aces aware
SCREEN. TREAT. HEAL.

CASE STUDY

Marin Community Clinics

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This Case Study describes the experience of Marin Community Clinics in obtaining buy-in for piloting and designing the implementation process for organization-wide ACE screening. It reinforces the importance ACEs Aware places on developing a robust implementation team, training staff on trauma-informed care and ACE screening, and expanding internal and external resources to respond to ACEs and toxic stress.

Organization Overview

Services: Full-scope adult and pediatric primary care, oral health, behavioral health, OB-GYN, family planning, confidential teen clinics, nutrition, optometry, radiology, pharmacy, labs, educational groups, specialties, and referrals to outside services

Organization size: 6 clinics

Patient age: 80% between 18-35

Patient ethnicity: More than 66.7% of patients identify as Hispanic/Latino

Patients enrolled in Medi-Cal: 66%

ACE screening: In pediatrics using PEARLS at well-visits and with any new patient under 12 years old (as of April 2021); OB patients in the second trimester; now piloting screening adults

Background

Marin Community Clinics (MCC) is the largest provider of comprehensive primary care, oral health, and behavioral health services to low-income residents in Marin County.

To support clinicians, we operate in a pod structure. Each clinician is surrounded by their team composed of a medical assistant (MA), nurse, care navigator, and a scribe. They can also connect with behavioral health, dental, nutrition, laboratory, pharmacy, or even access to food resources and social service enrollment assistance for patients (e.g., WIC, CalFresh, Medi-Cal).

Who is part of your implementation team? Get tips from ACEs Aware about how to form your own implementation team. You can also review "Key Considerations for Forming an Implementation Team."

Our path to getting buy-in

We began the process of screening for Adverse Childhood Experiences (ACEs) in 2017, with the help of a grant and participation in the National Pediatric Practice Community on ACEs (NPPC) pilot site program. The team at MCC was familiar with ACEs and we had wanted to implement screening for many years. We were approached by the Center for Youth Wellness to participate in their NPPC pilot site project; it was a natural impetus to begin the process of implementing ACEs screening. We also received grant funding through the Resilient Beginnings Collaborative (RBC). It covered staff time to develop the workflows as well as clinic-wide training in trauma-informed care.

After MCC leadership granted approval for a small pilot, we started screening for ACEs in our pediatric population in 2017-2018. The original pilot team was Dr. Heyman Oo, MD, MPH and Caren Schmidt, PsyD. We were aided by informal participation from our chief behavioral health officer and associate medical director of pediatrics. Through this project we designed our own ACE screening tool and piloted screening with a select group of pediatric clinicians. This method enabled us to identify participants who were particularly interested and invested in the idea of ACEs screening.

> **Through this pilot, we collected data and the subjective experiences of our participants, which generated buy-in with the larger clinic community.**

The pilot ran for six months with nine pediatric clinicians and their MAs at three sites. There were targeted ACE screenings for patients at:

- Nine-month well-child visits
- 30-month well-child visits
- Any new patient under 12 years old

MCC leadership was brought in at the end of the first pilot project to participate in the final presentation of our data, success, and learnings, and it was at this point that we began to receive stronger support from them. Many of the initial concerns around feasibility were addressed and we were able to demonstrate that screening was feasible logistically, acceptable to care teams, and not disruptive to existing clinical workflows.

With our participation in the NPPC pilot project came exposure to other practice communities and grant funding, such as grant funding through RBC that covered staff time to develop the workflows as well as clinic-wide

training. The clinic-wide training involved training on trauma-informed care (TIC) from Trauma Transformed, which constituted our macro level of training for staff on TIC and ACEs. Part of our focus during this collaboration was creating workflows and organizational change so that we could expand our pilot to clinic-wide ACEs screening. As a result, we were able to discuss the possibility of bringing our pilot to scale with all clinicians across all of our sites.

We achieved full buy-in from leadership for universal screening by being able to demonstrate through data that our pilot was successful because it:

- Enhanced medical care
- Did not significantly disrupt the flow of care
- Received grant funding to compensate for the time of the provider champions working on the pilot
- Was supported with funding and trainers available to train the entire MCC staff on trauma-informed care

Get ACEs Aware tips on how to engage leadership and peers.

Our challenges to achieving buy-in

As with any new clinical intervention, the key challenge was generating buy-in across all levels of the organization. Once we had the support of leadership for a full rollout, we realized we needed to focus efforts on all staff involved in the clinical change in practice. For ACEs screening, it was not enough to train just the clinicians. Because they all have individual roles in the workflow, we also trained:

- Front office staff
- MAs
- Care navigators
- Behavioral health specialists

Additionally, many concerns were raised about the patient and staff experience and comfort with the idea of screening for ACEs and toxic stress. We were mindful and cognizant that asking about ACEs and toxic stress and listening to patients talk about it can be triggering for our staff.

> **Our biggest takeaway was that generating buy-in is not a single event. We truly value the input of all stakeholders in this process.**

Like many Federally Qualified Health Centers, our staff comes from the community we serve. When we talked about this initiative, there was an artificial distinction between talking about ACEs and toxic stress in our patients and talking about it among our staff. We prioritized training and capacity-building in our staff to become more trauma-informed as an organization.

Our clinicians also voiced concerns that screening for ACEs and trauma needed to be supported by adequate resources to respond to and treat ACEs and toxic stress once they were disclosed. There was a general perception that our internal resources would be overwhelmed by the response once we specifically asked about ACEs.

Solutions

Careful and proactive planning with the leadership of MCC and each department, as well as soliciting feedback from staff champions from each department, was critical to developing buy-in, implementing the pilot projects, and then scaling up to universal screening. For the full rollout, we used a quality improvement-based feedback plan to collect data and feedback, which we then reported weekly to care teams and supervisors at each clinical site.

How we approached training

Because we were asking all staff members to adopt a new workflow and do something new and different, it was vital that they understood the importance of ACE screening for the patients and the clinic. The clinic-wide training sessions on trauma-informed care were an integral first step. These trainings:

- Helped create a shared language around trauma and its effects by focusing on ACEs and toxic stress
- Highlighted the benefits of asking about and responding to ACEs and toxic stress
- Provided tools for staff to use to regulate their own experiences with ACEs and responses to vicarious trauma
- Sent a clear message that MCC strives to be a trauma-informed and responsive organization

We leveraged existing department and site operational meeting times for presentations. We also worked with each site's leadership to schedule follow-up and individual coaching sessions. Since we decided to train each member of the clinical team (e.g., clinicians, MAs, care navigators, and behavioral health providers) separately at each of the three sites that support pediatric care, the entire process took about four months because of rotating training slots and the number of team groups involved.

While many of our staff now had an understanding of why screening was important to care, they expressed hesitancy in being able to discuss ACEs and toxic stress directly with patients. Many staff expressed concerns regarding the language of the newly adopted screening tools, including some staff who experienced strong personal reactions after reading the PEARLS screen. To address these concerns, we added a coaching model to our training plan. Through coaching, we were able to work one-on-one with each MA so each could reach a comfort level with reading the questions and discussing ACEs and toxic stress with patients.

Key to encouraging participation was the anecdotal data collected in the pilot that showed clinicians and MAs found the screening contributed to improved patient care, and did not find the workflow overly burdensome.

> **Hearing feedback from their peers about the value of ACE screening was vital in securing buy-in from the rest of the care teams during training.**

To address concerns about our ability to respond effectively to patients after the screening, we provided additional training to our care navigation team and behavioral health team. This training made them confident everyone was equipped to respond to and treat toxic stress.

As an added overall benefit, training de-stigmatized ACEs, toxic stress, and trauma and helped staff become more comfortable discussing it. They report feeling more able to help and feel more connected to their patients. It has also elevated the MAs' expertise and comfort levels in administering other sensitive screens, such as IPV, PHQ-9, and C-SSRS.

Get your clinicians ACEs Aware certified.

Consider ways to train all staff in Trauma Informed Care.

How we approached expanding internal and external resources

We also invested in training and certifying multiple staff in the Triple P Parenting Program, the most widely researched intervention for the prevention of several ACEs, to offer rolling enrollment groups that patients could be referred to easily and on-site (in Spanish and English). We also have robust nutrition and stress management programs, and worked to ensure there were multiple interventions available on-site to patients to further prevent ACEs and promote family resilience. These programs include:

- Stress Reduction Group
- Mind Body Teen Group
- Prenatal Yoga Group
- Wellness Skills Group
- Con Calma, a behavioral health group that incorporates Chi Gong and mindfulness
- Eat, Play, Grow Group led by our nutrition department

In addition, we plan to start Cognitive Behavioral Therapy for Insomnia (CBTi), behavioral health groups in Spanish and English, and a group for newcomer teens called FUERTE.

On-site interventions include:

- Behavioral health
- Nutrition
- Developmental specialists
- Acupuncture
- Complex case management

Use the Stage 2 workbook to map out your internal and external resources.

You can also find tips about how to identify your internal and external resources in the following documents:

Overview of a Tiered Response Framework

ACEs Aware Trauma-Informed Network of Care Roadmap

How we approached changing our screening tool

When the state of California adopted the new PEARLS tool for ACE screening, we performed another pilot. We switched from using an ACEs screen we had developed ourselves to PEARLS. The second pilot was shorter (only about two months in length) and more informal, but involved clinicians and their MAs from each site. As an organization, we use the Plan-Do-Study-Act-style implementation for small changes with quick pilots to ensure the overall plan works as anticipated. Though the screening tool switch was not a large change, we wanted to make sure everything worked on a small scale before rolling out PEARLS throughout the organization.

The biggest challenge in switching to PEARLS was the change in the language of the questions. We found that most of our staff had strong initial reactions to the language used in the PEARLS tool and were hesitant to ask these questions of our patients. This was particularly problematic at the time due to the pandemic; we had switched to telehealth, which required our staff to read the questions over the phone to patients.

Telehealth also required a new workflow. As a result, there was some initial pushback regarding time needed to complete the screen and how to incorporate it into all the other pre-visit prep, when staff were already feeling overwhelmed by the pandemic.

Our solution included our multi-level training approach, including coaching, which helped all MAs practice becoming comfortable with the language. We also reached out to many of the MAs and clinicians who had participated in the original pilot to spearhead the second pilot as they were familiar with the benefits of screening. Then, we used their buy-in to propel their peers.

We currently use PEARLS and continue to work with our team to increase comfort with the tool.

Find the PEARLS and ACE Questionnaire for Adults. Read an article about how the PEARLS was developed and the results of cognitive interviews with patients.

How we approached documentation

To address the data challenges, we spent significant preparation time building out our data collection systems to be able to track our progress with the rollout. Our electronic health record (EHR) is NextGen, and we had our information technology (IT) department build a new "template" specifically for ACEs+ Resilience screening.

- This template captures:
- The screening score
- The screening tool used
- Interventions done or referrals made by the care team in response to the score
- Any social history details entered by the clinician

As a separate, dedicated project between our implementation champions and IT team, building this template required a couple of months of development and feedback. Now built, it has been critical to our ability to gather and report data around screening and response.

How we approached sustainability

We worked to identify additional champions across clinic sites. These champion team members were vital in encouraging continued uptake of the screening workflows and were available to support staff as needed. We now have MA and provider champions at each clinic site, and these champions meet monthly with our operations team to discuss successes and challenges and adapt workflows as needed.

After about two months of screening, we also convened a group of stakeholder representatives (e.g., MA supervisors, clinicians, clinic directors, care navigators, etc.) to give feedback on how the process was going on the ground. Wherever possible, we would tweak or refine our workflow or do targeted re-trainings as needed based on this feedback.

Use the Stage 2 workbook to map out how your clinic will implement ACE screening, including (1) determining who and how to screen; (2) preparing your clinical response; and (3) integrating screening into your workflow.

Results

Through our pilot projects we:

- ✓ Successfully expanded to universal pediatric screening by the end of 2020
- ✓ Trained 520 clinicians and staff in four months
- ✓ Achieved a more than 80% average screening rate across all sites
- ✓ Are expanding to our OB and adult medicine patient populations with leadership support

Key Learnings

The biggest takeaway is that generating buy-in is not a single event. We had permission to start this project from our leadership from the beginning, but generating true buy-in meant regularly revisiting our workflows with stakeholders and taking the time to address their concerns. Clinicians and staff report that ACE screening is positively contributing to the enhancement of medical care, and that the act of ACEs screening, even when the score is zero (meaning the patient is at low risk of toxic stress) has allowed them to have conversations that they otherwise would not have had. In addition, clinicians say they are able to discuss possible effects of ACEs and intervene with supports for patients even before an issue has arisen, which is further contributing to enhanced care for our patients.

We are still generating buy-in every time we tweak something or move to expand screening, and we truly value the input of all stakeholders in this process.

Other key learnings include:

- Buy-in is essential from all levels and stakeholders impacted by the new initiative, not just leadership and not only clinicians
- A strong quality improvement culture is important
- Implementation is a team effort and adoption of new workflows depends on everyone's participation; therefore, it is important to involve the entire care team in every step of the implementation process
- Training is essential for implementation, but also enables clinicians and staff to be knowledgeable resources about ACEs, toxic stress, and trauma for patients and their communities
- For our FQHC, our staff come from the community we serve so we view this as the ultimate "win" because we create change internally as an organization, as well as potentially in the community

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