

BACKGROUND

- Providers commonly express concerns about the ability to assess, interpret and integrate findings into trauma-informed care (Palfrey et al., 2019).
- One measure of trauma, Adverse Childhood Experiences (ACEs), has been shown to negatively impact physical and mental health (Felitti et al., 1998; Edsen, 2018), as well as the continuation of adversity into the next generation (Tomaz & Castro-Vale, 2020).
- Outcomes have demonstrated that patients are comfortable with screening for ACEs and believe their provider can help (Goldstein et al, 2017), most notably leading to positive impacts on the practitioner-patient relationship (Green et al., 2016).
- Recently increased societal stressors heighten the importance of screening for ACEs and considering potential impact (Tomaz & Castro-Vale, 2020).

OBJECTIVES

The goal of this project was to increase the use of screening for Adverse Childhood Events (ACEs), which was utilized to support trauma-informed care by the patient's treatment team, referral to appropriate services, and impact on clinic culture.

METHODS

- The clinical pathway screened new patients with a modified ACE scale, with results recorded within their medical record.
- Patient's who rated three or more ACEs were identified for referral to Behavioral Health to support additional screening and the delivery of trauma-informed care.
- The clinical team also completed Pre and Post-measures to assess team member's beliefs about (1 [not at all] to 10 [very high]) and barriers to providing trauma informed care.

Objective Measures:

- Percent of new patients who had an ACE completed.
- For patients who scored 3+ on ACE, percent with appropriate Behavioral Health referral or Warm Hand-Off .
- For patients with a Behavioral Health Assessment, did the Behavioral Health Assessment include use of the PTSD Smartphrase & PCL5 scores.
- For Clinical Teams of Park Street Clinic: A survey was used to measure confidence in delivering trauma-informed care and identified barriers to working with patients with trauma.

RESULTS: CLINICAL PATHWAY

- Prior to initiating the pathway, 85 new patients were seen, none completed the ACE measure. After initiating the pathway, 33 of 69 (48%) completed screening. This represents a statistically significant shift in the proportion of patients who completed ACE screening ($p < 0.001$).

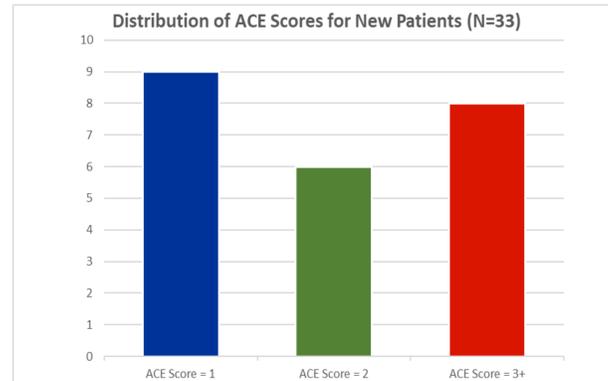


Figure 1:
New Patients completed ACE data (N=33), resulting in 8 (24%) patients with significant scores (3 or more).

- Of those 8 that scored 3+ on the ACE, one (13%) had an appropriate Behavioral Health referral or Warm Hand-Off documented in the medical record. This patient did not complete an assessment for potential trauma-related symptomology.

RESULTS: CLINIC CULTURE

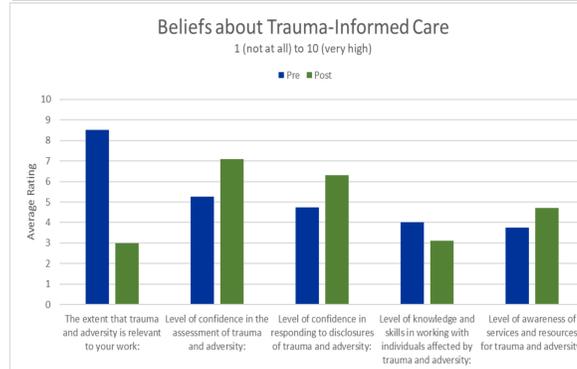
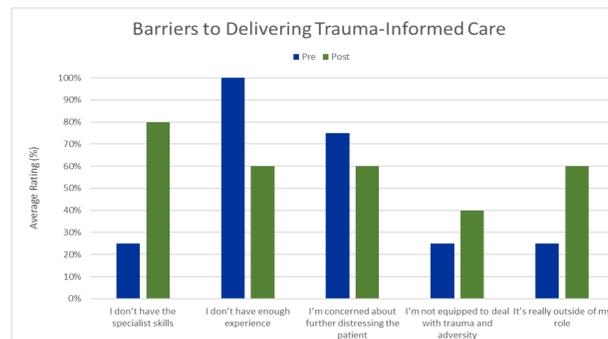


Figure 2:
The clinical team reported that trauma and adversity were less relevant to their work (pre: 9; post: 3 out of 10), though also reported improved confidence in assessment (pre: 5; post: 7 out of 10).

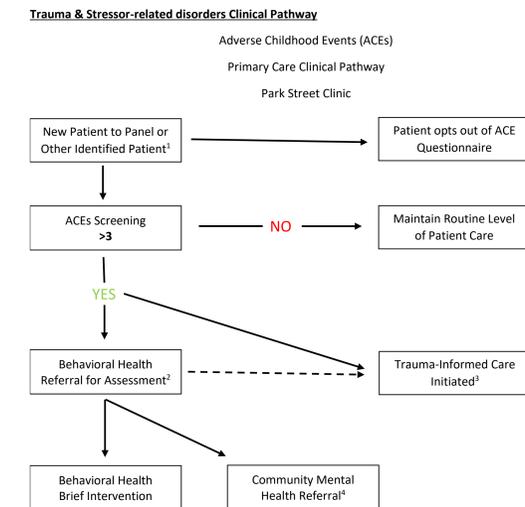
Figure 3:
They noted increased barriers in lack of specialist skills and poor alignment with their role, though a reduction in the barrier of lack of experience.



CONCLUSIONS

- The inclusion of a brief screener within new patient appointments reliably increased the assessment of ACEs, which demonstrates feasibility within primary care.
- The 52% of patients who did not complete ACE screening could have been due to unprovided documents, un-entered data, and patient refusal (per clinical team report).
- Patients reporting 3+ ACEs within this study replicate the prevalence of ACEs for the state of Oregon and nationally.
- With only brief training and engagement, clinical culture can be influenced:
 - More confidence in assessing/discussing adversity.
 - Believing it is less relevant to their position.
- The team also observed barriers in needing specialty training and role integration of trauma-focused care.

CLINICAL PATHWAY & NEXT STEPS



Clinic team education and skills training, including:

- Signs/symptoms of a trauma-response
- Assessing and responding to a trauma-response
- Supporting engagement with services via Motivational Interviewing
- Reducing Stigmatization
- Addressing systematic influences of social stress

Extension into clinic-wide screening with ACEs and trauma-informed care

REFERENCES & ACKNOWLEDGEMENTS

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Edsen, J. L. (2018). Adverse childhood experiences and implementing trauma-informed primary care. *The Nurse Practitioner*, 43(12), 10-21.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, 14(4), 245-258.

Tomaz, T., & Castro-Vale, I. (2020, September). Trauma-Informed Care in Primary Health Settings—Which Is Even More Needed in Times of COVID-19. In *Healthcare* (Vol. 8, No. 3, p. 340). Multidisciplinary Digital Publishing Institute.

Palfrey, N., Reay, R. E., Aglin, V., Cubis, J. C., McAndrew, V., Riordan, D. M., & Raphael, B. (2019). Achieving service change through the implementation of a trauma-informed care training program within a mental health service. *Community mental health journal*, 55(3), 467-475.

Goldstein, E., Athale, N., Sciollo, A. F., & Catz, S. L. (2017). Patient preferences for discussing childhood trauma in primary care. *The Permanente Journal*, 21.

Green, B. L., Saunders, P. A., Power, E., Dass-Brailsford, P., Schelbert, K. B., Giller, E., ... & Mete, M. (2016). Trauma-informed medical care: patient response to a primary care provider communication training. *Journal of Loss and Trauma*, 21(2), 147-159.