
Good health begins with harmony
Harmony
Health
MEDICAL CLINIC AND FAMILY RESOURCE CENTER
a californiahealth+center

Who We Are

- Main Location: 1908 N Beale Rd, Marysville, CA 95901
- Three Clinic Sites serving Sutter and Yuba Counties
- eMDs EHR system
- We are the only FQHC who has a freestanding “out of hospital” Birthing Center

Our CALQIC Team

Theresa Boswell, PhD, LCSW, Director of Behavioral Health, Oversee IBH, MAT, & Case Management Services

Johl Harpreet, MD, Chief Medical Officer, Oversee all patient care services

Alicia Aguirre, LVN, Operations Manager, Oversee clinical operations & MAT Case Management

Luis Palacios, Data Analyst

Bryana Mireles, MA, MAT Case Manager

[How You Pivoted in 2020]

- As a result of COVID-19 we began screening via Telehealth, which included Audio and Video visits. We are screening adult patients with the ACEs Identified screening tool.
- Screening patients over the phone and via video has been challenging for several reasons. The overall time that it takes to screen a patient has increased, there are more technical challenges, we have not been able to access as many patients due to technology limitations and constraints in our area, and patients are declining more due to the lack of connection created by the Telehealth visit.
- Before COVID-19 occurred, we were working on a pilot project providing a combined treatment approach with patients with SUD. Unfortunately, we had to postpone the project due to the inability to provide in-person visits/sessions. The program continues to be on hold.
- We are seeing an increase in our behavioral health visits due to COVID-19, and as a result, the Behavioral Health Director needed to take on more patient care time within her schedule. We initially had several providers take furlough as result of COVID and throughout 2020 providers and office staff were off work due to being impacted by the virus.

[Fall 2020 Capacity Assessment: What You Learned]

- In completing the assessment, we were surprised by our staff's overall resilience through the current pandemic and their willingness to engage patients in a deeper level with screening for ACEs.
- Our team works well together, and we trust and respect one another's unique lens for providing patient care. We are all flexible regarding thinking outside of the box to meet the needs of our CALQIC goals and activities.
- Our team's area of development include developing a QI process for tracking screening and response, providing patients with formal patient education on immediate safety, adversity, distress and resilience, and providing training to supportive staff on screening for ACEs.
- The assessment results impacted our work by bringing to our attention the need to provide more support to our healthcare teams with relationship- based trauma- informed information and training. We have also identified that we need to establish a process for patient and community input regarding our clinic activities and approach to patient care.

[Your CALQIC Aims & Sub-Aims]

What is your overall CALQIC Aim?

1. We will screen at least 50% of our cohort populations with the Adult Identified ACEs to include, MAT/Hypertensives/Diabetics/Prenatals
2. Train and attest 100% of eligible clinicians through ACES Aware
3. Develop the ability to report screening data by race/ethnicity
4. Our Sub-Aims is to improve our patient experience with improving the patient's ability to contact their providers in a timely manner.
5. Sub-Aim- Create patient information/education handouts on ACEs screening, community supports, & resilience
6.

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

- Screening our Cohorts:
  - Having our CALQIC coach provide training to our support staff around screening for ACEs and potential outcomes, to assist with providing appropriate responses and supports for patients
  - Expanding the number of providers screening per cohort versus having only 1 provider screen per cohort

- Improving our patient experience
  - We are working on implementing a “call-forward” feature to our phone lines to allow patients to connect with their direct provider
  - We have created an informal campaign to get as many patients connect with the patient portal
  - We are developing patient education tools around screening for ACEs to include community supports, explanation of ACEs and resilience

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

- We were testing having 1 provider/MA screen for ACEs with our Diabetes patients.
- Based on feedback from the provider/MA team and identifying the number of patients within our total population, we have learned that this is a huge population among our patients and therefore we decided to have all our PCP's assist with screening these patients
- We assumed that our provider who specializes in Diabetes could handle the screening, but this provided to be overwhelming, and we pivoted to include all PCPs in our screening efforts for patients with Diabetes
- We have learned that our MA's need additional training when providing the screening tool to be able to respond to difficult questions posed from patients and to avoid re-traumatization.
- Based on feedback from our MA/Provider team we have discovered that there are questions being posed to the MA that are outside of her scope of training. So, we have decided to provide specific ACEs training to our support staff proactively to avoid issues that may come up.

[Impact, Results & Stories to Date]

- We have screened approximately 55 patients based on Q4 data provided. We have approximately 12 providers eligible for billable ACEs screening. Five providers have completed the ACEs AWARE training reported on Q4 data report. As of date, we have 9 providers complete the training.

- We have been providing the ACEs screening tool to our existing and new MAT patients that are prescribed Suboxone for their Opioid addiction. While screening a new MAT patient who identified with 8 ACEs, I was able to have a conversation on how their ACEs may have contributed to their current drug addiction, and how receiving the current support is valuable in allowing them to get their life back. I was able to connect the patient with appropriate resources to support their journey of being sober. The greatest moment of this interaction was the patient realizing how their trauma impacted their current life (understanding the connection), but more important, that they have the where withal to bring about important change in their life (through identifying their resilience thus far)and that they are now in a program to support this change.

[Current Challenges or Barriers]

1. We identified a challenge with having an MA provide the questionnaires to patients. The MA struggled with how to respond to difficult questions and observations from patients being screened. We have already explored this topic with our CALQIC coach, and she will be providing training and additional vignettes around screening for ACEs for our Support staff.

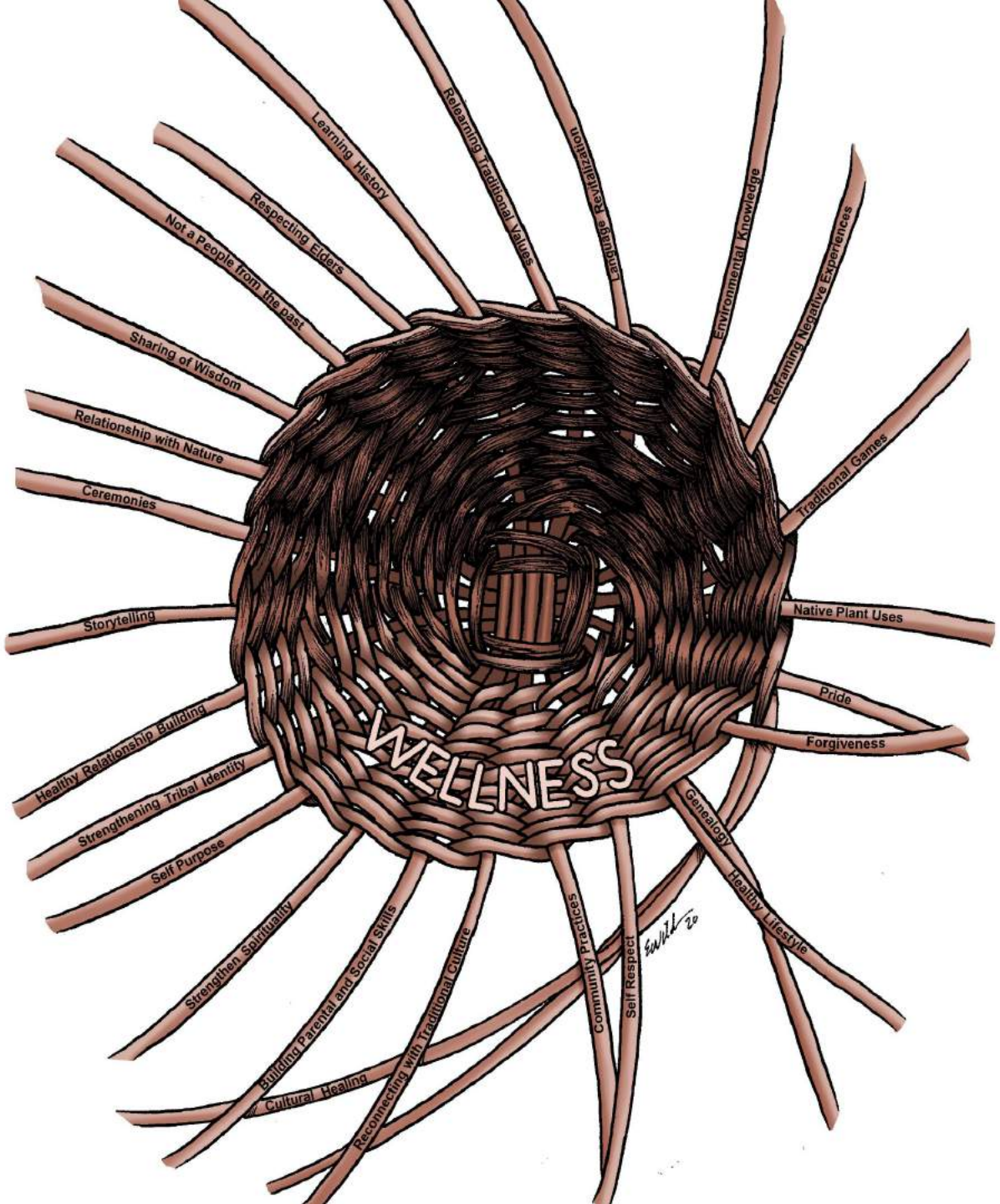
2.

[CALQIC Next Steps]

Our next steps are to include as many PCP's in the screening process as possible. We are working with our CALQIC coach around providing training for our Mas/PCPs and front office support staff to assist with expanding this process.

We have scheduled the supportive training for our staff with our CALQIC coach in April 2021.

Our next cohort of patients will be our Prenatal population, and we have hired an RN that will be integral in the screening process and coordinating patient care that results from the screening.



SCIHP
Sonoma County Indian Health Project Inc.

Who We Are - SCIHP

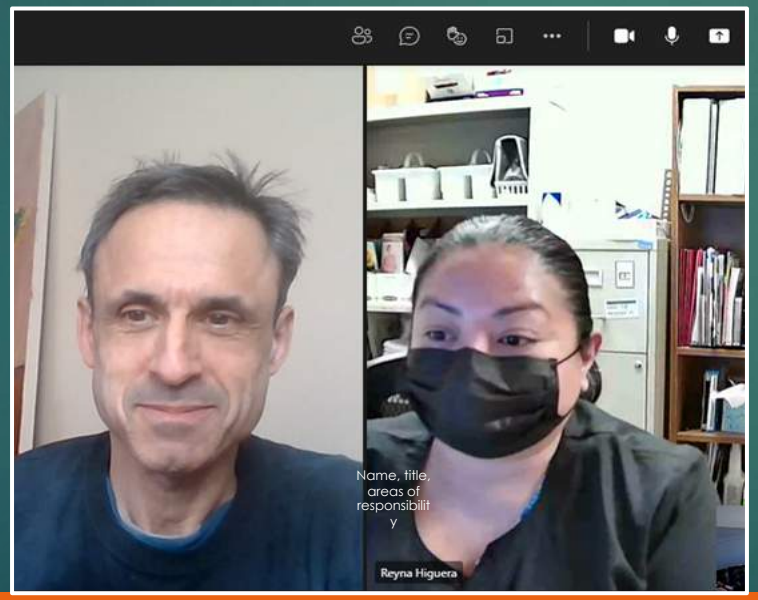
- 2 Clinic Sites, "Urban" and Tribal
- Santa Rosa and Point Arena, CA
- Next Gen system
- SCIHP is an organization truly lead "for and by the people". The organization was developed to meet the growing health disparities in local "Indian Country" and continues to be led by the local sovereign nations.

Our CALQIC Team on Teams

Alison Whitemore LCSW (Pomo)
Clinical Supervisor

Dr. Mark Goodwin
Medical Director

Kurt Schweigman MPH (Lakota)
BH Director



Champion Teamlet –
Dr. David Almond and Reyna Higuera CMA (Pomo)

Catherine Sorensen RN
Nurse Manager

2020 – Year of the False Starts

Staff relocation

- Lost first 2 champion teams
  - Starting again to train new teamlet

All the COVID ways

- Daily COVID testing for community
- Vaccine- All staff complete, offered to all patients over 18, next step; non-Native/non-patient families of staff and patients
- Quick pivot to telehealth
- Opening to more Wellness Visits

Return to Innovation

- Foundational trainings and staff wellness

Capacity Assessment as Storytelling

Multiple points of reflection

- We have a stronger sense of ACEs than we anticipated
- We have ongoing need for leadership and community readiness
- We need not to lose sight of resilience assessment and strength-based conversation starters

SCIHP CALQIC AIM -

SCIHP patients, the members of local and non-local tribes, have suffered generational trauma due to racism and classism. This endeavor to genocide intended to dismantle cultural lifeways and dispossess the people of their roles as stewards of these lands. Poverty, grief and the inability to use traditional healing caused violence and neglect to enter the Native family system. SCIHP intends to acknowledge these macro losses, current interpersonal traumas and to assist tribal community members to the connections between these extraordinary losses, health disparities and the opportunities for healing that exist today. Through the conversations created from the ACEs screening SCIHP endeavors to build the capacity of the staff to listen, understand and educate around the relationship between mind, body, spirit and heart, historical trauma, toxic stress and Native healing lifeways in order to transform the relationships community members have to their care at SCIHP.

SCIHP Sub-Aims- of Note

- Pilot based teamlet capacity building for implementation
- Train-the-Trainer sharing of innovation across teamlets
- Foundational trainings – TIC, HR, MI, ACEs
- Ensure policies impacting patients reflect relational healing through TIC system change

Testing Change

- Focus on Teamlet pilot and train the trainer to spread innovation and engagement
- Use of Social media to ready community
- Foundational training as lack of ACEs conversation in Indian Country

Impact, Results & Stories to Date

- Staff conversations about ACEs, Toxic Stress and epigenetics
- Deeper reflection on cultural fit of ACEs screening

Current Challenges

1. Foundational training gaps

2. Fear around implementation; retraumatizing, role confusion, edges of burnout

Los Angeles Christian Health Centers

- Located in Los Angeles
- 2 full time clinics, and 10 part time sites
- We serve the homeless, working poor, undocumented, and the healthcare underserved
- /marginalized populations
- We use e-Clinical Works

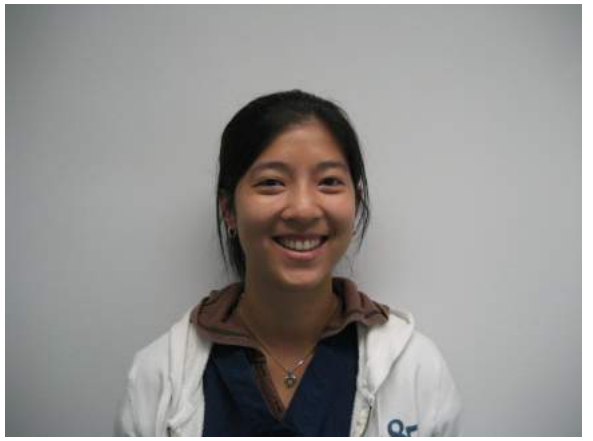
Los Angeles Christian Health Centers

- Important things to know about us:
  - Faith based organization
  - We provide provides optometry, dental, mental, and medical services

CALQIC TEAM

Pamela Roper MD
Co-Lead

Byron Rivera PsyD
Co-Lead



Christina Teeter PA
IT

Madison Godfrey RN
Outreach

Dina Brent MD
Data Collector

[How We Pivoted in 2020]

BEFORE

- Provider Driven
- Only pediatric patients being screened
- Referred to Mental Health if ACES score ≥ 4
- If score < 4 no discussion about important factors
- No healthy lifestyle handouts available
- No scripts or talking points for positive screens
- No resources readily available for the provider to give to patient (e.g., food pantry).

[How We Pivoted in 2020]

NOW

- **MA** Introduces the ACES form
- **Adults** and peds being screened
- Continued referrals to Mental Health if ACES score ≥ 4
- Healthy lifestyle handouts available
- Scripts and talking points available for providers, frontline staff, etc.,
- Ways to maintain a healthy lifestyle and the role of resilience
- Regularly updated digital resource guide accessible

We wanted to have specific scripts for various situations that might arise for providers, but our progress was slowed due to the pandemic, fires, and the focus on racial unrest.

[Fall 2020 Capacity Assessment: What We Learned]

- Completing the assessment, we were surprised by the lack of inclusion of the staff in discussing the screening, and that the work had been completely provider driven.

- Although we care for homeless folks, people of color and the underserved communities, we have no comprehensive training for our staff on how to deal with their trauma, or how to interact with people who are experiencing trauma.

[Fall 2020 Capacity Assessment: What We Learned]

- Strengths
  - Already screening for ACEs in pediatrics.
  - On site mental health services and care coordination at both clinics
  - Leadership is very supportive

- Areas of development
  - Staff training about ACES
  - Staff Wellness programs
  - Increasing Community Connections

[Our CALQIC Aims & 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.

[Top changes/ideas to achieve our aims]

- MA and provider scripts developed
- MA to introduce form prior to provider coming into room to increase completion rates
- Handouts given to providers about healthy lifestyles
- Screening workflow developed
- Computer template completed with codes and prompts on what things to discuss with patients who complete screening
- Posting signage reflecting that trauma screening is occurring
- Short videos to play in waiting room discussing trauma screening to increase awareness of ACEs and reduce stigma
- Didactic training for all staff on ACEs, trauma, screening tools, resources, and coping tools
- Photography contest to better reflect the communities we serve

[Testing changes & What We learned]

- Testing if MA introduction of the form will increase ACES/PEARLS completion rate.
- Testing with 2 adult teams, and the pediatric team
- Workflow for adults in progress.
- Attempting to determine when is the best visit to test (e.g., first or subsequent visits).
- Only with patients the provider knows.
- Workflow being done with one adult provider at each of our 2 sites.
- NO PDSA because changes just started this week.

[Impact, Results & Stories to Date]

- Staff is more informed of trauma and its relationship to health
- COVID caused surge in need of MH services (e.g., 100+ patients on waitlist), so we anticipate that COVID will have a significant impact on the ACEs in the communities we serve.
- Upcoming opening of Joshua House Health Center, which will drastically increase space and programming capacity (e.g., yoga class).

[Key Tools & Resources]

Please email CCI (nikki@careinnovations.org) copies of shareable resources so that we can post to the CALQIC program website.

Digital resource guide available to the providers, for the patients, updated regularly by our care coordinators.

Scripts available for MA to introduce the screeners, and for the provider to discuss the results of screening.

[Current Challenges or Barriers]

1. Challenge of getting permission to use video content of trauma screening related content, or creating our own content

2. The challenge of getting the screening workflows started because of the distractions/interruptions of COVID related activities such as screening, patients only coming for acute visits, and now developing a rhythm with giving COVID vaccines.

[CALQIC Next Steps]

Finalizing the work flows and starting adult screening..

Increased community engagement though our photography contest.

Developing a wellness program for our staff.