Implementing ACEs Screenings: How-To Guide and Lessons from the Field – Transcript

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Tanya Schwartz: Hello and welcome to today's ACEs aware webinar. My name is Tanya Schwartz and I'm with Aurrera Health Group and we're pleased to be supporting the California Department of Healthcare Services and the Office of the California Surgeon General on the ACEs Aware initiative. Next slide, please.

Tanya Schwartz: I'm excited to be joined today by some wonderful leaders in ACE screening, Dr. Mikah Owen, who's a clinical advisor to the ACEs Aware initiative. Also a pediatrician and an assistant clinical professor at UC Davis Health. Dr. Heyman Oo is the Novato South Associate Site Medical Director and pediatrician at Marin Community Clinics. And from FPA Women's Health, we have Joni Chroman, who's the chief operating officer, and Dr. Rachel Stewart, medical director and an OBGYN. And our panel today will be moderated by Dr. Dayna Long. She's a professor of clinical pediatrics at UCSF and co-principal investigator of the PEARLS tool. Next slide please.

Tanya Schwartz: Today, Dr. Owen and I are going to start by providing an overview of the ACE screening implementation how to guide that we recently released, and highlight key resources within the guide that you might find helpful. Then we'll switch over to our panel. Our panelists will introduce themselves and provide an overview of their organization and their ACE screening journey, and we'll spend most of the time doing a question and answer session. And so the questions for the panel have been developed based on the ones that many of you submitted when you registered for this webinar. But if you have additional questions, please feel free to type them in the Q&A and if we have time or if the panelists can incorporate them into their responses, then we'll do that. And otherwise we'll take all the questions back as we always do and incorporate them into our work going forward. And today's webinar is being recorded and the recording and the slides will be available afterwards at acesaware.org/events. Next slide, please.

Tanya Schwartz: All right. Well, I want us to start by making sure that we have a shared understanding of the purpose of ACE screening and what constitutes a complete ACE screening because the rest of the information that we discuss today will flow from this foundation. And so, ACE screening is a comprehensive holistic approach to determining a person's clinical risk for toxic stress. And knowing this risk of toxic stress helps clinicians develop an appropriate treatment plan. Often, ACE screening is thought of as just getting someone a screening tool to

fill out that asks about adversities that they've experienced. They fill out the tool and you can then see what the person's ACE score is.

Tanya Schwartz: But this is actually just one piece of information that's part of a more comprehensive ACE screening. So in addition to the person's ACE score, we can also assess for whether the ACEs have clinically manifested as toxic stress in the person's body. So for example, do they have any symptoms or health conditions that may be associated with ACEs such as asthma, cardiovascular disease and diabetes. And we refer to these as ACE associated health conditions.

Tanya Schwartz: And then thirdly and importantly, ACE screening also involves assessing for protective factors that can help prevent and mitigate toxic stress. This includes the presence of an evidence based strategies for mitigating stress that we often talk about a lot, and further research is being done to explore the impact of protective factors on risk of toxic stress and on health. But for now, the ACE score and the clinical manifestations of toxic stress can help us determine a patient's risk for toxic stress. And then the protective factors are used to help inform the treatment planning. Next slide, please.

Tanya Schwartz: As part of talking about screening for ACEs, we always like to ground the conversation in the importance of trauma informed care. Trauma informed care is a pillar for interacting with patients as you discuss ACEs and toxic stress and how you and the patient work together to prevent and treat it. So now we are going to switch gears and I'm going to turn it over to Dr. Owen to talk about the ACE screening implementation how to guide. Next slide, please.

Dr. Mikah Owen: All right. Thanks Tanya. I'm going to give a brief overview of the ACE screening implementation how to guide. And so the purpose of the how to guide is to be an approachable, evidence based tool designed to facilitate the adoption of ACE screening and trauma informed care by providing step-by-step considerations and resources to support clinics in their ACE screening journey. The content of the how to guide is based on research on ACE screening implementation, lessons learned from learning collaboratives and pilot programs, and reports and tools from other screening implementation initiatives. Authors of the materials include Dr. Rachel Gilgoff, Dr. Dayna Long and myself, along with Sarah Marks, Jennifer Marshall, Tanya Schwartz, Mallika Mahalingam, and Jennifer Ryan from the Aurrera Health Group. The guide was developed and informed by the ACEs Aware Clinical Implementation Subcommittee and the Provider Engagement & Education Subcommittee.

Dr. Mikah Owen: And with the implementation guide, we know that there's a wide range of readiness when it comes to the implementation of ACE screening. Some clinics and staff may be relatively new to ACEs and toxic stress, and some clinics and

staff may be experienced with screening for ACEs and treating toxic stress. We also know that there's a wide range of clinic resources, staffing model, buy-in for ACE screening among organizations, there's differences in patient populations, the prevalence of ACEs, and differences in community resources and linkages between primary care centers and community organizations. And all these factors will kind of influence how you introduce ACE screening to your clinic and how ACE screening and treatment of toxic stress is able to progress within your organization. So when writing the how to guide, we try to include a wide range of recommendations and resources with the hope that it can be a useful tool for organizations at various stages in their ACE screening and trauma informed journey. Next slide.

Dr. Mikah Owen: The how to guide starts with stage one, which is preparing the foundations for ACE screening. Stage one includes the five steps listed in this slide. I'm going to go through them in a second, so I won't name them off here. But in this stage, we really wanted to recognize that organizations may be approaching this process from many different starting points. For example, there may be a passionate provider or staff member who really wants to get the ACE screening initiative started and they may not have a lot of current buy-in from leadership or they might have a lot of buy-in from leadership, or it could be a relatively large organization with the capacity to develop a large implementation team with lots of buy-in from leadership and clinic staff.

Dr. Mikah Owen: So the process will look very different depending on the type of organization you have, the available resources and the starting point of your clinic or organization. Either way, the materials in stage one provide foundational information for how to develop an implementation team and recommendations for the implementation team as they start exploring what planning for ACE screening implementation might look like at your particular practice. So the goal of this stage is to learn what is needed clinic, operationally, administratively, and emotionally to get your practice or organization ready for screen for ACEs and implement or advance trauma informed care principles, and treat toxic stress with evidence-based strategies to mitigate the toxic stress response. So now I'm going to briefly walk through each of the steps in stage one. Next slide.

Dr. Mikah Owen: So I'm going to walk through the steps and then briefly mention some of the resources that are available for each of the steps. Step one is to refresh your knowledge about ACEs and toxic stress, ACE screening, trauma informed care and evidence-based interventions. And so here it's really important that the ACE screening initiative be grounded in the Science of ACEs and Toxic Stress. So materials that we have for review are documents such as why should my practice screen for ACEs and the risk of toxic stress? What value could it bring?

And how ACE screening, toxic stress treatment and trauma informed care work together in terms of implementation?

Dr. Mikah Owen: Step two is engaging leadership and peers to generate support for screening and documents in this stage include making the case to clinic leadership. So how can you tie the ACE screening initiative to other initiatives that you may have in clinic? And how can you get key buy-in from leadership to be able to implement the screening initiative. Another document is finding and engaging champions and key decision makers. So really identifying who you could bring in to get additional buy-in from the organization. Next slide.

Dr. Mikah Owen: Step three is to form an implementation team. And like I mentioned earlier, we understand that an implementation team will be highly variable depending on whether you're a clinic or a large organization, whether you want to implement this at one site, multiple sites, and what kind of staff you have available and what resources you can bring to the team. So in this document, key considerations for forming implementation team, we try to address it from multiple avenues or areas and provide some guidance for organizations who are working on developing an implementation team.

Dr. Mikah Owen: Step four is develop a high level implementation plan and timeline. And with this, we understand that it'll be different, again, for various organizations. So a helpful document for step four is No One Size Fits All: Different Approaches to Piloting ACE Screening and Toxic Stress Treatment. This document kind of gives guidance on whether you want to do a large scale rollout or whether you want to start with a pilot within your clinic or organization, and what considerations you might want to think about before doing that.

Dr. Mikah Owen: And then we end stage one with step five, which is review and reflect, which provides a worksheet and a reflection exercise. And at the end of stage one, we have a checklist and workbook. So the stage one checklist and workbook provides fillable worksheets to help clinics make decisions and really document their process and decisions in a little document that can help guide the screening initiative over time. And today we also, within stage one, we also have case studies from Marin Community Clinic and FPA Women's Health who are represented by our panelists today and we're excited to learn about their experiences and how they were able to implement ACE screening within their organizations. And with that, I will pass it back to Tanya who will talk about stage two.

Tanya Schwartz: Great, thanks Dr. Owen, and we can go to the next slide. Stage two of the how to guide is designed to help you understand and advance key decisions that need to be made in selecting your clinic's approach to screening. You can see

here there are three steps within this stage. Step one covers determining who and when to screen, which screening tool to use, how and where to administer the screening. Step two covers preparing your clinical response to toxic stress, and we'll talk more about that in a minute. And step three covers figuring out who in your clinic will carry out the ACE screening process and how you'll integrate it into your workflow.

Tanya Schwartz: Let's go to the next slide and we'll take a look at some key resources within each of these steps. Again, the first step provides considerations for determining who and how to screen. You can see on the slide there's a little snippet from our stage two workbook which walks through each of these considerations to help your team think about all of the key elements. For example, if your clinic is ready to offer universal and routine screening, there are certain decisions you'll need to make. If you're starting with a pilot project, there are other decisions that you'll have to make about your approach. Which patient visits are you going to screen at? How will you achieve the trauma informed care principles in working with your patients? So using these fillable worksheets, your team can document decisions that are made about your approach, and it allows you to have that information all in one place.

Tanya Schwartz: We're also really excited to share sample scripts that pediatric clinical teams can leverage in your conversations with patients and their caregivers to provide trauma informed care and to educate patients about the impact of ACEs and toxic stress and what they can do about it. This document provides workflow tips and sample scripts that walk through how to introduce the ACE screening to your patients and their caregivers, how to discuss the ACE screening results and the treatment plan based on your patient's risk of toxic stress, and how to handle the treatment plan. And these scripts were based on existing scripts that are being used in practice as well as input from clinicians. And I particularly want to thank Dr. Long and Dr. Gilgoff and Sarah Marks along with our clinical implementation team are working really hard with us to develop these scripts. And we hope to have scripts for adult providers in the future. All right, next slide.

Tanya Schwartz: Step two contains several materials that walk through the full ACE screening and clinical response process. The first document that's listed here talks about how to gather information about a patient, how to make a clinical assessment and apply the ACEs and toxic stress risk assessment algorithm, and determining the treatment and follow-up plan. It provides an example that walks through each of these steps so you can really see how it works in practice. The second resource is our third in our science series webinars that Dr. Gilgoff did last week. So we hope that you will check this out.

Tanya Schwartz: And in the next slide is the third resource, which covers the tiered framework for addressing toxic stress. And so as we all know, go to the next slide, in developing a patient's treatment plan, we of course want to tailor it to each patient but we have a framework that we've put forth of primary, second and tertiary prevention strategies that can be used to determine what patient education is needed, what level of intervention and what additional supports might be needed for patients at different risk levels of toxic stress. And while the clinical response starts with the clinician, it can be supplemented by the broader clinical team within the clinic and the clinic system and/or by others in the trauma informed network of care.

Tanya Schwartz: All right. I'm going to keep us moving because I want to get to the panel. So we go to the next slide. I've talked about stage two of the workbook. This is a worksheet that can help your clinic outline your interventions and support services by toxic stress mitigation strategies so you can assess what resources do you already have in place and where might there be gaps for other supports your patients may need. And in this workbook, we have examples of the types of interventions and support services you may want to consider and organizations with whom you may want to partner. Next slide.

Tanya Schwartz: We've heard from many of you in webinar evaluations that you really like examples, as I do. And so I want to highlight that throughout these clinical response materials, we've included patient examples to really try to explain how ACE screening in the clinical response work in practice. So we hope that you'll find those useful. Next slide.

Tanya Schwartz: And finally, step three covers considerations for integrating ACE screening into your workflow. So we have a worksheet where you can walk through and identify who from your team will take each action in conducting a complete ACE screening. And then another worksheet that you can see here where you can really map that workflow visually. So you can really see what the process is going to look like and what it's going to do and who's going to do that. So this is a really quick overview of the how to guide. We hope you'll go online and check it out. We hope that it'll be useful. You can find it at acesaware.org under implement ACE screening in the top navigation. And with that, I'm going to turn it over to Dr. Long and our wonderful panel to talk about how they approached implementing ACE screening in their clinics.

Dr. Dayna Long: Thank you so much, Tanya. Our greatest hope is that the implementation guide is a practical tool so that as you are implementing ACEs screening and response, you can have a go-to guide that can be there for you along your journey. I'm really excited to introduce our fantastic panel. And so we have Dr. Heyman Oo, Joni Chroman, and Dr. Rachel Stewart, and the panelists are going to take about

five minutes to really talk to you about a brief overview of their organization so you can understand what this actually looks like in the field. They'll describe their location, their number of clinics, their patient populations, who do they serve. They'll talk about what made them pursue ACEs screening and response, where did they start? They'll talk to us about their approach and some of their greatest successes.

Dr. Dayna Long: After each of the panelists talks about their journey in ACEs screening, we're going to open it up for questions and answers, and we have some questions that we've already gathered in the registration. And so we'll go through those first. So in order to open up the panel, I first want to introduce Dr. Oo followed by Joni and Dr. Stewart.

Dr. Heyman Oo: Thanks so much, Dayna. As mentioned by Tanya and Dayna, I'm Heyman Oo and I'm a pediatrician and I'm so grateful to be here. It feels like just yesterday that we were trying to pilot a tiny little ACEs project. And in reality, it actually has been about five years, but it is really, really beautiful to see that all of this work come together and this implementation side is just so impressive and that it is a culmination of [inaudible 00:19:10]. Like I said, I'm a pediatrician. I'm also one of the site medical directors at Marin Clinics. We are located in Marin county. So on the other side of Golden Gate Bridge from San Francisco.

Dr. Heyman Oo: We are an FQHC, so a fellow qualified health center that has six clinical sites, medical sites, as well as I think three [inaudible 00:19:33], and three of our clinical sites see pediatrics. We are a comprehensive patient centered medical home. So we provide OB services. We provide internal medicine services. [inaudible 00:19:44] providers. We have pediatricians. We also have dental, pharmacy, radiology in all very small spaces. Excited really to take care of our patients in a [inaudible 00:19:56].

Dr. Heyman Oo: Our patient population is predominantly publicly insured or uninsured. So we're about 60% Medi-Cal, 60+% Spanish speaking or non-English speaking in the home. And we have been screening in our pediatric population for about two and a half, three years now, starting with our pilots and then universal screening at all of our well visits annually for about a year now. In our OB population, we are screening for ACEs about six months now, at the second trimester prenatal visits. And then we are just on the cusp of starting universal adult ACEs screening at primary care follow-up visits.

Dr. Heyman Oo: Our general approach to screening is that it is a universal screening in that for these eligible visits, we try to screen but it is always patient driven. So if the patient declines the screen or if it's inappropriate to screen, we don't screen. Again, the next time that the visit [inaudible 00:21:07] successes that we've had

at our clinic is really in our people and I think that that will be a theme throughout the course of this [inaudible 00:21:17] and of really investing in our staff. I think that ACEs work has actually changed the nature of our organization for the better because of the amount of investment that we got from our highest level leadership and our frontline staff in really making this [inaudible 00:21:35] stop there because I want to make [inaudible 00:21:40].

Tanya Schwartz: Thanks Dr. Oo. Can I ask you to put your microphone a little closer to you the next time, thanks.

Joni Chroman: Dr. Steward, go ahead.

Dr. Rachel Stew...: Okay. Nice to meet everybody. My name is Dr. Stewart. I'm the medical director of FPA Women's Health, which is a women's health organization that was founded in 1969. So we have been in business for 52 years. We are a for profit privately owned organization, but the majority of our patients are Medi-Cal. So about 80% of our patients are using state funding for their care. And approximately 15% are using commercial services, and we have about 5% who are using cash. So we're seeing a very high need patient population and we have to do so in a very efficient manner, which we'll get to as far as incorporating the ACE screening into our clinical algorithms.

Dr. Rachel Stew...: We see predominantly reproductive age women. I'm a board certified OBGYN, so I spend the majority of my career trying not to see non reproductive age women and not seeing men. But I think one of benefits of the ACE screening is that it has broadened our perspective for our clinicians and the culture of the organization in that women are not an island. Reproductive age women are also taking care of their children and they may have partners and the trauma that those partners or their children are experiencing also affects the health of our patients. So that has been a transition for me and I can speak a little bit more about that transition as we talk further on in the webinar, but I'll turn it off to Joni now who can give a little bit more information about why we decided to start implementing ACE screening in this patient population.

Joni Chroman: Thank you, Dr. Stewart. I'm Joni Chroman. I'm the chief operating officer for FPA Women's Health. I've been in the role for about two and a half years. I'm so excited to be here this afternoon to talk to you about ACE screening. I actually started thinking about ACE screening before I even started with the role with the organization. So to be here and seeing this amazing implementation program is really fulfilling for me. Why ACE screening in FPA Women's Health? It's such an incredible tool for our population. As Dr. Stewart said, it's women of reproductive age between the ages of 16 and 35 mostly. These women generally don't access primary care very often. So they come to us for female

urgent care and for reproductive health issues, and they're generally not accessing primary care.

Joni Chroman: But we are so excited to say that we have screened almost 38,000 patients for ACE screenings since January 1st of 2020 when ACE screenings first came online with Medi-Cal. We have started from day one with a payer agnostic approach. That is that we screen every patient who is eligible regardless of payer. And so we do a lot of pro bono care as well. And the reason is because it's such an important, what Dr. Stewart likes to call such an important vital sign for our clinicians and staff to really understand from a holistic point of view where our patients are coming from and how we can direct their care. Also, ACE screening really fits our staffing model so well because our care coordinators are peers of our patients, they reflect our patient population, and they're going through the exact same issues that our patients are going through. And so they are very, very comfortable asking very intimate questions about sexuality and their reproductive health. And so we were very, very well poised to make this program successful at FPA.

Dr. Dayna Long: Thank you all so much for that really helpful information about how you all got started. I think what is most helpful is the understanding that so much thought went into how do we start to roll this out, and just an immense amount of dedication and commitment on your guys' part for being frontline providers and women health providers. Let's start with the questions. We have five questions that we took from when the audience registered and for each of the questions I will call on the panelists in order to answer them. I also see that there are some robust questions in the Q&A and so we'll see, hopefully we can get to some of those as well. The first question is, how did you build a team to implement ACEs screening and secure buy-in from leadership, from clinicians, from staff? In order to answer this question, Joni, I'm going to pass it to you first.

Joni Chroman: Okay. We started this project like we start all of our projects. We have a fully team-based approach. We didn't have this handy dandy implementation guide. And so we hired a consultant, shout out to Dr. Jonathan Goldfinger who really got us started on this path and using the consultant services he helped us craft, the training program. We had my director of strategic projects, of course our medical director. We had nurse practitioners, we had office manager, MAs, reception, completely front line. We wanted to make sure that the people who were doing the work were actually making decisions about the work they were going to do because that's a very important concept.

Joni Chroman: We don't want to create a program from on high and give it back to the offices and say, "Here you have to do it this way." We really needed to escalate problems from the frontline and we needed to hear how they do their work to

be able to embed it in their natural workflow. And so that's why we used this team based approach from the very beginning.

Joni Chroman: We piloted in one site to learn how the training program kind of landed. We developed very robust scripting. So even though our care coordinators are used to asking very intimate questions, we wanted to make sure that they learned the language and the verbiage about ACE screening and toxic stress so that they could understand it and so that they could explain it to their patients in a real way. So we created very clear, concise scripting. We trained them in this pilot site, then we did a road show. We took the team on the road and went to all of our different 25 clinics located from Sacramento down to San Diego and we made sure everybody got the initial hands on training.

Joni Chroman: We did a lot of role play, that is, somebody would be a clinician, somebody would be a staff member, somebody would be a patient. We practiced and we had fun and we wanted to make sure that people really felt comfortable before we rolled it out. We can't do that training roadshow all the time but now we have a PowerPoint presentation that all onboarding staff must review and understand before they implement ACE screening. We do that and an annual refresher to make sure that people are refreshed and learn the verbiage as we go because it does develop over time.

Dr. Dayna Long: Thank you so much. Dr. Oo, how did you build your team?

Dr. Heyman Oo: At Marine community clinics, when we started our ACEs journey, it actually started as a small little pilot. Back then we were a part of the National Pediatric Practice PD, or NPPC, which is another organization devoted to pediatric screening for ACEs. And we did this very similar process to Joni where we built a team of people that spanned the leadership. Our chief behavioral health officer was involved and then also our frontline staff, so our medical assistants. We really used the wisdom of the team members as the frontline staff to develop what would be our workflow. To echo Joni, they know what's going to work and what's not going to work in the clinical encounter. And so we made sure that we had stakeholders at the table from all levels.

Dr. Heyman Oo: And it's a slow process to actually have those conversations to bring people together. It aligns with our mission as an organization, as a community health center to address the whole person, to address the whole family. And so that was not a difficult challenge in terms of getting buy-in that this was a good idea. But the difficulty or some of the challenges is the logistics and how do you do it. Who has the time and enthusiasm to devote to doing this work? But that's a logistical problem and not a leadership buy-in problem. We actually had a lot of support from our leadership, which we were grateful for.

Dr. Heyman Oo: And then once we had that team, we have a very strong foundation in quality improvement at our clinic. Our medical assistants are actually involved in monthly quality improvement initiatives. And so we used that foundation to make ACEs another quality improvement project. And so we would come up with a plan, test it out, feedback, come back, change something. Our care teams felt that that was a familiar process based on their experiences with other clinical initiatives and there wasn't that huge barrier of how do we do this in every place at every time. It was we're going to start small and then develop the champions, develop the expertise, and then expand out from there.

Dr. Dayna Long: In answering the second part of that question about securing buy-in, I definitely heard you saying that leadership was really brought in because of this belief about whole person care as were the clinicians. Was the same true for the staff as a whole?

Dr. Heyman Oo: I would say that initially there was some hesitation to asking ACEs questions because of the nature of the questions. And when we reframed that this was for our patients and being more trauma informed care as an organization, recognizing that our patients live these lives, they have the experiences and whether or not we ask for them, it's still impacting them or it's not. And so I think recognizing that, and then also acknowledging that all of our staff, similar to many of the organizations I'm sure on this call, have staff that reflect the communities they come from. And so we couldn't ignore that in the process and in fact, we honored that, recognizing that this is hard.

Dr. Heyman Oo: This is hard to do and sort of assuming adversity and normalizing it, which is what we do with our patients, to say that these are common events and they happen and there are things that we can do to help mitigate the long term effects of that. And so how can we help you? And so once that conversation was had and the trainings were given to our staff in terms of trauma informed care and why this is important, and people started to draw the parallels to the many other things that we do in clinic like screening for intimate partner violence, which we already did, and screening for depression, which we already do, I think it all came together in a different way than if we just said here's another screener, go forth and screen.

Dr. Dayna Long: Absolutely. Thank you. For our next question, the question is, how did your clinical team and staff respond to implementing ACEs screening and what have you done to support them? Dr. Stewart, I'm going to have you answer this first.

Dr. Rachel Stew...: Thank you. Yeah. I forgot to mention that we do have 25 locations. So we have locations from Sacramento down to San Diego. One of the challenges was implementing this in a broad geographical range. There were definitely varying

amounts of passion and interests among the clinicians, and our patients are experiencing a lot of trauma. We have substance abuse. We have depression and anxiety. We have domestic violence. And patients, like Joni mentioned, are coming in for an urgent reproductive health need like a vaginitis or a condom broke. And so we try to pivot them from solving that problem to asking about a behavioral health issue that the clinicians didn't have the tools to solve. So, there was a lot of hesitancy about opening this panel of questions and not having a resolution. I think that was the biggest hurdle that the clinicians had was just not having the answers once you ask the questions.

Dr. Rachel Stew...: But I think they recognized that a lot of the procedures that we do to patients are retraumatizing. Pelvic exams or gynecologic procedures can often bring up a history of trauma. So when we started, I think they felt relieved that we were at least starting to have that conversation with the patients. Even if we didn't have the answers at the time we implemented, I think that in general it was recognized that this was a need in our patients and we weren't meeting it. And so it was the start of that conversation.

Dr. Rachel Stew...: But there was some reluctance, and as Joni mentioned, I started referring to the ACE screening as a vital sign because as OBGYNs, we take a blood pressure but we don't manage hypertension in our office. But it's still something that we can know and educate the patients about. So I started referring to the ACE screening in the same way that even if you take that temperature per se of their toxic stress in their background, that doesn't mean that you have to solve it at that appointment. So I think that was reassuring to the clinicians to know that just because we identify a need doesn't mean that they have to fix it at that visit.

Dr. Dayna Long: I feel as if that's a really big culture shift for us as clinical providers because our inclination is that we have to fix everything. So this recognition that we can respond by saying we understand that these ACEs are attributing to some of your health outcomes and we are here to partner with you without feeling like we have to fix everything is a really important paradigm shift. So thank you for bringing that up. Dr. Oo, I'm going to repeat the question for the audience. And so the question is, how did your clinical team and staff respond to implementing ACEs screening and what have you done to support the clinical team and your staff?

Dr. Heyman Oo: For us as primary care, we have thankfully a lot of opportunities to touch our patients. I think what our staff told us at the very beginning was their discomfort with asking these questions. And so instead of overriding that discomfort and saying, "Oh, it'll be fine," or finishing it, we actually leaned into it and asked our staff, well, it's uncomfortable, what do you need? What would help you make

this more comfortable? And through that process and through actively listening to our frontline staff, we were able to come up with a training program that involved general education about what ACEs are because people come to this work with different levels of education around what ACEs are and what it means for our long term physical health.

Dr. Heyman Oo: And then also we came up with a coaching program for all of our medical assistants. So one on one coaching with someone from our ACEs implementation team where they practiced administering the screener and then had an opportunity to ask further questions about why we're doing this or how to respond if a patient says this or is upset, or something. I think that that serve two functions. One, it was a level of quality control actually to be able to see where certain staff members might be having difficulties so that we can respond. And then also it helps to really make the staff feel like we were investing in them because as you can imagine, having an organization of 500+ staff, some portion of that being MAs and 30 minutes coaching sessions.

Dr. Heyman Oo: It was a long process but I think that we walked away knowing that that was actually one of the most valuable pieces of our training program. And now that we are, when we moved into OB and then also now moving into our adult population, that is the continual feedback from our MA supervisors. But that is the most important part of the training program. Our staff can review PowerPoints and listen to Zoom talks, but it's really that one-on-one coaching that helps them feel comfortable and competent enough to be able to do ACEs screening and to explain why we're doing this to patients or for patients.

Dr. Heyman Oo: And then for our clinicians, I think for pediatrics it makes a lot of sense to screen for ACEs and I think the vast majority of our clinicians were on board. The only questions that we often get are how do we do this in our clinic visit, in the 15 minute visit that we have. And if it's positive, what can we offer our patients?

Dr. Heyman Oo: And so we worked with our behavioral health team because we have integrated behavioral health at our clinics to come up with the menu of options that align very nicely with the ones that are outlined in the implementation guide. Here are the nutrition services. Here are our wellness services. Here's our stress management group. We saw a need for increased parenting support. And so we actually trained a bunch of our providers in PPP, the Positive Parenting Program. And so we did that before we started screening to say, "Hey providers, here's the support that we have put into place for you in case you need it when you're having these conversations with patients." And I think that helped a lot to alleviate some of that worry about do I have to hold all of this myself.

Dr. Dayna Long: When you talk about the coaches, can you just clarify who were the coaches and how did you select them?

Dr. Heyman Oo: The coaches were the members of the ACEs implementation team or the champion team that we had. I was one of them, our director of pediatric behavioral health was one of them. We had some other pediatricians and we actually did some of similar things that were mentioned before. It was a role play. So we were role playing with them. Our massive rollout was actually done in the last year via telehealth. So that added a layer of complexity to screening for ACEs. And so we were actually screening over the phone, if you can imagine. We had our staff do that with us and we pretended to be patients, parents of kids, and really having them go through the motions in a way that felt real.

Dr. Heyman Oo: I think that sometimes people do the role plays like on the Zoom turn to your partner, but it doesn't feel as real, but it is real when it's a different body voice on the other line of perhaps somebody that you don't actually know that well in the organization. And so some of those nerves are there and we wanted that to be the experience so that it felt real and that we could actually work through. For the clinicians on this call, it was sort of like an Oski if you remember that from our training where we had the standardized patient, and then we pretend that we're a doctor. And so that was somewhat the inspiration for the exercise.

Dr. Dayna Long: Thank you. We all know that when we are in clinic, it can get really hectic. We have 15 minute visits and in a typical morning, we might have 12 to 15 patients scheduled. So understanding that there are time limitations and that staff are very busy, how have your clinics been able to adopt ACEs screening? And I'm going to pass this question to Dr. Stewart.

Dr. Rachel Stew...: As Joni mentioned, we do have a team based approach. So the question that we had when we started was how would patients feel about being screened for behavioral health issues at a reproductive GYN visit? We didn't know whether our patients would feel as though that was an invasion of privacy. We didn't know if they would feel that it was appropriate. And because a lot of our patients have existing diagnosis of anxiety or depression or substance abuse, we didn't want to feel as though we were stigmatizing them or making it uncomfortable for them to access care with us. And so what we found is I think that it worked best for our patients if they were given the screening tool before they met with the provider.

Dr. Rachel Stew...: And so our care coordinators, who are peers, who are taking a lot of the patient history and inputting it into our electronic health record would incorporate the ACEs questionnaire into their intake of medical history. And then the providers would have the opportunity to review the score and discuss any options for

referrals or treatment that they recommended. But before I see the patient, the screening has already happened, which is very important. I don't have time to do the screening myself but I do have time to address it. And like Joni mentioned, we had very clear verbiage for the clinicians as well.

Dr. Rachel Stew...: "I see that your ACEs score is greater than four, which indicates that you have higher risk for developing certain illnesses in the future. Are you interested in any referrals or behavioral health services?" And sometimes our patients would say, "No, not interested." Or, "I'm seeing a therapist, I'm not interested." And then they would just leave it at that and document it. But at so many times patients said, "Thank you so much for asking. Yes, I really could benefit from those services."

Dr. Rachel Stew...: And in the beginning we didn't really have anywhere to direct the patients who didn't have healthcare coverage to receive behavioral health care. So we would give them a referral packet based on their zip code of resources for housing or domestic violence or substance abuse or suicide prevention, whatever their ACEs score had indicated. But thanks to Joni, we now have a behavioral health specialist. And so we can offer them treatment in our behavioral health program. And we have found that approximately 11% of our patients score four or greater. I do think that that is an under estimation of the actual need there is and that might be a reflection of the fact that at a gynecologic visit, certain patients don't want to talk about their toxic stress.

Dr. Rachel Stew...: And so of those that score four or greater, we have found that about 28 to 30% of them are interested in a referral to behavioral health services. Now, whether they have coverage for that is an entirely different elephant in the room and that is probably a topic for another webinar. But we have identified that there is a need and patients feel that at a gynecologic visit, it is not an invasion or imposition to ask about that need.

Joni Chroman: If I could add to that, Dr. Stewart, sometimes we found that our patients seem to really appreciate the acknowledgement. Even if we weren't able to link them to care at that visit or solve their problem in that visit, the fact that we were asking and the fact that we were showing these patients and demonstrating that what happened to them matters, that is an intervention in itself. We all needed to wrap our hands around that and wrap our heads around that, that we were doing something important even if we couldn't solve everything on that day.

Dr. Dayna Long: Absolutely. I 100% agree. Dr. Oo, how has your clinic been able to adopt ACEs screening despite the limitations that we have in terms of time with patients?

Dr. Heyman Oo: For us, we were very thoughtful when we were doing the ACEs screenings. So for our pediatrics, and again, as a primary care pediatrician, we decided that the well visits made the most sense for ACEs screening because a number of the interventions, if you want to call them that, that we would recommend based on high ACE scores were things that we talk about in well visits anyway. So it made clinical sense that asking these questions and then relating them back to nutrition and sleep and screen time and healthy relationships was actually just a part of our usual clinical flow. It was just reframing for our patients why it's important, and actually using their own lived experiences to make the case a little bit more compelling in some cases.

Dr. Heyman Oo: And then for our OB, I think we found we had the same experience that pregnant women actually generally when they're getting their OB care, while these are sensitive questions, don't think it's inappropriate to ask them. There were some sets of questions that our case managers were asking anyway and this was just a sort of different format, slightly different details but the themes were the same. And so it didn't feel like a huge list to screen at those prenatal visits.

Dr. Heyman Oo: For our adult patients, and this took a lot of discussion and thoughtful consideration, we're trying to find a similar situation clinically that made the most sense and that's why we settled on new patients and also chronic disease management with their primary care provider because we know that trauma generally tends to occur in relationships and healing occurs in relationships. That's a quote from Ken Epstein. And so we wanted to make sure that we were honoring the physician patient relationship and that they were seeing their primary care provider for a chronic issue like diabetes, hypertension and that if screening for ACEs was going to help move that clinical care forward, that's when we should be doing it.

Dr. Heyman Oo: In the 15 minute visit, we have the same team-based care approach that we do. We're so lucky to have integrated behavioral health. But I actually wanted to call attention to what Tanya pointed out before about the tier one and the tier two interventions. So actual universal education for prevention in pediatrics. So when our ACEs scores are zero, that doesn't mean that we don't address it. It actually means that I talk about it and say, "Hey, I'm so glad that you haven't had these experiences, but here's the reason why we're asking. And in the future if you do have these experiences, here are some things that we can work on to mitigate any of the negative outcomes that might come from that."

Dr. Heyman Oo: One of the experiences that I've had and our director for pediatric behavioral health has had is actually preventative behavioral health visits, if we can call it that. But something where there isn't an identified behavioral problem in that

moment with that one-year-old but there's a history of IPV in the family. And so we can actually do that psycho-education. We can get them connected to services and lower that barrier to care in a way that feels safe and not judgemental like something is now wrong with your child. That has actually been really, really beautiful. And we've also been able to see that patients actually are listening to that psycho-education and preventative counseling. Anticipatory guidance is what we call it in pediatrics. And they come back. They come back six months later and say, "Hey, remember when we talked about this and, well, this happened." So they disclose later or a new event happens and then we're able to address it and the foundation has already been laid.

Dr. Dayna Long: You just touched on really the job that we do as clinicians is to help to prevent, heal, and treat ACEs toxic stress so that our patients can be as healthy as possible. Our next question really gets at this conversation that's happening in exam rooms after we screen. And so, how have your patients responded to learning about ACEs and toxic stress and what has that conversation looked like with your families as patients start to connect the dots about how toxic stress is related to their health? Dr. Stewart, I'm going to have you answer this first.

Dr. Rachel Stew...: Okay. Thank you so much. I think patients appreciate the shift from what is your diagnosis to what happened to you in the past, and especially if they're coming for a pelvic exam or a potentially re-traumatizing experience, they really appreciate the fact that we're attuned to the fact that their history, what happened to them in the past, might make a pap smear more difficult or a procedure more painful. And so I want to give an example of in the OR, the anesthetists were not part of the ACE screening. They didn't have any training. They were very peripheral, but they had heard about it. And so we're putting in IVs and some patients tolerate IVs much better than others, and there was one patient who really wasn't tolerating it.

Dr. Rachel Stew...: She was an adolescent and she was not excited about getting an IV placed. And I had just noticed that at that point that her ACE screening was a nine. And so I just mentioned it to the anesthetist and immediately his tone changed. He's put in hundreds of thousands of IVs and he was getting irritated with her because she wasn't holding still. And immediately it shifted to I'm going to go very slowly and gently and if you need me to stop for any reason, let me know. And that was such a beautiful thing for me since he had not even participated in the ACE screening at all. And so the benefit of having this trauma informed approach does percolate down from the people who are involved to the MAs and then eventually the patients benefit. And I think that they have definitely felt more cared for since we started incorporating ACE screening into our algorithms.

Dr. Dayna Long: I agree with you completely. In my clinical experience, after we screen for ACEs and when I'm delivering the education around ACEs toxic stress and strength-based factors, I always feel as if there's this moment of aha, like I get it from the perspective of the family and a real eagerness from parents as well as children to be able to heal and move forward. An example from my clinical setting is that I recently saw a young adolescent and their PEARLS score was greater than four. When I went into the room and I asked him and his caregiver how was that for you, their initial response was, well, the questions are have these things ever happened. They haven't happened recently but we've had some difficult times, and being able to explain that stress impacts children and it impacts adults and it gets underneath our skin and it affects our heart, mind and bodies. And then here are some resources and tools in order to help to regulate your stress response.

Dr. Dayna Long: I find that patients are super willing because they're motivated to take care of their health and that it changes the way that we're managing typical conditions like asthma or obesity or diabetes. Or being able to be more trauma informed going into procedures like you mentioned around IVs, it helps to improve outcomes and efficiencies across the board. So my next question, and this is for all of the panelists as we close is, what advice do you have for clinicians, clinical staff who are at the beginning of their journey, who are thinking about or who are already implementing ACEs screening? What advice do you have? And I'm going to start with Dr. Stewart, and then go to Joni and Dr. Oo.

Dr. Rachel Stew...: I think it's always important to pilot any new initiatives. And so I would start by actually administering an ACE questionnaire to one of your patients personally just so that you get comfortable with how that goes. And I did that a few times before we rolled it out to training any of the MAs or any of the other clinicians. When you start any new clinical skill, you have to read about it, you have to learn, but most importantly, you have to practice it. And so in the beginning you might not feel as comfortable, but then after a few patients, you kind of get your talking points and you work through those moments of awkwardness or uncomfortable questions, and patients are so grateful and that's what pushes you to continue is that you realize, okay, this is a good thing. I'm making a difference. And like with all aspects of healthcare, it's a new skill. And so be gentle with yourself as you're learning, but do dive in and just try and you'll see that patients really appreciate it and it is making a difference.

Joni Chroman: Just to speak to the administrative piece of implementing any project, and you can use these tips for anything you do in your practice, it's very important water rolls downhill. You don't want to do something that is so hard. You don't want to make water roll uphill because it ain't going to roll uphill. You really have to work with the tools that you have and embed it into the regular workflow that

your staff have. Embed it into the EHR. Make sure that it's very simple and clear and they know exactly what step one is, step two, step three. Otherwise, if there's a lot of nuance and a lot of decision-making that has to happen, it's not going to happen consistently in a hardwired way.

Joni Chroman: The other thing I would say is you need to have a culture of support and accountability. You need to have a culture where people can ask questions, where they can escalate feedback, where they can say, "Hey, this isn't working but this is working, can I make a recommendation?" And supporting that culture is very, very important. Make it a routine, make it a habit. Design reports and share information. Whatever you share, whatever you highlight, that's going to get worked on and that's going to get focused on. So you want to share that information and share wins. Let people know the positive that's coming from it. Let people know that what they're doing is doing... The good work that they're doing, give positive acknowledgement and appreciation. That's very, very important.

Dr. Heyman Oo: Not wanting to duplicate answers, I think I will say only I agree with all of that. I would say that it's a journey. It's not going to be quick and it shouldn't be quick. It should actually be a process that takes investment and time in the clinic and organizations that you work for. And I think thinking very carefully about why you want to start ACEs screening because if it's a check box, that's what people are going to treat it like and that's going to be doing a disservice to our patients. And so if you can articulate like why it's important that you want to start this and articulate that to the people at your organization, nine times out of 10 they'll agree with you because I think all of us are here for the purpose of healing patients.

Dr. Heyman Oo: And then for the logistical pieces, start small, lower the barrier. It's okay to screen one patient a week to start because I think it is overwhelming to think about universal ACEs screening all patients, all visits, all the time. But you can get there. You just have to start small and find your champions and find those people that are willing to experiment with you so that then you can move forward and refine it and then build that credibility from inside because everyone has the resources within your organizations. You have those people. It's really about elevating them in the process.

Dr. Dayna Long: Thank you so much to our panelists for sharing lessons from the field. Tanya, I'll pass it back to you.

Tanya Schwartz: Yeah. I just also want to thank you all for participating today and to everyone who was on the webinar, we encourage you to go check out the how to guide. We think there are a lot of resources that we hope you'll find helpful. Also our

Science of ACEs and Toxic Stress webinar series. And to go to the next slide, if you have any questions, feel free to email the ACEs Aware inbox, that inbox@acesaware.org. And with that, we will close for today. And again, thank you everyone for joining. Thank you to our wonderful panelists and hope you have a great rest of your day. Take care.