A Quality Improvement Project to Implement ACES Screening During Pediatric Primary Care Visits

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Submitted to: Virginia Elder - Chair

This paper is submitted in partial fulfillment of the requirements for

the Doctor of Nursing Practice degree.

Abstract

Adverse Childhood Experiences (ACEs) are traumatic events in childhood that have been shown to have a negative effect on health outcomes. Over half of all adults in the United States have been exposed to at least one ACE, and early identification is key to improving overall health. This quality improvement project aimed to implement a universal ACEs screening in a pediatric primary care setting in a rural Federally Qualified Health Center. Using the Model for Improvement, children up to 17 years old were screened using the Pediatric ACEs and Related Life-events Screener (PEARLS) over the course of three PDSA cycles. Staff also received training and education to effectively screen and discuss ACEs with families and make evidence-based recommendations for treatment planning. By the end of the project, 78.6 percent of patients were screened for ACES during well-child visits and the clinic had incorporated the screening into their practice. Staff also demonstrated increased knowledge and awareness of ACEs. Implementing a universal ACEs screening is an important first step for providing trauma-informed care and allows for appropriate referrals to resources that can support families with high ACE scores.

Keywords: Adverse Childhood Experiences (ACEs), quality improvement, federally qualified health center, ACEs screening, trauma-informed care

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Introduction

Problem Description

Adverse Childhood Experiences (ACES) are traumatic events that occur during childhood (Morgan et al., 2021). This term was coined during a 1998 study by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente that measured the effect of negative early life experiences on health outcomes (State of California Department of Health Care Services, 2020b). ACEs are separated into ten categories of adversities within three domains: abuse, neglect, and household dysfunction. Repeated exposures to ACEs without supports in place can lead to "toxic stress" (Bryant & VanGraafeiland, 2019). According to the American Academy of Pediatrics, toxic stress is "*the excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships*" (Garner et al., 2012). Exposure to toxic stress during childhood affects brain development and can interfere with behavioral, economic, and health outcomes later in life. Children exposed to one or more ACEs have an increased risk of asthma, heart disease, obesity, diabetes, mental illness, and other chronic medical conditions, especially if they do not have the coping skills and external supports in place to support the development of resilience (Bryant & VanGraafeiland, 2019; Marsicek et al., 2019). There is a positive linear relationship between the number of ACEs and adverse health outcomes (Morgan et al., 2021). Children exposed to six or more ACEs have almost a 20-year reduced life expectancy (Bryant & VanGraafeiland, 2019).

Early identification of ACEs is key to preventing poor health outcomes (Morgan et al., 2021). At least 50 percent of children in the United States have been exposed to at least one ACE and 12 percent have been exposed to four or more ACEs. However, according to Marsicek et al. (2019), only four percent of pediatricians were universally screening all children for ACEs. This quality improvement

project was implemented in a primary care setting as it is the ideal place to identify exposure to ACEs since most children and their families interact with the primary care setting at least annually (Marsicek et al., 2019).

Available Knowledge

One systematic review addressed the potential concerns with implementing a screening process for ACEs, including patient discomfort, time, and clinician discomfort/inexperience in discussing screening results (Rariden et al., 2020). All the included studies found that most patients found it acceptable to complete the screening and supported using the screening to identify additional services and discuss the patterns of intergenerational trauma. Gillespie & Folger (2017) noted that the average ACE conversation after a positive screen lasted 3-5 minutes and that providers reported ACEs screenings increased empathy, fostered trusting relationships, and resulted in better communication between clinicians and families.

Several validated tools can be used for ACEs screenings. These include the ACE Questionnaire from the Center for Youth Wellness and the Pediatric ACEs and Related Life-events Screener (PEARLS), which was developed by the Bay Area Research Consortium on Toxic Stress and Health (BARC) (State of California Department of Health Care Services, 2020b). The PEARLS includes the 10-item ACE Questionnaire plus seven additional questions about additional childhood adversities. Both questionnaires are available in identified and de-identified forms, meaning that families either mark which specific ACE they have experienced or they write the total at the bottom of the form, respectively. According to Gillespie & Folger (2017), families were more likely to disclose ACEs when data was collected with a de-identified screening versus an identified screening, giving them a sense of privacy while having an initial conversation about trauma within the family unit.

The ACEs Aware initiative was started by the California Department of Healthcare Services (DHCS) and the Office of the California Surgeon General as part of Governor Gavin Newsom's California

For All initiative and transitioned to the University of California ACES Aware Family Resilience Network in 2021 (DHCS, 2020b). This initiative develops, promotes, and sustains evidence-based methods to screen patients for ACEs and implement evidence-based treatment plans to help families heal from traumatic events and toxic stress. They have also partnered with California's Medicaid program (Medi-Cal) to provide reimbursement to providers and organizations who implement ACES screening in their practice.

Screening for ACEs is an important first step, but the purpose of screening is to prompt a trauma-informed conversation with families about their specific experiences and needs (McLennan et al., 2020). Collecting the data should lead to an appropriate, evidence-based intervention within the treatment plan utilizing a trauma-informed approach. Clinicians have also expressed concern that screening should not be implemented until resources for treatment planning are in place and readily available for the clinician (Rariden et al., 2021).

Rationale

This quality improvement project used the Institute for Healthcare Improvement's (IHI) Model for Improvement (MFI). MFI is the most commonly used improvement framework in healthcare and has been shown to support improvement efforts in a variety of settings (Langley et al., 2009). Plan, Do, Study, Act (PDSA) cycles were developed to implement and test change on a small level before implementing systemic change (IHI, 2021).

A root-cause analysis was completed during the assessment phase to identify why families were not being screened for ACES, and several causes were identified (Appendix A). These included a need for more awareness among providers about California's *Aces Aware* initiative through the Department of Healthcare Services. There was also a lack of awareness of the clinic's ability to bill Medi-Cal for the ACES screening. There was also no workflow that outlined how to conduct the screening and to determine next steps if someone was experiencing or experienced childhood adversity. There was also no reminder system in the electronic health record when a patient had not been screened for ACEs. A

review of the literature demonstrated a large amount of evidence supporting the detrimental impact of ACEs on a person's health. As a result, several states have launched initiatives to encourage routine ACEs screening in a primary care environment (Gillespie & Folger, 2017).

Specific Aims

By November 2022, the clinic implemented a universal, standardized ACEs screening process during annual well-child visits for children ages six months through 17 years old. An educational campaign was implemented during provider and nursing meetings to build awareness. The goal was to increase screening rates from zero percent to 90 percent by the end of February 2023.

Methods

Context

This improvement project was implemented at a Federally Qualified Health Center (FQHC) in a rural county in northern California with a population of 27,828 (Freedman et al., 2019). They serve approximately 1700 pediatric patients, including 77 percent with Medi-Cal insurance and 19 percent with private insurance. The county experiences higher than average rates of homelessness, domestic violence, substance use, and reports of child abuse/neglect in California (Population Reference Bureau, 2022). The number of children in foster care is six times higher than the California average, and emergency calls for assistance with violence in the home are the highest in California (Freeman et al., 2019). Early identification of children and families who are experiencing or have experienced ACEs is important to provide additional support and resources to reduce the health burden of these childhood adversities.

The clinic exists within a network of FQHCs across two counties. They are in a three-year project with an outside consulting group as they strived to become a learning organization. The clinic was participating in quality improvement work at the time of this project to improve patient experience, improve staff workflow, and decrease staff burnout. This could be a helpful environment to continue

improvement work, as the outside consultants were also utilizing the MFI, so staff were already familiar with the model and PDSA cycles. This could also have a negative effect since staff could grow tired and frustrated with concurrent improvement projects. Other clinics within the organization were also in the process of implementing ACEs screening at their sites, which allowed for collaboration throughout the project.

Intervention

The intervention followed the recommendations of the California *Aces Aware* initiative so the clinic could meet requirements to bill Medi-Cal for this screening. The pediatric department, including the pediatrician, RN, two LVNs, and one medical assistant discussed the screening and referral process during an established team meeting and developed a workflow. The pediatrician completed the *ACEs Aware* online training in November 2022, and staff received additional information about the *ACES Aware* initiative during nursing and provider meetings.

After completing the required training, pediatric staff implemented the screening with families of 0–5-year-olds during well-child visits. The LVN or medical assistant that roomed the patient and their families gave the PEARLS screening tool to the family, along with other developmental screening tools normally given to this age group. Staff briefly discussed the tool with the family and encouraged them to speak with the provider during the visit. After completing the tool, the information was given to the provider, who began the well-child visit and discussed the results during the visit. The provider documented that the ACES screening was completed in their assessment and plan and made appropriate referrals and follow-up visits as necessary. The provider also selected the correct CPT code based on the screening results, so the clinic could bill for this screening. A reminder within the electronic health record was supposed to be built into the Health Maintenance tab so screening would occur annually moving forward, but this step was delayed. The intervention was implemented from November 2022 to February 2023.

Study of the Intervention

Co-occurring quality improvement initiatives through the outside consultants were monitored to determine if new projects affected care coordination with these families. Other community based organizations were also monitored for new initiatives related to ACEs screening. A questionnaire was also distributed to staff to gather feedback about the process of implementing the intervention (Appendix E).

Measures

The primary outcome measure for this project was the percentage of pediatric patients who were screened for ACEs between November 2022 and February 2023. Since the ACEs screening was a new tool and workflow for the clinic, we could not compare this data to previous data. This measure allowed the project team to determine if the ACEs screening process was implemented during the well-child visit, which was the primary aim of this project. Process measures included the number of pediatric staff who completed the ACEs training. Another process measure was the percentage of staff who attended the nursing and provider meetings to receive information about ACEs screening. Balancing measures included measuring the workload burden placed on staff to implement this screening. Appointment lengths were measured as part of a separate quality improvement project, so we could compare appointment lengths after the screening was implemented. These interventions did not increase clinic costs since the clinic could bill Medi-Cal for the ACEs screening.

Analysis

Run charts were used to gather data weekly during the intervention to determine the number of patients being screened for ACEs. The data from these run charts was used to determine if the intervention was having an effect and to determine future areas to target with subsequent PDSA cycles. Qualitative data was gathered during team meetings to determine workload burden and staff concerns and adjust future PDSAs to incorporate this feedback.

Ethical Considerations

Ethical considerations included patient consent and privacy, although no patient information or individually identifiable data was collected during the project. Patients were screened during well-child visits, and these visits included several screening tools that asked sensitive questions about patient history. Patients were not required to answer screening questions and could opt out during the screening process. The ACEs questionnaire was also available as a de-identified version so families could report the number of ACEs on the screening form and not the specific traumatic events. During the follow-up discussion with the provider, families could decline additional resources and referrals when offered to them. This quality improvement project was submitted to the OHSU IRB and determined to be Not Human Research (STUDY00024777).

Results

The project was implemented from November 14 to February 24, 2023. The clinic increased its screening rates to 78.6 percent by the end of 15 weeks, screening a total of 159 patients (Appendix D). During the first PDSA cycle, staff limited screenings to families of 0–5-year-olds over a two-week period. At the end of the first PDSA cycle, the team met to discuss modifications to the screening process. The screening form was changed to the de-identified version to increase patient comfort and disclosure of sensitive information. Providers had the opportunity to ask about specific ACES during the visit.

During the second PDSA cycle, screenings were expanded to include 6–12-year-olds. The de-identified screenings were continued and laminated to convey the temporary collection of data to families, with the goal of increasing patient comfort. The screening was built into the EHR system and could be pulled into a provider's note. Concerns about documentation were brought up during a team meeting, and a new dot phrase was created to capture the information quickly in the patient's chart while meeting requirements for Medi-Cal billing. During the third and final PDSA cycle, the screenings were expanded to include all age groups. The dot phrase was expanded to decrease the documentation

burden on providers and an opportunity for follow-up visits was built into the workflow if the provider felt a family needed an additional appointment to discuss results and referrals (Appendix C).

A survey was sent out to the pediatric department in February to measure the effectiveness of the intervention and assess process and balancing measures. Survey responses were received by all team members, and scores indicated that staff felt confident (4.5 on a 5-point scale) following the workflow and introducing the screening to families. Staff indicated they were less confident (3.5 out of 5) answering families' questions about the screening and deferred questions to the provider. Additional qualitative data suggested creating a follow-up appointment with an RN or case manager to discuss ACEs further to decrease the burden on providers during the visit. All staff attended staff meetings and participated in training. According to data gathered in another quality improvement project, visit times had increased by 2.5 minutes by the end of the intervention. However, this data looked at all appointment types and not just well-child visits.

Discussion

Summary

This project implemented an ACES screening tool to identify children at higher risk for toxic stress and ACE-related health problems. Strengths of this project include relevance to current grant funding and buy-in from clinic staff. The Model for Improvement allowed the implementation of the screening process to be rolled out incrementally with PDSA cycles and changes to be incorporated into each subsequent PDSA cycle. This allowed pediatric staff involved with the project to take ownership and incorporate changes they identified during the implementation process.

Interpretation

The desired outcome was to increase screening rates to 90 percent by the end of the implementation period. Although this goal was not met, clinic staff have incorporated the screening workflow into their well-child visits and continue to screen pediatric patients at the clinic. Staff's

knowledge of ACEs increased during the intervention, and staff reported they believed the ACEs screening is a valuable tool in their clinical practice (4.8 out of 5). The pediatrician in the clinic completed the required ACES Aware training to be able to bill Medi-Cal. The rollout of the screening process was delayed until this training was completed. The training, which was approximately two hours, was reportedly difficult to complete during scheduled administration time. In the future, blocking out time within a provider's schedule would ensure that the training was completed on time so the implementation would not be delayed.

Although there is evidence to support the role of ACE-related toxic stress in health outcomes, there is less evidence to support that universal screening improves these health outcomes through improved access to services, referrals, and education (Loveday et al., 2022). The implementation was likely successful because universal ACEs screening is more likely to be adopted by clinicians and organizations when resources are in place for those identified as "at-risk" (Rariden et al., 2021). Screening without an intervention may lead to re-traumatization and do more harm than good (Negriff et al., 2022). Providers at the project site could refer families to behavioral health providers within the clinic, a case manager, or outside community organizations.

The organization was recently awarded a Preventing and Responding to ACEs-Associated Health Conditions and Toxic Stress in Clinics through Community Engagement (PRACTICE) grant through the *Aces Aware* initiative in partnership with First 5 and Partnership Health Plan, the managed care organization that administers Medi-Cal benefits. This funding will be used for collaborating organizations to create and coordinate services for vulnerable children and their families. It will build on current work to improve care for children and families that are identified through routine screening for ACEs.

Limitations

One limitation of the project included gaps in staffing. Screening did not occur when staff floated from other departments when regular staff were out. Another limitation was that families could

opt out of the screening, which prevented the team from determining if the screening was not completed due to the family or the healthcare staff. To address this, staff began indicating if families declined the screening in the expanded dot phrase. This project was also limited to a small pediatric department within one clinic and did not track the follow-up after the ACEs screening was completed.

Conclusion

This quality improvement project served as a starting point for the organization to begin addressing ACEs in a high-need, resource-limited rural area. By adopting a universal ACEs screening in their pediatric department, the organization can begin identifying families in need of additional support and resources. With continued funding from the state, the organization can partner with other community organizations to build a strong network of services for vulnerable children and families in the county.

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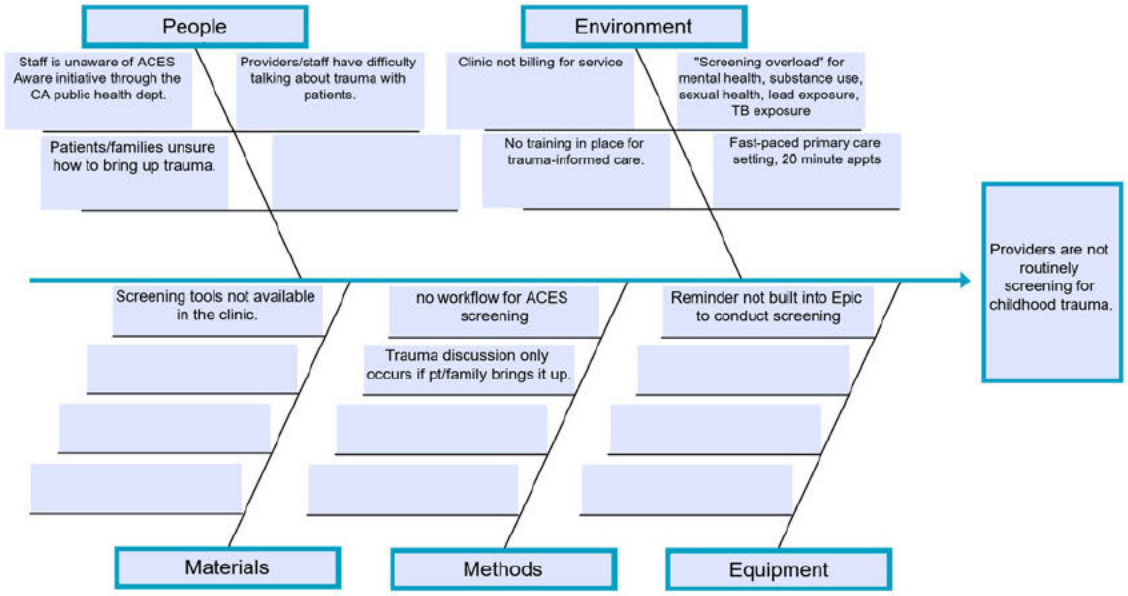
Appendix

Appendix A: Cause and Effect Diagram

Template: Cause and Effect Diagram

Team: Sara Haug, DNP student **Project:** ACES Screening In Primary Care

1) Input the effect you'd like to influence.
2) Input categories of causes for the effect (or keep the classic five).
3) Input causes within each category.

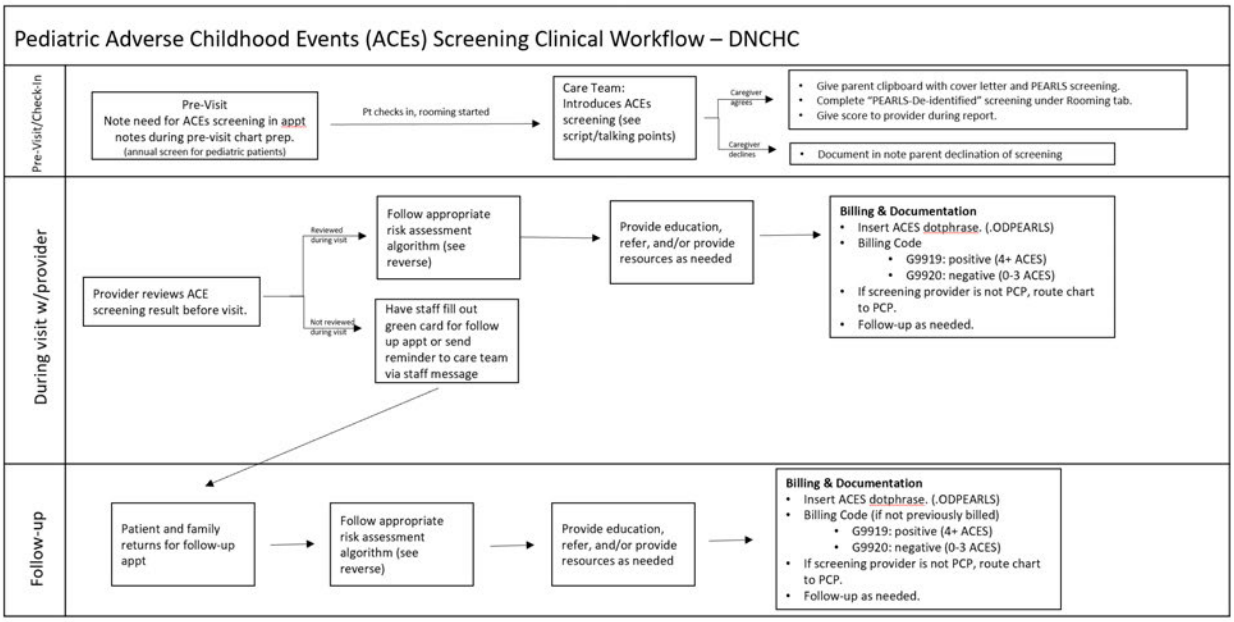


Appendix B: Project Timeline

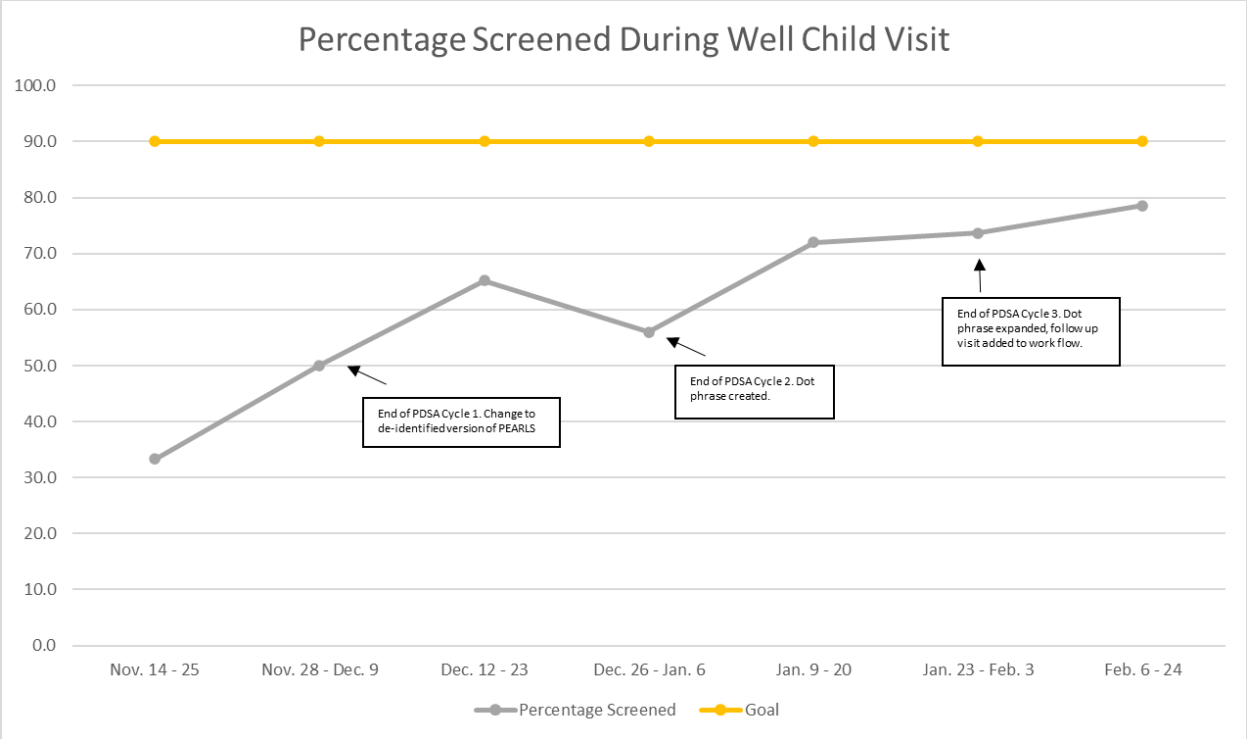
Project Timeline: Screening for ACES in a Primary Care Setting

	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Finalize project design and approach (703A)	X						
Complete IRB determination or approval (703A)		X					
PDSA Cycle 1 (703B)			X				
PDSA Cycle 2 (703B)				X			
PDSA Cycle 3 (703B)					X		
Final data analysis (703B)						X	
Write sections 13-17 of final paper (703B)						X	
Prepare for project dissemination (703B)							X

Appendix C: Workflow



Appendix D: Run Chart of ACEs Screening Results



Appendix E: Post-Intervention Staff Survey

Staff Survey – ACEs Screening

Thank you for taking the time to fill out this survey about your experience with the ACEs screening.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I understand the ACES screening workflow.	1	2	3	4	5
2. I feel confident introducing the screening to our patients.	1	2	3	4	5
3. I feel confident answering families' questions about the screening.	1	2	3	4	5
4. I think the ACES screening is valuable.	1	2	3	4	5
5. I have enough time to screen families.	1	2	3	4	5

Please circle a reason(s) below for why a screening wasn't completed:

I didn't have time. The family declined. I forgot! I felt uncomfortable.

I didn't know the workflow. I didn't think it was important.

Other: _____

What changes would you like to see? Any additional comments?

_____

_____

_____

Please return this form to Sara when finished. Thank you!

Appendix F: IRB Determination

IRB MEMO

Research Integrity Office
3181 SW Sam Jackson Park Road - L106RI
Portland, OR 97239-3098
(503)494-7887 irb@ohsu.edu

NOT HUMAN RESEARCH

September 14, 2022

Dear Investigator:

On 9/14/2022, the IRB reviewed the following submission:

Title of Study:	A Quality Improvement Project to Implement ACES Screening During Pediatric Primary Care Visits
Investigator:	Virginia Elder
IRB ID:	STUDY00024777
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

Sincerely,

The OHSU IRB Office

Appendix G: Letter of Support from Clinical Agency

Letter of Support from Clinical Agency

Date: 8/10/22

Dear Sara Haug,

This letter confirms that I, Maria Durazo, allow Sara Haug (OHSU Doctor of Nursing Practice Student) access to complete his/her DNP Final Project at our clinical site. The project will take place from approximately August 2022 to March 2023.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s):**
  Del Norte Community Health Center
  550 E Washington Blvd, Suite 100
  Crescent City, CA 95531
- **Project Plan: Use the following guidance to describe your project in a brief paragraph.**
  - Identified Clinical Problem: Adverse Childhood Events (ACEs) are traumatic events that occur during childhood. Without supportive relationships and resources in place, ACEs can result in poor health outcomes. Del Norte Community Health Center does not currently screen for ACEs during pediatric primary care visits.
  - Rationale: Using the Model for Improvement, the pediatric team will implement Plan, Do, Study, Act (PDSA) cycles to implement ACEs screening in a small subset of the population before implementing universal screenings. By developing appropriate workflows, providers can use this screening information to develop treatment plans to address ACEs. Resources are available via California's AcesAware initiative.
  - Specific Aims: By December 2022, the clinic will implement a universal, standardized ACEs screening process during annual well-child visits for children ages six months through 17 years old. The goal is to increase screening rates from zero percent to 90 percent by the end of December 2022.
  - Methods/Interventions/Measures: The pediatrician and pediatric staff will complete an AcesAware training and begin screening pediatric patients and their families during well-child visits. Using the developed workflow, the provider will create a treatment plan, make appropriate referrals, and bill for the service.
  - Data Management: The DNP student will pull de-identified data from the EHR to track the number of screenings performed at well-child visits.
  - Site(s) Support: The DNP student currently works at the site and has space within the pediatric pod to conduct activities. The pediatric staff will distribute screening tool to families. The pediatric care team will provide support as needed.
  - Other: N/A

During the project implementation and evaluation, Sara Haug will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact Sara Haug and Virginia Elder (student's DNP Project Chairperson).

Regards,

DNP Project Preceptor (Name, Job Title, Email, Phone):

Signature

Date Signed