

NPPC Pilot Site Clinic Profile:

Institute for Family Health's School-Based Health Center at Promise Academy 2

September 2019

NPPC Overview

The National Pediatric Practice Community (NPPC) on Adverse Childhood Experiences (ACEs) is a program of the Center for Youth Wellness (CYW) to support health care professionals in applying ACEs and toxic stress science to pediatric practice and shaping the field of trauma-informed medicine. The NPPC pilot program launched in 2017 to support integrating ACEs screening in pediatric clinical settings by providing training, technical assistance, and practice coaching to a small group of medical practices. The pilot included an intensive six-month period where organizations tested and refined screening implementation. For an additional six months, NPPC helped sites embed and spread their screening practices as appropriate, including supporting clinical systems for ongoing data tracking and monitoring.

Acknowledging that screening for ACEs is not yet standard practice in pediatric clinics in the United States, the NPPC pilot program was framed as a quality improvement endeavor using a plan-do-check-adjust (PDCA) framework with systems in place to monitor, reflect on, and formally document their experience and learning.

Pilot Site: Institute for Family Health in Harlem, New York

Organization: Federally qualified health center with 27 clinics

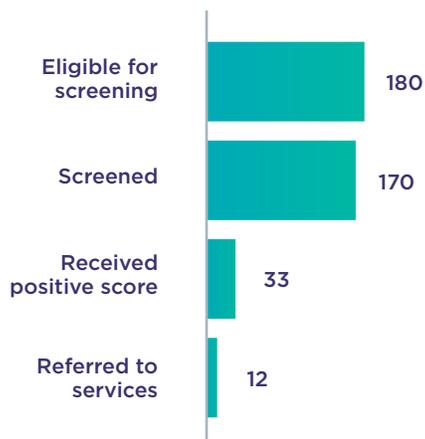
Description: School-based health center at Harlem Children's Zone's Promise Academy 2 (PA 2) with 1 full-time provider and an integrated clinical social worker. See ~15 patients per day.

The Institute for Family Health (Institute) was introduced to the NPPC pilot program through its partnership with the Harlem Children's Zone (HCZ). HCZ is a nonprofit, community-based organization focused on child welfare in a 97-block area in Harlem, New York. It operates two K-12 charter schools that house the Institute health centers to provide primary care services. HCZ leaders believed that ACEs screening at the Institute would complement existing efforts to make their schools more trauma informed. The Institute was interested in the pilot because its staff members perceived a high prevalence of trauma among their patients and potential alignment between ACEs screening and the mission of their school-based health centers. Finally, HCZ and the Institute's partnership was relatively new, and they hoped that the pilot would strengthen their collaboration overall.



Screening activities & outcomes

Training	12-15 staff were trained in the science of ACEs
Ages screened:	all 13-18-year-olds
Frequency:	annually
Tool:	Teen self-report ACE-Q core 10 questions + 7 suggested supplemental questions
“Positive” score:	4 or more ACEs, did not formally track symptoms
Workflow:	Leveraged the workflow from an existing survey. In the vitals room prior to the visit, the MA explained the screen and gave it to patients to complete on paper. The MA tallied and communicated the score to the provider prior to the appointment.
Follow up:	Providers referred patients with a positive score to the clinic’s social worker. Patients with negative scores were intended to be connected to the clinic’s health educator for information about toxic stress. However, the health educator position remained vacant throughout the pilot, so this element of the workflow was not implemented.
Screening results:	<ul style="list-style-type: none">• 94% of eligible patients were screened• 19% screened received a positive score• 36% of patients with a positive score were referred to services• Saw higher scores in the supplemental adversities than the core ACEs



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A personal accomplishment [is] becoming familiar with the ACEs theory and comfortable with the screening.... I think we've all become more familiar with childhood trauma and sensitive to that.

Institute staff member

The Institute reported several important outcomes from the pilot project. While pilot leads were bought into the concept of ACEs, the training increased provider and clinical staff knowledge and comfort regarding ACEs screening. Providers said that screening results enhanced understanding of patients and aided in symptom interpretation and treatment and reported opportunities for more systematically assessing symptoms in a more pro-active way.

Additionally, the Institute strengthened data capture in its electronic health record (EPIC) by building a best practice advisory that alerts them that the screening is due every 365 days from the last time it was done; although, at the time of this report it was unknown if this build and corresponding reporting function had been fully implemented.

The Institute anticipates continuing to screen patients at Promise Academy 2 and, after making some additional changes to its data system, plans to implement screening at its other school-based health center at HCZ (Promise Academy 1). This will require training a new group of staff and working through any differences in workflow at the new site.

Lessons learned

There is no one-size-fits-all approach for screening implementation, and practices will need to make a variety of key decisions at various stages in the process. Four key lessons learned for the Institute are detailed below.

“Putting forward this philosophy that we care about these issues is important. Some patients...commented, ‘no one asks me about this anywhere else.’”

Institute staff member

1 **Organizational buy-in was supported by ACEs screening aligning with organizational priorities and providing clinical value to providers.**

ACEs screening aligned well with the Institute’s organizational priorities around integrated behavioral health and trauma-informed care. Additionally, when leaders realized that the quality improvement summary by the NPPC coach at the end of the screening pilot could be used for other organizational priorities (e.g., patient-centered medical home designation, joint commission accreditation), they were excited and interested. Providers found patients receptive to the screening tool and it helped them identify patient needs. Importantly, the capacity of their social worker could absorb the additional patients into her workload.

2 **For their teen population, administering the screen in a private setting was necessary to preserve data quality.**

Initially the health educator explained the screen and gave it to patients to complete on paper in the waiting room before their appointment. They observed patients consulting each other while filling out their screens, so decided to change their workflow to have patients fill it out in the vitals room before their appointment. Overall, the new screening process was easily integrated into existing workflows, so the small staff was able to adapt quickly.

3 **It is necessary to have early and consistent involvement from technical professionals to integrate data tracking and reporting capabilities into electronic health records.**

The Institute was able to build a best practice alert in EPIC for recording screening scores but found that without the consistent involvement of an EPIC “super user,” the project team hit barriers and delays in building reports that provided data on screening roll-out. By the end of the pilot period, the team decided they would like to make four changes to their data recording capabilities in EPIC: add a way to postpone the screening until the next visit if the patient was too sick, and to document whether the patient refused the screening, was exhibiting related symptoms, and whether referrals were made.

4 **Serving teens in a school-based health center setting influenced the Institute's choice of screening workflow, educational materials, screening tool, how staff members communicated with parents, and how they coordinated around referrals.**

As mentioned previously, the Institute learned it was preferable to administer the screen in private. Additionally, the Institute decided to use a self-report version of the ACE-Q since parents do not generally attend appointments at a school-based health center. Parents provide general consent for their child to receive services from the Institute, so did not need specific consent for ACEs screening. However, they coordinated with the school to send home a letter explaining the purpose of the new screening process. HCZ staff were initially concerned that the screening activity might jeopardize their relationship with students' families. However, they reported hearing no feedback or complaints about the screening from students. This project provided the impetus for the Institute and HCZ to explore new ways to strengthen their partnership. For example, HCZ offers a variety of programs for their students that were identified as possible referral resources for the Institute.

CENTER FOR YOUTH WELLNESS

Clinical Office:

3450 Third Street, Bldg 2, Suite 201,
San Francisco, CA 94124

Administrative Office:

1329 Evans Avenue, San Francisco, CA 94124-1705

P: 415.684.9520

F: 415.920.1725

centerforyouthwellness.org

nppcaces.org

