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Title

Exploring clinical team perspectives on adverse childhood experiences and social risks screening in adult primary care

Priority 1 (Research Category)

Social determinants and vulnerable populations

Presenters

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Abstract

Context: Multiple organizations have recommended adverse childhood experiences (ACEs) and/or social risk (SR) screening (e.g., food, housing concerns) for adults as part of routine primary care, yet uptake in California primary care settings is limited. Among clinics investing in routine screening, both screening rates and approaches vary. In settings where both ACEs and SR screening are conducted, these assessments are not routinely integrated, which may limit reach and impact. Objective and Study Design: We present a qualitative exploration of barriers and facilitators to adult ACEs and SR screening and the perceived value of integrating these screenings in community health centers (CHCs). Setting and Population Studied: We recruited clinical staff and leaders from CHCs with documented ACEs screening programs based on claims data. Intervention: Clinic staff and leaders involved in adult ACEs and SR screening programs were invited to participate in semi-structured interviews. We used a rapid qualitative analysis approach to analyze interview data. Outcome Measures and Results: Thirty-nine interviews from 12 California CHCs were collected. Participants included allied health professionals (n=16), staff in leadership roles (n=15), and licensed clinicians (n=8). Most participants were involved with delivering, designing, or managing ACEs screening programs, and agreed that SR screening is in the scope of primary care. The majority of clinics offered systematic ACEs screening in adult primary care and addressed social risks informally. Staff perspectives on integrating ACEs and SR screening and response varied. Many suggested that combining ACEs and SR screenings could increase trust between patients and staff while addressing a wider range of health needs including current material needs. Common challenges to implementing either screening program in isolation and in tandem include the brief length of primary care visits, use of multiple screening tools, and staff turnover and burnout. Conclusion: Our findings suggest that CHC staff see both ACEs and SR screening as potentially beneficial for patients and staff alike, but that current challenges in primary care make these programs more complicated to consider integrating. Recommendations for ACEs and SR implementation should incorporate both staff and patient perspectives and address structural barriers to screening.