

ADVERSE CHILDHOOD EXPERIENCES SCREENING AND TRAUMA-INFORMED CARE IN PEDIATRICS
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Purpose/Aims: The purpose of this quality improvement (QI) project is to use the deep-seated body of existing evidence and current public health momentum to institute primary, secondary, and tertiary prevention measures for Adverse Childhood Experiences (ACEs) and toxic stress. By using the Pediatric ACEs and Related Life Events Screener (PEARLS) tool and a trauma-informed care algorithm, the overarching goal is to promote a culture of trauma-informed care in a pediatric primary care clinic in Southern California, for English- and Spanish-speaking patients. All pediatric providers and clinic staff screening patients for ACEs were asked to facilitate the mitigation of ACEs-Associated Health Conditions (AAHCs) by comprehensively screening patients for the triad of adversity: ACE score, AAHCs, and protective factors.

Rationale/Background: ACEs have been linked to nine out of 10 leading causes of death in the state of California. In Californians, 61.7% of adults have experienced a minimum of one ACE, with some counties representing as high as over 75% of individuals. Because one of six adults has experienced four or more ACEs, the need for trauma-informed risk assessments and provider-guided action planning during pediatric well child visits are crucial to prevent lifelong negative health outcomes, as early in life as possible.

Methods: A readiness assessment at a pediatric primary care clinic was conducted to establish which pediatric providers completed the *Becoming ACEs Aware in California Training*, and attested to completing it. The project investigator used the clinic's electronic medical record (EMR) to create and embed a smart phrase text, coded as ".aces", for comprehensive provider documentation of PEARLS screening, toxic stress risk stratification, and a relevant plan of care during pediatric well child visits. An ACEs Aware patient handout was uploaded to the EMR for prompt provider access to printable and electronic patient education (See Appendices D and E). Clinic staff and providers were given the primary intervention, an education session for ACEs awareness and effective clinical workflow screening, as well as pre-implementation and post-implementation surveys to demonstrate their learning regarding their role in the clinic's screening process, the trauma-informed network of care, the long-term effects of toxic stress, and the importance of screening patients and families for the triad of adversity using the PEARLS. Pediatric providers were asked to use the following evidence-based tools during every well child exam: *ACE Screening Clinical Workflow*, *ACEs and Toxic Stress Risk Assessment Algorithm*, and *ACE-Associated Health Conditions for Pediatrics* (See Appendices A to C). The project investigator is currently performing a chart review for eight weeks after the interventions were implemented, to assess for an improvement in ACEs screening, pediatric provider-offered anticipatory guidance, and use of evidence-based trauma-informed care strategies provided during the well child visit. An interim data analysis demonstrated a practice gap, warranting an additional in-service to support the provider's interpretation of ACE scores and risk assessment in their documentation.

Results: The preliminary readiness assessment demonstrated only two of five providers were *Becoming ACEs Aware in California* trained, however, all were screening for Medi-Cal reimbursement. Eight-weeks of baseline data was gathered prior to the new clinical workflow implementation, demonstrating a lack of adherence to proper ACEs assessment and documentation. During the primary education intervention and secondary in-service, the state of California's screening policy was reviewed as a reminder for providers to meet compliance, with additional continuing education reimbursement incentive offered by the clinic management following the intervention. During the eight-week data collection following the primary intervention, an interim evaluation demonstrated an implementation knowledge and practice gap in the provider's EMR documentation. Current documentation compliance assessment is still in progress. However, post-evaluation summary found 100% of clinic providers were *Becoming ACEs Aware in California* certified. A final provider and staff project evaluation found 100% felt more equipped with ACEs resources and a trauma-informed network of care to empower or refer families as needed, and 90% would like to continue to build a culture of trauma-informed care in the clinic or other work environment, because of this QI project.

Conclusions/Clinical Implications: This project demonstrated adopting an ACEs screening clinical workflow requires more than just a one-time education session. Reinforcement in state policy reminders and simulation of a case study in-service can be beneficial to link knowledge and practice. For ACEs screening and building a trauma-informed culture of care in the primary care clinic, engagement with clinic administration, including the clinic biller, is crucial for the implementation process. This QI project can be utilized in all pediatric or adult primary care clinics. Using the validated PEARLS tool allows for all ACEs Aware trained Medi-Cal providers in the primary care setting to receive reimbursement from the state for annual screenings for this triad to mitigate the intergenerational transmission of adversity.

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