TRAUMA-INFORMED SERVICES

COMMUNITY MEDICAL CENTERS
BEHAVIORAL HEALTH INTEGRATED SERVICES
HISTORY OF CMC

• Community volunteers including physicians, nurses, social workers, and community organizers

• Services to farmworkers in 1965 in San Joaquin county

• Grant to the Medical Society 1967 purchased 2 portable trailers
A truck driver from the blood bank moved the trailers from place to place each morning and set them up.

• The volunteers arrived at 5 pm to open.
• Most days there would be a long line of migrant workers waiting for services.
• Medical Records were 3x5 and then 5 x 7 cards

(M. Kirkpatrick)
During the early 1990s...

- Channel Medical Center
- School-based clinic at Martin Luther King Elementary School.

Name change to Community Medical Centers, Inc.
By 2005... More growth

- Vacaville
- Hammer Lane
- Mariposa in South Stockton.
- Operating budget grew to $25M
- Staff to 350

2011:
- GLEASON HOUSE (Before and after)

2013:
- **EHR:** Electronic Health Records (NextGen)
2014 to 2018: New Services

• Integrated Behavioral Health all sites
• Podiatry
• Optometry
• Physical Therapy
• Chiropractic
• Substance Use Treatment
• Virtual Dental Home (VDH), 121 participating sites

2015: New Logo
2018

CMC, Recovery Center
- Comprehensive SUD services
- Medication Assisted Therapy
- Sobering
- Assessment and Counseling

CMC, West Lane
- 20,000 Sq. Feet
- 21 exam rooms
- Peds, IM, Family Practice, Women’s Health, BH
- Specialty coming 2019
2019... and beyond.

**CMC, California Street Pediatrics**
- Formerly Stockton Pediatrics, Dr. Cesar Pabustan
- 10,000 Medi-Cal Patients
- Opened 2/4/19 as CMC, California Street Pediatrics

**CMC, Lodi Cherokee**
- 1115 Cherokee, Lodi
- +1.89 Acres undeveloped land,
- Proposed February 2020 opening
CMC Facts:

• 88,000 Patients served in 2018
• 287,000 Patient care visits in 2018
• 19 sites, 3 counties
• 96% of patients are below 200% of Federal Poverty Level
• $75M budget FY 18-19
• Staff: 710
Community Medical Centers
Behavioral Health Services

• Behavioral Health Program is currently providing services at 17 of our current 18 existing centers.

• In comparison to past years, in 2015 we provide more BH encounters than any other year with an increase of 53%.

• The BH Department accounted for 12% of the total unduplicated number of patients receiving services in 2018.

• 72% of patients were assessed with the PHQ9 process.

• Currently screening patients with SBIRT, PRAPARE, ACE, GAD7 and PHQ9.
Community Medical Centers Trauma-Informed National Collaborative.

• One of 14 primary care organizations who will play a significant role in recognizing and responding to the significant impact that traumatic life events have on the health of patients.

• Through the nine-month program, the organizations will create supporting environments, not only for patients with the long-lasting effects of trauma, but also for the clinical team members who are dedicated to their care.

• Channel Medical Center, Diabetic Clinic

• Specific Indicators

• Screening, Assessment, Treatment and Support.

• 5 different grants focused on TIC.
Trauma-Informed Collaborative

• 100% of patients were identified as having a serious, chronic, and poorly managed health condition
• 7 sites selected a cohort of patients with uncontrolled diabetes
• 2 sites selected patients with depression
• 1 sited selected a cohort of patients with uncontrolled diabetes and depression
• 1 site selected youth patients with obesity
Cohort Data

Total Cohort: 539

Screened for Trauma: 139 (25.3%)
- Negative: 27
- Positive: 109

Screened Positive: 109 (78.4%)

Referred to Treatment: 97 (114.1%)
- Group: 41
- Individual: 74

Assessed Positive for Trauma: 85 (83.3%)

Assessed for Trauma: 102 (93.5%)
- Negative: 19
- Positive: 85
# Health Indicators

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Number of Individuals Screened</th>
<th>Number of Individuals meeting Criteria/Cutoff</th>
<th>Percentage of Individuals meeting Criteria/Cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose</td>
<td>80</td>
<td>77</td>
<td>96%</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>12</td>
<td>10</td>
<td>83%</td>
</tr>
<tr>
<td>BMI</td>
<td>19</td>
<td>12</td>
<td>63%</td>
</tr>
<tr>
<td>Hospitalization/ER</td>
<td>4</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Criteria

- **Blood Glucose**: A1C level at or above 9
- **Blood Pressure**: Blood pressure at or greater than 120/80 mm Hg
- **BMI**: BMI of 24.9 or greater
- **Hospitalization/ER**: Hospitalized at least 1 time during reporting period
California Accountable Communities for Health Initiative

• Through the Healthier Community Coalition, leaders and residents have joined together to create the Healing South Stockton Accountable Community for Health.

• The primary goal is to identify residents suffering from trauma and link them with clinical services and community supports.

• Healing South Stockton partners – including the justice, education, and health sectors - will develop the resources needed to ensure that successful programs are expanded and new evidence-based projects adopted.

• A to-be-formed Healing South Stockton Wellness Fund will ensure sustainability. Further supporting this effort, the Reinvent South Stockton prioritizes policy and systems changes to prevent trauma in the first place. Together, these initiatives will build an environment where children grow up healthy, adults thrive, and everyone lives free from trauma.
California Accountable Communities for Health Initiative

• CACHI Grant Award for $850,000 to address issue pertaining to trauma in South Stockton.

• 3-year period to expand and develop successful trauma prevention and recovery programs in the South Stockton Promise Zone.

• Trauma prevention and recovery was identified as a key community health issue after an analysis of the 2016 Community Health Needs Assessment. This outlines the health priorities identified in San Joaquin County.

• These may include: Trauma and emotional health screening at CMC, a mentorship program for high need foster kids through Child Abuse Prevention Council, Fathers and Families of San Joaquin’s Trauma Recovery Center and training for schools.
South Stockton Promise Zone

• The South Stockton Promise Zone (SSPZ) is a public-private-non-profit collaborative initiative which aims to “empower residents to transform their community—to affect the root causes of intergenerational poverty through improvements in safety, education, housing, job creation, economic development, and health.”

• SSPZ has 3 major objectives:
  1. Create awareness and advocate for the strengths/needs of South Stockton.
  2. Align long-term strategies and resources to improve South Stockton.
  3. Develop civic engagement structures that will provide South Stockton residents a voice in decision-making.
### South Stockton Promise Zone Data Dashboard

**Updated 9/23/16**

#### Educational Equity

**Preschool**
- Percentage of children enrolled in preschool in 2015:
  - Promise Zone: 32%
  - San Joaquin County: 40%

**Elementary School (Snapshot of SUSD Data)**
- Elementary school youth 2015:
  - Promise Zone: 45%
  - San Joaquin County: 24%
  - Third-Grade Reading Proficiency Rate:
    - Promise Zone: 13%
    - San Joaquin County: 27%
- Truancy Rate:
  - Promise Zone: 36%
  - San Joaquin County: 35%

**High School (Snapshot of SUSD Data, traditional district schools)**
- High school A-G Eligible Rate 2015:
  - Promise Zone: 83%
  - San Joaquin County: 82%
- High school graduation rate 2015:
  - Promise Zone: 82%
  - Stockton Unified: 83%
  - San Joaquin County: 82%
  - California: 82%

#### Community Safety

**Uniform Crime Reports (UCR)**
- Percentage of Stockton Crimes within:
  - Violent Crimes: 37%
  - Property Crimes: 25%

**Gun-Related Crimes**
- Percentage of Gun Related Crimes within Promise Zone in 2015:
  - Stockton Crimes: 959
  - Promise Zone Crimes: 404
  - 42%

**Neighborhood Watch**
- Percentage of neighborhood watch groups in the Promise Zone in 2014/2015:
  - Promise Zone: 10%
  - Stockton: 127

For a detailed review of the indicators in the dashboard, please see the SPDZ individual indicator data reports. Any questions, comments, or concerns, feel free to contact Hector Luna at hlarorodriguez@gmail.com.
South Stockton Promise Zone (SSPZ) Organizational Structure

SSPZ Steering Committee

City of Stockton / Reinvent South Stockton Coalition (STAND, El Concello, Visionary Homebuilders, Community Partnership for Families, Dignity Health St. Joseph’s Medical Center, South Stockton Schools Initiative, Community Medical Centers, Fathers and Families of San Joaquin, Beyond Our Gates/University of the Pacific, San Joaquin Public Health Services, Housing Authority of San Joaquin, Data Co-Op.)

Coached by: Policilink

Goal 1: Create Awareness & Advocate for South Stockton

Goal 2: Align long term strategies and resources - South Stockton Promise Zone (SSPZ) Backbone: RSCC (Hector) / City (Michael/Christian)

Goal 3: Develop Civic Engagement Structures

Organizing Outreach Efforts - Partner efforts to engage and mobilize

Beyond Our Gates

Chief’s Community Advisory Board

Ceasefire Coalition

Community Engagement Coalition: OVP

County Homeless Taskforce

Healthy Neighborhoods Collaborative

Healthier Community Coalition

Educational Advocates

Result 1: Early Literacy
Backbone: Beyond Our Gates (Jennifer)

Result 2: Improve Safety
Backbone: SPD/OVP (Patricia/Denise)

Result 2: Trust with Law Enforcement
Backbone: OVP/FFSM/SPD (Denise/Jagada/Patricia)

Result 3: Quality Housing
Backbone: VHB (Blake)

Result 4: Healthy Lives
Backbone: Healthier Com. Coalition (Petra)

Result 5: Transition to Adulthood
Backbone: South Stockton Schools Initiative (Large)

Indicator 1a: Increase Pre-School Enrollment

Indicator 1b: Increase 3rd Grade Reading Rates

Indicator 1c: Reduce Truancy Rates

Indicator 2a: Reduce Violent Crimes

Indicator 2b: Reduce Property Crimes

Indicator 2c: Increase Trust with Law Enforcement

Indicator 2d: Increase Quality/Affordable Housing

Indicator 3a: Increase Homeownership Rates

Indicator 3b: Increase # of Behavioral Health Services Provided

Indicator 3c: Increase % of 5th Graders Who are Overweight

Indicator 3d: Increase # of Students Graduating High School

Indicator 4a: Increase % of Students Who Graduate with A-G

Indicator 4b: Increase # of Students Who Complete Post Degree Certification Year 2-3

Indicator 5a: Increase # of Youth Out of School Employed

Outcome: Data Coordination of all Results & Indicators

Backbone: Data Co-Op (Missy), Except health, that will be HIE