ACE SCREENING IN PRACTICE: THE MEDICAL HOME RESPONSE
Recognizing that families play a vital role in ensuring health and well-being of the patient. Acknowledging that emotional, social and developmental support are integral components of health care.

Simultaneously addressing medical, behavioral, and social issues. Treating the whole individual and ALL of his or her needs.
WHAT’S ACTUALLY HAPPENING...
MCHB Definition of CYSHN

• Children with special health care needs are those who have or are at-risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.
Considering CEV as CYSHN

• Medical home model originally developed for CYSHN

• 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 ACE Screening

- 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 (developmental promotion)
- Follow up on referrals / close communication loops

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Case Study: The Children’s Clinic

• 27 providers in two 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 aged children.
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 Others Have Done

• Formal screening protocols in primary care practices are pretty rare
• Public health?
  – Incorporating ACE questions into Behavioral Risk Factor Surveillance System (BRFSS)
• Home Visiting?
• Nadine Burke Harris, MD – San Francisco
  – Inner city practice – screening all children for ACEs, developed a multidisciplinary team approach to trauma-informed care
• Christopher Blodgett, PhD – Spokane, WA
  – Screening in elementary school settings, interventions included changes in disciplinary process. Found ACEs are the second highest predictor of academic failure (after being in special education classes).
    • If 3 or more ACEs: Academic failure 3x
    • Attendance problems 5x
    • School behavior problems 6x
    • *A single ACE more than doubled the risk of attendance and school problems*
Why am I looking?  
Building the Case

• Important to understand the impact
  – Educating other providers
  – Educating patients
  – Educating office staff
• Helps to drive QI change if there are practice champions (provider and office staff)
• After reading policy statement on toxic stress, several providers were left with a “now what?” feeling.
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.”
What am I looking for?
Our Starting Questions

• 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?
What am I Looking for?
Screening Parents for ACEs

• If the majority of what we learn about being a parent comes from our own experiences...
  – How do ACEs impact parenting choices?
  – Is it possible to counsel and support parents in making different decisions about parenting (that is, build resiliency)?
  – What resources do our parents want?

• Decided that focusing on parents’ experiences in childhood was a good starting point.
How do I find it?
Deciding on an Office Workflow

• Which visits will I begin to ask screening questions?
• How will I ask the questions? Pre-visit questionnaire versus direct interview?
  – If questionnaire, who will distribute, explain to patients, and get it to the provider? How do I ensure patient privacy as they answer the questions?
  – If direct interview, what decision supports will help me remember the questions?
• How do I document the results?
How do I Find it? Our First Small Step

• Eight providers piloting 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.
## Overall Results of ACE Screening

<table>
<thead>
<tr>
<th>ACE Score</th>
<th>Total (% of total)</th>
<th>Public Insurance (% of total Public Insurance)</th>
<th>Private Insurance (% of total Private Insurance)</th>
<th>Unknown Insurance Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>155 (47.5%)</td>
<td>54 (40.2%)</td>
<td>89 (53.6%)</td>
<td>12</td>
</tr>
<tr>
<td>1</td>
<td>107 (32.8%)</td>
<td>53 (39.6%)</td>
<td>44 (26.5%)</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>21 (6.4%)</td>
<td>7 (5.2%)</td>
<td>10 (6%)</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>18 (5.5%)</td>
<td>8 (6%)</td>
<td>10 (6%)</td>
<td>0</td>
</tr>
<tr>
<td>&gt;4</td>
<td>25 (7.8%)</td>
<td>12 (9%)</td>
<td>13 (7.8%)</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>326</td>
<td>134</td>
<td>166</td>
<td>26</td>
</tr>
</tbody>
</table>
Comparing TCC to Oregon

<table>
<thead>
<tr>
<th>ACE Score</th>
<th>TCC Average</th>
<th>State of Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>48%</td>
<td>38%</td>
</tr>
<tr>
<td>1</td>
<td>33%</td>
<td>23%</td>
</tr>
<tr>
<td>2</td>
<td>6%</td>
<td>13%</td>
</tr>
<tr>
<td>3</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>&gt;4</td>
<td>8%</td>
<td>17%</td>
</tr>
</tbody>
</table>
## Resiliency Scores

<table>
<thead>
<tr>
<th>ACE SCORE</th>
<th>Resilience (Range)</th>
<th>Public Insurance</th>
<th>Private Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>56 (36-60)</td>
<td>57 (38-60)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>53 (43-60)</td>
<td>57 (46-60)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>51 (41-60)</td>
<td>54 (47-60)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>51 (42-60)</td>
<td>50 (36-60)</td>
<td></td>
</tr>
<tr>
<td>&gt;4</td>
<td>43 (32-55)</td>
<td>45 (37-58)</td>
<td></td>
</tr>
</tbody>
</table>
# What Parents Want...

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Groups</td>
<td>20</td>
</tr>
<tr>
<td>Parenting Classes</td>
<td>18</td>
</tr>
<tr>
<td>Website Information</td>
<td>13</td>
</tr>
<tr>
<td>Twitter Feeds</td>
<td>10</td>
</tr>
<tr>
<td>Home Visiting Nurse</td>
<td>8</td>
</tr>
<tr>
<td>Relief Nursery</td>
<td>3</td>
</tr>
<tr>
<td>Other (Childcare assistance, Fathers’</td>
<td></td>
</tr>
<tr>
<td>Support Group, Mom and Baby Groups,</td>
<td></td>
</tr>
<tr>
<td>Job Assistance)</td>
<td>4</td>
</tr>
</tbody>
</table>
Our Results?

• Prevalence rate of ACEs ≥ 4 in our practice was around 8%.
  – Lower than overall prevalence for the state
  – Only recently translated materials for screening into Spanish, so missing a critical population

• Parents received the screening tools well, and were receptive to conversations about their experiences when presented in the context of offering support and guidance.

• Connected Kids materials and exercises used as part of the follow up; most parents were interested in parenting classes and parent groups.
Parent Comments...

I would like to have counseling because me and my boyfriend [daughter’s father] are getting into a lot of arguments and fights, also there’s a lot going on and I feel like having someone to come into the situation will really help better our relationship with each other and also raising [our daughter].

Ace Score: 8
Resiliency Score: 32
What do I do Once I’ve Found It?

Meaningful Conversations and Follow Up

• Selected Connected Kids resources stocked in exam rooms.

• 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.).
## Counseling Schedule

### Infancy and Early Childhood: Prenatal to 5-Year-Old Visits

<table>
<thead>
<tr>
<th>Visit</th>
<th>Introduce</th>
<th>Reinforce</th>
<th>Brochures</th>
</tr>
</thead>
</table>
| 2 Days to 4 Weeks | • What Babies Do  
• Parental Frustration  
• Parent Mental Health  
• Parent Support       |                                 | 1. *Welcome to the World of Parenting!* |
| 2 and 4 Months   | • Child Care  
• Family  
• Safe Environment  
• Parenting Style  
• Bonding and Attachment | • Parent Mental Health  
• Parent Support | 2. *Parenting Your Infant* |
| 6 and 9 Months   | • Establishing Routines  
• Discipline = Teaching  
• Firearms  
• Modeling Behavior | • Parent Support  
• Child Care  
• Safe Environment  
• Bonding and Attachment | 3. *How Do Infants Learn?*  
4. *Your Child Is On the Move: Reduce the Risk of Gun Injury* |
| 12 and 15 Months | • Child Development and Behavior | • Safe Environment  
• Parenting Style  
• Firearms  
• Modeling Behavior | 5. *Teaching Good Behavior: Tips on How to Discipline* |
| 18 Months and 2 Years | • Child’s Assets  
• Guided Participation  
• Media | • Parent Support  
• Establishing Routines  
• Firearms  
• Child Development and Behavior | 6. *Playing Is How Toddlers Learn*  
7. *Pulling the Plug on TV Violence* |
| 3 and 4 Years    | • Peer Playing  
• Safety in Others’ Homes  
• Talking About Emotions  
• Promoting Independence | • Modeling Behavior  
• Guided Participation | 8. *Young Children Learn a Lot When They Play* |

*OPIP - Oregon Pediatric Improvement Partnership*
Examples of Response Algorithm: Selected Topics From Connected Kids

• At 4 months:
  – How are you and your partner getting along?
  – What are you doing to take care of yourself?
  – Handout: Parenting your infant

• At 6 months:
  – Modeling behavior: How do you and your partner handle conflict?
  – How did your parents handle conflict with each other and with you?
  – Handout: How do Infants Learn?
  – Social connections exercise

• At 9 months:
  – When your child is doing something good, how do you encourage him / her?
  – Does your child hit or bite? If so, how do you handle this?
  – Handout: ASQ Activities handouts of parents’ choice
How we Found our Resources

• Don’t reinvent the wheel!
• Local Public Health Department / Defending Childhood Initiative
• CARES NW (our local child abuse hotline / clinic / resource)
• Child Care Resource & Referral
• Local Title V Division / CYSHN Program
  – Family2Family Networks
Now what?

• Our first pilot was really to answer the questions:
  – Is it feasible? Will our patients complete it? Will our
    providers accept it? Can we tailor a response to the
    screening results?

• Now what we want to know:
  – How do we spread screening?
  – What are the outcomes we are looking for?
  – How does the resiliency score form or tailor our response
    to ACEs?
  – What additional ACEs should we screen for?
  – Should we do universal screening?
What’s next for TCC?
Continuing to Focus on Simple Steps

• How do we improve detection rates?
  – Culture change in the patient-provider relationship...how is this facilitated?
  – Are we asking the right questions?
  – Are response rates different if asked as an interview (instead of paper)?

• What other times do we need to be asking these questions?
  – Universal screening: what ACEs are our patients experiencing...toddler years? School years? Teen years?
  – Targeted screening: screening at mental health visits? Screening when unexplained somatic complaints arise? Screening in the context of school failure?
What’s next for TCC?
Continuing to Focus on Simple Steps

• Some providers have added ACEs into the standard history for adolescents with mental health complaints.

• Adding additional questions...more ACEs to ponder:
  – Parental death
  – Food Insecurity
  – Racism / prejudice
  – Community violence

• Considering screening universally for childhood ACEs to understand prevalence in our patient population.
  – What is the right set of screening questions?
  – What is the right time to ask?
And getting into the weeds of statistics...

- Resiliency screener looks at three domains of resilience – individual, family, community.
  - Are there correlations with types of ACEs and types of resilience (either present or lacking)? If so, how does this inform our response?

- Are there differences in ACE rates based on race / culture / language?

- If there are no clear differences in public versus private insurance in terms of the number of ACEs, are there differences based on other patient / parent characteristics?
  - Which ones should we be looking for?
Other Ways to Get Your Feet Wet

• Some providers choose to work on a specific type of violence first, rather than the entirety of ACEs.
• Specific surveillance questions for exposure can be found at www.aap.org/medhomecev.
• Universal surveillance question:

  “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),
What if I’m not ready to start asking?

• Set the tone – let your parents know that the issues are important, impact the child, and are ok to talk about.
  – “You’re not alone, it’s not your fault, and I can help.”

• Other modalities for opening the door to conversation.
  – Exam room posters, resource lists and website links, “Did you know” statements on clipboards used to fill out office paperwork.

• Continue to encourage developmental promotion.
Thoughts About Next Steps in Oregon

- Research is clearly needed in terms of the best approach to ACEs in pediatric practices
  - Broader pilot for feasibility – different practice types and sizes, communities, etc.
  - Testing feasibility in other clinical settings
  - Understanding of prevalence in different communities – alters response
  - What are the outcomes of interest?
  - What are the correlations between ACE results and ASQ, MCHAT, Postpartum depression scales?
Thoughts About Next Steps in Oregon

• Developing a network of community resources to create an effective response for providers is essential
  – Connecticut model: TF-CBT is a reimbursable service for Medicaid / Medicare (by legislation) …immediately created a network

• Understanding practice barriers to implementation and addressing them requires practice facilitation (didactic alone is likely not enough)
  – “At the elbow” support at a practice level helps promote accountability, overcome barriers, and set goals for implementation
  – Community of practices engaging in this work to share experiences and collectively learn
Holding productive and effective meetings
Connecting with other practices
Team concepts and Collaboration skills
Workflow and process analysis
Using data to inform change
Using PDSA Cycles to test small changes
Understanding and addressing barriers to improvement
Understanding and implementing policies and related implications
Attaining useful tools, resources, expertise
Engaging Patients and Families in improvement efforts
Developing action plans to meet improvement goals

SUPPORT TOOLBOX
FACILITATOR

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Summary

• Screening for ACEs can and should be integrated into medical home model of practice.
• When considering screening for ACEs, remember to start small but think big.
• From Bright Futures:
  – Prevention works
  – Families matter
  – Health is everyone’s business
How to Cite This Presentation: