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| **Healthcare Domain Meeting**:  **June 19, 2020 9 am-10:30am**  Via Zoom | **Next Healthcare Domain Meeting:**  **July 17, 2020 9am-10:30am**  Via Zoom |
| **Attendees: Kathryn Goldberg, Luisa Montes, Jake McGough, Emma Wan, Deirdre Kleske, Lexie Palacio, Aryeh Feldheim, Shaila Serpas, Stacey Kurz, Julie Castaneda, Brigitte Lamberson, Amanda Mascia, Penny Adler, Mariela Martinez, Kusaynyonon Mackenzie, Shannon Jackson, Barbara Hughes, Joangrace Espiritu, Blanca Melendrez, Carissa Hwu**  **Recorder**: Carissa Hwu | |

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| **Topic/Issue** | **Discussion** | **Action** |
| **Welcome/Introductions** | Mary Beth led introductions. |  |
| **ACEs Presentation and Discussion** | **ACEs Screening in Primary Care Setting**  Background on ACEs   * Key components: abuse, physical/emotional neglect, household dysfunction * Original Kaiser Study laid the groundwork for ACEs. Found that there is a strong association between experiences of trauma and obesity. ACEs lead to adoption of health risk behavior. * ACEs 🡪 Social, emotional, and cognitive impairment 🡪 adoption of health risk behaviors (e.g., smoking, alcoholism, self-harm) 🡪 disease, disability, social problems 🡪 premature death * Leading causes of death in the US: heart disease, cancer * Exposure of 4 or more ACEs increases likelihood of dying from one of the leading causes of death * ACEs is associated with numerous different health conditions   State of California Initiative   * California Surgeon General has put spotlight on ACEs in California and brought it into legislation * AB 340: developed an advisory group for recommendations. Created 3 options for screening children (PEARLS), whole child assessment tool and third tool that meets same criteria as PEARLS too * AB 340 is good for providers and anyone else doing work with ACEs * Online training and in-person training * Option given to provider * 3 different age categories of forms depending on age of patient to fill out   Screening vs. Assessment   * Sample Workflow * PEARLS screen is entered into the patients’ electronic health record * Screening is one step, but assessment is the important part   Assessing ACEs at a School-Based Health Center at the US-Mexico Border   * Scripps Family Medicine Residency Program: started in 1999, over 100 graduates * ACEs-related efforts: Southwest High School Health Clinic. 13 year collaboration. Provide healthcare on campus. On a school-level, the school has been emphasizing restorative justice efforts. On-site, there is a psychologist, health educator, and more. * SBHC ACEs Screening: purpose is to conduct feasibility, assessment, and prevalence. Screening results: 80 total surveys (no opt-outs). Section 1: 49% have 3 or more ACEs   Reflections from Pilot Study   * Challenges: balancing competing requirements, survey fatigue, provider discomfort, unmasking trauma, how to handle high scores, how to address every positive score, adequate resources to provide support * Opportunities: integration of tool with EHR, expand screening beyond SBHC setting   Expanding Implementation of ACEs Survey   * Multidisciplinary team * Preparing the practice (staff, front office providers, patients) * Clinic and community resources * Logistics and workflow of implementing the survey * Selecting which form to use   Implementation of ACEs Survey During COVID-19   * Recognizing COVID-19 as an ACE * Challenges: reaching adolescent population with schools closed, continuing confidential services for adolescents, no sports physicals, fear to come to office, drop in immunization rates, regular preventive visits   Stress Busting Strategies   * Strategies during COVID * Balanced nutrition, mindfulness, physical activity, quality sleep, supportive relationships, mental health care   Building Resiliency   * Help high school students who are interested in health careers to acquire experience with suturing, etc. * Developing virtual activities to continue this work with students   **Discussion**  When it comes to screenings, at what point in the visit are the forms administered? How does the provider build rapport before these heavy topics are broached?  Still navigating this. Patients fill this out in the beginning of their visit. Discussion of whether the providers should be handing these forms to patients. The more trauma-informed we become with trainings, providers will not be imposing any plan. Rather, providers will build better tools to conduct motivational interviewing and help parents to develop ways better protect their children from ACEs.  The Y is having their staff go through ACEs training. Weaving trauma-informed care into their work has been really beneficial. It took a little bit to get the buy-in from staff to do this. But once staff sat down and listened, they oftentimes would see the importance of knowing about ACEs.  Have you tracked the relationship between ACEs score and behaviors like drinking, smoking, etc?  Tracked this relationship on a population level and seen this 1:1. Over the years, we have been screening for safety. Not enough data collection yet. Challenge is the confidentiality that needs to be maintained when working with teens. After entering data in EHR, these trends will be easier to be tracked.  School-based health centers are so important. City Heights has several school-based health clinics. Model of bringing healthcare to the school is growing. Teen pregnancy rates drop with school-based health clinics.  At the elementary school level, if children don’t have a constant source of healthcare, how will these assessments be made?  These assessments can be done at any visits. The challenge is actually for teens since their parents don’t have to fill these out for them. If they come in while sick, this may not be the opportune time to ask teens to fill out the screening because they may want to rush through it. But providers are being trained for this to try to make sure as many young people are being tested as possible at proper times.  Score of 1-3 may not trigger referral for the child. But other factors are also taken into account like co-morbidity, if parent is concerned about a behavior, etc.. Scores are not one size fits all. Don’t want to overwhelm behavioral health partners by sending all children with high ACE scores to them. So providers are taking on this work to support. Parents should also be given resources if they are dealing with their own mental health challenges. Shift to providers being tasked with providing resources and follow-up so behavioral health partners are not overloaded.  Clear need for teachers to learn more about restorative justice. Kids’ behavior in schools can be a reaction to things going on in their home life. The way teachers respond to kids’ behavior is extremely important, whether they choose to be punitive or supportive. This echoes the restorative justice piece that was discussed earlier.  There needs to be preparation for anyone handing out these forms that there is secondary trauma. There needs to be a context and system of support for anyone who will be screening so that screening will actually be followed with emotional support and referrals. Teachers cannot just screen students and then not give them resources or referrals.  How do we move forward with this knowledge in our work with ethnic-based organizations?  Cautionary tales should be integrated in all organizations. Need to be preventive about secondary trauma. Many people within these community-based organizations have experienced similar trauma to the children they might be screening. Need to have a system in place to support the people working in these community-based organizations as well as referral system for children. |  |
| **COI Announcements and Partner Updates** | Nominated two Champion Provider Fellowship facilitated by UCSF: Dr. Wendy Hunter and Dr. Fadra Whyte McPhee. This is a 2-year commitment with 5 hours a month to support providers in championing environmental, system and policy change for the health outcomes of an entire community.  COI Updates   * New Leadership Council Seats: Youth Ally Seat, Trauma Informed Seat, Food Systems Seat, Policy Seat * Currently also recruiting for Bi-National, Behavioral Health, and Tribal and Refugee Leadership Council Seats * Healthy Workplace Accelerator Program: free personalized workplace program through Live Well. Take an assessment for organizational support, nutrition/physical activity, other wellness efforts. Track progress, collaborate, get recognized. For small to medium sized organizations. * Community Domain Frontline Model: create “front-line community teams” in under-resourced communities. Enable “frontline” to identify needs and other unmet needs Elevate voices to ensure needs are part of central decision-making process * Summer Project: Assessing the Landscape of Lifestyle Medicine Resources in SD County for Children in Underserved Communities – treats underlying lifestyle factors of disease rather than symptoms. Healthful eating, physical activity, stress management, sleep, relationships * Kyleigh Kirbach will be working with 211’s Community Information Exchange (CIE) in developing children lifestyle medicine resources into their ecosystem to connect clinicians with community resources for children in the continuum of care. * Advocacy: School Nutrition Reimbursement. COI has signed on to support $63.2 million for the California State budget 2020-2021 for public school nutrition departments to receive flexible resources to continue feeding children. | Reach out to Amelia Barile-Simon to ask her to present on Healthy Workplace Accelerator Program at the next Health Care Domain meeting. |
| **Next Meeting** | The next meeting will take place on **July 17 from 9:00 AM – 10:30 AM.** |  |