Borrego Community Health Foundation

BORREGOHEALTH

Who We Are

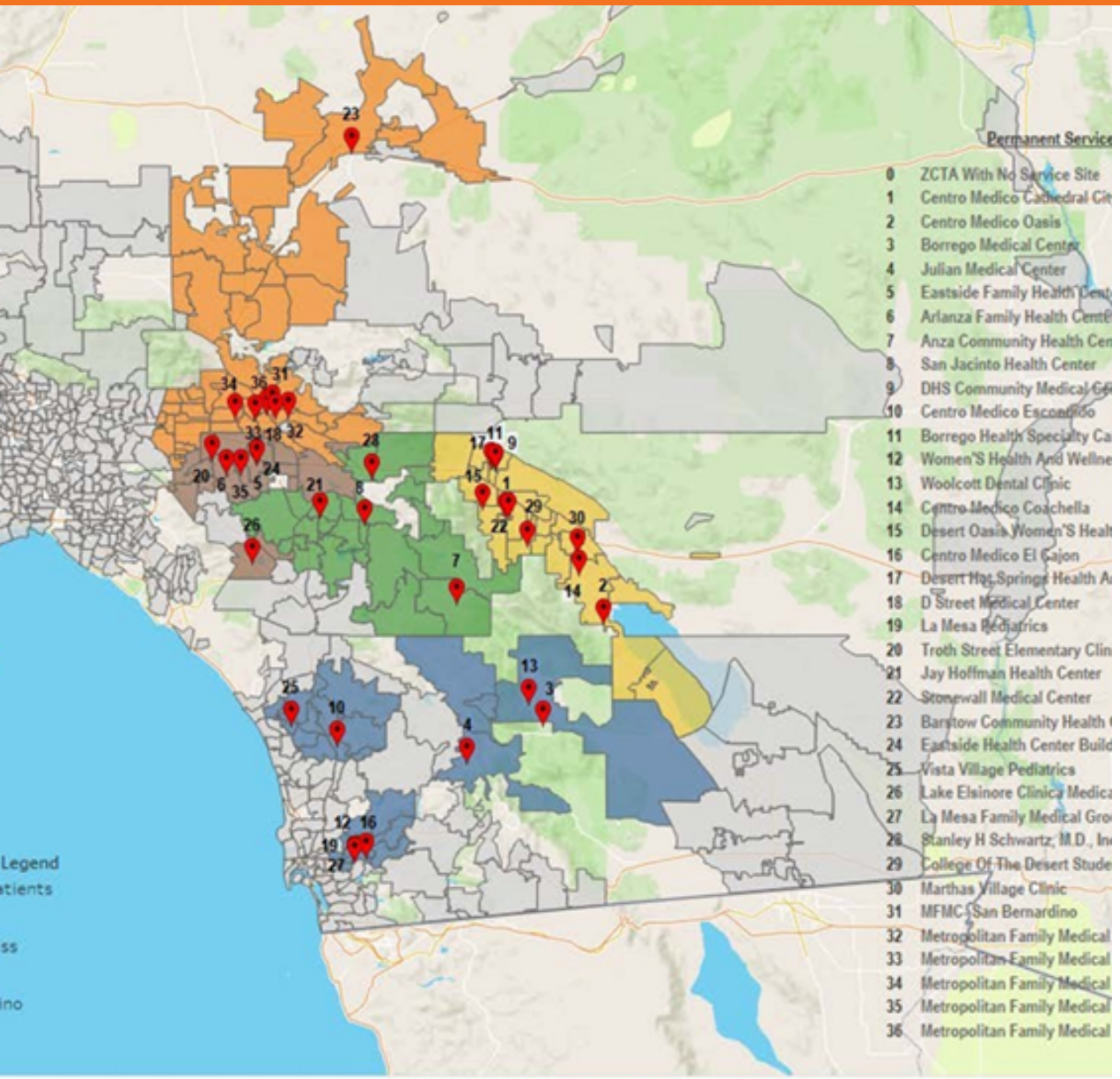
Borrego Community Health Foundation, (d.b.a) Borrego Health, is a 501 (c) 3 non-profit corporation and Federally Qualified Health Center since September 2002.

Our primary focus is the underserved, with an empowered workforce providing measurable quality and compassionate care to its 267,209 patients. 90% of those are low income living below 200% of the Federal Poverty Level (FPL) and 70% live in poverty. Approximately 67% are Medi-Cal (Medicaid) recipients or participate in other public health programs. Our patient population consist of 33% are under the age 18, and 91% are under the age of 65.

- Locations – Serving San Diego, Riverside and San Bernardino Counties
- # of Clinic Sites
  - 28 brick and motar clinics
  - 12 contract medical sites
  - 10 mobile units
- EHR system
  - Greenway INTERGY EMR

CALQIC

Borrego Health Locations



ACE's Screening and Response Pilot Site Locations

San Diego County

- Centro Medico El Cajon

Riverside County

- Centro Medico Cathedral City (Eastern Coachella Valley Region)
- Arlanza Family Health Center (Western Riverside Region)

Borrego Health Core CALQIC Team

Dr. Brenda Figueroa, Chair of Pediatrics, Core Team Member

Dr. Jorge Cervantes, Chair of Adult Medicine, Core Team Member

Sandra Rodriguez, Director of Health Plan Performance & Adult Medicine, Core Team Member

Lucy Aceves, HealthySteps Program Lead, Core Team Member

Stephanie Smith, Director of Program Development, Grant Management

Amar Nijjar, Assistant Business Intelligence Manager, Data Management

Borrego Health El Cajon ACE's Team

Dr. Setareh Jones, Pediatrician, El Cajon Pilot Team

Roxanna Saavedra, Medical Assistant, El Cajon Pilot Team

How You Pivoted in 2020

- January 2020 began with screening patients ages 6, 12 and/or 24 months old; with 1 champion team using PEARLS Screening, giving parents choice of using identified vs de-identified, in order to test our workflow and templates and to see overall patients population response and acceptance of screening.

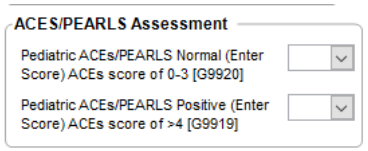
- Incorporate Reach out and Read Program and give books during Well Child screening visits

- We were able to create and test our charter and deliverables
  - Pilot Charter
  - Templates in EMR
  - Staff Workflow
  - Step-by-Step
  - Date Tracker and Dashboard

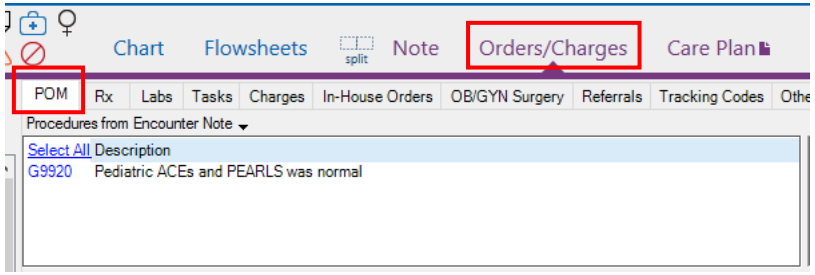
Key Tools & Resources

ACE's Screening Step by Step

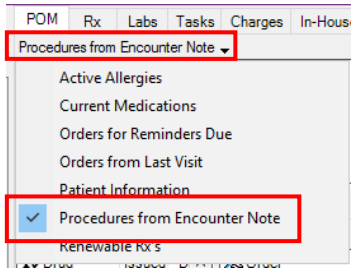
1. To document the Ace's assessment score you can go to the **Staff** or **Pediatric** Form templates.

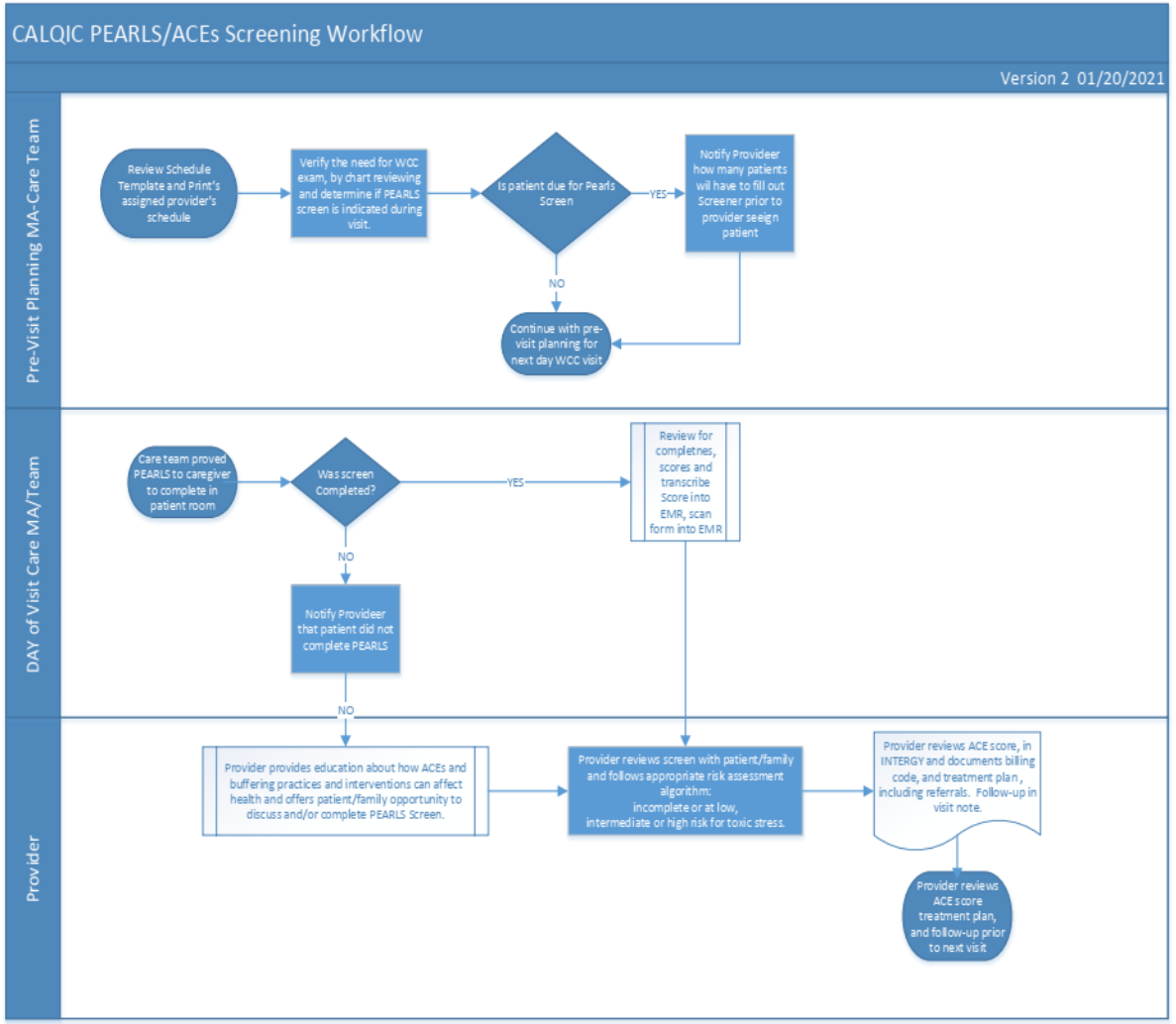


2. Now that the ACEs score is documented, go to the **POM** tab in **Orders/Charges** and select the code(s) to drop in the **Cart**.



Note: To view procedure codes selected in the Encounter Note, you will select the "Procedure from Encounter Note"





Your CALQIC Aims

What is your overall CALQIC Aim?

Current - "BCHF recognizes the impact of ACEs on the health and well begin of our patients and staff, and believes in a healing, relational, and integrated centered approach toward screening and responding to ACEs. To that end, BCHF will improve ACEs screening in all three piloted clinic (Arlanza Family Health Center, Centro Medico Cathedral City, Centro Medico El Cajon) sites using the PEARLS tool for pediatric patients **0-2 years of age."**

Short-Term – "BCHF recognizes the impact of ACEs on the health and well begin of our patients and staff, and believes in a healing, relational, and integrated centered approach toward screening and responding to ACEs. To that end, BCHF will improve ACEs screening in all three piloted clinic (Arlanza Family Health Center, Centro Medico Cathedral City, Centro Medico El Cajon) sites using the PEARLS tool for pediatric patients **0-5 years of age**".

Your CALQIC Sub-Aims

1. Train and attest 100% of eligible clinicians through ACES Aware
2. All participating sites will be screening for ACEs using PEARLS for pediatrics and/or an appropriate tool for adults.
3. Report screening data by participating sites
4. Able to report screening data by race/ethnicity
5. Screen at least 50% of the patients in target/eligible population
6. Become a Trauma Informed work force by Training all staff including Front Desk, Medical Assistants and Security guards at each clinic locations trauma informed training.

What are some of your top changes/ideas to achieve your aims?

1. Establish ACEs clinician training requirements into the Medical Staff Office onboarding process for new providers.
   *To assess the outcome of the PDSA, if proven successful we move towards implementation.
2. *If pilot was not successful, changes implemented in our PDSA, and repeat pilot and evaluate until successful pilot.
   *Validation phase is complete within two weeks from initiation.
3. Once assessment is complete, move towards implementation into expansion sites to begin screening for ACEs using PEARLS for pediatrics.
4. We will be able generate screening data reports by using i2i Tracks & Tableau by using codes built in INTERGY template.
   We will be able generate screening data by race/ethnicity reports by using i2i Tracks & Tableau by pulling patient demographic information in INTERGY EMR.
5. Trauma informed training and work force approach from all staff to assure clinical support staff are sensitive to trauma situations, in a way that enhances connection between patients and providers, helps connect patients to services that they want and need, and leads to better outcomes.
6.

What are you testing or what is your plan for testing changes? What have you learned?

Testing Screening Response and Acceptance

- Allowing parent to choose which screener they would like to use;
  Identified vs di-identified
- Provide Education on Why Screening is Important and how ACEs effect health
- Allow patient time to review and reflect in private setting
- Circle back with patients at future visits is if they declined to screen

What we have learned

- Having patient choose allows patient to disclose what is comfortable for them
- Some patients have stated that some questions are too personal and honest feedback may be difficult to attain
- Staffing shortages can impact workflow and can lead to screening being skipped
- High no show rates have impacted the number of screenings completed
- We are still in early stages of screening, workflows may need adjustment by site/ volume

Current Challenges or Barriers

1. Losing Staff at our 1st Pilot site in El Cajon and Origination wide staff turn over and staff burn out.

2. Rolling out ACEs screening in the new world of telemedicine and high no shows for in person visits.

CALQIC Next Steps

Short Term Next Steps

- Review Staffing at all pilot sites to ensure staff is adequate to take on screening
- Meet with providers to creat Champion Teams
- Expand throughout Peds departments in El Cajon, Arlanza and Cathedral City

Long Term Next Steps

- Expand to other ages within pediatrics ages 3-20 Years old, once ramp up starts and patients return to clinic
- Expand to all Borrego Sites 21-64 Years old

Long Valley Health Center

Who We Are

- Laytonville, CA
- Eclectic Population – small town of approximately 1500-2000, we serve approximately 2800 patients
- 1 clinic site
- E-Clinical Works (eCW)

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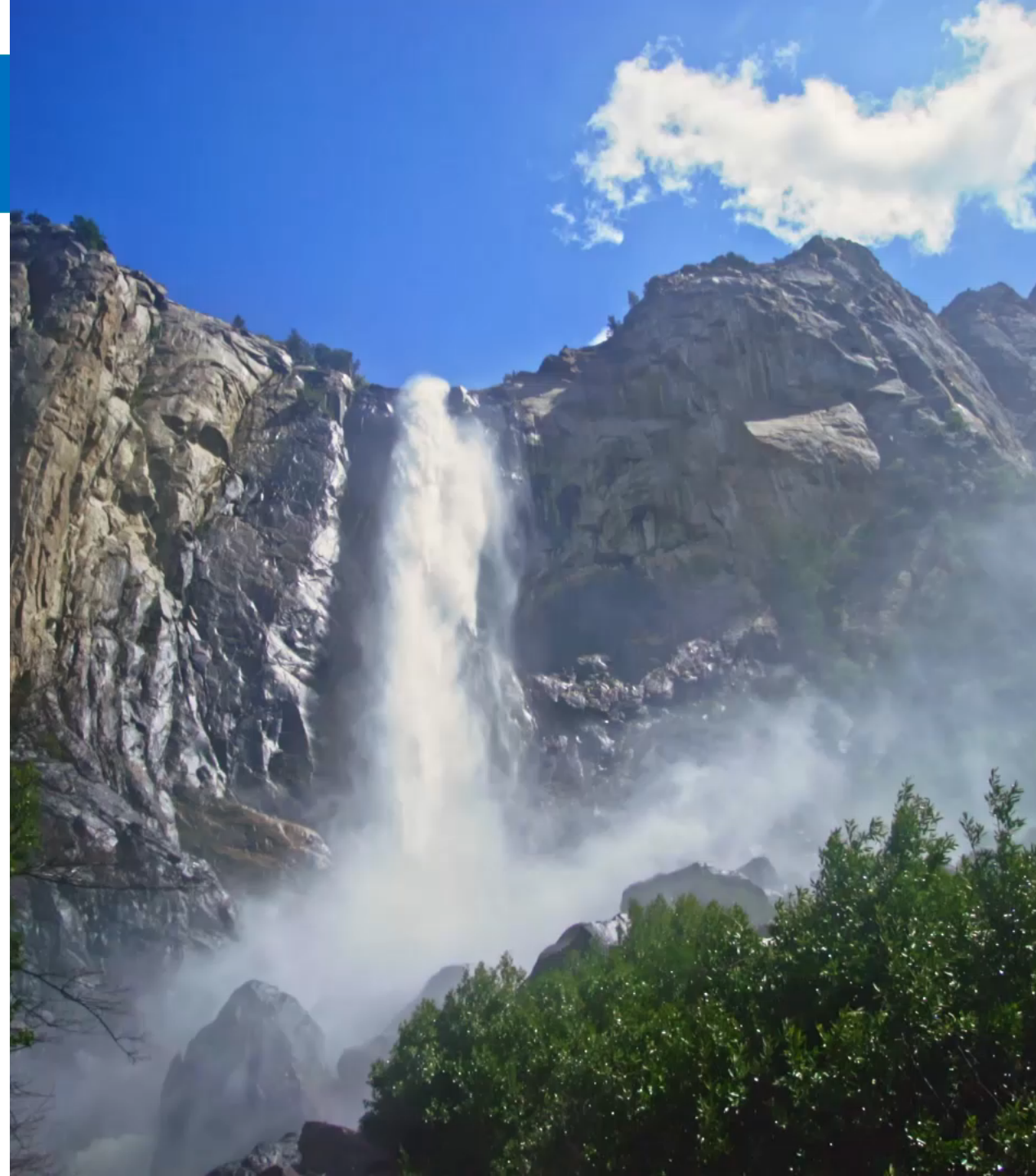


Our CALQIC Team

Rod Grainger, Executive Director

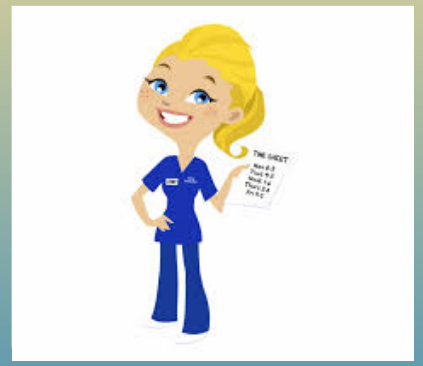
Larann R. Henderson, LCSW, Behavioral Health Director

Michelle Hill, Quality Improvement & Clinical IT Coordinator

Leanna Birge,

Grants Manager

Carrie Guilfoyle, NP,



Michelle Downes, Nurse Educator

Current State: ACEs Screening & Response

- Our original goal of having medical providers administer the ACE screening to all patients has evolved into a staggered 'roll-out' of 4 co-horts
    - Chronic Pain Patients 18 years and older
    - Diabetic Patients 18 years and older
    - Hypertensive Patients 18 years and older
    - Patients 18 – 35 years
- We have been providing trainings for staff who will be administering the ACE screening. This has included CALQIC partners demonstrating through role plays.
- The events of 2020 significantly impacted our clinic in a variety of ways. We had patients AND employees impacted by extreme weather and local wildfires.
- The COVID pandemic closed our doors, and we began to provide care primarily through telehealth. We continue this, only opening up to a limited number of in-person visits in the last month. This severely limited our ability to successfully administer the ACE screening to our patients.

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What have we learned

- Our team's strengths:
  - We have developed workflows, and a roll-out plan
- Areas for development:
  - We need to develop more education for those who are administering the screening
  - Tools and interventions to promote resilience

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Overall Aim & Sub-aims

LVHC will implement the ACE screening protocol for our four specific cohort groups starting March 1, 2021 with the goal to screen at least 20% of our target population by October 31, 2021 to improve the overall health, wellbeing and resiliency of our patients.

1. Train and attest 100% of eligible clinicians through ACES Aware
2. All participating sites will be screening for ACEs using PEARLS for pediatrics and/or an appropriate tool for adults.
3. Report screening data by participating sites
4. Able to report screening data by race/ethnicity
5. Screen at least 50% of the patients in target/eligible population
6. Improve ACE screening for each identified cohort by October 31, 2021

Challenges and Barriers

- Education –
  - We need to develop more information for patients and the community
  - We need to develop more educational trainings for staff to increase comfort in administering the screening
- Telehealth
  - Telehealth has brought with it unique challenges in administering the screening

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Family Health Centers of San Diego

Who We Are

- Founded in 1970, Family Health Centers of San Diego provides caring, affordable, high-quality health care and supportive services to everyone, with a special commitment to uninsured, low-income and medically underserved persons.
- 215,000 patients served each year, of whom 91% are low income and 29% are uninsured
- We operate 49 sites across San Diego County, including 23 primary care clinics, 10 behavioral health facilities, eight dental clinics, an outpatient substance use treatment program, three vision clinics, physical therapy departments, two mobile counseling centers, three mobile medical units and a pharmacy to support services throughout San Diego County.
- Lead service provider of Healthy Development Services funded by First 5 in East and Central San Diego

  EHR system is homegrown

CALQIC

Our CALQIC Team

Jenan Madbak- Clinic Director, Downtown Connections/Elm Street Clinics - TIC Champion

Sara Duran - Associate Director of Special Populations – TIC Champion

Dr. Wendy Pavlovich - Director of Training - Pediatrics, North Park FHC, Training Lead for Residents

Kimberly Kelley – Manager, El Cajon Youth Counseling Center – Mental health liaison

Janelle Kelso- Clinic Director, El Cajon FHC – Ensure operational rollout at sites

Shefali Sinha – Business Intelligence Analyst - Data, evaluation and reporting

Tony de los Santos – Clinic Director, North Park – Ensure operational rollout at sites

Dr. Khawla Suleiman-Qafiti – Chief of Pediatrics – Medical Leadership Champion

How FHCSD Pivoted in 2020

- Original plan – to begin at the smaller of the three clinics, among adult populations first.
    - Pivot – to begin at North Park where CALQIC provider champions were located and due to the abundance of pediatric resources vs the dearth of resources for adult ACE response.
- Original plan – start with the six members identified which included only clinic operations, one IT/data analyst, and one programmatic member
    - Pivot – included a medical leadership champion with vast experience in implementing innovative programs in pediatrics and a mental health liaison with experience in implementing ACE screening at another location
- Original plan – leverage ACE screening to further Trauma Informed Approach
    - Pivot – COVID made it difficult to meaningfully involve patients, their families, and other interested community members in the process
    - Pivot – COVID and responding to racial injustices also intensified other priorities across the organization, with CALQIC team members, and with agency executive leadership

Fall 2020 Capacity Assessment – Lessons

- Surprises?
  - We have a foundation that is well-suited to implement trauma-informed care and related activities even though we have not had any formal training or processes instilled within FHCSD.
  - Highlighted the need to center this work in equity and social justice.

- Areas of Strength:
  - Environment score was our highest average score.
  - Our sites and policies are set up to prioritize safety and privacy for patients during their interactions with FHCSD.
  - Multitude of comprehensive medical and psychosocial services our patients have access to.

- Areas for Development:
  - Patient education about toxic stress and it's link to health.
  - Education and training on trauma-informed care and toxic stress for staff and providers can be further developed. Since the capacity assessment we have worked towards providing more education and training opportunities for our staff.

- Impact of results:
  - Helped us to clearly see further areas we needed to focus on beyond just implementing the screening tool.
  - The assessment helped start a conversation and spark interest among team members to talk about and incorporate trauma-informed care into our practices.

CALQIC Aims & Sub-Aims

FHCSD aims to improve the quality of our patient's care and staff experience through to using a Trauma-Informed Care (TIC) methodology, including ACE screening, to identify and mindfully integrate all patients' traumatic experiences, beginning with the screening of pediatric patients, and responding to risks through referrals and resources that are culturally sensitive.

1. Train and attest 100% of eligible clinicians through ACES Aware
2. All participating sites will be screening for ACEs using PEARLS for pediatrics and/or an appropriate tool for adults.
3. Report screening data by participating sites
4. Able to report screening data by race/ethnicity
5. Screen at least 50% of the patients in target/eligible population
6. Provide training for all employees on equity and implicit bias

Changes to Achieve Aims

- Development of workflow with IT
    - Identify WHO and WHEN we screen (under 5, during WCC visit)
- Development of scripting
    - Incorporating feedback from MA staff
    - Scripting inputted into InterAct
- Hands on training with nursing leadership and preceptors for nursing and medical assistant staff
- Education and training of medical providers with continuous support through virtual meetings led by medical provider champions
- Formulating assessment and plan SMART phrase to incorporate in EHR
    - Inclusion of 'ACEs risk assessment algorithm' in the ACES screen order set
    - Develop referral(s) plan
    - Creation and inclusion of educational materials in multiple languages on toxic stress, ACEs, and self care
- Leverage additional grant funding to support response protocols for families identified with high-risk ACE scores

Testing Changes and Lessons Learned

- Tested workflow and scripts by eliciting feedback from providers and MA staff
    - Learned to use simpler language and had to shift language in different languages to ensure cultural responsivity (example - "challenges" instead of "traumatic experiences"
    - Modified handouts different languages to ensure cultural responsivity (Arabic)
    - Checking in with MA staff before every q2 week team meeting.
- Began pilot with one provider at one clinic site, then expanded to two providers, then all pediatric providers within the same clinic.
- After 3.5 weeks of piloting at one clinic site, we expanded to include an additional location.

Lessons Learned:

- Challenges with MA work flow – changes made were to have preprinted forms in the exam rooms available when screening indicated so MA didn't have to go to printers.
- MA and nursing staff absences - required frequent on the spot trainings and review to ensure that MA were completing the screening.
- Parents were open to talking about ACEs and interested.

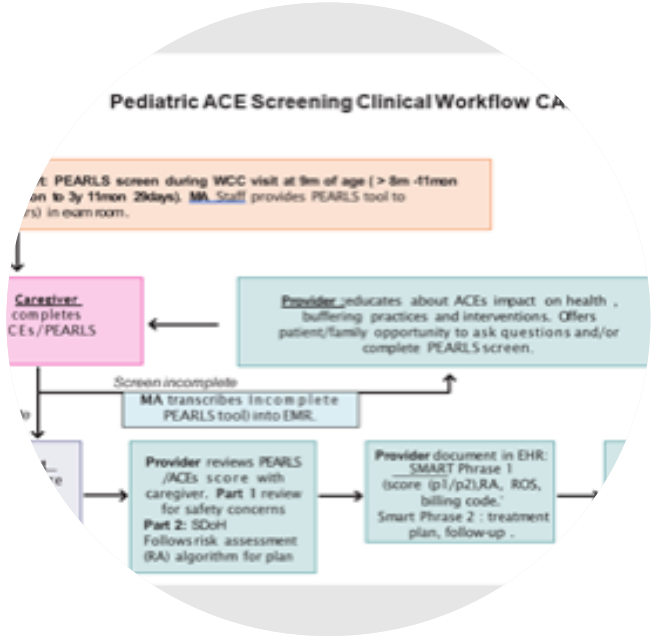
Impact, Results & Stories to Date

- Results
  - 31 total staff trained
  - 53 patients screened at North Park
  - 27 patients screened at El Cajon
- Impact
  - Patients are very responsive and feel that doing this screening “makes sense”
  - Identification of other family members who need support (Parents and siblings)
  - Broadening medical differential diagnosis
- Stories
  - 11-year-old sibling need was identified while doing the screening for the toddler, the parent chose to answer the PEARLs screener for her 11-year-old child instead.
  - During a toddler visit, PEARLs screening score was 1, parent discussed that she has a history of alcoholism, opened the door for discussion and history taking on alcohol consumption and neurodevelopmental issues related to alcohol that may be part of the developmental challenges her child is facing but was not discussed before.

Key Tools & Resources

ACE self care: created by our local AAP chapter with input from members of this team.

Understanding ACEs Arabic



Workflow

Current Challenges or Barriers

1. Encouraging patients of multicultural backgrounds to be honest forthcoming in their responses

2. When nursing staff and medical provider coverage changes/cross-coverage occur, and staff are not trained in delivering PEARLs screening

CALQIC Next Steps

- Begin ACEs screening at Downtown clinic
- Provide continued training and support to medical providers and provide opportunities for case discussion
- Develop documentation and communication tracking of Family Support Specialist with the medical providers and the individual families
- Developing a QA team to ensure our data collection is an accurate reflection of what we are capturing in EHR