

DNP CAPSTONE PROJECT SAMPLE



Childhood Screening Among Patients of Adult Primary Care

Abstract

The increasing occurrences of Adverse Childhood Experiences (ACE) in the US has been estimated to affect 60 percent of the entire population. There is also a growing body of evidences unequivocally stating the impact of childhood adversity on the surfacing of chronic negative health outcomes (Schafer & Altaro, 2010). It has also been observed that the cumulative impacts of adverse childhood experiences also present some profound societal implications and public health impact. Despite this highly overwhelming evidence, it has been suggested by research that a lack of highly effective ACE screening is popular in the primary care setting.

Dependable research evidences has further demonstration a connection in between experiencing childhood adversity, along with multiple negative chronic health conditions which are found to be prevalent in the adult primary care setting. Furthermore, managing chronic diseases also account for 86% of overall healthcare costs in the US (Greenfield & Alter, 2010).

Purpose

The aim of this project is to translate evidences of the negative influence of ACE on health, especially in the clinical practice. The ultimate purpose is to eliminate the existing gap between clinical practice and evidence-based ACE research.

Methods

In order to complete this project, a screening intervention which is designed to evaluate childhood adversity, along with the presence of various chronic diseases was further implemented among adult patients in the primary care setting. A chosen clinical site for the implementation was owned by a nurse practitioner, operating as a primary care office in a huge rural community.

Adult patients who have backgrounds of chronic pain, gastrointestinal complaints, anxiety, substance abuse, depression, as well as those with poorly managed chronic health condition were also screened for this condition (Edwards, Cook & Crook, 2011). Adult patients who are living in high-risk settings, or who previously had high health care utilization were screened as well.

A post-screening form was also used and filled out by the nurse practitioner student in order to collect information regarding the screening process which include patient responses, comfort level, provider preparedness, as well as patient-specific recommendations for follow-up. Descriptive statistics were then used in calculating total number of adults screened, provider and patient responses, and the overall prevalence of ACEs.

Results

Out of the convenience sample presented, 82% have reported experiencing ACE. Despite a high prevalence, a total of 24% of the patients received psychological counseling. These chronic diseases were also found to be linked with higher ACE scores. On top of that, relevant reports of additional chronic health problems were also found to expand on those that are hypothesized originally.

Moreover, the average screening time on ACE was 8.5 minutes. An increase in the comfort and knowledge of the provider left a strong positive correlation along with a decrease in ACE screening time. Also, providers which were more secure in ability and knowledge to screen for ACE were more comfortable.

Conclusion

The huge volume of individuals who had to deal with poorly managed chronic illnesses observed in the primary care setting makes it possible for identifying ACE. On top of that, ACE is also linked with other chronic diseases usually unrecognized by providers and patients.

The evaluation of this ACE screening also suggests that ACE screening is highly feasible in the primary care setting, thus allowing for the improvement of patient outcomes through purposeful interventions. Also, increasing comfort and knowledge in ACE screening is also shown to help providers and patients to improve their well-being further, while showing effectiveness in the management of chronic diseases.

References

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