



Screening for adverse childhood experiences (ACEs) in pediatric practices

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Introduction. We now know that trauma early in life can have a significant impact on an individual's health and wellness throughout their life. As a result, health care organizations are beginning to focus on providing more trauma-informed care, or care where all parties involved recognize and respond to the impact of traumatic stress and resiliency factors on children, caregivers, and service providers. Screening for ACEs in pediatric clinical settings promotes early intervention and can be a tangible entry point for organizations interested in providing trauma-informed care, especially when coupled with other efforts to build organizational capacity related to addressing trauma and promoting resilience with patients and families.

The Center for Community Health and Evaluation (CCH E) is evaluating two programs that are implementing ACEs/trauma screening in pediatric settings. Learning from these two programs can provide guidance to practices of all types that are interested in or already implementing ACEs screening. We propose five elements to ensure effective ACEs screening practice and provide tactical considerations and decisions required to for success (see box on page 3).

Insights based on learning from evaluations of two programs

The **National Pediatric Practice Community (NPPC) on ACEs Screening** is a pilot program of the Center for Youth Wellness to support health care professionals in applying ACEs and toxic stress science to pediatric practice and to shape the field of trauma-informed medicine. The NPPC pilot launched in 2017 and provided training, technical assistance, and practice coaching in pediatric ACEs screening to a small group of medical practices across the country.

The **Resilient Beginnings Collaborative (RBC)** is a partnership between Genentech Charitable Giving and the Center for Care Innovations. RBC launched in June 2018 and supports seven safety net organizations in the San Francisco Bay Area in strengthening their capacity to address childhood adversity and promote resiliency in pediatric care. Teams have focused on implementation of screening to assess for and address trauma as one element in a broader effort to respond to trauma and promote resilience.

1 Secure broad organizational support for ACEs screening and engagement across all key stakeholders.

ACEs screening can impact the work and workflow of many people within the clinic and has implications for how providers and staff interact with community partners via referral networks. Early buy-in ensures that key stakeholders understand the rationale for screening and provides insights on how to best implement screening given existing practices and systems. Key internal stakeholders include:

- **Leadership.** For most successful practices, leadership support has been essential to establish ACEs screening as an organizational priority, both for allocating the human and financial resources to support successful screening and for establishing commitment to providing trauma and resilience informed-care more broadly. Leadership buy-in can be cultivated by articulating how screening aligns with organizational priorities and positively impacts patients.
- **Providers.** As with other screening practices, providers play a key role in ACEs screening, including communicating with patients, interpreting results, and determining next steps. Identifying and engaging a provider champion along with clearly articulating the benefits of screening to patient care can help secure provider support.
- **Care team and front desk staff.** Successful and sustainable integration of screening into clinical practice benefits from the involvement of the entire care team. For example, front desk staff may need to explain or answer questions about the screen, while clinical support staff often are tasked with administering the screen.
- **Information technology (IT).** IT representatives are needed to ensure screening practices can be integrated with existing technology and that data can be captured in and retrieved from electronic health records.

2 Provide training on trauma and ACEs screening to generate support, establish a common language, increase awareness of ACEs, and build comfort with screening.

Training staff has been an important step for clinics implementing ACEs screening. Training should extend beyond providers and include all clinic staff impacted by screening implementation. Clinical practices have found that two levels of training have been needed. First, an initial overview for all or most clinic staff to establish a common language, build awareness, and establish screening as an organizational priority. Second, a more tactical and targeted training for clinical and support staff who will be more directly involved with screening. This second training should include designing or reviewing workflows, roles, and scripting (i.e., how to talk to patients about the screening).

3 When starting to screen for ACEs, start small and use data to support successful implementation and spread.

ACEs screening implementation is a clinic change effort that can complement broader practice transformation. Applying existing quality improvement approaches can support effective implementation. For example, many practices start with a small pilot to develop their processes, refine communication, and resolve any issues before implementing more broadly. The pilot can also prompt early thinking about how to best collect and report on data related to ACEs screening and referral, including integrating the data into their electronic health record, and establish processes for data sharing across team members, particularly between primary care and behavioral health. Involvement of IT and quality improvement staff during the pilot is key to establishing effective data tracking and reporting systems. Having reliable data systems facilitates more effective rollout across the organization and supports data collection and documentation for other priorities. For example, practices have written up their screening implementation process to meet patient-centered medical home, joint commission, or provider leadership credentialing requirements.

Decisions for implementing ACEs screening

Determining who and when to screen.

- Identify your target patient population (ages, caregivers or patients). When determining where to start screening, consider what follow-up and referral resources are available and for whom.
- Determine the frequency of screening. Pediatric practices tend to screen annually, typically at well child visits, but some practices are also treating it as a care gap (when screening is not complete) and opportunistically completing screening when patients are in the clinic (i.e., not just at well child visits).

Selecting the screening tool. Consider how the screening tool will serve your goals and patient population.

- Determine how to “score” and interpret the assessment to determine response and follow-up, including if/how symptoms factor into the screening process.
- Determine whether you will focus on ACEs or also want to capture patient/family strengths or resilience factors.

Establishing workflow. An effective workflow will help ensure your screening process gathers accurate results. Key questions include: how is the screen administered? By whom? Where (e.g., waiting room, exam room)? What happens afterward? What will the follow-up response be? Who will be involved in follow-up/response? How will results be documented?

Interpreting results and assigning risk. ACE screening requires a significant level of clinical interpretation and decision making. Most practices want providers to interpret the screen (along with symptoms, if appropriate), assign the level of risk, and determine appropriate follow-up.

Identifying referral and follow-up resources and services. The most common barrier to screening is: “How will we support patients who screen positive?” Practices are often worried about uncovering large numbers of patients with severe mental/behavioral health needs and having inadequate resources to support those needs. Most practices have found that hasn’t happened. However, it is important to have adequate follow-up systems in place. This includes internal and external resources including but not limited to mental/behavioral health therapy, anticipatory guidance, patient education, parenting programs, and other social services (e.g., housing, food).

4 Establish systems and practices to support staff and providers.

Screening for ACEs can be difficult for staff and providers, especially those that have experienced their own trauma. Organizations have learned that providing trauma-informed care and becoming a trauma-informed organization cannot only focus on care of patients; they also must create a supportive environment for staff. This could include reflective supervision, team debriefs, leaders modeling self-care and work-life balance, and communicating about and providing access to resources like employee assistance programs. Organizations that have committed to becoming more trauma-informed have seen value in engaging their human resources representatives in order to ensure internal policies and practices contribute to a supportive organizational culture.

5 Invest in building strong, trusting relationships with patients.

ACEs screening brings up sensitive topics that many people may not be comfortable discussing. Patients may experience fear and stigmatization if they disclose current or past trauma that they or their children have experienced. If this is a new practice, patients also may not understand why the clinic is asking about trauma and wonder what is being done with the information. Patients may be particularly worried about mandatory reporting and involvement of Child Protective Services.

While research on patient experience with ACEs screening is limited, how the screening is introduced and administered matters. Clinics should invest in training staff on how to administer the assessment and developing scripts for how to introduce and discuss the screen with patients. Additionally, staff need to have sufficient time to build trust and positive rapport with patients and their families in order to get accurate information in the screening process and effectively address patient needs. Some practices have reported that universal screening patients can help to decrease stigma and increase the receptivity of patients and their families to completing the screening. Practices have also advocated for pairing ACEs screening with efforts to assess patient strengths and resiliency factors. When done well, screening can open the door for deeper conversations with patients/families that strengthens relationships and improves care by signaling that the clinic cares about the overall health and well-being of its patients.

Conclusion. With appropriate support and processes, pediatric practices are an effective environment for early identification and intervention to mitigate the impact of childhood adversity and trauma. While there are still questions about the impact of implementing ACEs screening, it can be a concrete first step for practices who recognize the impact of trauma on their patients' health and well-being. Effective screening practice requires internal foundational work to secure broad organizational commitment for trauma-informed care, to train and support staff, be intentional about screening processes, identify appropriate referral services, and build trust with patients and families. Additionally, to more effectively meet patients' health and social needs, practices benefit from promoting resilience by understanding and supporting patients' strengths.

The Center for Community Health and Evaluation designs and evaluates health-related programs and initiatives throughout the United States. For more information, please contact Maggie Jones at Maggie.E.Jones@kp.org.