Kansas Maternal & Child Health Council (KMCHC)
Wednesday, January 11, 2017

ACEs & Trauma-Informed Care Flip Chart Notes

Highlighted indicate top choices ✓✓ indicate marks on flip charts Line separation indicates start of a new group

1. Screening for ACEs

1a. What are the barriers around **screening** for ACEs?

- Access ✓✓
- Time ✓✓✓
- Duplication of effort ✓✓
- Trust/Relationship ✓✓
- Knowledge/ Importance of doing it ✓✓
    - Evidence that ACE data has a function
- Liability ✓✓
- Referral – where can they get help resources ✓✓
- Labeling/categorizing ✓✓

- Is it appropriate for group settings ✓✓
- Not clear what you do with it ✓✓✓

- Lack of collaboration (ie: not sharing results among providers)
- How does it get woven into other practices

- Using the same "language"/tools/resources
- ~~Reimbursement~~/ Payment

1b. What are the opportunities around **screening** for ACEs?

- Record ACEs total scores – privacy for records ✓✓✓
- Listen and build relationships ✓✓✓
- Creates understanding and provide direction to wrap around services ✓✓✓
- Raise awareness of TIC ✓✓✓
- Engagement of schools and child care/ early childhood education ✓✓✓

- "Healing"
- Staff gratification

- Integrate/weave screenings with existing screening protocols
- Expand where screenings occur (ex: prisons) ✓✓
- Promoting importance TIC and screening ✓
- "Normalize" the conversation to increase awareness ✓

- More holistic approach (environmental focus)
- Better health outcomes

2. Follow-up Referrals

2a. What are the barriers to **follow-up referrals** for patients/families experiencing the negative effects of trauma?

- Provider assumption that they know the need – are we listening? ✓✓✓✓✓✓
- Contact information – loss of contact, moving, mobile communities✓
- Safety for home visiting ✓
- Capacity issues – people, $, bandwidth, time, competing priorities, etc. ✓

- Transportation ✓
- Access and distance ✓

- Lack of awareness of organization to refer

- Referral organization having the capacity to provide follow-up
- Confidentiality issues – especially in small/rural/frontier ✓
- Lack of trust of authority figures to help
- Community awareness of service, resources, etc.
- Patient ~~being willing~~ understanding and capacity to accept referral/resources ✓
- Closing the feedback loop when referral is made ✓

2b. What are the opportunities for **follow-up referrals** for patients/families experiencing the negative effects of trauma?

- Triggers within EMR/HER/DAISEY ✓✓
- "Why" did the client decline service to improve referral process ✓
    - Electronic tracking of referral and follow-up
- Home visiting ✓
- Identify general/ more broad referrals ✓
    - Parenting education
- Telemedicine/telehealth ✓

- Warm hand-offs/supportive follow-up
- Text messages ✓
- Collaboration/coordination with behavior health and other services
- Those making referrals receives feedback regarding referral
- Peer to peer support

- At WIC office
- Emergency services (fire, police, etc.)
- KIDS Network/FIMR
- Faith based
- Community Health Worker

3. Policies and Practice

3a. What are the opportunities for organizations to implement TI **policies and practice**?

- Educate on the models of existing policies and procedures. Finding and create templates to be easily adopted. ✓
- Integrating TI policies and procedures into systems that already exist. ✓
    - Don't reinvent the wheel – use the systems and lessons learned from other states ✓✓
- Leadership is aware and supportive of the policies and practices ✓✓
- Sense of urgency can help us work together ✓
- Lends itself to implementation in multiple sectors ✓✓✓
- Community-level coalitions in place to capitalize on TI policy and practices ✓✓✓

- Can implement evaluation and improve implementation (data)
- Incorporate into EHR/EMR or other program data systems
- Collaboration and sharing between providers
- Screening score doesn't change once you do it
- Initial patient check-in policy

3b. What are the barriers for organizations to implement TI **policies and practice**?

- Cultural assumption ✓✓
- Lack of model p & p ✓✓

- Funding for sustainability ✓
- Staff TRAINING/Technical Assistance✓
- Cuts to mental health/payment cuts ✓
- Sustaining momentum/ lack of short term outcomes
- Looks like gender issue/connection to MCH
- Lack of buy in ✓
- Focus on quantity/time constraints vs. quality ✓

- Outcome data – lack of?
- Viewed as "one more thing to do" ✓

- Staff themselves could be barrier/retraumatized due to personal experiences

4. MCH System

4a. What are the barriers for the **MCH system** to become more TI?

- Time (increase in work, decrease in time)
- 1) Terminology ✓ and messaging
- Lack of awareness
- Cost and benefit – system level benefit
- Messaging (agency wide) ✓
- Catalogue data can lead to blaming parents of riding off kids
- Need more evidence and evaluation
- ACE data vs. individual stories ✓
- What stops the cycle? Need a program/needs to be woven into practice ✓
- Parents can lose their kids ? trust in the system?

- Stability of the system – "inertia"
- There are some that don't want change
- See policy and procedure comments ☺

- Services to address identified concerns

4b. What are the opportunities for the **MCH system** to become more TI?

- Practice transformation – transform clinics to patient centered care; allow others to provide care ✓
- 3) Engage families and consumers in process (ongoing)
- Build more into a day (yearly requirements, agency-wide staff)
- KS-TRAIN - access to all of the system
- Focus on national organizations (APHA, City Match, AMCHP)
- Brach out to partners - be an example ✓✓
- Adapt to MCH from mental health (new terminology) → wellness driven
- 1) Common terminology ✓ & Workforce *Development*
- Map onto 10 essentials service (i.e. monitor, diagnostic supports) preventions caring
- Support build Healthy Mothers, Healthy babies ✓
- Workforce development (in a broader than traditional sense): WIC
- Grantees

- New year needs assessment opens up opportunity
- Agency Benefits < efficiency, self-care, client engagement
- 2) Better outcome data ✓
- See policy and practice comments ☺

Additional flip-chart questions…

If we did things completely right around TIC, what would it look like for your <u>organizations</u>?

- Common understanding
- Practices in place
- Know how our own triggers impact work place
- Incentives aren't what keeps them coming – relationship, empowerment
- Listening – part of our demeanor and practice
- Decrease in death on negative outcomes. Increase in positive outcomes
- Honor time to care for self
- Increase safety and experience recovery

If we did things completely right around TIC, what would it look like for the <u>system</u>?

- Increase connections to SVCS
- Identify immediate individual needs for custom support
- Teams and leadership are a focus – who you hire
- TIC built into mission and vision
- Follow-up and good feedback in the system
- Person centered care

What action can the MCH Council take to advance TISC in the state?

- Find templates (examples), resources, success stories
- Become community champions
    - Owning education of those around us
- Distributed BRFSS ACE data
- Promoting constructive behaviors

What do you need to successfully make progress on this issue?

- Individual vs. population data collection
    - What does it mean for resource allocation
- Basic info – leave behind to help talk about or start conversation