



OVERVIEW

The Center for Care Innovations (CCI) and our partners are now accepting applications for the [California ACEs Learning and Quality Improvement Collaborative](#) (CALQIC), a new program that will support clinics in screening for and responding to adverse childhood experiences (ACEs) in children and adults.

CALQIC is led by the [UCSF Center to Advance Trauma-Informed Health Care](#) in partnership with CCI, the California Office of the Surgeon General, California Department of Health Care Services, and the RAND Corporation. The program's goal is to integrate ACEs screening and response within health care settings in a way that enhances relationships between patients and providers, helps connect patients to supportive services, and leads to better outcomes such as reduced disparities and positive experiences with care. This learning collaborative will support up to 15 clinics representing at least 50 sites over 18 months to:

- Identify and overcome barriers to ACEs screening and response at both the site and organizational level;
- Align clinical efforts with the statewide initiative, [ACEs Aware](#), which is working to help providers get credentialed, use approved screening tools, bill using appropriate CPT codes, and more;
- Develop or strengthen models of care and tools for operationalizing ACEs screening and response (i.e., roles, workflows, scripts, etc.);
- Collect and track data to assess progress in ACEs screening and response.

Our learning collaborative is well suited for organizations that have some experience and infrastructure in place to screen and respond to ACEs. This includes organizations with most of the following elements in place:

- Started to implement organizational-wide, trauma-informed care practices;
- Piloted or implemented screening processes to identify ACEs OR have the ability to begin screening at least one clinical site by mid-2020;
- A desire to align clinical efforts with the statewide initiative, [ACEs Aware](#).

- Either behavioral health or other internal resources available, or partnerships with external agencies or community-based organizations to address identified adversity or other related needs; and
- Data, IT, and QI systems in place with the ability to track and make improvements to ACEs screening and response processes.

What We'll Provide

Selected organizations will receive a range of technical assistance support and up to \$70,000 in grant funds. Grant dollars can be used to offset staff time spent participating in this program or leading change efforts at your organization; travel costs to attend the program's in-person convenings and site visits; and other associated costs.

Training and technical assistance support may include, but is not limited to:

- Toolkits and resources to support ACEs screening implementation.
- Monthly coaching support.
- Access to technical expertise from organizations like UCSF Center to Advance Trauma-Informed Health Care in addition to safety net clinics leading similar efforts at their organizations.
- Three, one-day in-person convenings.
- Two optional regional workshops.
- Webinar-based learning, including a mix of expert- and peer-led sharing on topics participants identify as challenges.
- Site visits to exemplar organizations who have successfully implemented ACEs screening and integrated trauma-informed care principles into their workplaces.
- Support measuring and tracking your organization's progress in ACEs screening and response.

Timeline

The learning collaborative will run for 18 months, from May 1, 2020 to October 31, 2021.

Key dates:

- **Informational Webinar:** Thursday, March 12, 2020 at 12-1pm. Register [here](#).
- **Application Deadline:** Tuesday, March 31, 2020 at 5pm
- **Cohort Announced:** By Thursday, April 30, 2020
- **Program Kickoff Webinar:** Wednesday, May 20, 2020 at 12-1:30pm
- **In-Person Learning Session 1:** Tuesday, June 23, 2020 (Bay Area)
- **In-Person Learning Session 2:** Tuesday, December 8, 2020 (Los Angeles)
- **In-Person Learning Session 3:** Thursday, May 20, 2021 (Bay Area)
- **Program End:** October 31, 2021

Eligibility

The learning collaborative will include up to 15 organizations representing at least 50 sites that provide comprehensive primary care services to Medi-Cal adult and pediatric patients. Organizations will be selected across the state with the goal of achieving geographic diversity.

While the participation and funding for CALQIC will be at the organizational level, ACEs screening and response is expected to be carried out at an initial pilot site (or sites) with the goal of spreading ACEs screening to additional sites (for organizations with multiple sites). We will be offering two tiers of grant support depending on the organization's size and ability to spread to other sites:

- Tier 1 (1-2 sites): \$50,000 per organization
- Tier 2 (3-5 sites): \$70,000 per organization

In the application, organizations will be asked to identify at least one pilot site as well as up to four additional spread sites, depending on which tier you are applying for.

Qualifying organizations include:

- Federally qualified health centers (FQHC) and FQHC look-alikes
- Community clinics, rural health clinics, and free clinics
- Ambulatory care clinics owned and operated by public hospitals
- Indian Health Service clinics
- Other primary care (or pediatric) practices serving mostly Medi-Cal patients

Regional clinic consortia and statewide clinic associations are not eligible to apply.

Learn More

Join us for an informational webinar on **Thursday, March 12, 2020 at 12-1pm** to hear a detailed description of the program and ask us questions. **Register [here](#)**.

For any other questions, please contact:

Megan O'Brien

CCI Senior Program Manager
mobrien@careinnovations.org

ABOUT THE LEARNING COLLABORATIVE

Background

The state of California, led by California's Surgeon General Nadine Burke-Harris, in partnership with Governor Newsom, the California Department of Health Care Services (DHCS), and health and community leaders, is leading system reform that recognizes, and responds to, the effects that adverse childhood experiences (ACEs) and toxic stress have on our biological systems and addresses the lifelong impacts of ACEs.

Key to that roll out is the *ACEs Aware* initiative. Starting on January 1, 2020, DHCS will provide a payment to Medi-Cal providers for screening their patients for ACEs. The Office of the California Surgeon General and DHCS are committed to providing organizations and providers across California's health care system and communities the training, tools, and resources needed to effectively and equitably incorporate ACEs screening into patient care.

ACEs are stressful or traumatic events experienced by age 18 that relate to adversities across three domains:

1. Physical, emotional, or sexual abuse;
2. Physical or emotional neglect; and
3. Household dysfunction (e.g., a parent with a mental health condition or substance use disorder, absence due to separation or divorce, or intimate partner violence).

In recent years, [ACEs research has expanded](#), and the current screening tools approved by the state include assessing for other traumatic experiences, like discrimination, food and housing insecurity, separation from a caregiver due to foster care or immigration, and community violence.

According to the most recent California Department of Public Health data reporting from the Behavioral Risk Factor Surveillance System, 63.5 percent of Californians have experienced at least one ACE, and 17.6 percent of Californians have experienced four or more. Nationally, the prevalence rate is similar. Research also shows that individuals who experienced ACEs are at greater risk of numerous ACE-associated health conditions, including nine of the 10 leading causes of death in the United States.

At the same time, research also shows that early detection, early intervention, and trauma-informed care can improve outcomes. Trauma-informed care refers to care in which all parties involved recognize and respond to the impact of traumatic stress and resiliency factors on patients and service providers. Recently, the U.S. Centers for Disease Control and Prevention issued a special report on ACEs and suggested that the prevention of ACEs may lead to a reduction in a large number of health conditions, including heart disease, stroke, cancer, and diabetes, as well as depression, unemployment, and substance dependence.

Despite all of the mounting research, ACEs screening and response is still an early-phase health care innovation. CALQIC has been designed to support clinics and providers in adopting successful ACEs screening and response and aligning efforts with the larger ACEs Aware initiative. CALQIC's ultimate goal is to integrate ACEs screening and response in health care settings in a way that enhances relationships between patients and providers, helps connect patients to supportive services, and leads to better outcomes such as reduced disparities and positive experiences with care.

Learning Collaborative Structure & Core Content

The goal of CALQIC is to support organizations over a 18-month period with experience and commitment to ACEs screening for and responding. The learning collaborative will build on existing organization-led initiatives and interventions so that clinics can further test, develop, and strengthen their role as a place to screen for ACEs, treat trauma, and promote resilience.

CALQIC will offer training, tools, expertise, and support to address clinical and organizational issues associated with ACEs screening and response, including, but not limited to:

- **Trauma-informed care principles** and how to achieve them in patient care and for your organization;
- **Information on ACEs and toxic stress physiology** related to implications for patients' short- and long-term health;
- **Clinical algorithms and workflows to address ACE-associated health conditions** by supplementing usual care with education on toxic stress and strategies to regulate the stress response;
- Tools and interventions to **promote resilience**;
- Knowledge and tools for preventing, recognizing, understanding, and responding to **vicarious trauma and burnout among staff**; and
- Knowledge and approaches for **involving patients and families** in designing and implementing trauma informed approaches to care.

A cohort of up to 15 California health care safety net organizations that have demonstrated experience in addressing trauma and adversity, as well as a commitment to build on their work and learn with others, will be selected to participate in CALQIC.

This program will include three in-person sessions and two regional workshops over the course of the 18-month period, webinars to hear from experts and your peers, monthly coaching calls, and site visits to exemplar organizations. Key partners and faculty from across the country will be available for participating clinics to connect with and learn from throughout the learning collaborative. An external evaluator will help in developing and collecting metrics at the site and organization level and in assessing the overall impact of the program.

Selected organizations will participate in the following phases of the program. The length of time for each phase may vary depending on an organization's capabilities as teams begin this program.

Phase 1: Building a Foundation for ACEs Screening & Response

Organizations will build on their internal program infrastructure to communicate and implement ACEs screening at their initial clinic site and participate in the following activities:

- Identify a project team to participate in the learning community and champion the organization-wide efforts.
- Ensure clinical and administrative leaders are knowledgeable and regularly involved in the initiative.
- As a team, complete a baseline assessment in order to identify strengths and opportunities related to ACEs screening and response.
- Work with the selected evaluator to finalize metrics and collect baseline data.
- Understand current state of ACEs screening and response, including what's working and what could be better.
- Develop a plan to identify goals, the activities and approaches for ACEs screening implementation, and what technical assistance resources would support your success.

Phase 2: Test and Implement ACEs Screening and Response

After selected organizations have set up the internal program infrastructure, identified goals, needs, and started collecting baseline data, they will:

- Begin testing and implementing the core changes (i.e., workflows and protocols to strengthen internal clinic infrastructure) identified to drive ACEs screening and response.
- Build or strengthen a cadre of internal and external referral resources and design a process for referrals.
- Co-design strategies with patients and community partners to ensure screening, referral resources, and coordination efforts to meet the needs of patients and families.
- Report data and insights regularly to CCI coaches and the evaluation team.

Phase 3: Spread and Sustain

Teams will build upon plans for broader organization-wide implementation. This phase is critical to set organizations sustain efforts over time. They will:

- Standardize and embed workflows and protocols for screening and response into organizational policies, procedures, and systems.
- Spread ACEs screening and response to additional sites (if applicable) as identified in the initial application.
- Document, communicate, and spread lessons and stories of success within the clinic and across the learning collaborative.
- Report data and insights regularly to CCI coaches and the evaluation team.

APPLICATION

Who's Eligible?

The learning collaborative will include up to 15 organizations representing at least 50 sites that provide comprehensive primary care services to Medi-Cal adult and pediatric patients. Organizations will be selected across the state with the goal of achieving geographic diversity.

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What Makes a Strong Applicant?

1. **Foundational Trauma-Informed Care Efforts in Place:** Successful applicants will have started their journey to become healing organizations and should have some elements of trauma-informed care in place. For example, clinics should already have provided some level of education or training about trauma-informed care at the site or organizational level, made strides at promoting emotional wellness and addressing secondary trauma in staff, or worked to transform their office environment to be more welcoming of patients from different backgrounds and cultures.
2. **Prior Experience and Strong Commitment to Screening for ACEs:** Successful applicants will have piloted or started screening for ACEs in at least one clinical site or population OR the ability to begin screening at one or more clinical sites by mid-2020. Organizations should have some level of experience in integrating

practices to address trauma (vs. not starting from scratch) and an early implementation of practices to promote resilience and address trauma (at the clinical and/or organizational level).

3. **Desire to Align with Statewide Goals:** Successful applicants will have a desire to align their efforts with the statewide initiative, [ACEs Aware](#), including ensuring that providers complete the two-hour credentialing training, understand systems for billing for screening, and plan to use the approved screening tools (including the PEARLS tool for pediatrics and the ACES-Q for adults).
4. **Evidence of Behavioral Health or Other Internal Supportive Resources, or Partnerships with External Agencies or Community-Based Organizations:** Successful applicants will be able to demonstrate evidence of behavioral health resources available and the ability to make effective warm-offs to internal clinical staff and other supportive resources. For applicants without robust internal behavioral health resources, organizations should be able to demonstrate existing (even if early) partnerships with external agencies or community-based organizations focused on addressing adversity or other related topics (i.e., early childhood development or social determinants of health).
5. **Data, IT, and QI Systems in Place:** Successful applicants will have data, IT, and QI systems in place with the ability to track patient level data and make improvements to ACEs screening and response processes.

Our Expectations

This program is intended to be flexible and responsive to the needs of participants, so we ask each organization to act as a partner in shaping the program by committing to the following:

1. **Leadership Buy-In:** Successful organizations will require leadership that is committed to ACEs screening and response. It will also require leaders to understand the importance of how a trauma-informed approach relates to both organizations and clinical interventions and willingness to change internal systems to best support staff and patients. We expect strong leadership support from the CMO and COO at a minimum, as demonstrated through the letter of leadership support.
2. **Patient and Community Involvement:** Successful organizations will involve patients and community members perspectives and experiences in plans to implement ACEs screening and response.
3. **Continuity and a Dedicated Team:** At least four individuals are required to be committed to the core program team to promote continuity, with a maximum of eight members per organization participating in core activities (i.e., in-person convenings and evaluation interviews). The team should include:

At least one senior leader who can ensure protected time for team members to participate in learning collaborative activities as well as lead change within their organizations. This individual should also have decision-making authority to move ACEs screening and response work forward.

- A provider champion that has a significant role in your organization's ACEs screening efforts;
 - At least one frontline staff or provider who can inform and lead the operational and clinical implementation within the organization; and
 - A data or IT staff that can help to manage data and metrics collection and reporting.
 - Representatives from additional sites beyond the pilot site (as appropriate).
4. **Participation in Program Activities:** Team members are expected to fully participate in program activities including all three in-person sessions, virtual sessions, and monthly coaching calls. Teams will be asked to complete defined pre-work assignments for virtual and in-person sessions as well as share lessons learned by presenting examples of their project successes and challenges.
 5. **Metrics Collection & Evaluation Activities:** Teams are expected to work closely with an external evaluator to collect and submit quarterly data on a standardized set of measures as well as quarterly progress reports to share stories about the impact of the work. Teams will submit data on five required measures and up to one additional optional measures during each quarter of the program. (See [Appendix A](#) for a current draft description of the measures.) The finalized definitions of program measures, including detailed specifications, will be shared during the program's kickoff webinar. The evaluation team will work with individual organizations about how best to pull and report data, with the goal of all clinics providing CPT-code based reporting by December 1, 2020.

Finally, there will be an option to collect and report data monthly for those organizations which would prefer to track data more frequently than quarterly in order to use more rapid data cycles for improvement.

How to Apply

STEP 1: ATTEND INFORMATIONAL WEBINAR (OPTIONAL)

Interested organizations are encouraged to participate in an informational webinar on **Thursday, March 12, 2020 at 12 pm** to hear a detailed description of the learning collaborative and ask questions. Please register [here](#).

STEP 2: APPLY ONLINE

Your proposal and budget [must be submitted online](#) by **Tuesday, March 31, 2020 by 5pm**.

Applications should include the following:

1. [Application Submission Form](#)
2. **Application Narrative:** Includes responses to the nine questions listed below.
3. [Budget Template](#)
4. **Tax Status Documentation**
5. **Letter of Leadership Support:** This letter should demonstrate organizational commitment to ACEs screening and response. This includes dedicated time for the core team to fully participate in program convenings, activities, and implement changes at the clinical and organizational level. The letter should be submitted by either the CMO, COO, or CEO.

Application Narrative Questions

Please limit responses to a maximum of 6 pages, using at least 11-point font and 1-inch margins.

1. **Timeliness and Alignment:** Why is it important for your organization to address this topic at this point in time? How does this learning collaborative align with your broader organizational goals?
2. **Organizational Commitment to Trauma-Informed Care:** What past or current work has your clinic engaged in to understand and implement trauma-informed care? What training has your staff undergone in this area? What are 1-2 lessons that you have learned about what it takes to build a trauma-informed organization?
3. **ACEs Screening:** How do you currently assess for trauma and ACEs at your organization? What improvements would you like to make to your current screening processes?
4. **ACEs Treatment and Response:** If a patient screens positive, what are the ways your organization responds to identified ACEs? What are the options available

for treatment or referrals, both internal and external?

5. **Resilience and Protective Factors:** What are you currently doing to promote resilience in your patient population? Are resilience and protective factors integrated into care? If so, how?
6. **Site Selection:** What site will you start piloting ACEs screening and response (in alignment with ACES Aware) and why did you select this particular site? What are some key characteristics about that site (for example, number of patients, number of providers, and prior trauma-informed care work)? What other sites (up to four additional) will you plan to spread to within the timeframe of the learning collaborative?
7. **QI Experience:** Please describe a clinical improvement project you implemented in your organization. What data (outcome measure, processes measures, balancing measures) did you collect and how often? What is an example of one change you made based on what you learned from the tests and/or data?
8. **Data Reporting Capabilities:** Please describe your current ability to collect and report on data regarding ACEs screening and response/referral. How are data currently collected? How are data used? If not currently collected or if collected manually, what is the process for creating new reports on clinical quality metrics?
9. **Looking Ahead:** What challenges would you expect to face in participating in this program? What challenges do you foresee impacting your ability to implement ACEs screening and response? What can CCI do to help address these potential constraints? For example, what resources might you need to implement your work (i.e., expertise, coaching, technology or other outside partners)?

Next Steps

CCI and our learning collaborative partners will review applications. Our intent is to select an engaged group of up to 15 organizations representing at least 50 sites that have already started their journey toward ACEs screening and response and are committed to leveraging this support to advance their efforts. Priority will be given in order to ensure geographic diversity in the final cohort as well as to ensure a mix of organizations focused on screening pediatric and adult populations. The cohort will be announced via email by **Thursday, April 30, 2020**.

APPENDIX A - CALQIC Measures

The purpose of the CALQIC measures is to support CALQIC teams in understanding their progress over the course of the program and to understand how screening and response practices are advancing across the learning collaborative participants. The CALQIC measurement approach will collect a mix of qualitative and quantitative data from all 15 organizations and their participating clinic sites.

The measures described in the tables below will be used across the participating organizations and their sites. The learning collaborative will provide coaches and technical experts to support clinics in developing additional measures that are meaningful to them, if they choose to measure additional aspects of care beyond the requirements.

Table 1. All measures	
Data type	Description
Clinical data reporting*	Quarterly reporting from all clinics on key quantitative metrics related to ACEs screening implementation (see Table 2).
Organizational and clinic capability assessments	Assessment at both the organization and clinic levels to capture changes in capacity and practices related to building a trauma informed culture (TIC) and healing organization, ACEs screening, and response. Assessments will be conducted at baseline, mid-point, and end of the learning collaborative.
Participant interviews	<p>Reflective interviews will be conducted to collect qualitative data on progress and lessons related to ACEs screening and response, care team experiences in screening and building healing relationships with their patients, families, and caregivers. Interviews will include:</p> <ul style="list-style-type: none"> • Interviews with key leaders at each participating organization (n=15) at mid-point and the end of the learning collaborative • Interviews at site level from a sample of clinic sites (potentially including leaders, clinicians, frontline staff)
Coaching logs and interviews	CCHE will review coaching logs and conduct reflective interviews with coaches to capture insights on organizations' progress and quality improvement and implementation lessons learned.
Learning collaborative activities	Post-event surveys will be conducted to understand satisfaction with the activity and how future offerings can be improved.

* Data collection options: Because clinics have different data infrastructure, IT, and reporting capacity, there are different options for collecting the quantitative measures in Table 2:

- extract data from an EHR or registry (some clinics may already have these or be interested in building them)
- manually conduct a small number of chart reviews each month (10-20)

c) use administrative data (e.g., HCPCS/CPT codes) for measures 2 and 3 in Table 2

It is possible for a clinic to use different data collection methods for different measures. CCHE will work with each organization and their coach to create operational definitions for these metrics that align with the clinics screening processes and systems for reporting (example definitions are provided below).

Table 2. Quantitative measures		
Measure description	Definition (Required numbers to report)	Data source(s)
Required Measures		
% providers credentialed to bill for ACEs screening	<i>Numerator:</i> # of providers (including MDs, DOs, NPs and PAs) that have completed the state-approved training <i>Denominator:</i> # of clinic providers that are billable under Medi-Cal.	Internal registry
Screening rates (% of patients screened for ACEs)	<i>Numerator:</i> # of patients screened using PEARLS or ACE-Q <i>Denominator:</i> # of eligible patients (depending on defined screening target population)	CPT/HCPCS codes EHR fields Chart review
% of patients at high risk for ACE associated health conditions (per the state definition)	<i>Numerator:</i> # of patients with a PEARLS or ACE-Q screen score of 4 or greater <i>Denominator:</i> # of patients who were screened using PEARLS or ACE-Q	CPT/HCPCS codes EHR fields Chart review
% of patients with a positive screen indicating clinical response (per sites' clinical definitions)	<i>Numerator:</i> # of patients with a PEARLS or ACE-Q screen score of [at least XX without symptoms (or at least YY with symptoms of trauma)] <i>Denominator:</i> # of patients who were screened using PEARLS or ACE-Q	EHR fields Chart review
Response rates (% of patients with a positive screen receiving response)	<i>Numerator:</i> # of patients that received a response (categories to be finalized) to a positive screen <i>Denominator:</i> # of patients with a positive screen (using either state or site-specific definition—see below)	EHR fields Chart review
Optional Measures		
Strengths and resilience	Options for measures will be presented on the CALQIC kick-off call. This will likely include as potential measures: <ul style="list-style-type: none"> • number of patients who are screened for ACEs who are also screened for resilience or positive childhood experiences • results of resilience measurement <p>These will be optional measures for reporting but we are including this as a category as we know many clinics are pairing ACES screening with resilience or strength-based questions.</p>	