ACEs Connection

NPPCACES
National Pediatric Practice Community on Adverse Childhood Experiences

NPPC PILOT SITE CASE STUDY WEBINAR

Lessons Learned from Pilot Site Cohort I

December 2019

Objectives

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- Overview of Pilot Site activities and results
- Review lessons learned from individual sites and the cohort as a whole
- Provide practical tips clinics can use in their own screening processes
- Present experiences from pilot site participants

Who you'll be hearing from today

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Hosts

Leena Singh, DrPH, MPH
Program Director, NPPC

Karissa Luckett, RN, BSN, MSW, CPHQ
NPPC Implementation Coach

Pilot Site Participants

Mercie DiGangi, DO
Southern California Permanente Medical Group

Nancy Tillie
CEO/COO
Santa Barbara Neighborhood Clinics

Andria Barnes Ruth, MD, FAAP
Santa Barbara Neighborhood Clinics

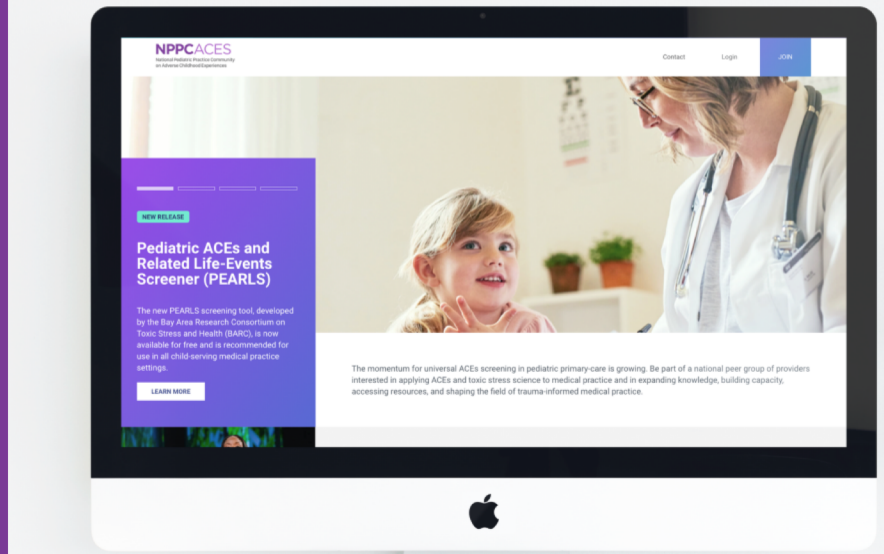
National Pediatric Practice Community Overview

Website (Resource Hub)

Training and Technical Assistance

Peer to Peer Exchange

www.nppcaces.org



ACEs Connection is an active, social network of nearly 38,000 members nationally and internationally that supports communities to heal trauma and promote resilience. ACEs in Pediatrics is a community on ACEs Connection that facilitates interaction among health care providers and staff who are implementing ACEs education and support in their practices. It includes original articles, links to pertinent research, curated content from other sources, and an "Ask the Community" feature. Go to: acesconnection.com to join ACEs Connection and the ACEs in Pediatrics community.

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Theory in Action: NPPC Pilot Sites

- Expand knowledge of ACEs screening beyond the Bayview Child Health Center
- Provide the NPPC virtual network with real-world examples in varied settings
- Long-term engagement to test and adjust approaches when encountering roadblocks
- Establish valuable relationships and cultivate physician advocates “in the field”

Pilot Site Objectives

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- Identify key drivers and best practices to implementing and sustaining an ACEs screening program by working closely with a diverse set of clinical settings

- Identify and learn how to overcome common barriers in screening through tailored content, coaching, and collaboration between pilot sites

- Facilitate opportunities for a robust understanding of each clinic's unique experience and journey to integrating screening and how these learnings can be translated into strategies for similar clinics

- Increase the number of clinics screening for ACEs

NPPC Pilot Sites Cohort I

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Name	Location	Pilot Target Population	ACEs Screening pilot start date
Kaiser Southern California	Downey, CA	3 and 5 year well child visits	July 15, 2018
La Clinica de la Raza	Oakland, CA	7, 8, 9, 10, 11 year well child visits	May 14, 2018
Marin Community Clinic	Novato & San Rafael, CA	High risk OB, and well child 9 months, 30 months, and all new patients under 12	April 9, 2018
Santa Barbara Neighborhood Clinics	Santa Barbara, CA	4, 6, and 9 month well child visits, parents at the 4 month visit	March 5, 2018
Zuckerberg San Francisco General Hospital	San Francisco, CA	Moms at 4, 6, 9, and 12 month well child visits in Friday morning clinic	June 15, 2018
Institute for Family Health	Harlem, NY	13+, non urgent visits	December 4, 2017

Program Phases

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- Phase 1: testing & refining screening protocol development and implementation (6 months)
  - Staff and provider training
  - Patient education materials for providers and patients
  - QI coaching to support implementation, data tracking and reporting
  - $15,000 stipend
- Phase 2: embedding and spreading screening practice (6 months)

A Performance Improvement Framework

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Plan:

Kickoff
Planning calls
EHR build
Site visits & training

Do:

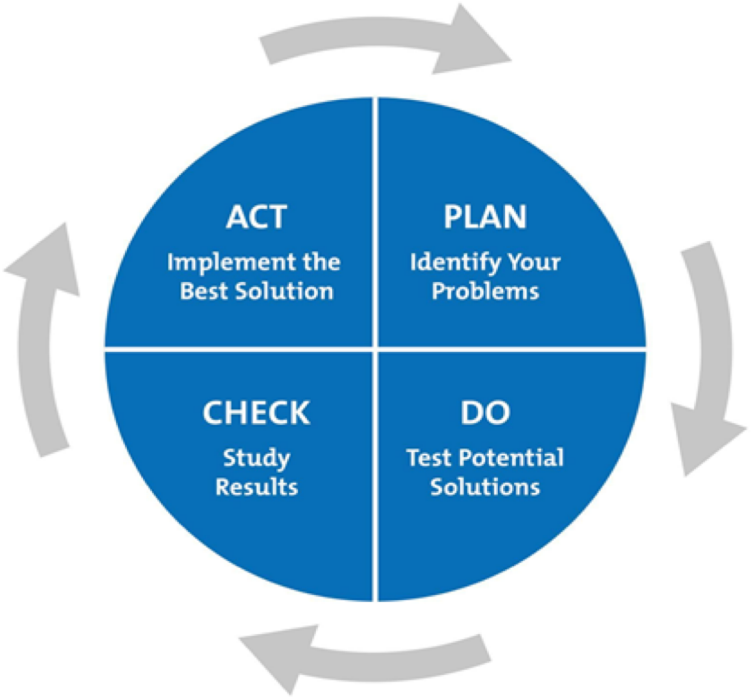
Launch screening pilot
Monthly data analysis
Begin monthly coaching calls for 6 months

Study/Check:

6 month data analysis

Act:

Sustainability and spread planning



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Performance Improvement Initiative: PDSA Summary

Adverse Childhood Experience Screening Implementation Pilot

Plan: In the initial pilot phase it was identified that the optimal patient population was 13 year old patients and greater, who came to the clinic with a non-urgent visit in a given month, who had not been screened in the previous year. The rational for choosing this population was that the students were thought to be at higher risk for ACEs, and that that the teen self-report screening tool could be utilized.

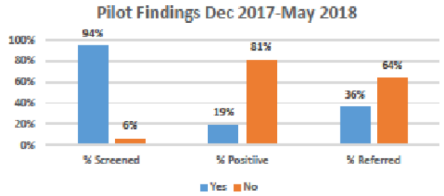
Do: The process for implementing the screening tool was to identify the eligible patients during registration for each clinic visit. The screening tool was provided to the student once they were brought back to the vital signs room. Three performance measures were developed for the pilot phase. Operational measure definitions were:

1) % of patients screened
Numerator: The number of patients in a given month that were screened using an ACE questionnaire
Denominator: The number of patients that were 13+ years old with a non-urgent clinic visit in a given month, who had not been screened in the previous year

2) % patients with positive ACE score
Numerator: The number of patients that screened positive (score of 4 or greater with/without symptoms) in a given month
Denominator: The number of patients in a given month that were screened using an ACE questionnaire

3) % patients positive ACE score patients that have appropriate referral
Numerator: The number of patients that were referred to additional services/resources related to positive ACE screen, in a given month.
Denominator: The number of patients that screened positive (score of 4 or greater with/without symptoms) in a given month.

Study:



Other subjective findings included: They had no patients refuse to participate in the screening process. The program was not able to utilize the Health Educator staff as originally identified in the implementation process due to vacancies in these positions through-out the majority of the pilot.

Act: The study resulted a manual capture of all data points, despite planning in the implementation phase regarding reporting. This finding has been consistent with all other pilot sites, as the standardized reporting out of EHR, has consistently proven difficult consistently. As such, the program did not experience standardized EPIC reporting of results from the medical record, during the initial pilot phase, that, therefore, produced variability in the inter-rator reliability of the denominator of the percent screened measure, as well as the numerator of the percent referred measure. The program was also unable to collect the number of patients that exhibited symptom either related to or not related to a positive score. There are identified barriers to the success of the pilot phase for PA II, in that there has been a change in the Team Lead implementation staff, and the lack of standardized reporting from EPIC.

Using a Performance Improvement Methodology

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- Structure and standardization aid in successful implementation
- PDCA cycle can be used to as carrot for leadership support
- Meet requirements of funders, and other community stakeholders
- For HRSA, and Patient Centered Medical Home Certification
- Capitalize on PCMH pre-visit planning, referral tracking, huddle processes
- Meets Joint Commission Accreditation Standards:

  Performance Improvement Chapter Standards--PI.01.01.01, PI 01.02.01, PI 01.03.01
  Leadership Standards--LD 03.02.01, LD 03.05.01, LD 04.04.03
  Quality Improvement and Patient Safety Standards—QPS 03.04, QPS 04.02

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Monthly Coaching Calls

1. Review monthly data (a two way street - need data to address areas of work needed)
2. Discuss barriers
3. Identify solutions
4. Reflect on lessons learned and capture positive experiences

NPPC Evaluation

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Completed by the Center for Community Health and Evaluation (CCHE)

Evaluation goals:

1) document progress & impact related the NPPC

2) capture lessons to facilitate real-time learning & improvement

Evaluation focus areas	Where we get information
1. Changes in **awareness and knowledge** related to ACEs screening & appropriate follow up 2. Changes in **clinical practice** related to ACEs screening & appropriate follow up 3. Assessing the **broader impact of NPPC** on patient care and pediatric practice 4. Lessons learned related to **implementing ACEs screening** **5. Effectiveness and contribution** of NPPC	• NPPC site visits (including planning calls) • Coaching call notes • Monthly data submission • NPPC enrollment assessment • NPPC participant interviews

Pilot Site Case Studies

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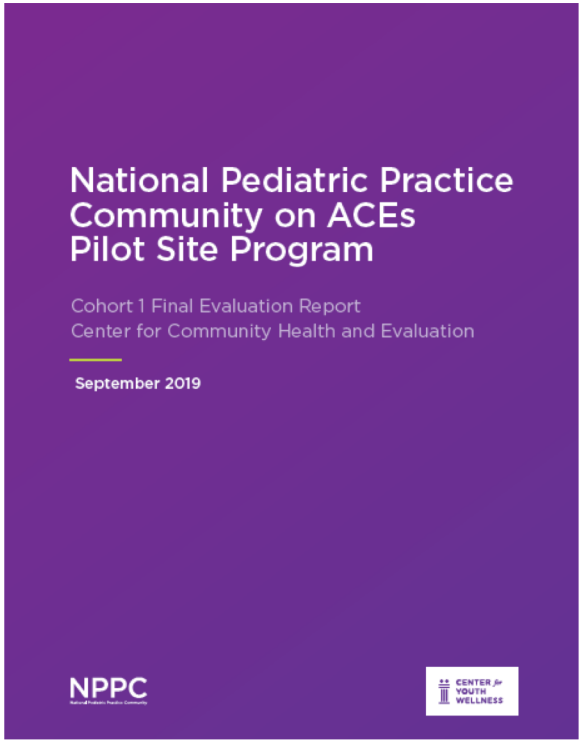

- 6 documents: 1 summary document and 5 in-depth studies on individual pilot sites
- Contain site overviews, lists of screening activities, discussion of challenges, results and lessons learned
- Compiled by our evaluation team at the Center for Community Health and Evaluation (CCHE)
- Released in October, all reports available online at nppcaces.org/casestudies

Results

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- All 6 sites successfully implemented screening
- 1,900 children under 18 were screened
- All sites screened at least half of eligible patients
- Range positive screens (7%-58%)
- All sites made improvement to data tracking
- Half the sites strengthened referral networks
- 50% expanded screening to other sites within organization

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Lessons Learned

- **Ensure organizational goals align**
  - Aligning with established organizational goals created synergies and enhanced leadership buy-in

- **Broad Level Buy-in**
  - Leadership buy-in is necessary, but all stakeholders must be included (organizational leaders, providers, mental health clinicians, clinical support, front-line staff)

- **Provide Training**
  - Training (general & specific to role) provides confidence critical for effectively implementation of ACEs screening

Lessons Learned

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- **Provide adequate follow-up**
  - Create clear scoring algorithm and assess strength of referral systems to ensure adequate interventions

- **Integrate your EHR (early!)**
  - Build data capture and reporting capabilities into the EHR (IT *build* and *reporting* often involve two separate areas with in IT departments)

Pilot Site Participants

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- Kaiser Permanente - Downey CA
  - Mercie DiGangi, DO

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- Santa Barbara Neighborhood Clinics - Santa Barbara, CA
  - Andria Ruth, MD
  - Nancy Tillie, CFO/COO

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Q & A


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