

# Making the Case to Clinic Leadership

*How to bring key decision-makers on board with ACE screening*

Securing buy-in from practice leadership is a critical step in initiating and sustaining Adverse Childhood Experiences (ACE) screening and toxic stress treatment. Since ACE screening to assess for risk of toxic stress is an emerging medical field, leadership may not be familiar with it nor understand the value-add to clinical practice. Therefore, you will want to be prepared to explain the value and importance of screening children and adults for ACEs to assess for risk of toxic stress and responding with evidence-based interventions.

This article offers five principles to help structure your approach for achieving your organization's support to implement ACE screening and toxic stress treatment.

## 1. Understand your work environment

Who influences whom? Some people in your organization may be reluctant to implement ACE screening because they feel it may compete with and take resources away from other organizational priorities and programs. To determine how to best navigate the political dynamics of your organization, it can help to identify the essential decision-makers and stakeholders you need to get on board, such as the practice manager, medical director, and/or CEO (read [\*Finding and Engaging Champions and Key Decision-Makers for Implementing ACE Screening and Toxic Stress Treatment\*](#)).

It also can be helpful to think about how other new efforts have been successfully introduced into your organization in the past. Furthermore, it is important to anticipate how the ACE screening process may impact each member of the clinical team and existing clinical workflows (e.g., changes to the language used in patient conversations, when patients get roomed, data entry requirements, and patient education needed) so you can anticipate and proactively address concerns.

## 2. Align with leadership priorities

What are your organization's existing goals and priorities? They may include population health management initiatives (e.g., mitigate chronic health issues, improve health equity), efforts to integrate medical and behavioral health, or working to be recognized as a patient-centered medical home.

If ACE screening can support achieving at least one of your organization's strategic goals, you can make a stronger case for prioritizing ACE screening, integrating it into existing work, and requesting resources. How can ACE screening support existing goals and priorities? For example, screening for ACEs and treatment of toxic stress can be an essential practice for improving individual and population health and making health care more equitable.

## 3. Anticipate and address potential barriers

What will leadership's concerns be? Before you engage with leaders, think about any barriers, practical issues, and concerns that might come up during discussion so that you are prepared to address them. Questions may include:

- Will there be any required additional costs and resources?
- How will we integrate ACE screening into the existing clinic workflow?

- What impact will ACE screening have on our team (e.g., clinician and staff time, burnout, secondary traumatic stress)?

ACE screening and toxic stress treatment has been successfully integrated into a wide range of clinical settings — from small to large — and practice specialties including pediatric primary care,<sup>1</sup> adult primary care,<sup>2</sup> family medicine,<sup>3</sup> and women’s health and prenatal care.<sup>4</sup> It can be effective to highlight examples of practices similar to yours that have successfully overcome challenges and implemented ACE screening. The case studies in this How-To Guide can be a good place to start.

In addition, more information about common questions and concerns that implementation teams have encountered in the past can be found in the [FAQs](#).

#### 4. Propose starting small

Does it have to be all or nothing? Implementing ACE screening and toxic stress treatment across your organization may seem like a tough sell, particularly given all of the other work going on. One way to begin moving forward is by reviewing your practice’s experience in successfully implementing other clinical care changes and thinking about how to learn from and build on these approaches.

It may be practical to start with a smaller pilot to try out the selected ACE screening approach. Data can be collected to demonstrate the potential value of screening to patient care and to support decision-making to inform how the program is scaled over time. (Stage 3 of this How-To Guide provides more information on scaling up a pilot and how to collect and track performance indicators.)

A pilot generally requires fewer resources, can be conducted with little formal support, and allows you to demonstrate the feasibility of ACE screening within your organization. It can also demonstrate your clinic’s

commitment and capacity to ultimately implement ACE screening and toxic stress treatment across the organization. You can approach designing an ACE screening pilot in different ways. Ideas that can be adapted from other ACE screening pilots include:<sup>5</sup>

- Limit screening to patients of only one or a few clinicians
- Screen patients only on certain days/times
- Screen a specified/limited number of patients each day
- Screen for a specified time period
- Start by screening a certain sub-population of patients; i.e., all 4-year-olds or all pregnant patients.

For more information about piloting, read [No One Size Fits All: Different Approaches to Piloting ACE Screening and Toxic Stress Treatment](#).

## 5. Stay the course

What do you do if leadership turns you down? Do not be discouraged if your initial attempt to secure buy-in from leadership is unsuccessful. Instead, work to address the concerns they bring up and suggest revisiting the conversation at a later date. In the meantime, continue to strategize how to align ACE screening and toxic stress treatment with your organization's priorities and consider starting (or continuing) a small pilot screening program. You and other ACE screening champions at your clinic can also continue to engage and educate leadership, clinical teams, and staff about the science of ACEs and toxic stress, as well as the importance of ACE screening and evidence-based responses.



## Citations

- 1 Koita K, Long D, Hessler D, et al. Development and implementation of a pediatric Adverse Childhood Experiences (ACEs) and other determinants of health questionnaire in the pediatric medical home: A pilot study. *PLoS One* 2018; **13**(12): e0208088.; Purewal SK, Bucci M, Wang LG, et al. Screening for Adverse Childhood Experiences (ACEs) in an integrated pediatric care model. *Zero to Three* 2016; **36**(3): 10-7.; Selvaraj K, Ruiz MJ, Aschkenasy J, et al. Screening for toxic stress risk factors at well-child visits: The Addressing Social Key Questions for Health Study. *Journal of Pediatrics* 2019; **205**: 244-9.e4.; Conn A-M, Szilagyi MA, Jee SH, Manly JT, Briggs R, Szilagyi PG. Parental perspectives of screening for Adverse Childhood Experiences in pediatric primary care. *Families, Systems, & Health* 2018; **36**(1): 62-72.; Kia-Keating M, Barnett ML, Liu SR, Sims GM, Ruth AB. Trauma-responsive care in a pediatric setting: Feasibility and acceptability of screening for Adverse Childhood Experiences. *American Journal of Community Psychology* 2019; **64**(3-4): 286-97.; Marie-Mitchell A, Lee J, Siplon C, Chan F, Riesen S, Vercio C. Implementation of the Whole Child Assessment to screen for Adverse Childhood Experiences. *Global Pediatric Health* 2019; **6**: 2333794X1986209.; Marsicek SM, Morrison JM, Manikonda N, O'Halleran M, Spoehr-Labutta Z, Brinn M. Implementing standardized screening for Adverse Childhood Experiences in a pediatric resident continuity clinic. *Pediatric Quality and Safety* 2019; **4**(2): e154.; Choi KR, McCreary M, Ford JD, Rahmanian Koushkaki S, Kenan KN, Zima BT. Validation of the Traumatic Events Screening Inventory for ACEs. *Pediatrics* 2019; **143**(4): e20182546.; DiGangi MJ, Negriff S. The implementation of screening for Adverse Childhood Experiences in pediatric primary care. *Journal of Pediatrics* 2020; **222**: 174-9.e2.
- 2 Goldstein E, Athale N, Sciolla AF, Catz SL. Patient preferences for discussing childhood trauma in primary care. *The Permanente Journal* 2017; **21**: 16-055; Kalmakis KA, Shafer MB, Chandler GE, Aponte EV, Roberts SJ. Screening for childhood adversity among adult primary care patients. *Journal of the American Association of Nurse Practitioners* 2018; **30**(4): 193- 200.
- 3 Glowa PT, Olson AL, Johnson DJ. Screening for Adverse Childhood Experiences in a family medicine setting: A feasibility study. *Journal of the American Board of Family Medicine* 2016; **29**(3): 303-7.
- 4 Flanagan T, Alabaster A, McCaw B, Stoller N, Watson C, Young-Wolff KC. Feasibility and acceptability of screening for Adverse Childhood Experiences in prenatal care. *Journal of Women's Health* 2018; **27**(7): 903-11.; Young-Wolff KC, Alabaster A, McCaw B, et al. Adverse Childhood Experiences and mental and behavioral health conditions during pregnancy: The role of resilience. *Journal of Women's Health* 2019; **28**(4): 452- 61.
- 5 Bhushan D, Kotz K, McCall J, Wirtz S, Gilgoff R, Dube SR, Powers C, Olson-Morgan J, Galeste M, Patterson K, Harris L, Mills A, Bethell C, Burke Harris N, Office of the California Surgeon General. *Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health*. Office of the California Surgeon General, 2020. DOI: 10.48019/PEAM8812.

## References

American Academy of Family Physicians. CDC: Preventing ACEs May Mitigate Chronic Health Issues. 2019; published online Nov 13. <https://www.aafp.org/news/health-of-the-public/20191113mmwraces.html> (accessed Jan 27, 2021).

Bhushan D, Kotz K, McCall J, Wirtz S, Gilgoff R, Dube SR, Powers C, Olson-Morgan J, Galeste M, Patterson K, Harris L, Mills A, Bethell C, Burke Harris N, Office of the California Surgeon General. *Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health*. Office of the California Surgeon General, 2020. DOI: 10.48019/PEAM8812.

Choi KR, McCreary M, Ford JD, Rahmanian Koushkaki S, Kenan KN, Zima BT. Validation of the Traumatic Events Screening Inventory for ACEs. *Pediatrics* 2019; **143**(4): e20182546.

Conn A-M, Szilagyi MA, Jee SH, Manly JT, Briggs R, Szilagyi PG. Parental perspectives of screening for Adverse Childhood Experiences in pediatric primary care. *Families, Systems, & Health* 2018; **36**(1): 62-72.

Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science* 2009; **4**:50. doi:10.1186/1748-5908-4-50

DiGangi MJ, Negriff S. The implementation of screening for Adverse Childhood Experiences in pediatric primary care. *Journal of Pediatrics* 2020; **222**:174-9.e2.

Flanagan T, Alabaster A, McCaw B, Stoller N, Watson C, Young-Wolff KC. Feasibility and acceptability of screening for Adverse Childhood Experiences in prenatal care. *Journal of Women's Health* 2018; **27**(7): 903-11.

Glowa PT, Olson AL, Johnson DJ. Screening for Adverse Childhood Experiences in a family medicine setting: A feasibility study. *Journal of the American Board of Family Medicine* 2016; **29**(3): 303-7.

Goldstein E, Athale N, Sciolla AF, Catz SL. Patient preferences for discussing childhood trauma in primary care. *The Permanente Journal* 2017; **21**: 16-055.

James T. Gaining Leadership Buy-in for Organizational Change in Health Care. Harvard Medical School Lean Forward blog. 2020; published online Mar 12. <https://leanforward.hms.harvard.edu/2020/03/12/gaining-leadership-buy-in-for-organizational-change-in-health-care/> (accessed Jan 27, 2021).

Kalmakis KA, Shafer MB, Chandler GE, Aponte EV, Roberts SJ. Screening for childhood adversity among adult primary care patients. *Journal of the American Association of Nurse Practitioners* 2018; **30**(4): 193- 200.

Kia-Keating M, Barnett ML, Liu SR, Sims GM, Ruth AB. Trauma-responsive care in a pediatric setting: Feasibility and acceptability of screening for Adverse Childhood Experiences. *American Journal of Community Psychology* 2019; **64**(3-4): 286-97.

Koita K, Long D, Hessler D, et al. Development and implementation of a pediatric Adverse Childhood Experiences (ACEs) and other determinants of health questionnaire in the pediatric medical home: A pilot study. *PLoS One* 2018; **13**(12): e0208088.

Marie-Mitchell A, Lee J, Siplon C, Chan F, Riesen S, Vercio C. Implementation of the Whole Child Assessment to screen for Adverse Childhood Experiences. *Global Pediatric Health* 2019; **6**: 2333794X1986209.

Marsicek SM, Morrison JM, Manikonda N, O'Halleran M, Spoehr-Labutta Z, Brinn M. Implementing standardized screening for Adverse Childhood Experiences in a pediatric resident continuity clinic. *Pediatric Quality and Safety* 2019; **4**(2): e154.

National Pediatric Practice Community on ACEs Pilot Site Program. Cohort 1 Final Evaluation Report, 2019. <https://nppcaces.org/wp-content/uploads/2019/10/NPPC-cohort-1-Report-08-26-19-.pdf>.

Purewal SK, Bucci M, Wang LG, et al. Screening for Adverse Childhood Experiences (ACEs) in an integrated pediatric care model. *Zero to Three* 2016; **36**(3): 10-7.

Schulman M. Making the Case for Trauma-Informed Care: Tips for Talking with Leadership. Center for Health Care Strategies, 2019. [https://www.traumainformedcare.chcs.org/wp-content/uploads/Make-Your-Pitch-for-TIC-TA-Tool\\_111819-1.pdf](https://www.traumainformedcare.chcs.org/wp-content/uploads/Make-Your-Pitch-for-TIC-TA-Tool_111819-1.pdf).

Selvaraj K, Ruiz MJ, Aschkenasy J, et al. Screening for toxic stress risk factors at well-child visits: The Addressing Social Key Questions for Health Study. *Journal of Pediatrics* 2019; **205**: 244-9.e4.

Young-Wolff KC, Alabaster A, McCaw B, et al. Adverse Childhood Experiences and mental and behavioral health conditions during pregnancy: The role of resilience. *Journal of Women's Health* 2019; **28**(4): 452- 61.

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