SciMedCentral

JSM Health Education & Primary Health Care

Mini Review

The Importance of Trauma-Informed Systems in Adverse Childhood Experiences Screening

Claire O'Connell Boogaard* and Jessica Hippolyte

Division of General and Community Medicine, Children's National Hospital, USA

***Corresponding author**

Claire O'Connell Boogaard, Division of General and Community Medicine, Children's National Hospital, Washington, DC, USA

Submitted: 17 October 2022

Accepted: 03 November 2022

Published: 05 November 2022

ISSN: 2578-3777

During the Spring of 2018, our community pediatric clinic embarked on Adverse Childhood Experience (ACE) screening. We were searching for a solution to the recurrent behavioral issues, somatic concerns, and exacerbations of chronic illness that standard therapies were not providing. Some of these patients had obvious stressors in their life, but for others it was less clear, leaving us frustrated about how to help. When we read the original ACEs study [1] and consumed the emerging research on the topic, our experiences as primary care pediatricians were affirmed: strong, frequent, or prolonged toxic stress negatively impacts health [2]. Optimistic that focusing our efforts on the causative sources of illness could prevent a career of suboptimal symptomatic treatment, we set out to identify patients and families with elevated ACE scores. We reviewed the most recent studies and designed the project around lessons learned. We followed the Bayview Child Health Center-Center for Youth Wellness (BCHC-CYW) Integrated Pediatric Care Model that focused on screening with an ACEs score followed by offering counseling and referral in an integrated care approach [3]. We also chose to screen in both children and parents to best understand patients' behavior [4]. The goal was to identify individuals with elevated ACE scores and connect them with clinical and community resources to alleviate stress and build resilience.

ACES SCREENING PILOT OBJECTIVES

We knew the plan was bold and would require flexibility and innovation but were optimistic our clinic had the resources and infrastructure needed to make this a success. Our clinic is an academic community-based Patient-Centered Medical Home with onsite mental health providers, social workers, and specialty care who function as referral sources for our patients. The clinic is in an under-resourced urban neighborhood, and although ACEs touch every community, the residents of this neighborhood experience significant stressors related to racial and social injustices, putting them at greater risk for poor health outcomes. Although the topics of ACEs and toxic stress could be new conceptually to our patients and families, we hypothesized the screen would help identify risk early and educating families about the connection between adversity and health could create new avenues for healing.

ACES SCREENING PILOT DESIGN

Our team studied the available academic guidance on implementing ACEs screening and began the process. We sought approval and support from our institution and local clinic. We provided group training for all members of the care team, surveyed providers on their concerns, created scripts to standardize language and approach, educated families on the relationship between toxic stress and health to help build trust, and established referral pathways to resources at the provider's request. Screens were incorporated in the patient's pre-visit form packet and self-administered at age 6-month, 1-year, 2-year, and 3-year well visits. The associated EMR templates were updated for ease of ACE score documentation. We piloted the screen with a small number of parents to obtain their impressions and feedback and adjusted the language and design to increase patient comfort. We picked a small population of patients to start with and had a plan on how to quickly screen and adapt our approach as barriers presented themselves. Through our PDSA (Plan, Do Study, Act) cycles, we further adjusted the screen to include resiliency measures and continued to assess provider satisfaction with the new screening tool and available resources. According to the latest review by Kaiser Permanente Washington Health Research Institute, we targeted the 5 necessary elements required for successful ACEs screening [5]:

1) Secure broad organizational support for ACEs screening and engagement across all key stakeholders (leadership, providers, care team, IT)
2) Provide training on trauma and ACEs screening to generate support, establish a common language, increase awareness of ACEs, and build comfort with screening.
3) When starting to screen for ACEs, start small and use data to support successful implementation and spread.
4) Establish systems and practices to support staff and providers
5) Invest in building strong, trusting relationships with patients

ACEs screening: Lessons Learned

We began the process of screening and found ourselves increasingly more uncomfortable with the process. The screening tools were only filled out 28% of the time and the scores obtained did not always reflect the experiences our families had already shared with us. We were puzzled with why the screen was being underutilized and delivering inconsistent invalid results.

Organizational prioritization is needed for successful screening: After several group meetings and reflection, we discussed that although incorporating the above elements for successful screening is necessary, these elements are fragile and require a dynamic system to be executed effectively. On an institution level, this work needs approval and support but also needs prioritization in order to secure the adequate time with patients and resources to appropriately respond to the illuminated results. Screening can quickly come in conflict with productivity goals or flood the available resources already on site. Without prioritization and flexibility, the process becomes less helpful to patients and families. Prioritization also includes producing data efficiently and regularly to adjust PDSA (Plan, Do, Study, Act) cycles and improve the screening process. Our data reports were difficult to pull and implementing changes in our electronic medical record were also untimely. One year after screen implementation, the majority of the staff and provider's lost confidence with the benefits screening, with providers reporting the intervention had no impact on patients (43%), had a negative impact because it was more paperwork to complete prior to the visit (29%), and positively impacted only those willing to discuss the screen openly, though admitting majority of patients were "not ready" to discuss or acknowledge ACEs (14%).

Discomfort with the topic of ACEs is a barrier to successful screening: Amongst our clinic staff, there is diversity in experience and comfort with ACEs that needs to be acknowledged. Although we provided staff training on ACEs screening, toxic stress, and trauma-informed care to generate support locally within our division, some staff still did not build comfort with the screen. Many people still questioned if the screen was the best way to address this topic with families, as they accurately anticipated many families would not feel comfortable completing or acknowledging their ACE score. We hoped our data would be able to show not only the prevalence of these experiences in our families, but also could show the value in recognizing it through referral outcomes. However, elevated scores were low and accepted referrals were even lower, so we were not able to capture the widespread benefit that some patients experienced from the screen.

Negative impacts of screening on staff need to be prioritized: As we embarked on this work, we assessed staff willingness and readiness to screen, but did not appropriately acknowledge the personal impact this work could have on us. Although our institution offers many wellness benefits and outreach opportunities, there was no formal assessment of the vicarious trauma this topic could bring up in staff and providers. Even for those not personally affected by the topic, incorporating a new screen, workflow, referral process, and need for therapeutic intervention results in additional tasks that increase stress and burnout in the current health care environment. The stress is compounded if this new process causes more disruptions in workflow or there is not timely closed loop communication with referrals.

System factors are barriers to successful ACEs screening: There are systematic changes we need to consider for our system to build more trust with our patients and families. As much as we try, there is a lack of continuity with patients that is a product of trying to keep access available to all. This can make it challenging for patients to trust providers with sensitive information, especially if the patient and provider differ on educational status, race/ethnicity, or perceived power. Although ACEs are universal and found in every community, patients may perceive the provider will see the ACE as a parenting problem (or worse, report it to authorities), rather than as a tool to help us better understand the context of the individual. This lack of trust is amplified if the system does not deliver care as promised. Long wait times, frequent changes in workflows, and inconsistent access to providers can make individuals lose trust in the system and be even more hesitant when it comes to sharing information with their provider.

THE PATH FORWARD FOR ACES SCREENING: BUILDING TRAUMA-INFORMED SYSTEMS

What can we do to improve the success of these screens in this fragile medical landscape? We need to have a universal yet personalized approach to screening. Experiences and trust vary with patients, so we need to be flexible with our approach: screening is not a "one fits all" model. Building a secure relationship with families as a system is essential if continuity with providers is not guaranteed. This relationship should be in place before the topic is introduced. The relationship may often require more than one visit to develop, as the priorities of the patient must first be addressed. Building this trusting relationship not only requires trauma-informed staff, but a trauma informed system. Even if staff have the training and education, it is vital that everything from schedule design to data collection is executed to strengthen relationships and adapt as necessary to improve care. This will require flexibility in resource allocation, possible changes to staff roles or schedules, and may interfere with other priorities of the clinic or institution. Finally, acknowledging and accommodating for the inherent stress this work places on providers and staff is crucial. This work can be fulfilling but can also be difficult, time consuming and triggering to personal experiences that should not be ignored. Lastly, although our ACEs screening journey started in the pre-COVID era, we have all witnessed increased levels of trauma and health inequities from the pandemic that disproportionally impact our under-served communities. Approaching patients with a trauma-informed lens has even greater significance now and challenging our health care systems to strategize and improve our health care delivery models is critical for meaningful and impactful change.

REFERENCES

1. Felitti VJ, Anda RF, Nordenberg D, Edwards V, Koss MP, Marks JS, at al. Relationship of Childhood abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998; 14: 245-258.

2. Flaherty EG, Thompson R, LItrownik AJ, Zolotro AJ, Dubowitz H, Runyan DR, et al. Adverse Childhood Exposures and Reported Child Health at Age 12. Acad. Pediatr. 2009; 9: 150-156.

3. Purewal SK, Bucci M, Gutierrez Wang L, Koita K, Silverio Marques S, Oh D, at al. Screening for adverse childhood experiences (ACEs) in an integrated pediatric care model. Zero to Three. 2016; 37: 10-17.

4. Stevens JE. To prevent childhood trauma, pediatricians screen children and their parents…and sometimes, just parents…for childhood trauma. 2014.

5. Center for Community Health and Evaluation. Screening for adverse childhood experiences (ACEs) in pediatric practices. 2019.

Cite this article

O'Connell Boogaard C, Hippolyte J (2022) The Importance of Trauma-Informed Systems in Adverse Childhood Experiences Screening. JSM Health Educ Prim Health Care 4(1): 1048.