Addressing ACEs in Your Primary Care Practice

ACEs Summit
November 15th 2017
THE TRUTH ABOUT ACES

WHAT ARE THEY?

ACES are ADVERSE CHILDHOOD EXPERIENCES

HOW PREVALENT ARE ACES?

The ACE study revealed the following estimates:

<table>
<thead>
<tr>
<th></th>
<th>ABUSE</th>
<th>NEGLECT</th>
<th>HOUSEHOLD DYSFUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>72%</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>Neglect</td>
<td>75%</td>
<td>25%</td>
<td>27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Physical Abuse</th>
<th>Sexual Abuse</th>
<th>Emotional Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>72%</td>
<td>25%</td>
<td>25%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Emotional Abuse</th>
<th>Physical Abuse</th>
<th>Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

WHAT IMPACT DO ACES HAVE?

As the number of ACES increases, so does the risk for negative health outcomes.

RISK

EXPECTED RISK OUTCOMES:

Behavior:
- Lack of physical activity
- Smoking
- Drug use
- Mental illness

Physical & Mental Health:
- Suicide attempts
- Cardiovascular disease
- Diabetes
- Depression

ON 17,800 ACE study participants:

- 30% of participants at least 1 ACE
- 25% of those with 2 or more ACES
Think Adult – Think Child!
Value of ACE’s history taking in Primary Care
Dr June S Bergman, MD CCFP

- ACE’s known to cause more poor health
- Higher Utilization
- Usual biological approach less effective
- Frustration for all involved
- High association for complex conditions with yellow flags

- Changes perspective of provider and patient
- Tools available, more and different
- Walk with patient to discover path to wellness
- Does not always require intervention
- Family physicians have many of the skills already
Primary Care Initiatives

- Research in the primary care setting
  - Shared care models
  - Trauma informed care
- Care of complex patient
  - Broader history taking
  - Self management core
  - Expertise shared
- Low risk maternity clinic
  - Part of history taking
  - Providers gaining comfort
- Primary Care Clinic
  - Partner with patients around total health

Alberta Health Services
UNIVERSITY OF CALGARY
Primary Care Network
We care about you and your health

• Information – patients, providers at all levels
• Care processes defined
  • Usual care
  • Administration and discussion at different points
• Integrating electronic charting
• Developing scripts
• Identifying support resources
• Developing information supports
Lifetime Effects

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

- Mindfulness; taking care of the body
- Cognitive, emotional and social skills
- A Self-Care Plan

Life Cycle:
- Conception
- Disrupted Neurodevelopment
- Adverse Childhood Experiences
- Social, Emotional, and Cognitive Impairment
- Adoption of Health-risk Behaviors
- Disease, Disability, and Social Problems
- Early Death
- Death
Take Home

- Critical part of History Taking
- Does not necessarily require intervention
- Changes our perspective as care providers
- Requires change management
- Requires work at various levels
- Primary care is ideally located to do this work
- Works with root cause
Embedding ACEs into Primary Care

DR. SHIRLEY SZE – FAMILY PHYSICIAN, KAMLOOPS, BC
Why I did not inquire about ACE and What changed in my practice

1. Why I did not ask about ACE in the past 25 years of practice: 3 reasons
   - not aware of evidence and no systematic way of doing it
   - knowledge of potential to re-traumatize if re-open wounds
   - need to focus on here and now for strength-based strategies

2. When did I start and why: 3 reasons
   - compelling evidence came to light – see handouts and links at end
   - safe way to do so – focus not on “What’s wrong with you?” to “What happened to you?”
   - Deepening the understanding and relationship
   - focus on enabling resiliency and stopping intergenerational trauma –
   - wrap around empathetic care – “I am sorry that happened to you.”
How I am doing it now

3. ACE - Normalizing Trauma History Taking and identifying patients at risk

3 Questions – describe in one sentence? Have you experience mental or physical abuse or being molested? (Dr. Nataliya Grishin)

Develop team-based trauma informed care

Connection to community services to support patients (parents) - drafts

SEE: Center for HealthCare Strategies
https://issuu.com/chcshealth/docs/understanding_effects_of_trauma_on

HEAR: Dr. Nadine Burke-Harris & Dr. Edward Machtinger

EXAMPLES OF COMMUNITY SUPPORTS – in your hand-outs
Bridging the ACES Gap: How can we mitigate the impact of ACEs?

Working with More Vulnerable Populations Using a RICHER Social Pediatrics Approach

Christine Loock¹, ² with support from Julie Conry², Judith Lynam², Ingrid Tyler³, Dzung Vo¹, ² Eva Moore¹, ² Tatiana Sotindjo¹, Lorine Scott, Kristina Pikksalu⁴, Tanjot Singh⁵, Doug Courtemanche², ⁵

¹Department of Pediatrics, BC Children’s, ²University of British Columbia, Vancouver, ³MHO, Fraser Health Authority and Dalla Lana School of Public Health, ⁴Primary Care FNP, RICHER Program, BC Children’s Hospital, Vancouver, Canada, ⁵Department of Surgery, BCCH

ACES Summit BC & Beyond 2017

Loock, 2017
“It’s about who we aren’t seeing!”

Dr. G.C. Robinson, Order of Canada
Professor Emeritus UBC Pediatrics

Loock, 2017
Social Determinants & Health Equity

Healthy Public Policy:
(1) Best start (0-6 years)
(2) Maximize potential (youth)
(3) Strengthen public health - obesity, smoking, alcohol
(4) Good work for all
(5) Healthy standard of living
(6) Sustainable communities

Marmot & Allen, 2014
Canadian Institute of Health Research, 2012
Loock, 2017
<table>
<thead>
<tr>
<th>Commitment to Health Equity</th>
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</thead>
<tbody>
<tr>
<td>1. Horizontal Relationships</td>
</tr>
<tr>
<td>2. Trust</td>
</tr>
<tr>
<td>3. Training</td>
</tr>
<tr>
<td>4. Empowerment</td>
</tr>
<tr>
<td>5. Participatory Research</td>
</tr>
</tbody>
</table>

Loock, 2017
Adverse Childhood Experiences

Deck of 10 ACE’s:
1. Physical neglect
2. Emotional neglect
3. Physical abuse
4. Emotional abuse
5. Contact sexual abuse
6. Mother treated violently
7. Parental Separation (e.g. only one or no parents)
8. Household substance abuse (alcohol and/or drugs)
9. Incarcerated household member
10. Household mental illness (e.g. chronically depressed, mentally ill, institutionalized, or suicidal)

*Centers for Disease Control (R.F. Anda, MD) & Kaiser Permanente (V.J. Felitti, MD) of > 17,000 adult participants, grouped by decade of birth (going back to 1900) collected between 1995-1997

Loock, 2017
Applying ACE Scores to the Experiences of Youth with FASD
Comparison with Kaiser ACE Study Participants

<table>
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<tr>
<th>ACE Item</th>
<th>ACE Study %</th>
<th>FASD %</th>
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<tr>
<td>Physical abuse</td>
<td>26</td>
<td>54</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>10</td>
<td>48.6</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>21</td>
<td>48.6</td>
</tr>
<tr>
<td>Alcohol/drug abuse in household</td>
<td>28</td>
<td>78.4</td>
</tr>
<tr>
<td>Incarcerated family member</td>
<td>6</td>
<td>13.5</td>
</tr>
<tr>
<td>Family member with mental illness</td>
<td>20</td>
<td>37.8</td>
</tr>
<tr>
<td>Mother treated violently</td>
<td>13</td>
<td>40.5</td>
</tr>
<tr>
<td>Only one, or no parents</td>
<td>24</td>
<td>94.6</td>
</tr>
<tr>
<td>Emotional or physical neglect</td>
<td>10-15</td>
<td>56.8</td>
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</tbody>
</table>

Majority of youth with FASD had 4 or more ACES (4.8). Only 1 had no score. The coding did not capture the extent of trauma or intergenerational trauma experienced by many of these youth and their families of origin.
RICHER SOCIAL PEDIATRICS
COMMUNITY-HOSPITAL-UNIVERSITY
PARTNERSHIP

RESPONSIVE
INTERSECTORAL
INTERDISCIPLINARY
COMMUNITY
CHILD
HEALTH
EDUCATION
RESEARCH

With BC CHILDREN’S & WOMEN’s HOSPITAL & UBC
Loock, 2017
“IT HELPS”
TO TAKE A SOCIAL HISTORY

- Income
- Transportation
- Housing
- Education
- Literacy
- Legal Status
- Personal Safety (ACES)
- Primary Care
- Supports

Adapted from Kenyon et al PEDIATRICS Vol. 120 No. 3 September 2007
Why early life matters.

Figure 12. Rates of return to human capital investment in disadvantaged children.

From James J. Heckman and Dimitriy V. Masterov, 2007

C. Loock, May 2015
Strathcona: Critical Decrease in Vulnerability

Understanding Critical Difference.

Scale: ONE OR MORE SCALES PHYSICAL SOCIAL EMOTIONAL LANGUAGE COMMUNICATION

Base Wave: 2 3 4  Comparison Wave: 4 5

Strathcona

Vulnerable on one or more scales of the EDI

<table>
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<tr>
<th>Wave</th>
<th>Count</th>
<th>Percent Vulnerable</th>
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<tbody>
<tr>
<td>3</td>
<td>56</td>
<td>70%</td>
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<tr>
<td>5</td>
<td>60</td>
<td>52%</td>
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<tr>
<td>Change</td>
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<td>-18%</td>
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Data Source:
HELP EDI
Wave 2 04/05-06/07
Wave 3 07/08-09/09
Wave 4 09/10-10/11
Wave 5 11/12-12/13
Conclusions

1. The “RICHER” approach was effective in dismantling barriers by providing access to timely health services.
2. It has helped bridge trust and empower families and communities to collaborate regarding vulnerability, SDoH, and ACEs.
3. Other Canadian communities are adopting our “RICHER” research approach.
4. By investing earlier in children and youth in our communities, we have the opportunity to improve the health of our entire population.

Loock, 2017
Youth Engagement: Resilience & Positive Youth Development

Youth are not problems to be managed, but resources to be developed.

- Roth & Brooks-Gunn

Empower all our children and youth to be good at something.

- Marmot and my mom

http://byutv.org/watch/0256de75-38d7-4b47-9b54-eb46cd1ae881/turning-point-naskarz#ooid=RzaHJrazoXPAWncP_tLJKWIQ5HM2NE1X
http://www.alivesociety.ca/news/68-documentary-on-nascarz

Loock, 2017
Realist Synthesis

Tyler, Manson, O’Campo, Lynam, Loock, et al

Introduction

The International Society of Social Pediatrics and Child Health defines social pediatrics as “a global, holistic, and multidisciplinary approach to child health which considers the health of the child within the context of their family, environment, school, and community, integrating the physical, mental, and social dimensions of children’s health and development as well as care, prevention and promotion of health and quality of life.”

In this project we characterize social pediatrics across three dimensions: (1) an approach concerned to foster health equity; (2) through interprofessional education, and (3) community embedding, all of which involve independently complex sets of interventions, which are philosophically combined.

Objective

The aim of the realist review is to better understand how SPh work, for whom, and in what circumstances, in order to produce an explanatory model to assist decision makers in developing and planning child health equity-based, integrated, embedded approaches to child health.

Contact

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604-607-2769

Acknowledgments

The authors would like to acknowledge the Canadian Institutes of Health Research (CIHR) for funding this research. The authors would like to acknowledge Daili Abdul-Karraz, Breeno Dantas, Meghan Lynch, and Nicole Turner for their contributions to this study.

References

As per O’Campo and colleagues and in accordance with Pawson et al., the method we employed is outlined as follows: (1) identifying the review question, (2) formulating the initial theory, (3) searching for primary studies, (4) selecting and appraising study quality, (5) extracting, analyzing and interpreting relevant data, and (6) refining the theory. A theoretical framework was developed in consultation with the research team along with an exploratory search of the literature and key informant interviews. Emerging theories were captured through pre drafting that describes possible reasons why an outcome was or was not achieved? A formal literature search was conducted by using search terms based on the initial theory. The search was further refined after incorporating feedback from the advisory committee. Inclusion and exclusion criteria were applied to the search results to include interventions that were health care focused and driven by health equity. Integration, and embeddedness. Two reviewers independently appraised included articles based on criteria appropriate for the methods used. Two reviewers extracted data using a standard, from this study which identified initiative activities, reported outcomes, successes and failures, and key contextual factors. All articles related to a specific initiative were considered together as a “family of articles.” Analysis of the literature resulted in “demirregularities” or unpredictable patterns where outcomes are linked to activities through mechanisms. Loock, 2017
Range & Nature of our RICHER Partnerships.....

Community Partners
NEVCO - NICCSS
Ray Cam Community Co-operative
Child Health BC
Vancouver Native Health
ALIVE

Neighbourhood outreach sites
Elementary/secondary/alternative schools (6 schools + alt schools)
Child care centers (2)
Community Centers (2)
Community Housing (1)

Governmental Partners
MCFD/VACFASS

UBC Academic Partners
School of Nursing
Faculty of Medicine – Department of Pediatrics

Health Authorities
Provincial Health Services Authority
- BC Children’s, Sunny Hill & BC Women’s
Vancouver Coastal Health Authority (VCHA) – public health, mental health

Key Clinicians
Specialist Lead - C. Loock, Developmental Pediatrician
Primary Care Lead – L. Scott, Nurse Practitioner

Loock, 2017
RICHHER Publications


Corey Reid – Young Adult Practice Lead

Keli Anderson – Pres. & CEO
TRAUMA
FamilySmart® Practice Filters
It LOOKS LIKE...
“Images in my memory that I wish I could delete.”
It FEELS LIKE ... "Sharing is shedding what I have wrapped myself in to protect me"
It SOUNDS LIKE ...

“I get that trauma has impacted my life and health. Will you help me once you know?”
THANK YOU
Check us out at familysmart.ca
Adverse Childhood Experiences & IM/IT

W.L. Clifford, OBC, MD, FCFP, BSc, BMedSci, MScF
October 26th, 2017
For every 100 adults in England 48 have suffered at least one ACE during their childhood and 9 have suffered 4 or more

0 ACEs  52%
1 ACEs  23%
2-3 ACEs 16%
4+ ACEs  9%

Figures based on population adjusted prevalence in adults aged 18-69 years in England

Diabetes Prevalence

Legend
- **Prince George Division**
- **Northeast**
- **Northern Interior**

**Data Source**
- Prince George Division: 5852 / 80312 (7%)
- Northeast: 1958 / 37846 (5%)
- Northern Interior: 7874 / 115038 (7%)

**Data as of**
- 2017 Q4
BMI or WC documented in last 2 yrs age >19

Legend
- Prince George Division
- Northeast
- Northern Interior

Data Source | Ratio | Data as of
--- | --- | ---
Prince George Division | 15249 / 62787 (24%) | 2017 Q4
Northeast | 6826 / 27454 (25%) | 2017 Q4
Northern Interior | 23654 / 89168 (27%) | 2017 Q4
BMI or WC documented in last 2 yrs age >19
Overweight or Obese Age > 19 (HDC)

Chart 2
Percentage who were obese or overweight (self-reported), by sex, household population aged 18 and older, Canada, 2003 to 2014 percent

Point of Care

Practice

Population
Point of Care
**MICKEY MOUSE 26 YEAR OLD M**  chart no.: 5756 - encounter no.: 684433

**FIRST:** MICKEY  **MIDDLE:** SUITE#6  **LAST:** MOUSE  
**DoB:** 1991.01.01  **M**  **Service Provider:**

**PHN:** BC 901118273  **00**  **Home:**

**Date:** 2017.11.10  **0:00**  **Slots:** 6

**Provider:** DOCTOR "D"  
**Ser. Loc.:**

**Visit Code:** R  
**Visit Reason:** Anxiety  
**Appt Status:**

**Progress Note[s]**

**Note 1 of 1**  
**Author:** CLIFFORD, WILLIAM

3 months increasing anxiety

---

**Code** | **Test Name** | **Value** | **Flag** | **Units**
---|---|---|---|---
34496 | CIGARETTES SMOKED.TOTAL (PACK-YEARS) | | | 
34494 | CIGARETTES SMOKED.CURRENT (PACK/DAY) | | | 
39957 | ALCOHOL DRINKS PER WEEK | | | drinks/wk 
39959 | PHYSICAL ACTIVITY MINUTES PER WEEK | | | mins/wk 
1984 | WAIST CIRCUMFERENCE | | | cm 
3552 | ALCOHOL BINGE EPISODES/MONTH REPORTED | | | 
83191 | ADVERSE CHILDHOOD EXPERIENCES SURVEY (ICD) | | | 
76916 | HAVE YOU STRUGGLED MAKING ENDS MEET AT E | | | 
76917 | SUSPECT SIGNIFICANT SOCIOECONOMIC CHALLENGE | | |
## COPD Encounter Template

**CHART:** 5756  
**FIRST:** MICKEY  
**MIDDLE:** SUITE#6  
**LAST:** MOUSE  
**DOB:** 1991.01.01

**Enc #:** 684433  
**Attending:** DOCTOR "D"  
**Create by:** CLIFFORD, WILLIAM  
**Date:** 2017.11.10

### Physiology

<table>
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<tr>
<th>Physiology</th>
<th>Self Management</th>
<th>Therapy</th>
<th>Investigation</th>
<th>Review</th>
<th>Information</th>
</tr>
</thead>
</table>
| Acute Exacerbation Since Last Time?  
If Yes - Date: | ○ Yes ○ No ○ NA | | | | |
| Corticosteroids Prescribed? | ○ Yes ○ No ○ NA | | | | |
| Antibiotics Class Prescribed?  
- Sulpha  
- Macrolides  
- Beta-Lactams  
- Quinolone  
- Other | | | | | |
| Exacerbation Plan in Place??  
- Exacerbation Plan Template - LH6  
- Exacerbation Plan Template - VCH | ○ Yes ○ No ○ NA | | | | |
| Exacerbation Plan Review? | ○ Yes ○ No | | | | |
| COPD Classification:  
[See GTS 2009 Guidelines***]  
CTD 2008 Guideline | ○ At Risk ○ Severe ○ Mild ○ Not Done ○ Moderate | | | | |

* Not Assessed / Asked
Poverty Intervention Tool

Put patient poverty on your radar...

“There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health.”

– Public Health Agency of Canada

Three steps to address poverty

1. Inquire about poverty when screening all patients.
2. Include poverty as a health risk factor.
3. Intervene to address poverty-related issues.

Despite B.C. citizens having better health behaviours than others, a recent Canadian Institute for Health Information report found a higher prevalence of illnesses among those with low incomes.

Four reasons to address poverty

1. Poverty affects health on a gradient: there is not just one health poverty line.
2. Poverty is not always apparent.
Patient: MICKEY MOUSE
D-b: 1991.01.01
Ins. No: BC 90118273
Age: 26    SEX: MALE

GENERAL AND AGE/SEX SPECIFIC SCREENING
PHYSICAL ACTIVITY MINUTES PER WEEK - 2005.04.10 - 200 [150 to 1500]
ALCOHOL DRINKS PER WEEK - 2005.04.10 - 1 [0 to 1.4]
CIGARETTES SMOKED/CURRENT [PACK/DAY] - 2015.04.10 - 2 [0 to 6.01]
WAIST CIRCUMFERENCE - 2015.04.10 - 34 L [10 to 101]
BODY MASS INDEX - 2017.09.06 - 20.5 [18.5 to 25]
TETANUS VACCINE - 2015.09.20
BLOOD PRESSURE (SYSTOLIC/DIASTOLIC) - 2017.07.06 - 150/89 [N/A] GOAL: < 150/100
EX-SMOKER for 4 Year(s)
HIV Screening Not Found

INCENTIVE CLAIM HISTORY
24000 25000 INCENTIVE FOR FULL SERV - NOT COMPLETED
14005 INCENTIVE FOR GP ANNUAL CHRON - NOT COMPLETED

ANTICOAGULANT THERAPY - LONG TERM
INR FPP - 2011.05.05 - 2.3 [N/A]

CARDIOVASCULAR DISEASE - MYOCARDIAL INFARCTION - OLD
BLOOD PRESSURE (SYSTOLIC/DIASTOLIC) - 2017.07.06 - 150/89 [N/A] GOAL: < 150/100
CHOL/HDL RATIO Not Found
CHOLESTEROL Not Found
HDL Not Found
LDL Not Found
TRIGLYCERIDES Not Found
CIGARETTES SMOKED/CURRENT [PACK/DAY] - 2015.04.10 - 2 [0 to 0.01]
PHYSICAL ACTIVITY MINUTES PER WEEK - 2015.04.10 - 200 [150 to 1500]

MAJOR DEPRESSION - DEPRESSIVE AFFECTIVE DISORDER - MAJOR - SINGLE EPISODE
MOST RECENT ENCOUNTER - 2017.07.06
PHQ-9 TOTAL SCORE - 2015.06.25 - 17 [N/A]

UNSAFE DRUG USE - DRUG ABUSE - OTHER, MIXED OR UNSPECIFIED
MOST RECENT ENCOUNTER - 2017.07.06

UNSAFE ALCOHOL USE - ALCOHOLISM - CHRONIC
MOST RECENT ENCOUNTER - 2017.07.06

DIABETES, TYPE 2, - UNCOMPLICATED
LDL Not Found
HDL Not Found
CHOLESTEROL Not Found
CHOL/HDL RATIO Not Found
TRIGLYCERIDES Not Found
ALBUMIN/CREAT UR-RTO - 2012.11.01 - 1.8 [N/A]
GFR (MPLD-VRATE) - 2015.04.10 - 68 [60 to 500]
HEMOGLOBIN 6.1G - 2016.05.17 - 12 H [12 to 30 G/DL]
Practice
# Score Card for: Practice: DEV

**As Of Date:** 2013.01.29  
**Patients Seen in Last 3 years:** For Provider(s): ALL PROVIDERS

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th></th>
<th>FEMALE</th>
<th></th>
<th></th>
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<th></th>
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<td>2</td>
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<td>1.25</td>
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<td>1.80</td>
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<td>70-79</td>
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<td>0.00</td>
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**Unknown Age or Sex:** 1  
**Total Patients:** 61

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<th>Eligible Population</th>
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<td>Current Tobacco use age 12-19</td>
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<td>Prevention</td>
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<td>Influenza Vaccination age 65+</td>
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<td>Screening</td>
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<td>Screening</td>
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<td>Screening</td>
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Using the Adverse Childhood Experiences Scale (ACES) Misty McIntyre Goodsell, LCSW Odyssey House of Utah,
**Selection Parameter**

<table>
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<tr>
<th>Problems:</th>
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<td>OR Select by...</td>
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<td>Problem Concept:</td>
<td><strong>DRUG OR ALCOHOL DEPENDENCE</strong></td>
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<tr>
<td>Resolve Date</td>
<td>Include problem if the resolve / stop date is present</td>
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**Labs: Lookup Type / Code (Concept) / Description / Comparison / Value**

1. **Code** ○ Concept 83191 | ... ADVERSE CHILDHOOD EXPERIENCES SURVEY (CDC) |
2. **Code** ○ Concept 76916 | ... HAVE YOU STRUGGLED MAKING ENDS MEET AT EDM? |
3. **Code** ○ Concept 76917 | ... SUSPECT SIGNIFICANT SOCIOECONOMIC CHALLENGES |

Collected Date: [Field] to [Field] (INCLUSIVE)

**Other Options:**

- Patients List:  ![Check box] Active Patients Only
- Last Visit: ![Field] (years since last contact)  ![Radio button] All Providers
- Age Range: ![Field] to ![Field] (Leave blank or zeros to ignore)  ![Radio button] All Providers
- Facility Code: ![Field]
- Service Center: ![Field]
- CSV Output: ![Check box] Direct output to Excel

[Ok]  [Cancel]
# LIST OF PATIENTS WITH SELECTED MOST RECENT LAB RESULTS FOR PROBLEM

Problems Name Includes: **DIABETES CONCEPT** and Excludes: 
Active Patients Only: Y Include Stop Date: N Yrs Since Last Contact: 3
For Patients Aged: 0 to 120 For Practice: All Providers

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<th>LABS.</th>
<th>1: BP</th>
<th>2: HGBA1C</th>
<th>3: LDL</th>
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<table>
<thead>
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<th>NAME</th>
<th>BP DATE</th>
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<th>HGBA1C DATE</th>
<th>VALUE</th>
<th>LDL DATE</th>
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<td>LANE, LOIS</td>
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Total Records Printed: 12

Total Records Printed w/o Date: 1 1 1
### Selection Parameter

#### Selection Options

- **Patients List:** Active Patients Only
- **Age Range:** 0 to 120 (Leave blank or zeros to ignore)
- **Appoint Date:** 2016.11.14 to 2017.11.14 (INCLUSIVE)
- **No. Visits:** Greater Than
- **Number:** 15

#### Select Providers to exclude from report:

<table>
<thead>
<tr>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
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</table>
Population
Incorporating ACEs into BC Guidelines

Dr. Sandra Lee
ACEs Summit
November 15th, 2017
WHAT ARE BC GUIDELINES?

- Concise, user-friendly clinical practice guidelines
  - Focused on primary care
  - Tailored to BC practice
  - 58 guidelines freely available at:
    - BCGuidelines.ca
    - BCGuidelinesApp.ca
INCORPORATING ACEs

Trauma-Informed Practice Guide

May 2013

ACEs Summit Presentation
EXAMPLE: OPIOID USE DISORDER

- Scope
- Key Recommendations
- Background
- Diagnosis
- Treatment Options
- Maintenance
- Alternative Treatment Options
- Additional Supports

Trauma-Informed Practice and Adverse Childhood Experiences
RELEVANT BC GUIDELINES

ACEs
- Obesity
- COPD
- Heart Failure
- HTN
- CKD
- Depression
- CVD
- Diabetes Care
- Asthma
- Problem Drinking
- Stroke
Support Programs for Youth and Parents

Bounce Back for Youth, Confident Parents: Thriving Kids and Living Life to the Full for Youth

Presented by: Bev Gutray, CEO BC Division
Welcome to Bounce Back ® Online

Bounce Back ® On-line is a CBT based self-help program for those who want help with everyday problems such as feeling depressed, stressed or anxious. The program is comprised of modules for you to work through at your own pace. You can choose which modules are appropriate for you and you can try it out below – before you sign up. Consider Bounce Back ® if you like self-directed, independent learning.

Already Registered?

Sign Up

Login Now

Register Now

Preview the program

Modules

E-Books

Worksheets

Videos

Changing extreme and unhelpful thinking

Short, practical and powerful tools you need – now

You didn’t think you’d just be listening did you?

...because we all like to watch TV
Bounce Back: Check In on Your Mental Health

https://www.youtube.com/watch?v=-Sa5wZYwpUg
Bounce Back: Check In on Your Mental Health

Stats from the campaign period of October 2-16, 2017:

- 9915 page views (includes repeat visits by individuals)
- 9131 unique views
- 8862 entrances (ie. People who searched by typing in www.bouncebacktoday.ca)
- 3850 quizzes taken to date
Confident Parents
Thriving Kids

• **Family-focused** coaching service that teaches caregivers key positive parenting practices through a **6, 10 or 14** week program

• **Length of program based on the severity** of presenting problems and the level of support required by the parent

• **Delivered via telephone** at times convenient to families including evenings and weekends
Confident Parents
Thriving Kids

Gender of target child
Female: 30%
Male: 70%

Brief program:
- F: 27%
- M: 73%

Full program:
- F: 31%
- M: 69%

Age of target child

- 3-4: 17%, 2.5%
- 5-6: 35%, 22%
- 7-8: 20%, 31%
- 9-10: 16%, 24%
- 11-12: 10%, 15%
- 13: 2%, 5.5%
Confident Parents: Thriving Kids

- **Positive parenting** plays a crucial role in supporting children to recover from traumatic events and circumstances.

- **Stress from adverse situations** can result in difficulty for parents to respond to their children’s behaviours calmly and effectively. The program offers parents sessions on emotion recognition and regulation, using positive communication and collaborative problem solving to support parents to respond to challenging situations successfully.

- In 2016/17 **81.3% of families** report that the challenging behaviours that brought them to the program are resolved or significantly improved.
Living Life to the Full

• Group-based resilience course offered in Canada since 2010
• Based on cognitive-behavioural therapy (CBT)
• Developed by Dr. Chris Williams, UK psychiatrist and CBT expert
• 8-session, 12-hour course in group setting
• Fun and friendly individual and small group activities
• Booklet and handout for each session
• Led by trained and certified facilitators
“I learned how to help myself feel happier.”

“Made me feel better in general in a friendly environment.”

“This course affected me positively because I learned ways in helping myself solve my behaviours/problems that occur.”

“It has made me more confident and boosted my self-esteem.”
Self-Management Programs for Persons with Chronic Conditions
Patrick McGowan – University of Victoria

- Self-Management BC has been delivering peer-led community self-management programs around the province for over 30 years.
- Chronic Pain Program
- Diabetes Program
- Cancer: Thriving and Surviving Program
- Chronic Conditions Program
- Three venues used to deliver programs
  - in person group 6-session programs (up to 16 persons)
  - online program delivery (up to 26 persons)
  - self-management telephone coaching (one on one)
- 3500 persons per year - Since 2000 nearly 40,000 persons
1. Programs are delivered by trained volunteer peers most of whom have chronic conditions themselves
2. Strong probability that participants have experienced ACEs
3. Self-Management BC has been able to develop an effective community infrastructure throughout BC
4. Minimal intervention strategies are used
Core skills taught in self-management programs

- how to use a problem-solving process to resolve life dilemmas or to access services
- how to make difficult life decisions
- how to start and maintain healthy behaviours (e.g., exercise) or discontinue unhealthy behaviours (e.g., smoking, eating)
- how to access and use stress management and relaxation techniques
- how to deal with difficult emotions, and
- how to use good communication skills
What Self-Management BC can achieve through the self-management infrastructure

- Provide explanation of ACEs and relation to health
- Get people to complete the ACEs questionnaire
- Demystify the myth that “It’s your fault”
- Discuss if and how ACEs has affected them
- Describe and initiate health promotion strategies that mitigate impact of ACEs
- Provide resiliency training
- Establish a provincial ACEs support organization
- Become a clearinghouse of information and resources
- Link people to programs and services