Therapeutic… But Who the Listener is Matters

- For a person who has experienced trauma, authority figures (including parents / caregivers, schools, health care systems, mental health institutions, etc.) were often those inflicting the trauma.

- When an authority figure becomes the listener, that authority becomes a positive, strategic force for healing.
  - Can the adults around us tolerate the conversation?
  - The message of silence or ignoring: history is not important or speaker is not safe.

Validating the Experiences

- When survivors said they had been listened to with compassion, they were 2.9 times more likely to report being mostly or completely healed.
- When survivors believed that people understood the impact of trauma on their lives, they were 2.2 times more likely to report being mostly or completely healed.
- When survivors believed that people knew how to help them heal, they were 2.3 times more likely to report being mostly or completely healed

From: Survivor Voices Study, 2009 & 2011, Trauma Healing Project, Eugene, OR

Redefining Our Role and Goal: Understanding the "Righting Reflex"

- "Success" in our conversations about ACEs and trauma is relational.
  - Is the door open to further conversation?
- Conversation should be validating, safe and non-threatening.
- If we're leaning on our training to "fix everything" we may not be present to hear the stories.
- Parents' behaviors make more sense if you understand their story.
  - Instead of "what's wrong with this person?", think "what happened to this person?"

More National Survey of Children's Health Data

- **Positive relationships with providers matter for building resilience.**
  - Children with 2+ ACEs whose parents report that their child's health care providers "always" listen, spend needed time, and give needed information are over 1.5x more likely to live in families that practice four basic resilience skills.
  - Children whose parents report "always" having positive communication with their child's health care providers are over 1.5x more likely to practice 3 or more (of 5) recommended protective family routines and habits.

Modifiable Resilience Factors in Pediatrics

- Positive appraisal style and executive function skills
- Responsive / positive parenting skill building
- Treating maternal mental health problems
- Self-care skills and routines
- Enhancing trauma understanding

Traub & Boynton-Jarrett, Pediatrics 2017

Teach Parents What Resilience Means

- Defining resilience: the ability to resist, recover from, and grow from adversities.
- If parents understand resilience factors, they can identify where they need to strengthen their own systems.
  - Include the message of hope…ACEs are not our destiny – resilience gives us the chance to shape our future.
- Once parents have understood and worked on resiliency, they can model that for their children.

Potential Programs that Work

- Some positive parenting / attachment programs have been shown to moderate the effects of parental ACEs on children's social-emotional development
  - More work needs to be done in examining overall development
- Remembering what parents want… parenting classes and support groups
  - How do we make these programs responsive to parents / families who have experienced trauma?
  - How do we make these services available to families in a context that works for them?

Public Health / Community Interventions

- Nurse family partnerships and other home visiting programs
  - 2 home visits in the first year shown to reduce child abuse by 50%
- Community referral agencies
  - 211 Info
  - Help Me Grow
- Early intervention / early childhood special education
  - Parent coaching model to improve interactions between parent and child
  - Some states include family risks as qualifying diagnoses – Illinois uses maternal depression as a qualifying diagnosis for EI
- Mother-baby dyad interventions
- Mentoring programs (Big Brother / Big Sister Programs, Boys & Girls Clubs, etc.)
- Trauma-informed schools: major work being done in implementing trauma-informed discipline, resilience programs within school systems with great success.

Pick a Screening Tool or Surveillance Question

- Many practices may not be ready to address screening for ACEs themselves
- How are other social determinants of health addressed in your practice?
- Sometimes as simple as how we frame our approach to patients and clients
  - Instead of "what's wrong with this person", think "what happened to this person?"
  - We only see behaviors, not backstories.
  - Approaching patients and families with curiosity means we are suspending our judgment.
- Remember quality improvement 101: start with small tests of change
  - Start screening or surveillance with one or two champions… commit to 5-10 patients
  - Evaluate how the pilot went
  - Increase either scope or scale with subsequent cycles of change

Social Determinants of Health

- "The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels." ***World Health Organization***

  - Food insecurity
  - Housing insecurity
  - Poverty
  - Unsafe neighborhoods
  - Access to high-quality education
  - Adverse childhood experiences

Surveillance Option for Identifying Trauma

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)

Social Determinants of Health: A Few Screening Options

- Food insecurity screening (two-question validated screen)
- Broader screening tools (Safe Environment for Every Kid, WECARE, Survey of Wellbeing in Young Children, others)
- Screening for intimate partner violence
- Maternal depression (remember that parental mental illness is an ACE for the child)

Get Connected

- Email me: rgillespie@childrens-clinic.com
- The National Pediatric Practice Community: www.nppcaces.org

The future…

From Nadine Burke-Harris: Where Do You Want to Be in 30 Years?

References

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Café Sessions: Overview & Instructions

- Two 90-minute café sessions
- Each café session has three 30 minute-rounds, with 27 minutes of presentation time & three minutes of transition time
- Participants will choose three presentations to attend during each café session
- Presentation descriptions and locations are noted in your event booklet

Café Session 1

10:05-11:35 a.m.

Lunch Plenary Panel

Strategies for Youth Resilience:
Strengthening Trajectories from Early Childhood through Young Adulthood

Maggie Steele, MSW, Peace in Schools
Wes Rivers, MPA, OHA Adolescent and School Health
Susan Fischer, M.Ed., AllCare Health
Safina Koreishi, MD, MPH, Columbia Pacific CCO

Oregon Health Authority

Peace in Schools

transformative mindfulness education

History of PINS

Current Schools

In the Classroom

Measuring Adolescent Resilience

Wes Rivers
Innovation Café June 2018
Adolescent & School Health
www.healthoregon.org/ah

OREGON PUBLIC HEALTH DIVISION
Adolescent and School Health Unit

Oregon Healthy Teens Survey

- Representative sample of Oregon's 8th and 11th graders
- Survey takes place biennially in odd years (most recent 2017)
- ~27,000 students, 600 schools surveyed
- Provides state and county level estimates
- Questions cover: general, oral, and mental health topics, resilience, behavior, and perceptions of peer and parental attitudes.

For more on the survey:

https://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx

Positive Youth Development Benchmark

- Uses Oregon Healthy Teens questions to measure strengths and attributes that can buffer the impact of stress and obstacles young people face.
- Supporting PYD often requires a shift from viewing adolescents as trouble makers who exhibit risky behavior to seeing youth as positive change agents, willing and able to contribute to society.
- The PYD benchmark that is reported is calculated based on responses to six questions in the survey related to well-being and social connectedness

Positive Youth Development Benchmark: Questions Incorporated in Benchmark

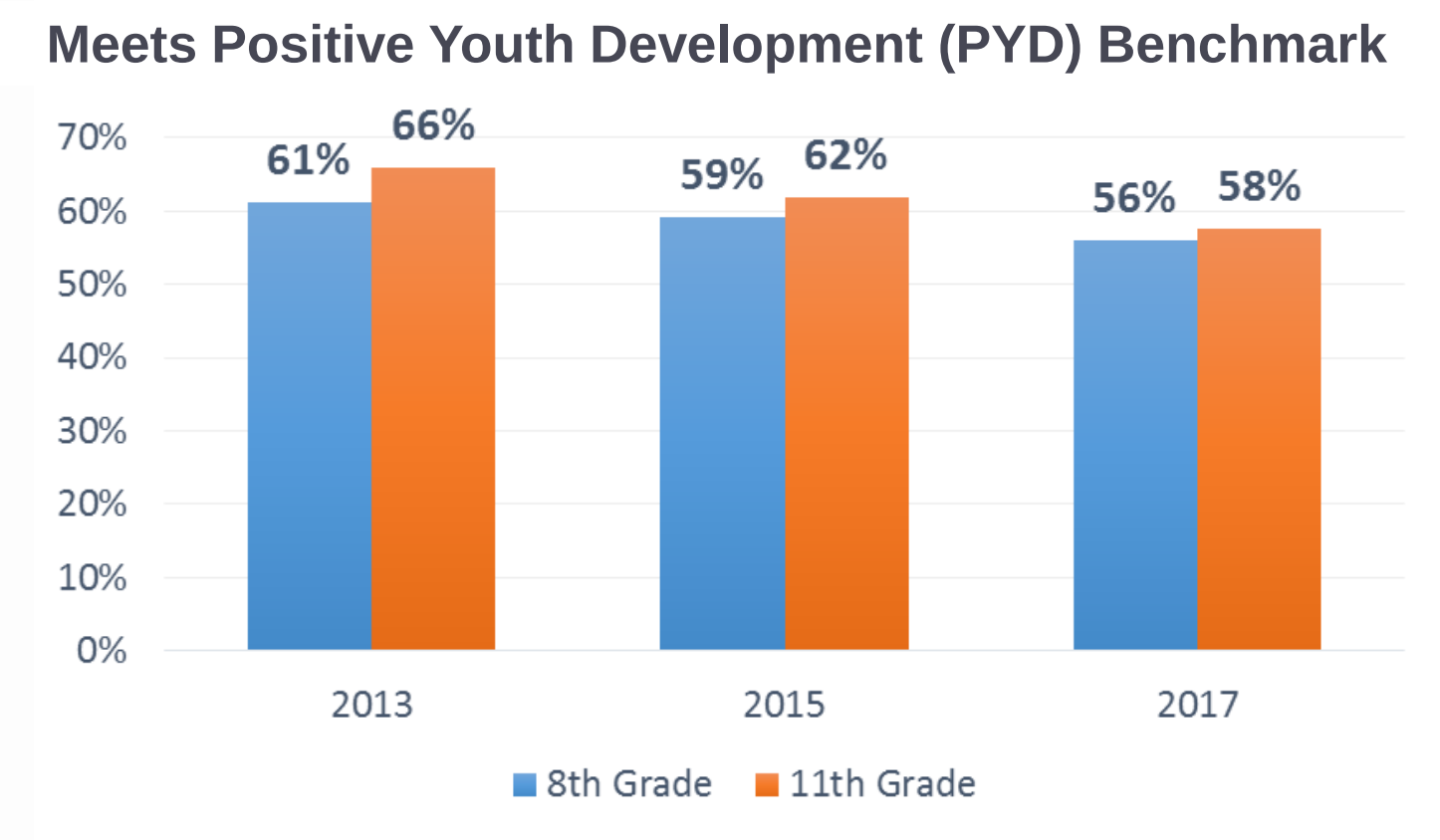
Rate Poor, Fair, Good, Very Good, Excellent

1. Would you say that in general your *physical health* is?
2. Would you say that in general your *emotional and mental health* is?

Mark how true you feel each statement is to you

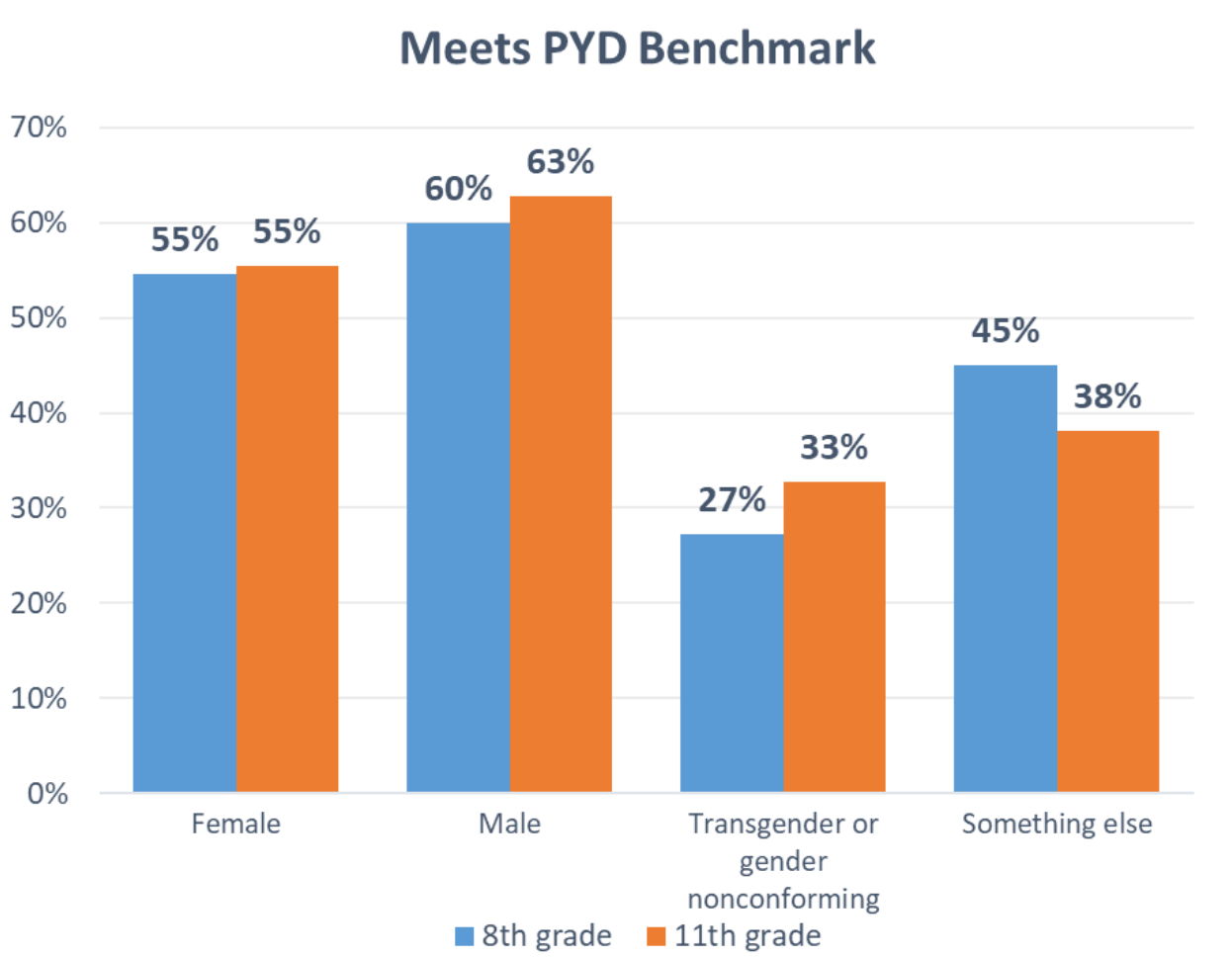
1. I can do most things if I try
2. I can work out my problems
3. There is at least one teacher or other adult in my school that really cares about me
4. I volunteer to help others in my community.

Resilience



Source: 2013, 2015, 2017 Oregon Healthy Teens Survey

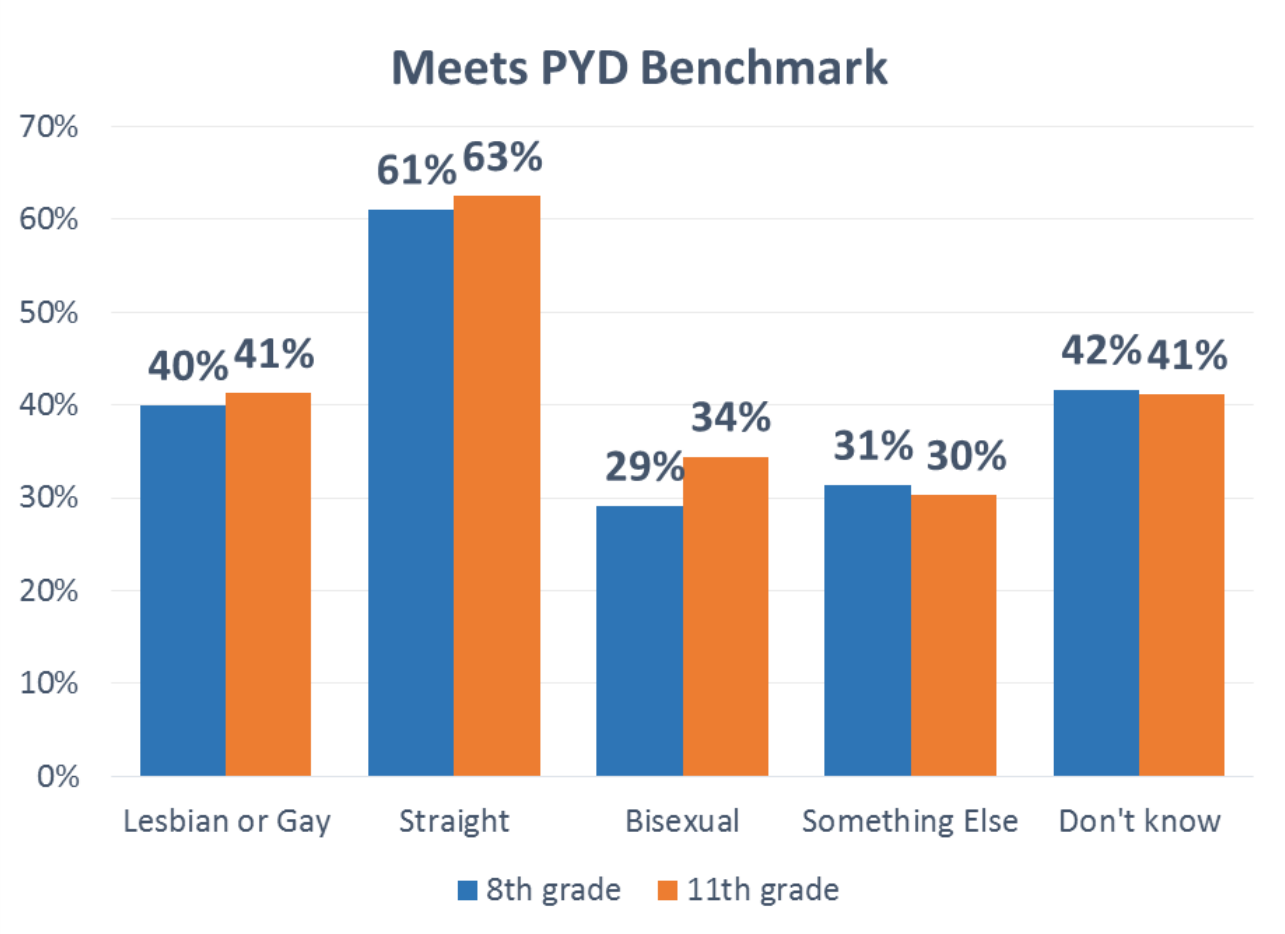
Resilience by Gender Identity



Source: 2017 Oregon Healthy Teens Survey

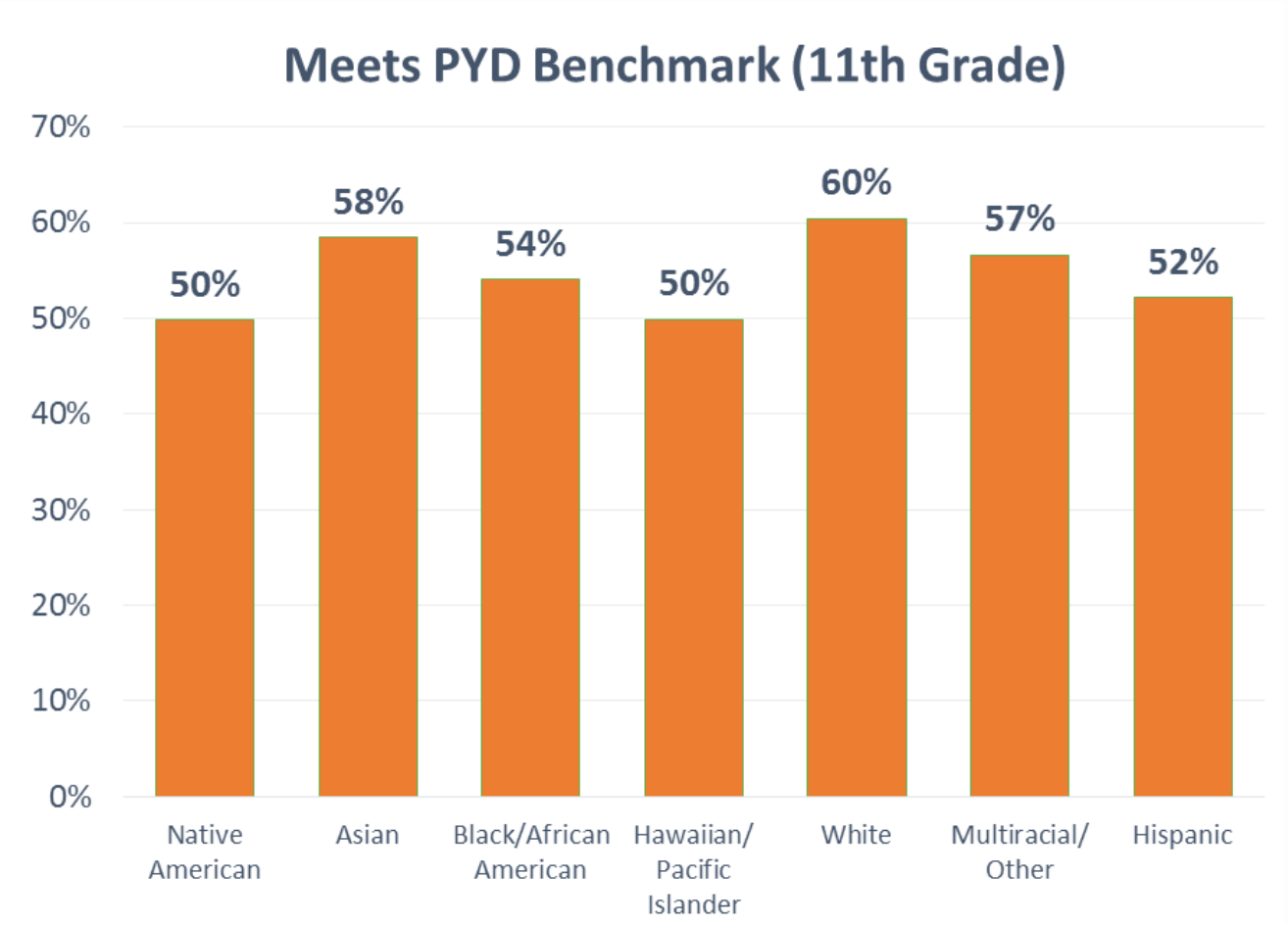
Note: "Transgender or gender…" includes those who identified as transgender, gender fluid, genderqueer, gender nonconforming, intersex/intergender, multiple responses, and "not sure of gender"

Resilience by Sexual Orientation



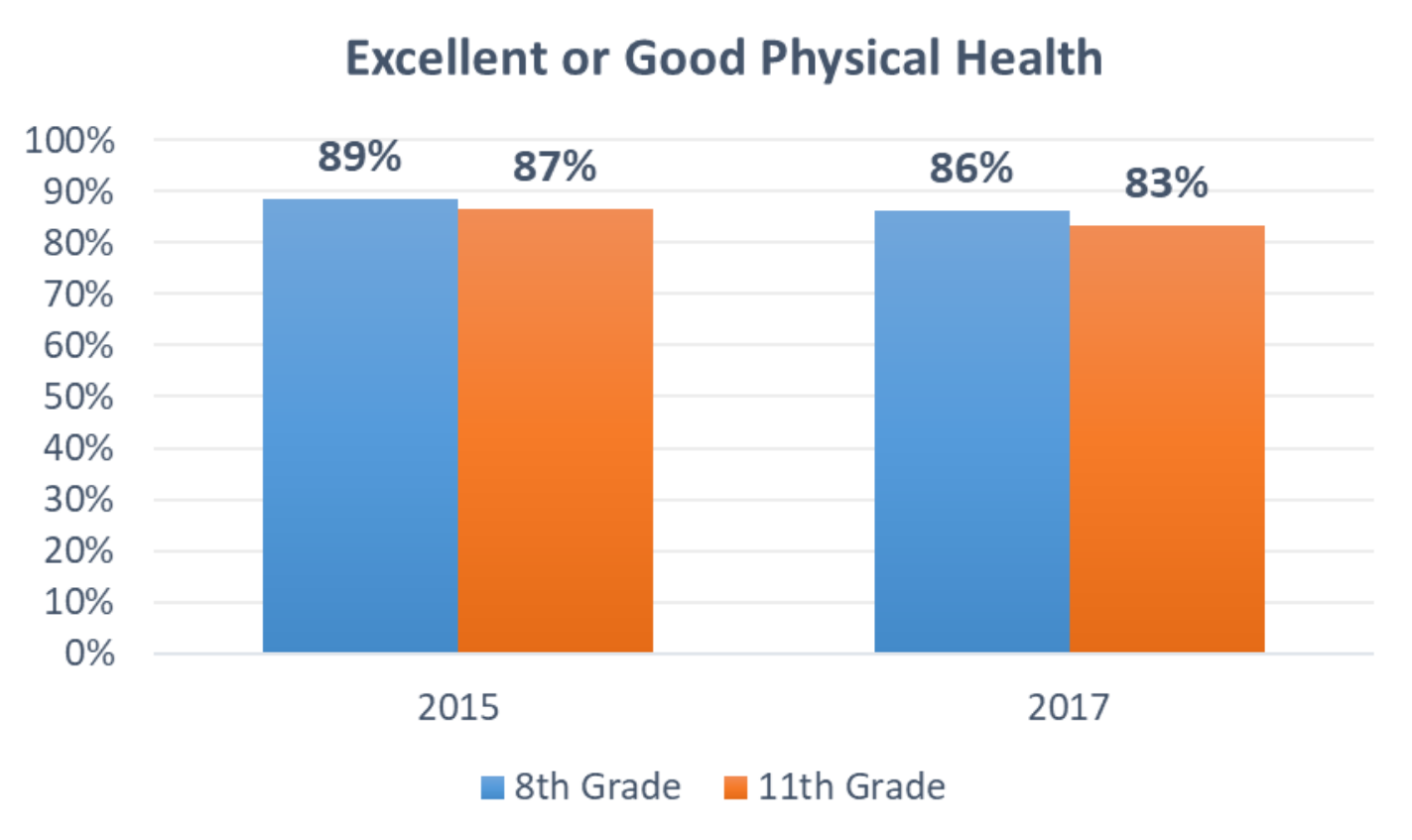
Source: 2017 Oregon Healthy Teens Survey

Resilience by Race/Ethnicity



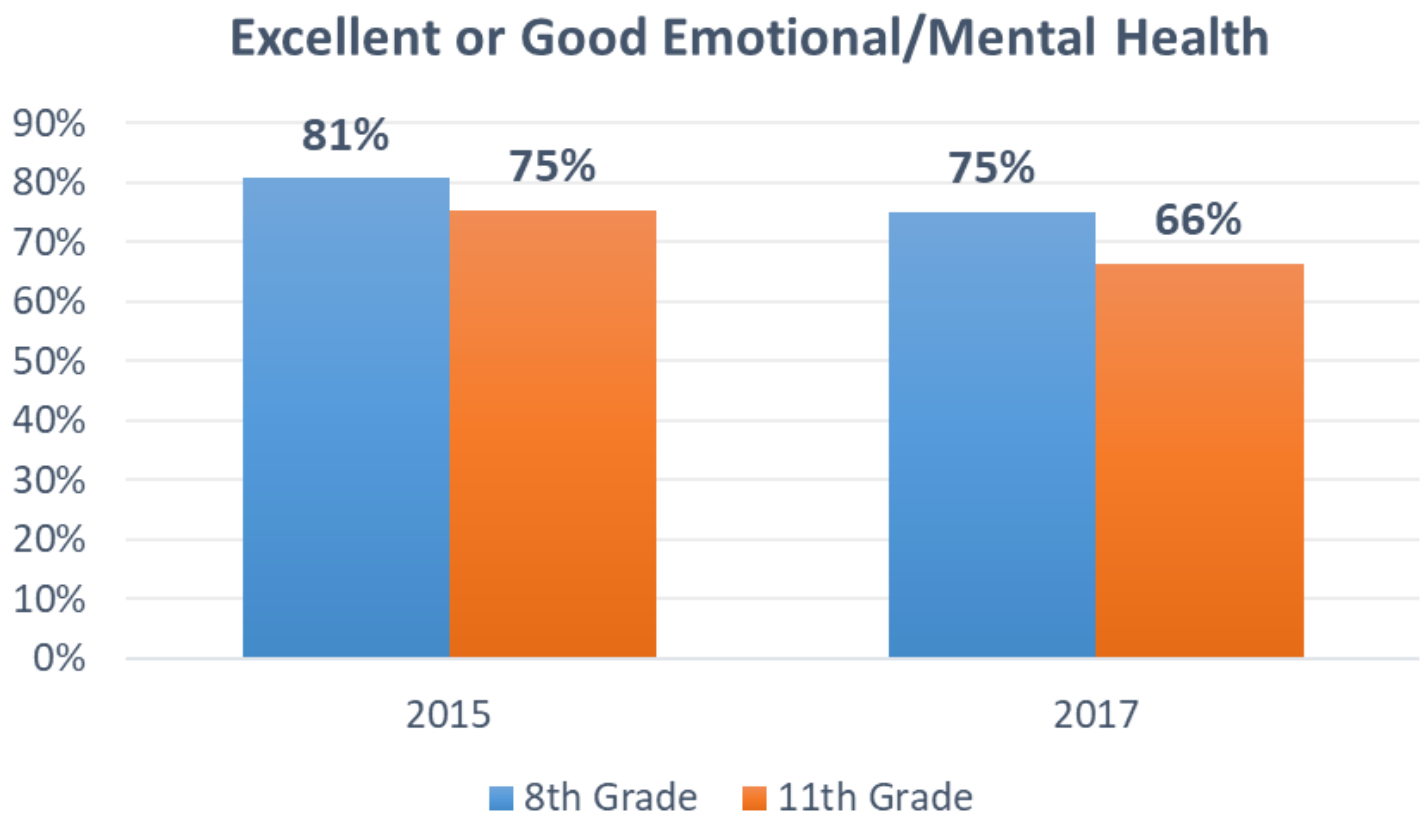
Source: 2017 Oregon Healthy Teens Survey

Resilience Metric – Physical Health



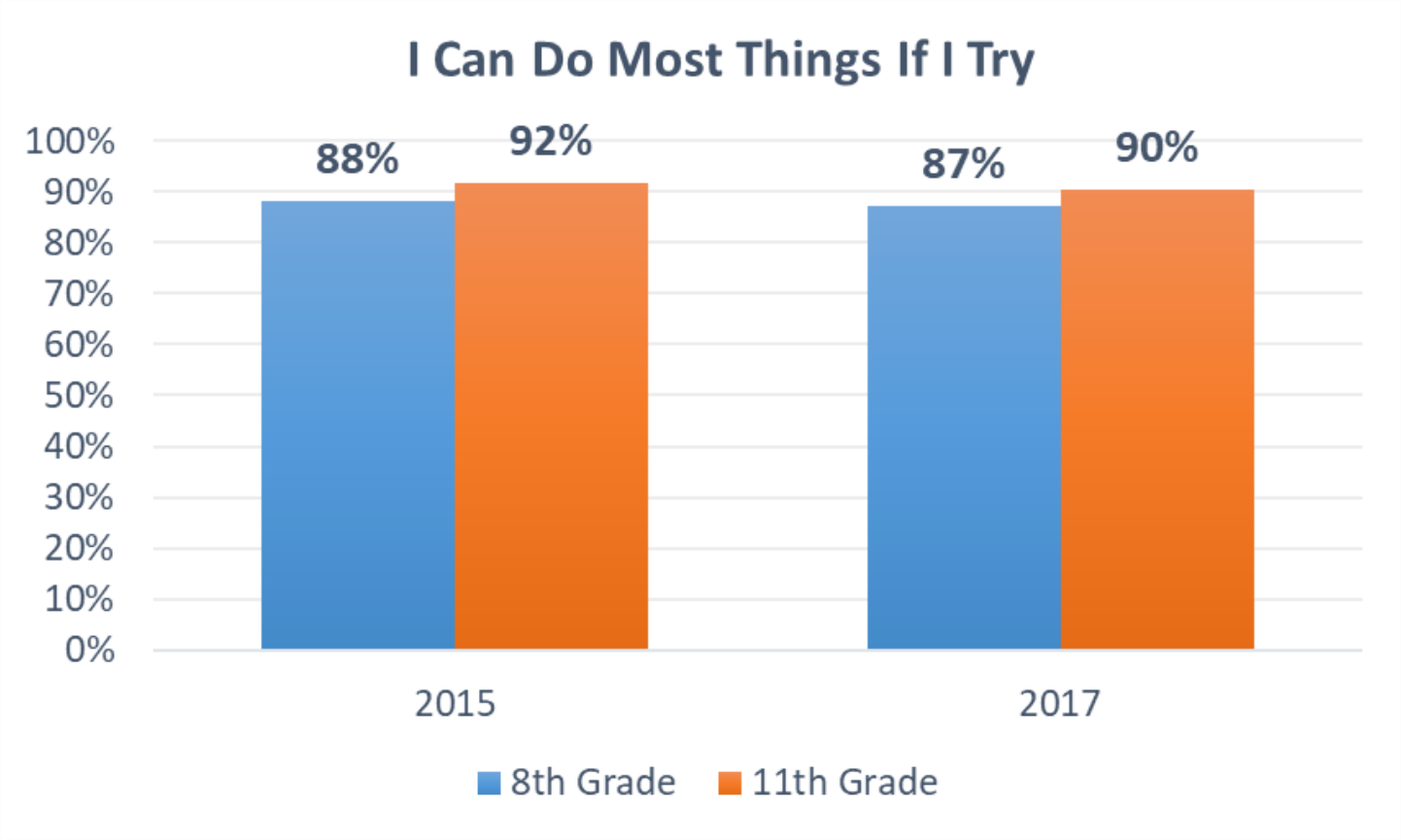
Source: 2015 and 2017 Oregon Healthy Teens Survey

Resilience Metric – Mental/Emotional Health



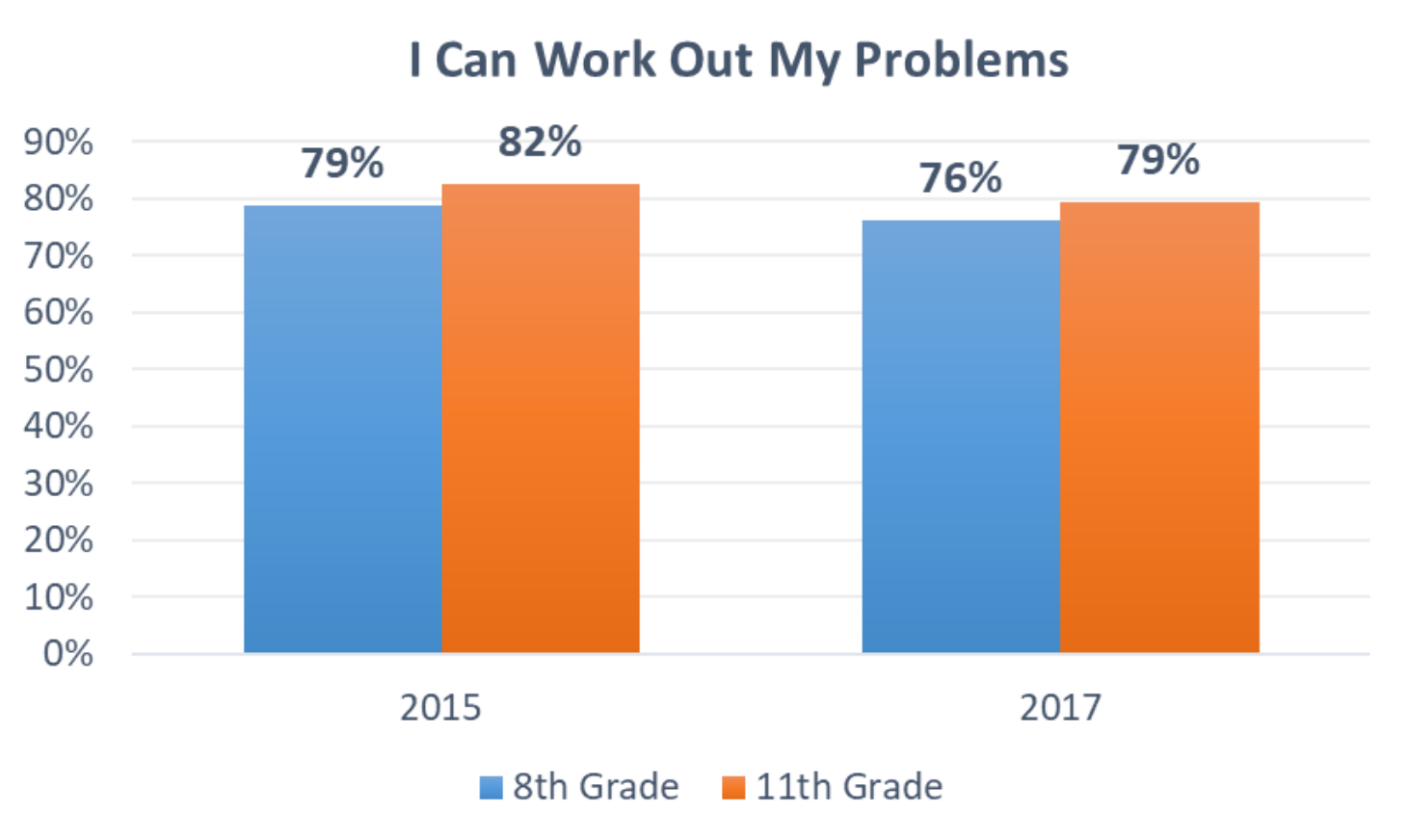
Source: 2015 and 2017 Oregon Healthy Teens Survey

Resilience Metric – Competence



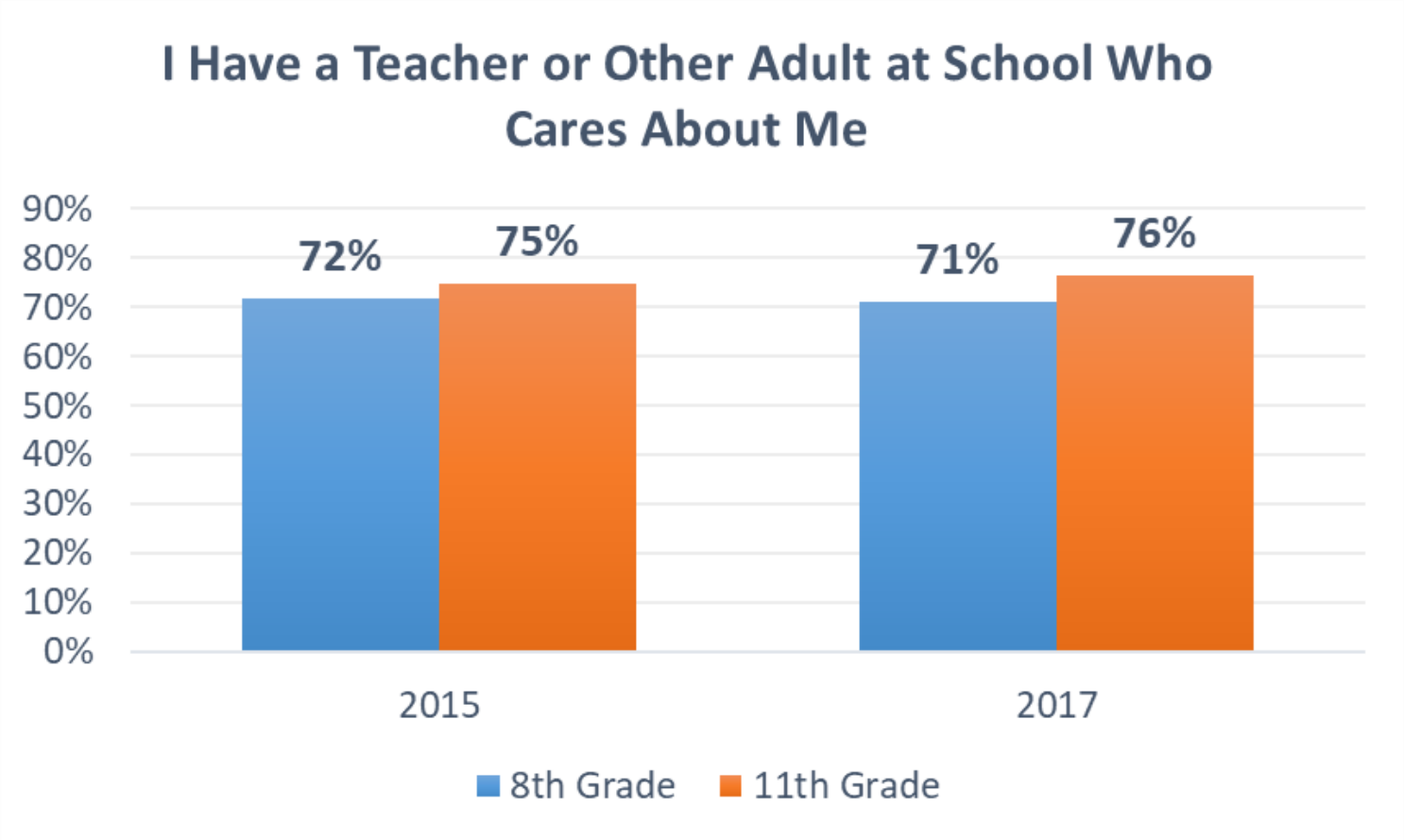
Source: 2015 and 2017 Oregon Healthy Teens Survey

Resilience Metric – Confidence



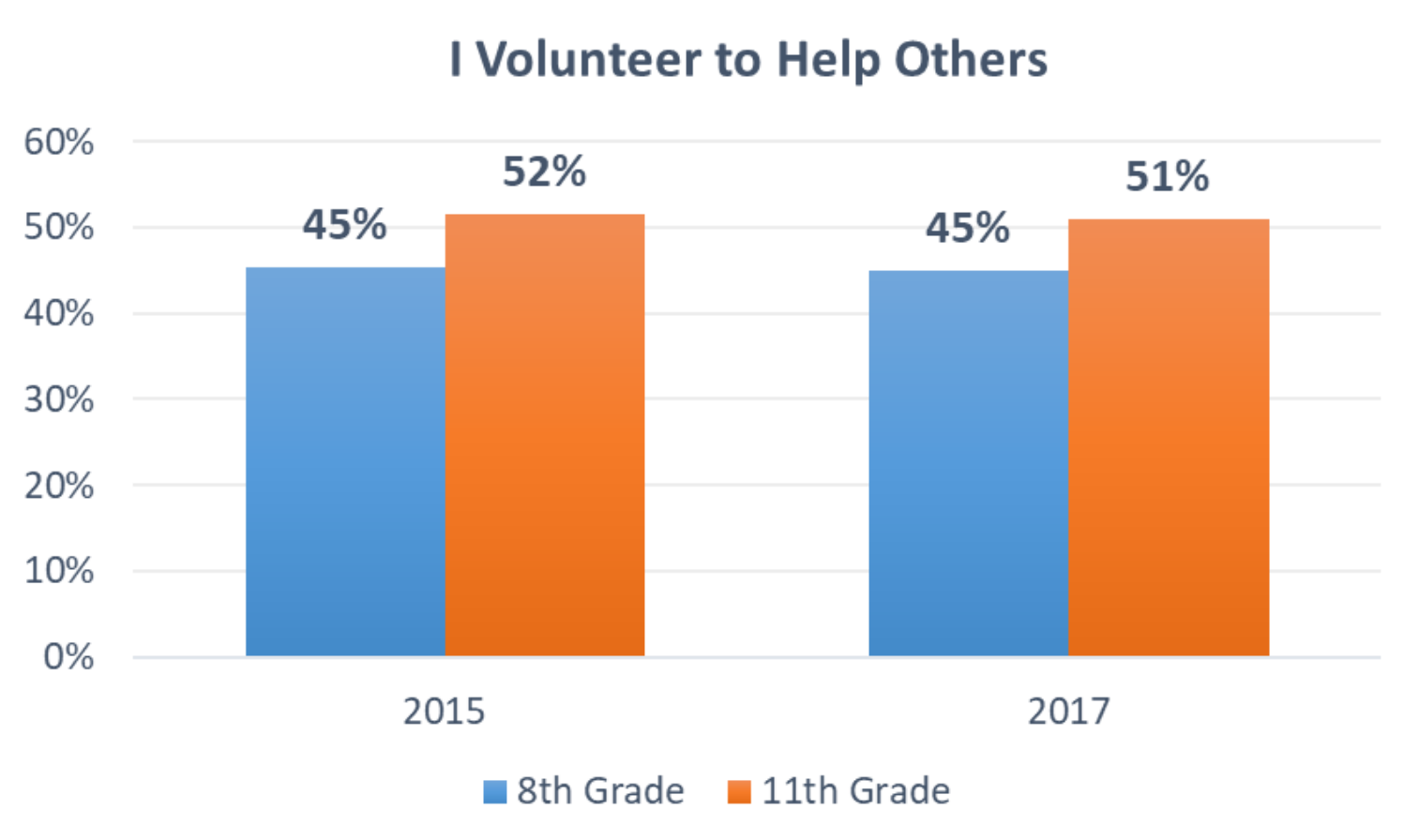
Source: 2015 and 2017 Oregon Healthy Teens Survey

Resilience Metric – Support



Source: 2015 and 2017 Oregon Healthy Teens Survey

Resilience Metric – Service



Source: 2015 and 2017 Oregon Healthy Teens Survey

Building Resilience

- Creating trusting and supportive relationships
- Supporting physical, emotional and mental health
- Engaging youths' strengths and interests
- Building confidence and connectedness to community

Supportive Adult Relationships at School

	With Caring Adult at School	Without Caring Adult at School
Percentage of **8th Graders** who are chronically absent	**9%**	**14%**
Percentage of **11th Graders** who are chronically absent	**17%**	**23%**
Percentage of **8th Graders** who missed school b/c felt unsafe	**7%**	**13%**
Percentage of **11th Graders** who missed school b/c felt unsafe	**6%**	**9%**

Source: 2017 Oregon Healthy Teens Survey

Thank You

Wes Rivers
971-284-9023
Wesley.r.rivers@state.or.us
www.healthoregon.org/ah

Link to video:

https://www.youtube.com/watch?v=Xbvdxg4HO2A

13%

OF OREGON'S YOUTH EXPERIENCE EPISODES OF SEVERE DEPRESSION – THE HIGHEST RATE IN THE NATION

26%

OF THESE YOUTH RECEIVE CONSISTENT TREATMENT

Ratio of School Counselors to Students

1 TO 491

Nationally

Ratio of School Counselors to Students

1 TO 604

In the State of Oregon

Cultivating Self-Awareness

Link to video:

https://www.youtube.com/watch?v=N2hDnuQJyh4

27% of students in the state of Oregon have two or more ACEs

THIS MEANS IN A CLASS OF 30 STUDENTS, 8 OF OUR STUDENTS WOULD HAVE 2 OR MORE ACES.

National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [mm/dd/yy] from www.childhealthdata.org.

Relational Pedagogy

Breathing

Breathing Awareness Meditations have been shown to:

LOWER BLOOD PRESSURE
DECREASE HEART RATE
SOOTHE THE NERVOUS SYSTEM

Gregoski, M. J., Barnes, V. A., Tingen, M. S., Harshfield, G. A., & Treiber, F. A. (2010). Breathing awareness meditation and LifeSkills Training Programs influence upon ambulatory blood pressure and sodium excretion among African American adolescents. Journal of Adolescent Health, 48, 59–64.

WHY MINDFULNESS?

Without Mindfulness

Stimulus → Reaction

With Mindfulness

Stimulus → Mindfulness → Response

Learning to Pause

School-Based Mindfulness

A 12-week school-based mindfulness intervention at 4 public schools showed a positive impact in problematic responses to stress including rumination, intrusive thoughts, and emotional arousal.

Mendelson, T., Greenberg, M. T., Dariotis, J. K., Gould, L. F., Rhoades, B. L., & Leaf, P. J. (2010). Feasibility and preliminary outcomes of a school-based mindfulness intervention for urban youth. Journal of Abnormal Child Psychology, 38(7), 985-994. DOI: 10.1007/s10802-010-9418-x

Paying Attention

Cultivating Compassion

Cultivating Compassion

Research suggests that self-compassion is strongly related to:

+ psychological well-being
+ increased happiness
+ optimism
+ personal initiative
+ connectedness

- decreased anxiety
- decreased depression
- decreased neurotic-perfectionism
- decreased rumination

SC is a significant predictor of mental health. Adolescents with more self-compassion reported less depression and anxiety as well as greater feelings of social connectedness

Neff, K. & McGehee, P. (2009) Self-compassion and Psychological Resilience Among Adolescents and Young Adults, Self and Identity, 9:3, 225-240, DOI: 10.1080/15298860902979307

School Connectedness

School Connectedness

- Decreases feelings of isolation
- Increases a sense of belonging
- Critical protective factor for suicial thoughts and behaviors in school-aged youth

Marraccini, M. E., & Brier, Z. M. (2017). School connectedness and suicidal thoughts and behaviors: A systematic meta-analysis. School psychology quarterly, 32(1), 5.

92% REPORT FEELING LESS STRESS AND ANXIETY

86% REPORT FEELING MORE OPTIMISTIC AND LESS WORRIED

85% REPORT FEELING REDUCED LEVELS OF SADNESS OR DEPRESSION

85% REPORT FEELING MORE SELF-ACCEPTING AND LESS SELF-CRITICAL

79% REPORT FEELING MORE EMOTIONALLY RESILIENT

80% REPORT USING THE MINDFULNESS TOOLS THEY LEARN OUTSIDE OF SCHOOL

Serving our Schools

Dr. Christina Bethell, Johns Hopkins

"The new science of thriving and the role of mindfulness show us the possibilities to flourish despite adversity.

Practicing mindfulness helps unlock, integrate and heal embedded stress, interrupt harmful reactions to daily stress, open possibilities to rewire the brain and begin to heal the heart.

Our well-being—individually and as a society—depends on mindfulness."

—Dr. Christina Bethell, Johns Hopkins

Link to video:

https://www.youtube.com/watch?v=kSs5r68xqhw

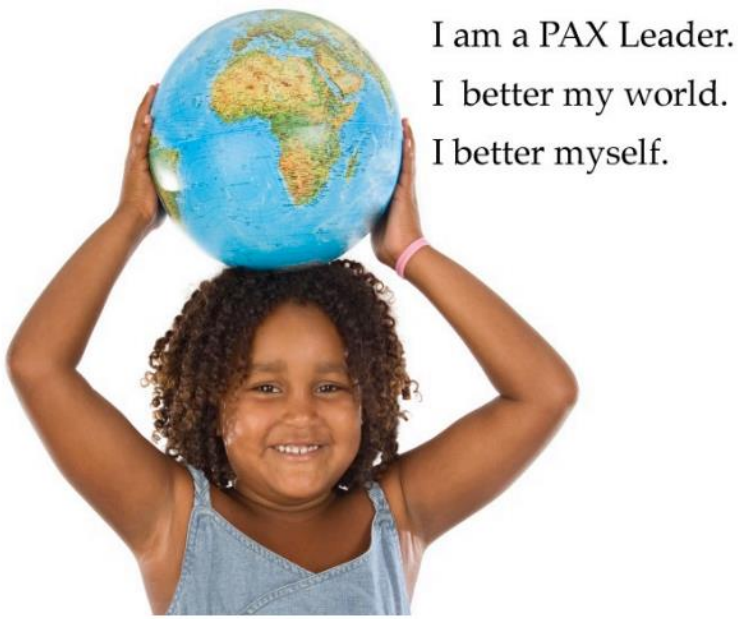
The Fourth Miracle of Education

Disclosures:

I am a current contractor with PAXIS, the company which produces the PAX Good Behavior Game materials and research.

June 8th, 2018
Prepared for the OHA Innovation Café

Susan Fischer, M.Ed.
Health & Education Integration



Why PAX?

An evidence-based, SAMSHA endorsed practice that is universally beneficial;

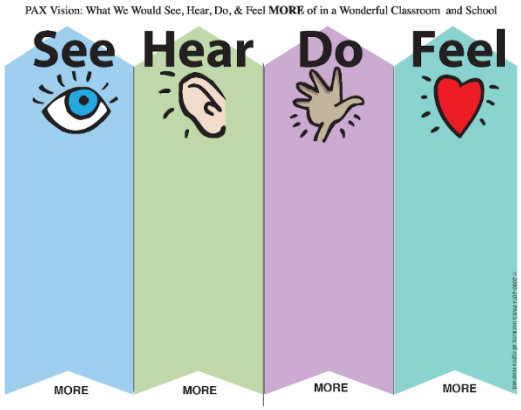
Creates Nurturing Environments to achieve population-level protection that has lasting effects;

Reinforces prosocial behavior, limits problematic behavior, reduces toxic influences, and increases psychological flexibility;

This benefits not only students and families, but today's teaching workforce.

Started in December 2015, with 25 teachers. Now over 500 trained.

Certified B Corporation



- ✓ PAX Vision
- ✓ I'm A PAX Leader
- ✓ PAX Quiet
- ✓ Granny's Wacky Prizes
- ✓ Beat the Timer
- ✓ PAX Stix
- ✓ PAX Tootle Notes
- ✓ PAX Voices
- ✓ PAX Hands & Feet
- ✓ OK/Not OK

What is PAX?

A system of classroom supports that encourages student self-regulation, self-control, and self-management.

Not a behavior management structure, but rather it is a peer supported, collaborative model for building life-long skills.

In PAX, students are
the HEROES OF THE CHANGE.

7 Kernels and 3 Cues, the individual components of the PAX model, support LIVING this VISION each day in the multiple contexts in which students make decisions.

Then these are put into practice through the Good Behavior Game.

Certified B Corporation

PAX VISION

allcare health™

Certified B Corporation

PAX VISION

allcare health™

Certified B Corporation

PAX TOOTLE NOTES

allcare health™

Certified B Corporation

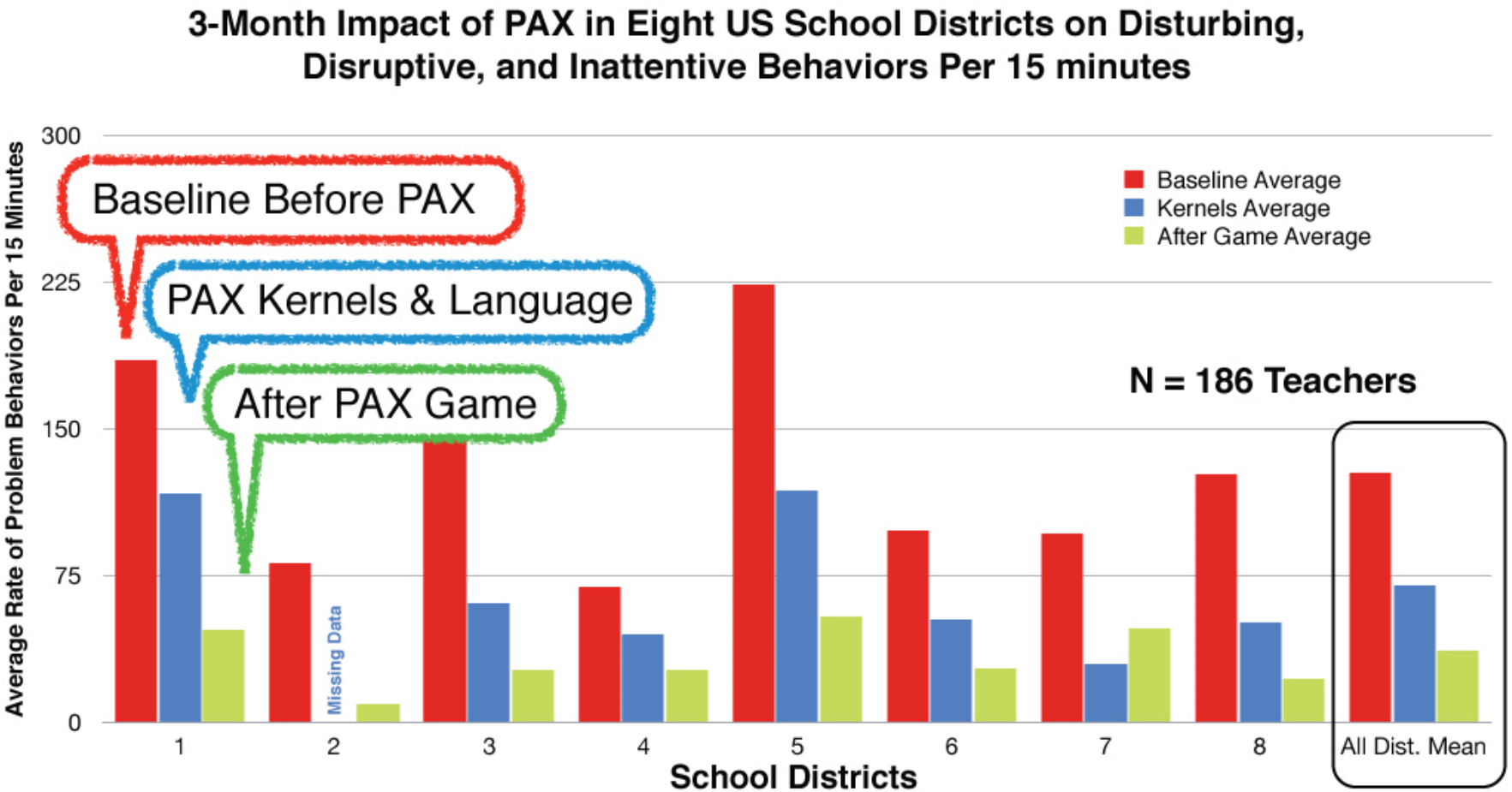
Why PAX?

When we create safe and predictable environments we NURTURE all the members of a school community.

This allows for prefrontal cortex activity and disengages the amygdala—even for our youngest learners.

In these nurturing environments, students are able to foster authentic relationships with their peers and are open to the guidance of adults.

PAX is trauma informed and works seamlessly with other common school frameworks (i.e., PBIS, Second Step, Whole Brain Teaching, etc.).


3-Month Impact of PAX in Eight US School Districts on Disturbing, Disruptive, and Inattentive Behaviors Per 15 minutes
Average Rate of Problem Behaviors Per 15 Minutes
300
225
150
75
0
Baseline Before PAX
PAX Kernels & Language
After PAX Game
Baseline Average
Kernels Average
After Game Average
N = 186 Teachers
Missing Data
1
2
3
4
5
6
7
8
All Dist. Mean
School Districts

By reaching all 1st graders in Oregon each year, the estimated results based on previous research findings are listed below:

- 4,029 fewer young people will need any form of special education services.
- 2,607 more boys will likely graduate from high school and 3, 129 more will likely attend college.
- 4,157 more girls will likely graduate from high school and 3,249 will likely attend college.
- 455 fewer young people will commit and be convicted of serious violent crimes.
- 4,503 fewer young people will develop serious drug addictions, 3,081 fewer will become regular smokers, and 1,659 fewer will develop serious alcohol addictions.
- 2,272 fewer young women and 3,081 fewer young men will contemplate suicide.

Certified B Corporation

PAX is already creating change in our community.

Over 400 staff within our schools and early childhood education programs have joined the PAX movement.

allcare health™

Hub
Southern Oregon
Early Learning Services

SOUTHERN OREGON
SUCCESS

pax
Good Behavior Game

nurture
Oregon

JOSEPHINE COUNTY, OREGON
SINCE 1856
PROUD TO BE THE BEST

JACKSON
COUNTY
Health & Human Services

The Family
Connection

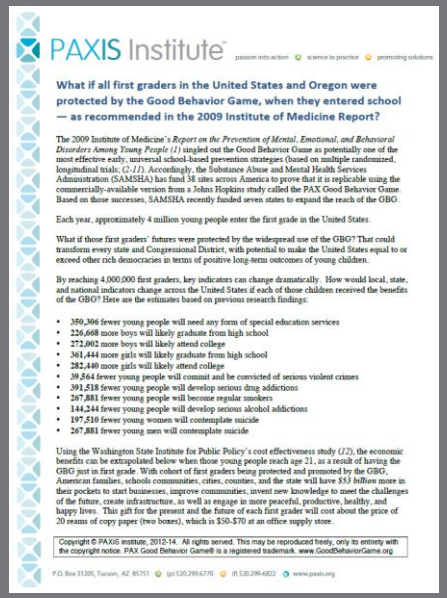
Measuring Success:
Quantitative Data

VARIABLE	MEASUREMENT	TIME FRAME
Disruptive Behavior	Spleem Counts	Short-Term
Implementation Fidelity	PAX Perfect Surveys & Rubrics	Short-Term
Focused Attention Time	PAX Minutes	Short-Term
Risk of Mental Health Disorders	Strengths & Difficulties Questionnaire (SDQ)	Intermediate-Term
Social Emotional Learning	Social Competence Scale (SCS)	Intermediate-Term
Student Attendance & Discipline	School Records	Intermediate-Term
Academic Performance	School Records	Intermediate-Term
Teacher Sense of Efficacy	Teachers' Sense of Efficacy Scale (TSES)	Intermediate-Term
Teacher Depression, Anxiety & Stress	Depression, Anxiety & Stress Scale (DASS)	Intermediate-Term
Teacher Burnout	Maslach Burnout Inventory (MBI)	Intermediate-Term

Looking to the Future

- ✓ Moving schools into a credential-like status and putting HB 4018 to work;
- ✓ Review of PAX for goodness of fit as a health-related service;
- ✓ Collaborate with Head Start and SOELS to move PAX into ECE;
- ✓ Develop comprehensive CQI system—to include robust data;
- ✓ Develop engagement campaign for parents and community; and
- ✓ Statewide funding proposal in coordination with NURTURE OREGON.

Resources to Share



PAXIS Institute

What if all first graders in the United States and Oregon were protected by the Good Behavior Game, when they entered school — as recommended in the 2009 Institute of Medicine Report?

The 2009 Institute of Medicine's *Report on the Prevention of Mental, Emotional, and Behavioral Disorders Among Young People (1)* singled out the Good Behavior Game as potentially one of the most effective early, universal school-based prevention strategies (based on multiple randomized, longitudinal trials; *(2-11)*. Accordingly, the Substance Abuse and Mental Health Services Administration (SAMSHA) has fund 38 sites across America to prove that it is replicable using the commercially-available version from a Johns Hopkins study called the PAX Good Behavior Game. Based on those successes, SAMSHA recently funded seven states to expand the reach of the GBG.

Each year, approximately 4 million young people enter the first grade in the United States.

What if those first graders' futures were protected by the widespread use of the GBG? That could transform every state and Congressional District, with potential to make the United States equal to or exceed other rich democracies in terms of positive long-term outcomes of young children.

By reaching 4,000,000 first graders, key indicators can change dramatically. How would local, state, and national indicators change across the United States if each of those children received the benefits of the GBG? Here are the estimates based on previous research findings:

- **350,306** fewer young people will need any form of special education services
- **226,668** more boys will likely graduate from high school
- **272,002** more boys will likely attend college
- **361,444** more girls will likely graduate from high school
- **282,440** more girls will likely attend college
- **39,564** fewer young people will commit and be convicted of serious violent crimes
- **391,518** fewer young people will develop serious drug addictions
- **267,881** fewer young people will become regular smokers
- **144,244** fewer young people will develop serious alcohol addictions
- **197,510** fewer young women will contemplate suicide
- **267,881** fewer young men will contemplate suicide

Using the Washington State Institute for Public Policy's cost effectiveness study *(12)*, the economic benefits can be extrapolated below when those young people reach age 21, as a result of having the GBG just in first grade. With cohort of first graders being protected and promoted by the GBG, American families, schools communities, cities, counties, and the state will have *$53 billion* more in their pockets to start businesses, improve communities, invent new knowledge to meet the challenges of the future, create infrastructure, as well as engage in more peaceful, productive, healthy, and happy lives. This gift for the present and the future of each first grader will cost about the price of 20 reams of copy paper (two boxes), which is $50-$70 at an office supply store.

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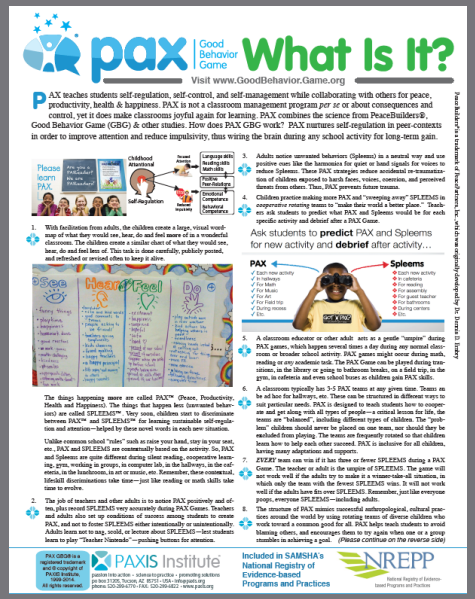
P.O. Box 31205, Tucson, AZ 85751 (p) 520.299.6770 (f) 520.299-6822 www.paxis.org

Outcomes Calculator



pax Good Behavior Game **What Is It?**

Visit www.GoodBehavior.Game.org

PAX teaches students self-regulation, self-control, and self-management while collaborating with others for peace, productivity, health & happiness. PAX is not a classroom management program *per se* or about consequences and control, yet it does make classrooms joyful again for learning. PAX combines the science from PeaceBuilders®, Good Behavior Game (GBG) & other studies. How does PAX GBG work? PAX nurtures self-regulation in peer-contexts in order to improve attention and reduce impulsivity, thus wiring the brain during any school activity for long-term gain.

1. With facilitation from adults, the children create a large, visual word-map of what they would see, hear, do and feel more of in a wonderful classroom. The children create a similar chart of what they would see, hear, do and feel less of. This task is done carefully, publicly posted, and refreshed or revised often to keep it alive.

The things happening more are called PAX™ (Peace, Productivity, Health and Happiness). The things that happen less (unwanted behaviors) are called SPLEEMS™. Very soon, children start to discriminate between PAX™ and SPLEEMS™ for learning sustainable self-regulation and attention—helped by these novel words in each new situation.

Unlike common school "rules" such as raise your hand, stay in your seat, etc., PAX and SPLEEMS are commonally based on the activity. So, PAX and Spleems are quite different during silent reading, cooperative learning, gym, working in groups, in computer lab, in the hallways, in the cafeteria, in the lunchroom, in art or music, etc. Remember, these consensual, lifeskill discriminations take time—just like reading or math skills take time to evolve.

2. The job of teachers and other adults is to notice PAX positively and often, plus record SPLEEMS very accurately during PAX Games. Teachers and adults also set up conditions of success among students to create PAX, and not to foster SPLEEMS either intentionally or unintentionally. Adults learn not to nag, scold, or lecture about SPLEEMS—lest students learn to play "Teacher Nintendo"—pushing buttons for attention.

3. Adults notice unwanted behaviors (Spleems) in a neutral way and use positive cues like the harmonics for quiet or hand signals for voices to reduce Spleems. These PAX strategies reduce accidental re-enumeration of children exposed to harsh faces, voices, coercion, and perceived threats from others. Thus, PAX prevents future trauma.

4. Children practice making more PAX and "sweeping away" SPLEEMS in cooperative rotating teams to "make their world a better place." Teachers ask students to predict what PAX and Spleems would be for each specific activity and debrief after a PAX Game.

Ask students to **predict** PAX and Spleems for new activity and **debrief** after activity…

5. A classroom educator or other adult acts as a gentle "umpire" during PAX games, which happens several times a day during any normal classroom or broader school activity. PAX games might occur during math, reading or any academic task. The PAX Game can be played during transitions, in the library or going to bathroom breaks, on a field trip, in the gym, in cafeteria and even school buses as children gain PAX skills.

6. A classroom typically has 3-5 PAX teams at any given time. Teams are be ad hoc for hallways, etc. These can be structured in different ways to suit particular needs. PAX is designed to teach students how to cooperate and get along with all types of people—a critical lesson for life, the teams are "balanced", including different types of children. The "problem" children should never be placed on one team, nor should they be excluded from playing. The teams are frequently rotated so that children learn how to help each other succeed. PAX is inclusive for all children, having many adaptations and supports.

7. *EVERY* team can win if it has three or fewer SPLEEMS during a PAX Game. The teacher or adult is the umpire of SPLEEMS. The game will not work well if the adults try to make it a winner-take-all situation, in which only the team with the fewest SPLEEMS wins. It will not work well if the adults have fits over SPLEEMS. Remember, just like everyone poops, everyone SPLEEMS—including adults.

8. The structure of PAX mimics successful anthropological, cultural practices around the world by using rotating teams of diverse children who work toward a common good for all. PAX helps teach students to avoid blaming others, and encourages them to try again when one or a group stumbles in achieving a goal. *(Please continue on the reverse side)*

PAXIS Institute

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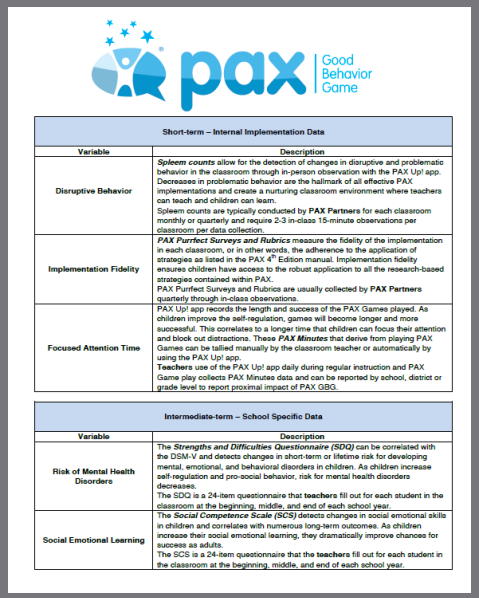
Included in SAMSHA's National Registry of Evidence-based Programs and Practices

NREPP National Registry of Evidence-based Programs and Practices

Framework Summary



pax Good Behavior Game

Short-term – Internal Implementation Data	
Variable	**Description**
Disruptive Behavior	***Spleem counts*** allow for the detection of changes in disruptive and problematic behavior in the classroom through in-person observation with the PAX Up! app. Decreases in problematic behavior are the hallmark of all effective PAX implementations and create a nurturing classroom environment where teachers can teach and children can learn. Spleem counts are typically conducted by **PAX Partners** for each classroom monthly or quarterly and require 2-3 in-class 15-minute observations per classroom per data collection.
Implementation Fidelity	***PAX Purrfect Surveys and Rubrics*** measure the fidelity of the implementation in each classroom, or in other words, the adherence to the application of strategies as listed in the PAX 4th Edition manual. Implementation fidelity ensures children have access to the robust application to all the research-based strategies contained within PAX. PAX Purrfect Surveys and Rubrics are usually collected by **PAX Partners** quarterly through in-class observations.
Focused Attention Time	PAX Up! app records the length and success of the PAX Games played. As children improve the self-regulation, games will become longer and more successful. This correlates to a longer time that children can focus their attention and block out distractions. These ***PAX Minutes*** that derive from playing PAX Games can be tallied manually by the classroom teacher or automatically by using the PAX Up! app. **Teachers** use of the PAX Up! app daily during regular instruction and PAX Game play collects PAX Minutes data and can be reported by school, district or grade level to report proximal impact of PAX GBG.

Intermediate-term – School Specific Data	
Variable	**Description**
Risk of Mental Health Disorders	The ***Strengths and Difficulties Questionnaire (SDQ)*** can be correlated with the DSM-V and detects changes in short-term or lifetime risk for developing mental, emotional, and behavioral disorders in children. As children increase self-regulation and pro-social behavior, risk for mental health disorders decreases. The SDQ is a 24-item questionnaire that **teachers** fill out for each student in the classroom at the beginning, middle, and end of each school year.
Social Emotional Learning	The ***Social Competence Scale (SCS)*** detects changes in social emotional skills in children and correlates with numerous long-term outcomes. As children increase their social emotional learning, they dramatically improve chances for success as adults. The SCS is a 24-item questionnaire that the **teachers** fill out for each student in the classroom at the beginning, middle, and end of each school year.

Data Measures

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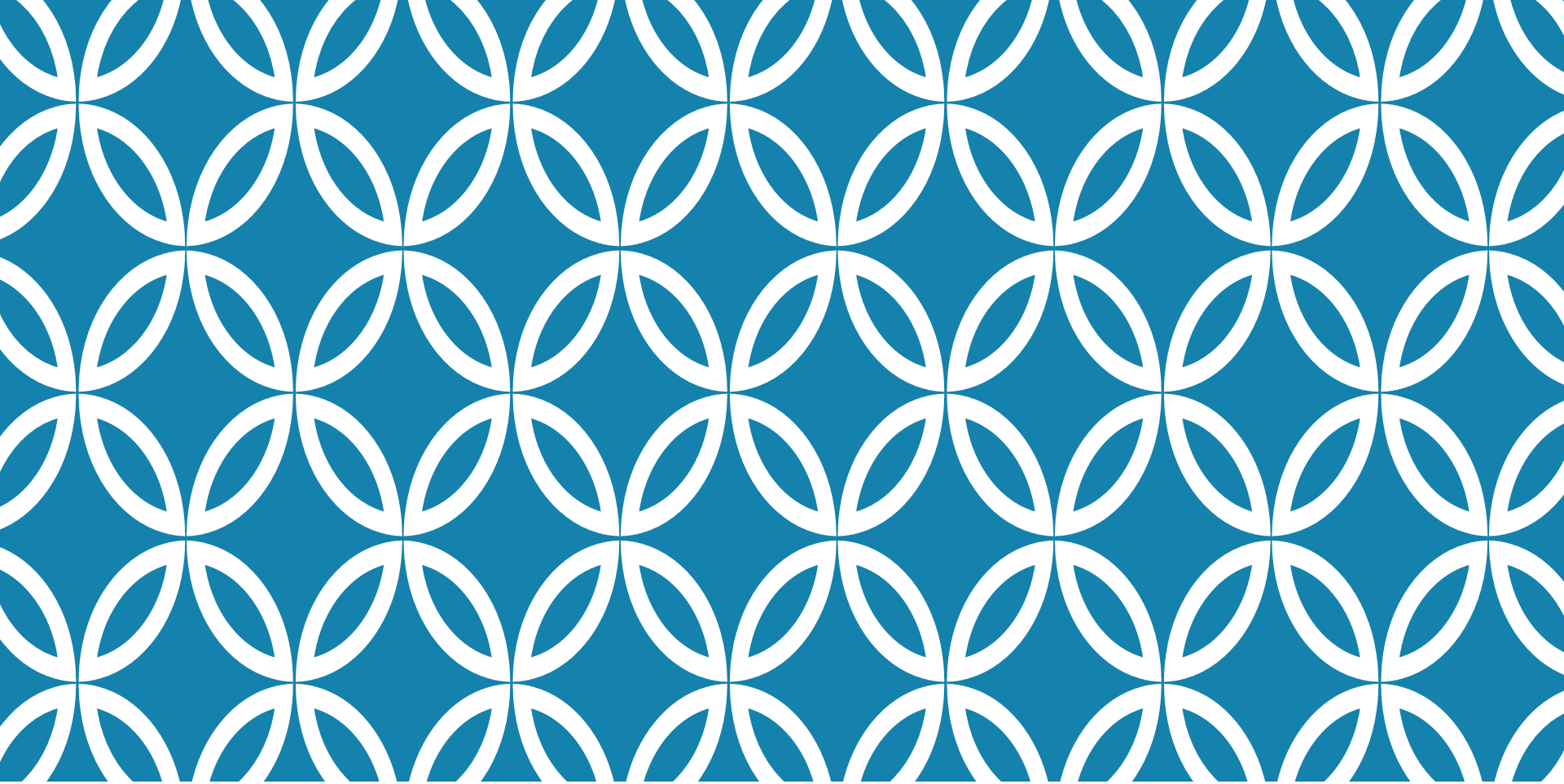


CULTIVATING RESILIENCE: A CLINICIAN'S PERSPECTIVE

Safina Koreishi
MD, MPH

SERVING CHILDREN AND FAMILIES WHO HAVE EXPERIENCED TRAUMA

- Mindfulness practices can support children, youth and families
- Mindfulness practices and organizational support for clinicians serving these families
- Vicarious trauma

When you identify with the pain of people who have endured terrible things, you bring their grief, fear, anger, and despair into your own awareness and experience.

RESILIENCE

"Resilience is the capacity to respond to stress in a healthy way such that goals are achieved at minimal psychological and physical cost." (Epstein)

Resilient individuals (and organizations) "bounce back" after challenges while growing stronger. (Epstein)

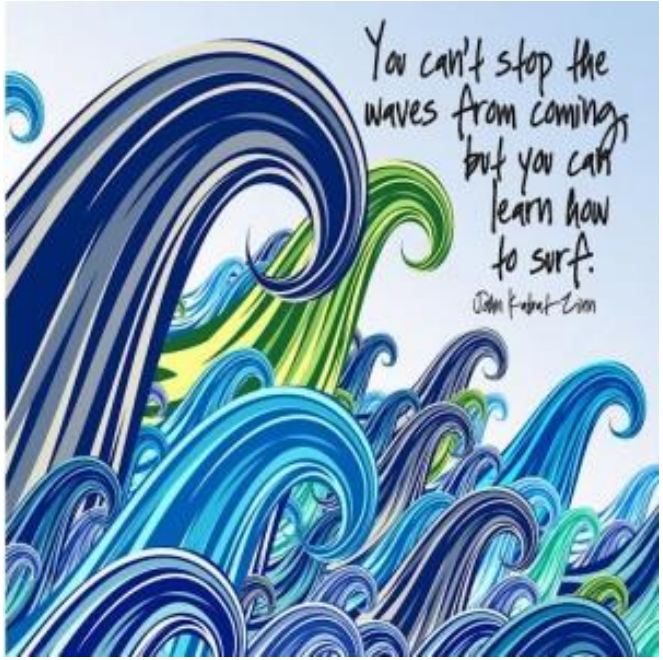
Resilience is dependent on related influences such as mindfulness

- Self-monitoring
- Social support
- Institutional support

MINDFULNESS-BASED STRESS REDUCTION

Evidence in improving individual provider and patient outcomes

- Reduced stress, ruminations, and negative affect
- Improved physical and mental self-care, quality of life, self-compassion, and patient care
- Evidence of sustained effects in long-term follow-ups
- Improved patient-centered care and empathy scores



COLUMBIA PACIFIC CCO CLINICIAN WELLNESS INITIATIVE

- CPCCO clinical strategic goal:
  - Addressing clinician wellness
  - Workforce recruitment and retention
- Hear from CPCCO clinicians ideas/thoughts of what could help
- CPCCO Clinical Advisory Panel taskforce recommended developing clinician wellness program
- Linking to trauma-informed care initiative

COMMUNITY LEVEL WORK

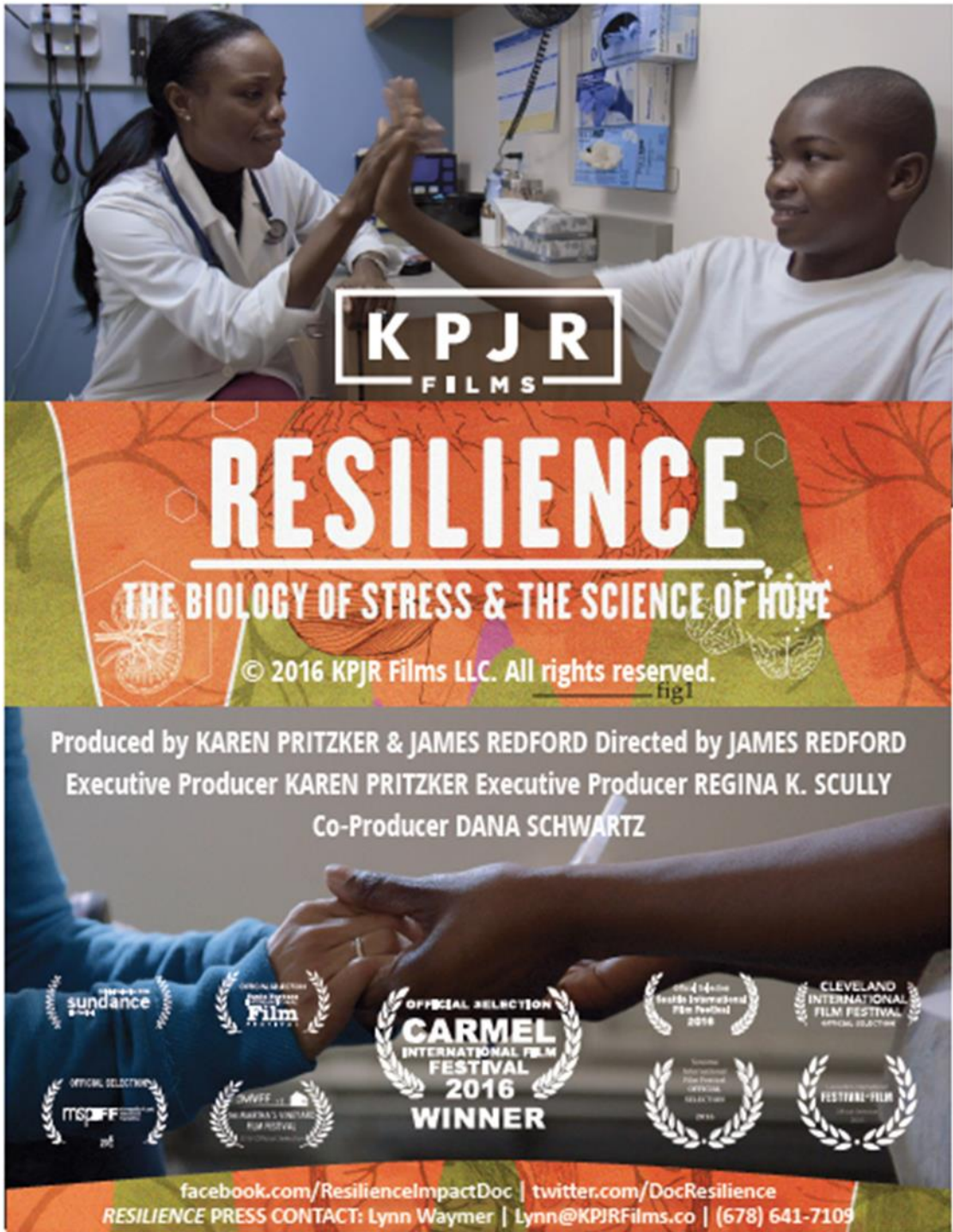


fig1

Link to video:

https://www.youtube.com/watch?v=L_GQ_wzCd1Q&t=8s

Questions?

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