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## Responding to Adverse Childhood Experiences in the Primary Care Setting

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# RESPONDING TO ADVERSE CHILDHOOD EXPERIENCES IN THE PRIMARY CARE SETTING

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# PROBLEM

Seminal research connecting Adverse Childhood Experiences (ACEs) and adverse health outcomes published 20 years ago

Information has not been integrated into care

Providers lack knowledge about ACEs or confidence in responding ACEs

# AVAILABLE KNOWLEDGE



Lifelong effects of ACEs established and validated by a multitude of studies

Providers perceive many barriers to incorporating ACEs screening into care, pilot studies demonstrate that barriers can be overcome

Interventions can be offered to build resiliency and mitigate effects of high ACE scores

# RATIONALE

Screening for ACEs informs treatment planning and referrals to services

Integrated services with trauma-informed interventions and prevention of ACEs lead to improved health and decreased costs



# PURPOSE & AIMS

Increase knowledge about ACEs and resilience

Identify available community evidence-based resiliency building interventions.

Implement sustainable screening protocol for ACEs



# CONTEXT

Federally Qualified Health Center (FQHC)  
with 12 primary care providers and  
expanded health services

Commitment to medical home model

Low income, under-resourced, rural  
community

# INTERVENTION



Education with showings of the documentary  
*Resilience*

Provider education at staff meeting

Initiation of “opt-in” screening

Screening kits supplied to all exam rooms

# POSTERS ON DISPLAY

## ADVERSE CHILDHOOD EXPERIENCES. LIFELONG HEALTH OUTCOMES

RESILIENCY

YOGA

MEDITATION

MINDFULNESS

SOCIAL SUPPORTS

COMMUNITY

COUNSELING

EQUALS

HEALTH

PHYSICAL HEALTH

EMOTIONAL HEALTH

BEHAVIORAL HEALTH

MENTAL HEALTH

PERSONAL GROWTH

LEARN MORE ABOUT ACES AND RESILIENCY-BUILDING. ASK YOUR PROVIDER TODAY

ADVERSE CHILDHOOD EXPERIENCES:  
LIFELONG HEALTH OUTCOMES

ACES

ASK!

ASK YOUR PROVIDER ABOUT AN ACES SCREENING AND LEARN MORE HOW TO BUILD RESILIENCE

# ACES SCREENING TOOL

**Find your ACE score.**This survey asks about difficult experiences during your childhood, and may bring up memories that are difficult. **BEFORE YOUR 18<sup>th</sup> BIRTHDAY....**

Did a parent or other adult in the household often or very often... swear at you, insult you, put you down, or humiliate you? <b>OR</b> act in a way that made you afraid that you might be physically hurt?	
Did a parent or other adult in the household often or very often... push, grab, slap, or throw something at you? <b>OR</b> ever hit you so hard that you had marks or were injured?	
Did an adult or person at least five years older than you ever... touch or fondle you or have you touch their body in a sexual way? <b>OR</b> attempt or actually have oral, anal, or vaginal intercourse with you?	
Did you often or very often feel that... no one in your family loved you or thought you were important or special? <b>OR</b> your family didn't look out for each other, feel close to each other, or support each other?	
Did you often or very often feel that... you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? <b>OR</b> your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	
Was a biological parent ever lost to you through divorce, abandonment, or other reason?	
Was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her? <b>OR</b> sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? <b>OR</b> ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	
Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?	
Was a household member depressed or mentally ill, or did a household member attempt suicide?	
Did a household member go to prison?	

<b>You do not need to tell your healthcare provider about specific experiences you may have had.</b>	<b>TOTAL SCORE</b>	
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# STUDY OF THE INTERVENTION

Observe and learn from patient and provider experiences with ACEs screenings

Make recommendations for adaptations to the protocol as needed for continued utilization of ACEs screenings



# MEASURES

## Quantitative:

- Number of screenings completed during study period
- Reported ACEs score for screened patients

## Qualitative:

- Provider pre- and post-implementation survey asking about ACEs knowledge, biases, and beliefs

# ETHICAL CONSIDERATIONS

“Opt-in” approach allows patient to control screening interaction

Erasable screening tool for patient privacy and control

ACEs screening is voluntary and optional

Providers also able to “opt-out”

Pre- and Post-surveys for providers anonymous and confidential

# ANALYSIS

Collected pre-and post-surveys examined for patterns in successful and unsuccessful screenings

Screening program adapted and improved for continued use



# RESULTS — DETAILS OF THE PROCESS MEASURES AND OUTCOMES

210 screenings

6 Pre- and Post-implementation surveys  
returned

No significant shift in beliefs or attitude

Continued interest in screening

Positive feedback from providers and  
patients

# SUMMARY — KEY FINDINGS



Successful integration of ACEs screening into practice

ACEs screening model allowed for a great deal of flexibility in use of screenings, gave control of initiation of screening to the patients, and offered education in a variety of modalities

Ease of screening tool and adaptability of implementation between providers and patients

# INTERPRETATION



ACEs screening can be successfully integrated into a primary care setting

Community education, flexibility in the design and delivery of screening are essential to building support and gaining trust from staff members and patients

Financial costs minimal, easily supported by most practices

# LIMITATIONS

Generalizability of this project limited to practices with similar levels of prior knowledge and interest

Key components of education, “opt-in” for both providers and patients, patient control of score and details, flexibility of structure to screening need to be maintained for generalizability

# SUGGESTIONS FOR NEXT STEPS



Continued community education events about ACEs

Training for nursing staff

Assess provider interest in incorporating screenings routinely at annual health supervision visits

Standardize introduction of screenings into workflow

Resiliency resources to offer patients will need continued development

# CONCLUSIONS

This project is useful and relevant to primary care providers

This model is easily replicable, and easily adaptable

Successful screenings will require ongoing training and development of local resiliency resources



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