

RESILIENT BEGINNINGS: TRAUMA- AND RESILIENCE-INFORMED ACES SCREENING AND RESPONSE LEARNING BRIEF



INTRODUCTION

A growing awareness around the impact of trauma on people's health and wellbeing has underscored the need for trauma-informed and strengths-based approaches to working with patients and communities. Since 2018, the Center for Care Innovations (CCI) has offered programs aimed at supporting health care safety net organizations in being more trauma and resilience informed, particularly through its Resilient Beginnings portfolio (see Box 1).

Formal screening for Adverse Childhood Experiences, or ACEs, is an increasingly common strategy for identifying and addressing toxic stress in pediatric care settings. In 2020, the State of California enacted a policy that provides reimbursement for ACEs screening among patients enrolled in Medi-Cal and has invested in establishing statewide infrastructure to support screening implementation. Given this context, the Resilient Beginnings Network (RBN) included ACEs screening and response as one core component of advancing more trauma- and resilience-informed pediatric care.

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BOX 1: RESILIENT BEGINNINGS

Resilient Beginnings is a 5-year investment from Genentech Charitable Giving. The second phase is the Resilient Beginnings Network (RBN), a 3-year learning collaborative launched in November 2020. RBN supports 15 safety net organizations in the San Francisco Bay Area to advance pediatric care delivery models that are trauma and resilience informed. Each organization has a multi-disciplinary "RBN team" of between four and ten people dedicated to testing and implementing changes at their clinics to improve the health and wellbeing of children aged 0-5 and their families.

As part of the RBN evaluation, the Center for Community Health and Evaluation (CCHE) spoke with teams from nine organizations working on ACEs screening as part of their program participation. These organizations:

- Consisted of seven independent Federally Qualified Health Centers (FQHC) and two FQHCs housed within public hospital systems
- Provided services in seven Bay Area counties (Alameda, Marin, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma)
- Varied in size: one serving under 400 patients aged 0-5 annually, one over 17,000
- Operated between 2 and 22 sites that provide primary care for children ages 0-5 years

Past evaluations of other CCI programs have documented promising practices related to general ACEs screening implementation. While this brief provides an overview on the practice of ACEs screening, it primarily focuses on what ACEs screening has looked like as part of RBN's larger effort to advance trauma- and resilience-informed care (see Box 2).¹

BOX 2: TRAUMA- AND RESILIENCE-INFORMED CARE refers to care in which all parties involved recognize and respond to the impact of traumatic stress and resiliency factors on children, caregivers, and service providers.

(adapted from **SAMHSA**)



¹ See [Screening for adverse childhood experiences \(ACEs\) in pediatric practices](#) or the [California ACEs Learning and Quality Improvement Collaborative evaluation results](#) for more information on what it takes to implement ACEs screening more generally.

ACES SCREENING EXPLAINED

What are ACEs? Adverse Childhood Experiences, or ACEs, are potentially traumatic events that occur in childhood (ages 0-17 years). ACEs can have tremendous impact on lifelong health and opportunity.²

What is ACEs screening? ACEs screening is a clinical questionnaire and assessment process to: 1) rapidly identify patients at highest risk for toxic stress (i.e., the body's long-term stress reaction absent enough support) and 2) perform the next steps of a more complete, individualized assessment. A complete ACEs screening involves assessing:

- Exposure to adversity (i.e., the ACE score)
- Clinical manifestations of toxic stress (ACE-associated health conditions)
- Protective factors (e.g., nurturing, social supports)³

ACEs screening is most effective when the organization has infrastructure and a culture supporting the process versus being approached as yet another screener patients need to complete.

Why perform ACEs screening? When done well, routine and universal ACEs screening helps clinical teams provide more effective, holistic, and equitable health care. Screening results can help focus clinical interventions, while the process of ACEs screening can promote relational healing and reduce stigma associated with ACEs.



² See Center for Disease Control and Prevention's [Fast Facts: Prevention Adverse Childhood Experience](#).

³ See [ACEs Aware's Learn About Screening](#).

What does ACEs screening look like in RBN? By the end of 2022, nine teams were working to implement or strengthen ACEs screening practices in pediatric care as an RBN priority. Seven of those were either new to screening or implementing at new clinic sites. Teams were in different stages and focused on various phases of the ACE screening process: foundational work, screening implementation, and response and follow-up. See table below for a description of the work within the various phases.

Phase of screening	# of RBN teams	Description (bold indicates at least 4 of the 9 teams doing this work)
Laying the foundation	9	<ul style="list-style-type: none"> • Identifying champions, training, developing workflows, and piloting screening (includes ACEs Aware certification) • Determining when to screen, typically occurred during well child visits at various ages—e.g., one team was screening ages 0-18 years at one clinic site while another team targeted patients ages 3-11 years • Establishing or refining technological infrastructure (e.g., building workflow elements into the EHR, electronic screening tools) • Strengthening data systems to capture and track metrics related to screening (e.g., screening rates, results, and response) • Building structures for peer support and coaching (e.g., behavioral health staff coaching the medical assistants administering the tool)
Implementing workflows	8	<ul style="list-style-type: none"> • Rolling out screening with specific patient populations, care teams, or clinic sites • Incorporating resiliency or strengths-focused language into the screening process • Conducting pre-visit activities (e.g., identifying eligible patients, preparing the chart) • Monitoring implementation, including: <ul style="list-style-type: none"> ◊ Continuing to build buy-in and engagement ◊ Tracking, sharing, and using screening-related data to adjust processes ◊ Exploring inconsistent screening practices • Spreading to multiple clinic sites
Response & follow up	7	<ul style="list-style-type: none"> • Responding to ACEs screening results either in-visit, through internal services and supports, or external referral • Positioning care manager/coordinator roles to support the screening and response process • Networking in the community to increase connection to available resources and expanding the referral base • Strengthening collaboration and bi-directional communication with community partners

LESSONS LEARNED AND CHALLENGES FROM IMPLEMENTING TRAUMA- AND RESILIENCE-INFORMED ACEs SCREENING

RBN coupled ACEs screening within a broader effort to advance trauma- and resilience-informed care, which generally helped strengthen screening practices.

ACEs screening was the most common strategy for many RBN teams. It was seen as a best practice and provided a tangible and concrete entry point for advancing trauma- and resilience-informed care. Additionally, given the supportive policy and reimbursement environment for ACEs screening in California, safety net organizations across the state were prioritizing ACEs screening during the timeframe of RBN.

RBN's support for implementing ACEs screening within the broader context of trauma- and resilience-informed organizational cultures of care has influenced how some RBN teams have approached ACEs screening and response and their perceptions of the value and importance of screening activities. In general, teams see screening as one important component in a larger effort to be healing organizations⁴. As a result, teams reported being **mindful about how they are screening** beyond only tracking whether or not screening occurred. As one team member reported: *"I think all of us have a very heightened awareness of our role in making sure that the way that we do this is intentional and lifting up our patients and not causing any greater harm."*

"I started RBN thinking that we need to do ACEs screening because it's the right thing to do and [RBN would] help us with the nuts and bolts (e.g., workflows, scripts). I didn't expect this overall organizational transformation. I really needed to internalize what I was hearing and feeling [about trauma- and resilience-informed care] and slow down, take a beat, and realize there's a lot more to it. It's a journey."

Several lessons can be elevated from RBN teams that situated ACEs screening in the broader frame of trauma- and resilience-informed care:

- **Elevate the importance of foundational organizational work related to trauma- and resilience-informed care so that it is the backdrop for screening.** Several teams discussed the importance of strengthening organizational environments to be more trauma- and resilience-informed prior to implementing ACEs screening so they are more supportive of both patients and staff. Two teams began RBN with a primary goal of starting ACEs screening and decided to pause, step back, and conduct general trauma- and resilience-informed systems training for all staff first. Two other teams discussed creating safe and trusting environments and training their providers in leading empathetic conversations with patients.

"Our experience with RBN and with COVID is reframing how we can show up as better partners, getting closer to the patients we serve. That proximity is the ultimate of incorporating trauma-informed care."

⁴ Healing organizations have policies, procedures, services and treatment models that have an understanding of trauma embedded within them. Their approaches to providing services, are trauma-shielding or trauma-reducing. (Definition from [Trauma Transformed](#))

- **Engage staff in developing screening practices (e.g., workflows, scripts) and provide training and support.** Two teams commented that it is helpful to engage multi-disciplinary staff members in planning workflows so that the people expected to perform the screening provide input on how to ensure its success. Other teams highlighted the usefulness of providing opportunities for staff to personally connect with the screening content prior to implementing with patients and families. A couple of RBN teams also described peer support structures to help provide training, support, and coaching to care teams during implementation.
- **Ensure patient and family strengths and resiliency messages are part of the screening process.** Nearly all teams were explicitly incorporating conversations about strengths through mostly informal processes. Five teams commented that ACEs screening has given providers opportunities to point out the family strengths and shift their questions from “What are you going to stop doing?” to “What do you like to do already that benefits your health?” Bringing in strengths and resiliency discussions can also increase patient engagement, improve overall screening processes and help address reported challenges related to patient/families’ roles in the screening process (e.g., reluctance completing the questionnaire/forms, honestly answering the screening questions, and accepting or following through with referrals or additional services).
- **Integrate a case manager or care coordinator position to support the screening process.** Three teams discussed the importance of having a dedicated position to help ensure both staff and patients have the support they need at all phases of the screening process. Teams perceived screening to go more smoothly and be more effective in sites where these roles were in place. These roles:
 - ◇ Helped explain or administer the screening to patients
 - ◇ Provided additional resources for staff during the screening process
 - ◇ Were a warm handoff for providers when patients/families needed additional services or support
 - ◇ Identified and provided connection to community resources and services
 - ◇ Built relationships with patients and community-based organizations
 - ◇ Managed follow-up communication with patients and partners to close the loop
 - ◇ Assuaged providers’ concerns that they would not be able to address patient/family needs that emerged from screening

“I feel like the parents really appreciate the follow-up calls because they know that we care and we're there following up with them, they don't just come in and fill out a questionnaire and that's it.”

See CCI’s feature articles on two RBN teams testing this strategy for more information: [How One California Clinic Tapped a Bilingual Medical Assistant to Lead ACEs Work](#) and [Pediatric Care Coordinators: Closing the Loop to Help Children at Risk Thrive](#).

Overall, RBN teams reported challenges typical with general ACEs screening efforts. While teams did not explicitly link them to the trauma- and resilience-informed approach, several of these challenges are exacerbated or even more salient given the broader context of trauma- and resilience-informed care:

- **Time and competing priorities:** Pediatric primary care teams have a lot of demands on their time and are trying to cover a lot in a relatively short visit. Adding one more thing to do is difficult and allowing adequate time to fully explain the purpose of screening and discuss results, whatever they may be, is an additional time burden. One team discussed a “push-pull tension” where they are trying to move quickly to complete all the tasks, but also trying to slow down and make space for patients/families to open up and discuss difficult things in their lives. Additionally, providing training and opportunities for reflective, debrief conversations for providers and staff to support them in doing ACEs screening, an important aspect of the trauma- and resilience-informed approach, requires carving out even more time.
- “[ACEs screening] is the most important stuff we do, I believe, but it really is both time and emotionally taxing. You’ve got to give respectful space and quiet around something so heavy.”*
- **Fears of “opening a can of worms.”**
Several teams reported that providers were concerned that ACEs screening would “open a can of worms” or a “Pandora’s box” of issues that they do not have the time or expertise to address. Typically, RBN teams were able to assuage these concerns through robust workflows and links to internal or external supports. The case manager or care coordinator position was particularly effective at addressing this challenge.
 - **Staff turnover:** Turnover or transition in care team roles, particularly clinical care support staff, disrupts screening practice and workflows, placing additional burden on providers that can contribute to burnout. Additionally, bringing on new team members requires training (both related to the technical screening process and also the foundational trauma- and resilience-informed approaches) and building buy-in and comfort with the screening process and associated conversation.



OUTCOMES & IMPLICATIONS

Situating ACEs screening within a broader context of trauma- and resilience-informed care brought beneficial outcomes for both staff and patients/families, ensuring that screening was helpful and not harmful. Teams overall saw value in ACEs screening believing that it was a helpful tool to gather important information about their patients, introduce education and resources, have deeper conversations, and build relationships and trust.

Specifically, teams reported that this approach to screening helped **improve care delivery to more holistically work with patients and families.** Teams reflected on how the process of ACEs screening, including the related in-visit discussions, helped them to see their patients/families as whole people and better address relevant needs. One RBN participant reflected that trauma and resilience, along with associated practices and approaches, were not concepts that pediatricians have historically focused on in their training and that RBN's approach equipped them with that needed language and framing.



Given that the State of California provides training, support, and reimbursement for ACEs screening, Medi-Cal-serving health care organizations will likely continue to pursue this work. **RBN has helped show how to advance screening in an intentional way and couch this work in broader trauma- and resilience-informed principles.** This work by RBN teams reinforced essential elements needed for responsible and effective ACEs screening practice that have implications for others interested in or conducting ACEs screening.

- 1 Investments in foundational work related to establishing trauma- and resilience-informed cultures of are necessary.** This requires the organization to slow down and make sure there is leadership support, buy-in from providers and staff, dedicated time and space for staff support, and training and capacity building for screening. The changes in workflows and practice needed for screening implementation benefit from training and collaborative approaches (e.g., getting input from affected staff on workflow changes). In addition, screening for ACEs can be emotionally taxing for patients, families, providers, and staff. Establishing structures and spaces for dialogue and reflecting for patients and families, as well as clinic staff, can support the various people involved in the screening process. All of this requires investments of time across the organization, which is difficult given current health care reimbursement structures and competing priorities.

- 2** **The screening questionnaire is a tool; the value comes from the supportive organizational structures and practices and the conversation between patients and families and their care teams.** RBN teams agreed that the screening process is an opportunity to learn more about their patients, provide more holistic care, and build relationships and trust. This requires time allocated before, during, and after the appointment.
- 3** **Assigning dedicated staff to support follow-up allows for a more trauma- and resilience-informed process.** Intentionally identifying follow-up processes and resources is important for addressing provider concerns and ensuring patient needs are met. RBN teams agreed that securing and connecting patients to follow-up resources, either internal or external, is a key challenge. Structures like a case manager or patient navigator role can help support all aspects of the process for patients and families, as well as the care team. For patients and families, additional assistance understanding screening results, potential next steps, and how to access additional resources provides a more supportive and healing experience. For staff, having a dedicated care team role whose responsibility it is to work with patients who need additional support after screening can assuage concerns about meeting patients' needs, support internal and external communication, and mitigate stress and burnout for other care team members.
- 4** **Integrating concepts of resilience and strengths into ACEs screening is a promising practice.** RBN teams reflected on how important it is and how good it feels to ask about what's going right for patients/families versus only focusing on what's wrong, which is what happens if you only focus on the questions in the ACEs screening questionnaire.

CCI and CCHE will continue to learn from these teams and any additional teams who work on ACEs screening in the final year of RBN.

The **CENTER FOR COMMUNITY HEALTH AND EVALUATION** designs and evaluates health-related programs and initiatives throughout the United States. For more information, please contact Lisa Schafer at Lisa.M.Schafer@kp.org.