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ABFM Performance Improvement Pilot Project
Summary Report
State AAFP Chapter: California AFP
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Goals/Objectives for the Pilot....1
Project Overview....1
Timeline....3
Evaluation....3
Conclusion....6
Appendix 1: Survey (English version)....7
Appendix 2: Patient Education Materials (English versions)....8
Appendix 3: Learner Attestations....11

Goals/Objectives for the Pilot

CAFP achieved all three goals of our Project:
To advance family physicians' certification process by

1. educating CA family physicians about the benefits of structured quality improvement efforts;
2. providing CA family physicians with an opportunity to virtually participate in a quality improvement effort concerning Adverse Childhood Events (ACEs) and Trauma Informed Care; and
3. documenting the process, tools and resources used for state chapters to participate in ABFM's Organizational PI Pathway with the hope of encouraging other states to offer this service to their diplomats.

Project Overview

Learning Objectives

This PI project is designed to improve patient and physician awareness of ACEs (Adverse Childhood Experiences) and toxic stress, and to study the impact of educational materials on patients' understanding of ACEs and its health impacts.

Origins

CAFP brought together interested family physicians and their practice teams to participate in an ABFM-approved Performance Improvement Project using IHI's Model for Improvement process.

We began by engaging our state and chapter leadership to determine the subject of the PI Project. From a list of options, including Health Equity/SDOH; Wellness/Self-Care; Adverse Childhood Events (ACEs); and Trauma-Informed, Resiliency-Oriented Healthcare (TIROH), we selected ACEs. Faculty Erika Roshanravan, MD, Adia Scrubb, MD, MPH, and Brent Sugimoto, MD, MPH, AAHIVS, FAAFP led the project.

Needs Analysis

Adverse Childhood Experiences (or ACEs) are associated with some of the most common, serious, and intractable health conditions facing our patients. Toxic stress from ACEs such as poverty, violence, and emotional or physical abuse can cause wear and tear on all body systems. In fact, ACEs are associated with increased risk for heart disease, cancer, accidents, respiratory disease, stroke, diabetes, kidney disease, and suicide.

ACEs are common across all populations. Over sixty-two percent of California adults have experienced at least one ACE and over sixteen percent have experienced four or more. Many of our patients do not realize that exposure to ACEs is associated with increased risk for health problems across their lifespan.

Project Description

For our PI project, faculty designed a survey instrument to gauge patient knowledge and perceptions of ACEs in the primary care context. The survey was translated into Spanish, Mandarin, and Tagalog – the most spoken non-English languages in California. Faculty also identified simple ACEs patient education materials and we had them translated into Spanish, Mandarin, and Tagalog.

The activity shell – enrollment, distribution of materials, data collection, reporting – was constructed in CAFP's Homeroom (Ethos/Cadmium) Learning Management System (LMS), where all data and attestations were submitted.

Physicians were invited to involve their entire office staff and to gather data as a team with other physicians in their clinic. This increases the potential success of the project and the likelihood that the changes will be acknowledged and adopted across the organization.

Physicians/teams first surveyed ten patients about ACEs and toxic stress without offering them ACEs education materials. They next distributed two educational flyers about ACEs and toxic stress to a second group of ten patients, then administered the same survey. Participants then analyzed survey data and reflected on how distributing patient information changed patient attitudes about ACES and the resulting practice improvement.

Marketing

Recruitment commenced with extensive marketing across California through CAFP newsletters, email, social channels, and in our SPARK online community. We also invited other California

medical associations and AFP chapters across the country to participate by means of email invitations to key organizational staff.

Timeline

- Subject determination and approval by ABFM, faculty recruitment and acceptance, PI dashboard completion – January-April 2022
- Confirm topics, complete practice assessments – April 2022-July 2022
- Recruit participants, collect data, implement PDSA cycle – August 2022 – May 2023
- Analyze data, summarize factors impacting success, share outcomes – July-August 2023

Evaluation

This project had a clear positive outcome and did achieve the learning objective: *This PI project is designed to improve patient and physician awareness of ACEs (Adverse Childhood Experiences) and toxic stress, and to study the impact of educational materials on patients' understanding of ACEs and its health impacts.*

Project Complexity & Learner Time Limitations

Initially, a more complex project was anticipated, with live check-in calls and exercises with participants. We quickly realized that we did not have sufficient resources to offer this degree of complexity. Additionally, we learned that it was important to create a streamlined activity that could fit into doctors' busy schedules while delivering maximum impact. Both of these lessons – project resources and provider time limitations – are important to bring forward into future projects and to share with others seeking to develop PI projects.

Project Management Efficiencies

Use of the Ethos Learning Management System (LMS) allowed us significant efficiencies by automating communication and data collection. We will consider automation through the LMS – to the extent possible – for all future PI projects.

Engagement

After extensive marketing efforts, 72 individuals registered for this activity. Nearly all (70) are family physicians. Registrants received regular email reminders with encouragement and project deadlines. Thirty-two registrants (44%) completed the project. Seven (10%) registrants disenrolled and 33 (45%) failed to complete.

Thirty-two (44%) of participants were from California, and the remainder hailed from other states, with Michigan and Washington well represented. This demonstrates the importance of casting a wider net. While the primary audience remains our own California membership, we recognize that

there is interest beyond the borders of our own state. Future projects will include multi-state marketing.

Teamwork

Nine (13%) participants worked in physician PI teams. There was one team of four learners and one team of five learners.

All but one of the other participants indicated in their attestations that they worked as a team with other clinicians and staff at their site. This is especially important for the advancement of ACEs, as implementing Trauma-Informed, Resilience-Oriented Healthcare (TIROH) necessarily involves all members of the office staff, not just the physicians.

Survey Results – Patient Awareness

The survey contained a Likert 1-5 scale with 1=strongly disagree and 5=strongly agree. The patients who received ACEs and toxic stress educational materials had an overall average score increase of 15%. This indicates that patient education does increase ACEs/toxic stress awareness as a health topic.

The largest change in average score (28%) was shown in Question 1*: I am knowledgeable about Adverse Childhood Experiences (ACEs)*, moving from 3.16 (Neither agree nor disagree) to 4.06 (Agree).

Of interest is Question 6: *A doctor can provide better care when they know their patients' history of Adverse Childhood Experiences (ACEs)*. Patients already largely held the opinion that doctors can provide better care when they know their patients' history of ACEs, even before receiving education. Thus, their scores did not increase in proportion to their understanding of ACEs. While there was a 28% increase in knowledge of Adverse Childhood Experiences (Question 1) in the patient group that received education, there was only a nine percent increase in the belief that a doctor can provide better care when they know their patients' history of ACEs (Question 6) after education. Patients continued to Agree (rather than Strongly Agree) that doctors should be involved.

Question	No Education	After Education	Increase After Education
Question 1: I am knowledgeable about Adverse Childhood Experiences (ACEs).	3.16	4.06	28%
Question 2: I know what "toxic stress" means.	3.69	4.18	13%
Question 3: I understand that many people may have experienced one or more Adverse Childhood Experiences (ACEs).	3.77	4.41	17%
Question 4: I understand that toxic stress and Adverse Childhood Experiences (ACEs) can impact my health as an adult.	3.96	4.40	11%
Question 5: Talking about Adverse Childhood Experiences (ACEs) with a doctor should be a routine practice.	3.81	4.18	10%
Question 6: A doctor can provide better care when they know their patients' history of Adverse Childhood Experiences (ACEs).	4.02	4.38	9%

Learner Attestations – Physician Awareness

Attestations almost uniformly supported the value of incorporating ACEs and toxic stress educational materials into the patient visit. Many participants expressed that they would help their patients understand ACEs moving forward.

A common fear is that there is not enough time in a standard patient visit to raise the topic of ACEs. However, no participants experienced this, and at least one expressed their surprise that it did not add burden or time to their interaction with their patients.

Representative Comments

"Surprisingly I did not find that this slowed me down. I thought I would have a lot of questions that would come up after they did the survey but that did not happen."

"Most patients agree that talking about ACEs with a doctor should be routine practice, and doctors can provide better care when they know their patients' history of ACEs."

"Basic education does impact patients and is worth implementing."

"I was quite surprised at how much the average score on the responses increased in the patients who had read the educational handouts, because in live time, the patients did not engage much in conversation about the handouts or the topic, so I couldn't tell if they were interested or learning much."

"I learned that distributing basic educational materials can raise enough awareness to shed more light on patient health, and spark conversations about health interventions that may be helpful in terms both of treatment and prevention."

“This project participation did raise my personal awareness. I do believe that we need to make more resources available in every means by which we deliver care.”

“My staff responded well to this and seemed to really find it to be beneficial.”

Contradictions

“I was surprised that not many patients are knowledgeable about adverse childhood experiences or toxic stress.”

“I was quite surprised at how many patients were already familiar with ACES.”

Concerns

The need for translation into other languages

“Our clinic is almost exclusively publicly insured or uninsured which is associated so strongly with ACEs that in some ways the screening feels a little unnecessary; most of the providers at our clinic assume our patients have had many ACEs”

Conclusion

This pilot Performance Improvement project demonstrates the viability of AAFP Chapters producing ABFM PI projects for family physicians. With creativity, member participation and teamwork we can help family physicians initiate and implement practice change to improve the health of our patients.

Appendix 1: Survey (English version)

ACEs and Toxic Stress Patient Survey

Please read the statements on the left and indicate the degree to which you agree or disagree with each by circling the appropriate number.

STATEMENTS	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I am knowledgeable about Adverse Childhood Experiences (ACEs).	1	2	3	4	5
2. I know what "toxic stress" means.	1	2	3	4	5
3. I understand that many people may have experienced one or more Adverse Childhood Experiences (ACEs).	1	2	3	4	5
4. I understand that toxic stress and Adverse Childhood Experiences (ACEs) can impact my health as an adult.	1	2	3	4	5
5. Talking about Adverse Childhood Experiences (ACEs) with a doctor should be a routine practice.	1	2	3	4	5
6. A doctor can provide better care when they know their patients' history of Adverse Childhood Experiences (ACEs).	1	2	3	4	5

Appendix 2: Patient Education Materials (English versions)

Stress Busters

We are all living through an incredibly difficult time. For many of us, the COVID-19 pandemic has brought change, loss, and grief. It has also caused a lot of stress. While this stress may feel overwhelming, there are things we can do to calm our bodies and brains.

- We can pay attention to how stress affects us to help us identify it early, decide if it is helping us, and work to manage it. How does stress show up in your body, emotions, and behaviors?
- We can be kind to ourselves. As researcher Kristin Neff says, "With self-compassion, we give ourselves the same kindness and care we'd give to a good friend." What can you do to be kind to yourself right now?
- We can make time to do at least one thing that brings us joy every day. Laugh at a cat video. Read a book or do a puzzle. Buy yourself flowers. Reach out to someone you care about. Have a cup of tea. We all deserve joy in our lives, especially during tough times!
- We can reach out to get support and learn more about managing stress. The evidence-based stress busters can help!

Ways We Can Bust Stress

We all have inner strengths and resilience that can help us deal with challenges and stress. What helps you get through stressful times? Here you'll find some additional stress-busting strategies. Which new ideas do you want to try? Remember that you are the expert on what works for your body and brain. Think about developing a plan just for you to help you manage stress.

Turn this page over to find ways to build your stress-busting muscles.

SOURCES: Bhushan D, et al. *The Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health. Office of the California Surgeon General, 2020.* • *California Surgeon General's Playbook: Stress Relief during COVID-19.*

The above sources are available at https://osg.ca.gov/aces-toxic-stress/

This resource was reviewed by the California Collaborative ACEs Learning and Quality Improvement Collaborative (CALQIC) Patient Community Advisory Board.

SUPPORTIVE RELATIONSHIPS

Spend time with family. Connect with friends and coworkers.

- ▫ Connect with supportive family, friends, and neighbors from a distance.
  - Call or do a video chat.
  - Send a text or picture.
  - Write a postcard or send a care package.
  - Take a socially distant walk together.
- ▫ Get involved in your community.
- ▫ Explore ways to find support at work.

QUALITY SLEEP

Sleep, nap, and rest.

- ▫ Create a calm, cool, quiet, distraction-free place for sleep.
- ▫ Be patient, kind, and compassionate with your-self when resting and sleeping are challenging.
- ▫ Try to go to bed and wake up at the same time each day.
- ▫ Avoid electronics, caffeine, alcohol, and exercise close to bedtime.

BALANCED NUTRITION

Try to eat regular meals at a relaxed pace.

- ▫ Create a calm space to sit and enjoy your food.
- ▫ Try to include a variety of whole grains, fruits and vegetables with meals and snacks.
- ▫ Go easy on sugar, alcohol and highly processed foods.

PHYSICAL ACTIVITY

Find fun ways to move, move, move!

- ▫ Find ways to move that feel good to you every day.
- ▫ Schedule times to get up, stretch, and move during your workday.
- ▫ Walk or run. Dance. Stretch. Do a few jumping jacks, push-ups, or sit-ups.
- ▫ Play catch, throw a frisbee, jump rope, or hula hoop.

MINDFULNESS PRACTICE

Notice how you feel. Take a deep breath.

- ▫ If accessible, guide your attention to how you're feeling, physically and emotionally.
- ▫ If noticing your breath is useful, take a few moments to breathe in and out.
- ▫ Reflect on 3 things you're grateful for.
- ▫ Try a mindfulness app (e.g., Insight Timer, UCLA Mindful, 10% Happier).
- ▫ Make prayer, meditation, and/or yoga part of your daily routine.

EXPERIENCING NATURE

Get outside, breathe fresh air, feel the sun.

- ▫ Go outside every day!
- ▫ Look up at the sky. Feel the sunshine or rain on your face.
- ▫ Breathe fresh air.
- ▫ Smell flowers, walk on grass, listen to birds, touch a tree.

MENTAL HEALTHCARE

Resources and support are available if you want them.

- ▫ Talk with your family about how everyone is feeling.
- ▫ Minimize news or other media content that feels upsetting.
- ▫ Make a plan for what to do when you get stressed, angry, or overwhelmed.
- ▫ Reach out for support. You can start by calling the warm line at 1-855-845-7415.

ADD YOUR OWN IDEAS HERE!

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Resources for More Support

AAFP Neighborhood Navigator
https://navigator.aafp.org/

Find resources at 2-1-1 California:
https://www.211ca.org/

California Parent and Youth Helpline:
1-855-427-2736 (8am - 8pm)

California Mental Health Warm Line:
1-855-845-7415 non-urgent support (24/7)

PACEs Connection | aces aware SCREEN. TREAT. HEAL.

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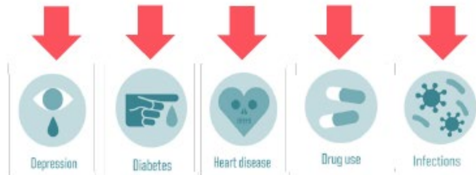
You can lower your risk of toxic stress and negative outcomes from ACEs.

Talk to your health provider and try these steps:

What are ACEs and effects of ACEs?

Adverse Childhood Experiences (ACEs) happen to people before their 18th birthday. They include exposure to abuse, neglect, and household challenges like mental illness, divorce, or substance abuse.



1 in 6 adults have 4 or more ACEs.

ACEs cause toxic stress for your body. These traumas increase the risk for smoking, alcoholism, suicide attempts, cancer, drug use, infections, diabetes, obesity, lung problems, broken bones, stroke, heart disease, depression, and other serious health conditions.

Adapted from the RWJF, CDC, ACEs Connection, and the Office of the California Surgeon General by Health Services of LA County and by CAFP

Mental Health Care
- Be open with your feelings
- Care for yourself so you can care for others

Balanced Nutrition
- Eat 5 servings of fruit and vegetables each day
- Drink water

Mindfulness Practices
- Take breaks and time to relax from work and school

Physical Activity
- Exercise for 1 hour each day

Quality Sleep
- Sleep 7-9 hours each night
- Stop TV or phone use before bed

Supportive Relationships
- Be there for friends & family
- Give compliments & praise for others' efforts

SCAN THE SQUARE WITH YOUR PHONE CAMERA

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Appendix 3: Learner Attestations

I appreciated getting the additional learning myself plus the ability to work with patients on their own learning around their aces and aces in general.
I think the handout provided will be useful and beneficial to my patients. They were already filling out an ACES questionnaire but the added information in the handout will help them understand why they are given the questionnaire. I did the entire project because I run a micropractice.
1.I personally administered the first ten surveys to serial adult patients in my clinic. I developed the plan for administration of the educational material and reviewed instructions for clinic staff to administer the second series of surveys following the provision and review of the educational material. They were administered to serial adult in-person patients in other clinicians clinics at our primary office. 2.I was surprised by the degree of awareness of these important issues in the patients that I see and treat routinely. I was not surprised by the high degree of agreement between patients that physicians knowledgeable about their patients history of ACEs would be perceived to be able to provide better care. 3.I suspect the wording of question 5 caused patient to pause and might have resulted in lower numbers in group 2. The concept of routine practice...when relevant, might be more appropriate as patients with a history might fear it being brought up repeatedly if not clinically appropriate 4.Because I work primarily in Mental Health my awareness was already fair to good. But I was surprised (pleasantly) by the receptiveness to the survey and the educational materials. The broad based resilience enhancing activities information will be utilized routinely to structure discussions I frequently have with patients 5. Having completed this project (and recently attending the AAFP physician Wellness and lifestyle medicine program) I intend to incorporate "Stress Busters" and similar resources much more routinely than I had been
I was the only participant in my clinic in the project, so the reach was really limited. Our clinic has very large Dari and Somali-speaking patient populations so these translations would be helpful to a full integration in our clinic. Our clinic is almost exclusively publicly insured or uninsured which is associated so strongly with ACEs that in some ways the screening feels a little unnecessary; most of the providers at our clinic assume our patients have had many ACEs. I think the most helpful thing for our patients would be the coping with stress parts. And we had lots of questions about what it had to do with LA County (my clinic is in Washington) so we might consider a new design if we rolled it out in our clinic.
I or my MA distributed the surveys to patients. I or my MA collected the surveys. I did the data entry and discussed the 3 page handout I gave every patient to read prior to them filling out the final surveys. I did a few hours of reading about ACES and I educated both of my MAs in this regard. It's clear that toxic stress especially in childhood but even in adulthood affects our health and that we have failed as culture to emphasize the importance of basic self care, stress control and mindfulness to our great disadvantage and that of our children.
I directly administered surveys for both groups, and distributed the learning materials. I learned that distributing basic educational materials can raise enough awareness to shed more light on patient health, and spark conversations about health interventions that may be helpful in terms both of treatment and prevention.
Iam very excited to this project including my staff, very educational and informative

I personally delivered all surveys and educational materials.

I was surprised that not many patients are knowledgeable about adverse childhood experiences or toxic stress. The average score for these 2 categories started at 1.6 and 2.2.
I was also surprised by how much improvement was seen in the patient's understanding and willingness to talk about these topics after giving the patient education information.

I would like patients to know that there are available resources when help is needed.

This project participation did raise my personal awareness. I do believe that we need to make more resources available in every means by which we deliver care.

My staff responded well to this and seemed to really find it to be beneficial.

I was the primary questioner, gatherer of information, and inputer of data. We are a small practice. Learned from, and appreciated the hand-outs as well. Realized that I don't talk enough with my patients about stress relief in general, and certainly not ACEs. I've found that many strongly shy aware from discussing ACEs, but seemed to appreciate that I was open to discussing and asking them regardless. Again, the stress busters handout, specifically the second page, was very informative and useful.

Although difficult to apply in the Emergency Department setting, taking that extra little time to understand the patient's background will help in patient care and decrease med Mal

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ACEs are essentially the nurture of one's health, and their perceptions of health and overall wellness can greatly be affected. Our impact as a PCP and for preventive care should emphasize limiting ACEs

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I introduced, administered surveys and patient educational materials, and compiled, analyzed and entered results of surveys directly. I was impressed at patient knowledge of ACEs and interest in discussing ACEs with me, as patients were generally aware of their potential implications on health in adulthood.

I reviewed materials on the CAFP website, printed handouts and surveys for my patients, and reviewed and entered the data. I learned there are lots of resources available in this area and that patients appreciate learning more about it.

I see enormous value in explicitly naming ACEs and what they are with my pts. It then follows that a conversation can be had about how these effect health and wellbeing.

I distributed the surveys, collected and inputted the data. I had not heard the term ACEs. I am surprised to hear that 1 in 6 adults have 4 or more ACEs. It verified my strong belief that many of the health care costs in our country are a result of stress. We have got to address this. I love the term I learned " Stress busters" and will hang the various methods of busting stress in each of my exam rooms.

I selected which patients to give the surveys to. I placed a yellow dot next to the patient on my schedule for whom I wanted my medical assistant to give the form to. I informed her to explain to the patient why we are doing the surveys. We informed them that these surveys are not connected to their chart.

The criteria I created in choosing which patients to give the surveys:
1) Pt is able to speak and read English well enough.
2) Patients 18 and older
3) Those patients who I've known for a long time as I felt they are more likely to complete the survey.
4) Since these forms were given before I entered the room, I carefully selected those patients who visits were a little longer (like those who are coming in for a physical) so that them doing the survey would not take up too much of my time. I especially felt this helpful for the group 2 survey patients since they had to read the handouts first.
5) I chose patients who I thought would benefit from knowledge about ACEs, particularly those who have chronic pain or mental health issues. Surprisingly I did not find that this slowed me down. I thought I would have a lot of questions that would come up after they did the survey but that did not happen. The patients just acknowledged that this is an important topic but did not seem compelled to connect it to their health conditions.

Assisted with collection and interpretation of data.
I assisted with analyzing both data sets and developing next steps for our clinic and reviewed our resolution for MAFP and AAFP.
Planning, data collection, data analysis, wrote resolution to state and national specialty association to increase EMR recording of ACEs and PCEs and to support payment for administering the surveys
I distributed the surveys to my staff and educated them about ACEs. The education group did score higher in every category. Some patients thanked me for the materials. Basic education does impact patients and is worth implementing.
I participated individually including buy-in by my advanced providers and clinical staff. Discussed, prepared and implemented project and gather data and discussed importance of assessing and referring patients in need of further assistance as assessed during appointment time.
Participated in distributing and implementing surveys and educational/post-study materials. I've realized the ACES as a concept is very foreign to patients and that there is some discomfort when discussing childhood trauma even as a theory. It is a concept that is quickly grasped, however. My hope is that patients are able to reflect on their own childhoods and identify ways that events in the past can present real time in adulthood. If more providers made discussion about ACES a routine item in preventive medicine visits, it could greatly reduce stigma surrounding childhood adverse events and, in turn, stigma surrounding mental health and its connection with physical health in adulthood.
I actively participated in the project and asked patients to fill the pre and post surveys. I learned that more people were aware of ACES and toxic stress than I thought. Patients were also eager to read the handouts and even wrote down other ways to decrease stress. The ones that read the handout seemed to read more confident in their answers. Patients were also comfortable discussing the survey. Interestingly, the patient that I know had a higher ACE score was hesitant to fill out the survey based on the topic but amenable once they realized it wasn't asking about personal experience. I think this observation will motivate me to dig in a little more with their history in a future visit.
I was the lead for this project. I learned of it and proposed the project to the other members of my team, and helped orchestrate and lead the others for the project, including holding them to the timeline. I familiarized myself with the ACES resources so that I could discuss them with patients. I gave a lecture about ACES to the resident physicians at my program. I was quite surprised at how many patients were already familiar with ACES. I was also surprised that many patients, while knowing that ACES could lead to health problems, did not feel it was that important to discuss them with their physician.
I performed the work with individual patients. Interestingly, the patients I choose came from trafficking backgrounds. Their case worker was well versed in ACEs and made a valid point they needed to be re-stratified using lower socioeconomic status patients as well as increased patients from underrepresented populations.
I participated in gathering data, as attested to above. ACEs information has been out for awhile, so the general public is somewhat aware. Published information on the subject is helpful to increase awareness. In addition to real-time detection of issues as a patient grows up, The connection to adult physical illness is the part that might surprise, but engage adults and older adults. We have a lot of patients who are older and may think that since they or their children are grown, that the information doesn't apply to them. However, learning about the number of illnesses and issues that they might be experiencing, as well as reflection on their personal histories might provide both insightful awareness, as well as the legitimacy of addressing emotional and mental health issues with the same intent and lack of judgement that we do physical illness. Our clinic delivers and teaches trauma-informed care, so the concepts aren't new to our staff and providers. We actually see how more of the techniques are applicable to our "normal" population (probably because the ACE score in the "normal" population is much higher than one might guess, if they didn't ask. We need to screen more of our patients, especially our "high utilizers" and "difficult" patients and keep this in consideration as we try to help them.

I worked with my medical assistant to distribute Group 1 and Group 2 surveys. I provided follow up education to patients who were interested in learning more. As an acceptability trial, the limited data suggested that patients found this topic acceptable, and learning more stimulated their interest in this topic, suggesting they found relevance for their own health. However, the delta in the results (increased acceptability between 1 & 2) between the two groups suggests that providing context is important to have patients understand and be willing to talk to their physician about such sensitive topics.
I introduced this project to my support staff and explained ACES to them and helped them realize the importance of ACES on patients health and how knowledge of their ACES can help us be more effective and compassionate with our patients. I learned that although many patients didn't know the term ACES they understood the concept of toxic stress and generally agreed that it was important for their team to understand the impact of these on their lives. I was also amazed at how the short reading about ACES significantly increased patient's awareness of the concept and the importance of sharing these things. The questionare and the information sheet generated discussion about things in our childhood can affect us in ways we don't even realize. . I really enjoyed this process and the patients seemed to as well
I planned and coordinated the project for our clinic. I lead meetings with the clinic staff to discuss distribution of the surveys and documents to patients and collection of the completed surveys. I gathered all of the surveys, inputted the data, and then analyzed the data between the two survey groups. I learned that most patients have at least some knowledge regarding adverse childhood experiences, but patients gained a much better understanding of the impact of adverse childhood experiences on their health after being provided educational handouts. Even more, I have learned that despite patient's level of understanding of adverse childhood experiences, most patient agree that talking about ACEs with a doctor should be routine practice, and doctors can provide better care when they know their patients' history of ACEs. After participating in this project, I plan to incorporate discussion of ACEs with my patients and include patients' history of ACEs in my overall care.
I participated in planning the data collection and intervention, reviewed the data after it had been collected from our group practice, reviewed the results after they had been analyzed, and participated in group discussion about the implications of the results. I participated in developing a next step intervention for our group (writing a resolution).
I was the leader for my team for this project. I work daily with the same nurse and medical assistant, so our team was consistent. I explained the purpose and the procedure. We did the pilot with just our team first, but plan to share our results with the other adult primary care teams so that they can incorporate the educational materials . I was quite surprised at how much the average score on the responses increased in the patients who had read the educational handouts, because in live time, the patients did not engage much in conversation about the handouts or the topic, so I couldn't tell if they were interested or learning much. Admittedly, with the fast pace of clinic, we also did not take enough time on each patient to elicit comments or questions about the material. We work in a safety net setting in which patients have likely experienced toxic stress now or in the past, so the material is very relevant. In the next phase of the project, I'd like to have the material posted in all of the rooms for patients to look at while waiting. In addition, we can pilot the Spanish and Tagalog version for the appropriate patients. I plan to ask the medical assistant and nurse for their suggestions on how to invite patient to ask questions about the topic (i.e., trying out touching on the topic at different stages of the visit flow to see what works best.). My first effort will be to try this during my portion of the visit if time allows, but if not, the nurse can broach at the end of the visit, at which time the patient can be offered a session immediately with our integrated behavioral health team.
It was interesting that the handout seemed to make the patients feel much more confident in their knowledge about ACEs and most wanted doctors to be aware of ACEs in order to provide better care.