NPPC Pilot Site Clinic Profile:

Marin Community Clinics
Novato & San Rafael Clinics

September 2019

NPPC
National Pediatric Practice Community

CENTER *for* YOUTH WELLNESS

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 coaching and systems in place to monitor, reflect on, and formally document their experience and learning.

Pilot Site: Marin Community Clinics in Marin County, CA

Organization: Federally qualified health center with 3 main primary care sites and integrated behavioral health services. Serves over 32,000 insured and uninsured patients annually.

Site Description: Implemented ACEs screening with select providers across 3 sites (7 providers total).

Marin Community Clinics is a multi-clinic network with a wide array of primary care, specialty, and referral services in Northern California. Leadership wanted to address the impact of trauma on a system level and joined the NPPC pilot to identify patients at risk for trauma and intervene as early as possible. ACEs screening fit within broader efforts related to prevention, including ACEs screening and coordination with their high-risk obstetric program and implementing universal social and psychosocial screening. During the pilot, Marin Community Clinics was also accepted into a complementary initiative focused on increasing health centers' efforts to become more trauma- and resilience-informed organizations.

Screening activities & outcomes

Training 27 staff were trained in the science of ACEs

Ages screened: 9 months and 30 months at well-child visits and new patients up to 12-years-old. Pregnant women in the high-risk obstetrics program also screened, but not reflected in their data.

Tool: combined and simplified an existing tool they were using with the ACE-Q (7 questions, deidentified ACEs)

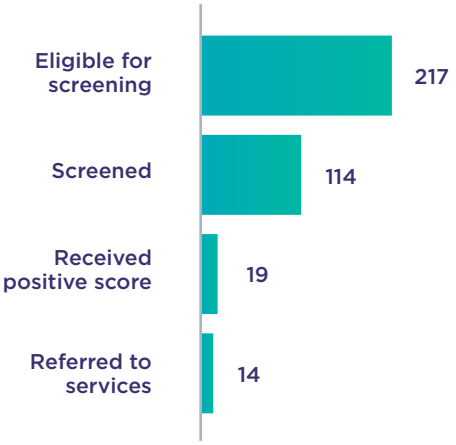
"Positive" score: 2+ ACEs, did not formally collect symptoms

Workflow: Medical assistants (MA) administer to caregivers in the exam room. Primary care provider reviews and discusses with patient.

Follow up: Patients screening positive are connected to a care navigator who provides information on ACEs and links to appropriate services (e.g., behavioral health, positive parenting program, legal).

Screening results:

- 53% of eligible patients were screened
- 17% screened received a positive score
- 74% of patients with a positive score were referred to services
- Note: manual data collection made it difficult to determine the exact number eligible for screening



> *"As a provider you are always looking for more information and to build the therapeutic relationship [with patients] and shared goals. I found [screening] was a neutral way to start the conversation…. Parents either nod or they start to put things together. It sets the tone that I'm here for you and your family as whole people.*
>
> **Marin Community Clinics provider**

Marin Community Clinics reported several other important outcomes from the pilot project. It introduced the concept of ACEs to several providers, medical assistants, and care navigators; while some had heard about it previously, they had not put it into practice until the pilot. The project also helped increase providers' understanding of patients, which helped in symptom interpretation and treatment. Both pediatric and behavioral health providers indicated that screening has given them a language for talking to patients when not in crisis and shifted the care and conversation to be more preventive. They believed it "plants the seeds" and that patients exhibit more motivation and follow-through on behavioral health or programmatic referrals. Furthermore, providers reported that the process of screening enhanced the relationship between the [medical doctor] and behavioral health provider.

Additionally, towards the end of the pilot program the pilot team was working to integrate data tracking related to screening and follow-up into their electronic health record (NextGen) by developing a screening form that they planned to test out at one clinic. The pilot provided the foundation for the organization to be competitive for other programs supporting this work. Marin Community Clinics planned to leverage participation in a trauma-informed care initiative to conduct organization-wide training on trauma- and resilience-informed care, continue refining their data tracking and reporting systems, roll out screening to additional providers throughout the organization, and further strengthen families' transition from obstetrics to pediatrics.

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. Three key lessons for Marin Community Clinics are detailed below.

1 **Early stakeholder engagement, especially with leadership and information technology (IT) staff, helps to build buy-in and ensure that the project has the support it needs.**

It may require different approaches to secure the support you need. Pilot staff reflected that it can be difficult to get providers to change their practice, and a provider champion as the project lead helped make the case for others. In addition, the NPPC quality improvement framework and approach helped achieve small wins that assisted in building additional leadership support.

> *"The [medical assistant] care navigator staff buy-in was important. We made them feel like they had a part in developing the protocol.*
>
> **Marin Community Clinics provider**

2 **Marin Community Clinics pilot providers found screening to be useful and easy—when they did identify needs, they were able to connect patients with appropriate resources.**

The pilot core team administered a survey to understand providers' experiences with the pilot. At the start, they worried about overwhelming their internal behavioral health services. This did not occur—they indicated that they still had some capacity, and providers reported that 90% of the time they were able to provide needed resources. In addition to behavioral health, patients were often linked to the organization's positive parenting program.

3 **Provider champions and effective care navigators were key ingredients to implementing across sites.**

Having a committed provider champion at each site with some dedicated administrative time to support the change process helped implementation occur across sites. And since care navigators are the first line of response to a positive screen, staff requested and received additional training from NPPC to support them in identifying patient needs. Additionally, navigators' work is context-specific for each site—they must know the local resources available and how to access them, while also effectively connecting effectively and compassionately with patients.

> *"Something we did right is having the planning team represent who's going to be implementing it. Having the lead pediatrician on the grant helped create buy-in among other providers..*
>
> **Marin Community Clinics provider**

4

Integrating data tracking related to screening and follow-up into the electronic health record (EHR) is crucial for sustainability and broader implementation.

For the NPPC pilot program, Marin Community Clinics tracked its screening and follow-up data manually and had an intern clean and analyze the data for monitoring and reporting, which was time-consuming and burdensome. To support rollout of ACEs screening to other providers, the pilot team engaged an internal data analytics representative to build out a form for their EHR (NextGen) that medical assistants would complete that mimics other screening processes. The form would collect myriad items, including the screen score and action checklist (e.g., ACEs information, housing resources, and a referral to behavioral health). Marin Community Clinics is still developing systems to more easily report on the data captured to monitor progress and use for decision making.

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