The Trauma-Informed Network of Care Roadmap: A Guide for Strengthening Community Relationships – Transcript

June 28, 2021

Jennifer Ryan: We're very excited with the progress that's been made to date. I think we're approaching about 20,000 providers, having taken the training, and over 300,000 screenings have occurred even during the time period of COVID. So, a lot of great progress underway there. Then third, the work to develop a functional Trauma-Informed Network of Care in every community in California. We are going to talk a little more about how we're pursuing that today, and share with you the roadmap, but also some of the great work that's happening at the community level to forward these goals. Next slide.

Jennifer Ryan: So I've already introduced myself, but I'm also very pleased to have Mr. Frank Mecca, the former executive director of the County Welfare Directors Association of California with us today, he was the gracious chair of our network of care subcommittee, and is going to share some of his reflections on that experience. Then Carol Backstrom, vice president for Medicaid Policy and Programs here at Aurrera Health Group, who is leading a lot of the work around the network of care grants on behalf of the initiative. Next slide.

Jennifer Ryan: So our agenda for today is to just share a little bit with you about the history and purpose of the Trauma-Informed Network of Care roadmap, talk to you about some strategies for building and supporting robust networks of care, and also thinking together with you about some action steps for clinics, practices, and community-based organizations to start working together, to grow those cross-sector networks of care. Then of course, we will save some time for questions and discussion.

Jennifer Ryan: So I'm going to share a little bit about the history and purpose, but then Frank Mecca is going to give you more full color commentary on the work of the subcommittee. I think where this conversation started in many ways was that, for those of you who are involved in work around trauma-informed care and adverse childhood experiences, you know that sometimes folks are concerned about screening for ACEs, because they don't know what to do with the information that they learn, particularly if they don't feel connected to the resources in their community, and places that they can refer families to get help.

Jennifer Ryan: So that is fundamental purpose of the network of care, is to really integrate those health care clinics and practices with the community based organizations in their area, so that they can support families in navigating the process. Then the other, I think, purpose of the network of care concept, and this is something that's been around for a long time, it's not unique to California, and it's not unique to ACEs Aware, but really the success and the importance of trying to build a shared accountability for the well being of patients and families, that is really what we're all about here. Next slide.

Jennifer Ryan: So, we established the network of care subcommittee, which Frank is going to share more about, we also studied and discussed a lot of different models that have had similar purposes across the country. I think many of you are familiar with Project ECHO, that has been a really important strategy for care management and coordination for families, and in the medical setting as well. The Ryan White program is a really important example, I think, in its evolution, and in its success, frankly, in providing that whole person support for children with HIV.

Jennifer Ryan: You also may be familiar with some of the hub-and-spoke models that have been used over time and are particularly effective right now with promoting access to medication assisted treatment in terms of treating substance use disorders. Then accountable communities for health or accountable health communities, depending on what point you got involved in the initiative, through the Center for Medicare and Medicaid Innovation, but also in a number of different states, including Washington, have tested out these types of strategies.

Jennifer Ryan: And that led us to planning for the ACEs Aware grants, and really being able to provide a commitment out to the community level to fund planning and implementation of Trauma-Informed Networks of Care. So with that, we go to the next slide. I am very pleased and grateful to Frank Mecca for joining us today, and I'm going to turn things over to him right now. Frank.

Frank Mecca: Thank you very much, Jennifer, and welcome to everyone. Thanks for the gracious introduction. As Jennifer indicated, I had the pleasure actually to co chair the network of care subcommittee with Mary Ann Hansen from the First 5 Association of California and First 5 Humboldt, who regret said she couldn't join us today. So I owe her deep things as I do to the rest of the members of this network of care subcommittee who you can see on your screen right now, who are really critical to helping pull the roadmap together. Next slide.

Frank Mecca: So, we all know that developing a network of care is critical to addressing ACEs and toxic stress, and I think it was really important to everyone, most notably

the surgeon general, that a network of care needed to create an actionable roadmap to how communities can get to develop those networks. Our goal was to be concrete, to develop step by step guidance for how clinical care teams and their community partners can ensure that the buffering supports were available for individuals who experience ACEs and toxic stress.

Frank Mecca: So, over the course of several months, our subcommittee heard from a really broad array of experts, from health care world, from community based nonprofit agencies, schools, companies that specialize in technology. All groups that were working in the trauma-informed care space to help us formulate the content of the roadmap. In the course of those conversations, we wanted to understand how all those various multiple sectors could come together to provide a coherent system of buffering supports for children who have experienced toxic stress. So schools, community behavioral health agencies, managed care plans, technology platforms, how do they all come together so that service providers can access buffering supports, and so buffering service providers can give feedback back to care teams?

Frank Mecca: Those topics distilled into roadmap milestones, and you can see in the report that there are milestones for clinical care teams, and there are additionally milestones for communities. Finally, in the development of the roadmap, we heard from all of you, many of you, while we received extensive public comment during the public comment period that we opened up after the draft of the report was ready in December of 2020. So thank you to all of you and all the groups that helped bring the roadmap together. With that, I'm going to turn it over to Carol Backstrom, who will walk us through the contents of the roadmap.

Carol Backstrom: Thank you, Frank. And yes, indeed, thanks both to Frank and Mary Ann for heading up our subcommittee, but certainly all of the members and all of the other several stakeholders that helped us think through what the network of care roadmap was going to look like. With that, I think Jen talked about the fact that really, the purpose of this roadmap was to think about what can providers do? What can primary care providers do in terms of screening and referrals out if there are services that are needed? And so, to that end, we wanted to create a document that really helped communities think about what that was going to look like, and make it very concrete, we wanted to make it actionable. Next slide, please.

Carol Backstrom: One of the first tasks we said about doing is really defining what it is to be a part of a Trauma-Informed Network of Care. For our purposes in the roadmap, a Trauma-Informed Network of Care is a group of interdisciplinary health, education and human service professionals, community members and

organizations. All of these organizations come together to support families by providing access to evidence based buffering resources and supports, and which in turn, helps to prevent, treat, and heal the harmful consequences of toxic stress. Next slide.

Carol Backstrom: When we talk about evidence based buffering supports, we're talking about the supports that help regulate the stress response, and they are all included in this figure. This figure came from the surgeon general's report, which we will have a link to at the end of this presentation. And also, it's also pointed out and highlighted in the network of care roadmap as well. The seven pillars to regulate the toxic stress response include supportive relationships, including with caregivers for children, other family members and peers, high quality, sufficient sleep, balanced nutrition, regular physical activity, mindfulness and meditation, exposure to nature and mental health care, including psychotherapy or psychiatric care, and substance use disorder treatment services when indicated. Next slide.

Carol Backstrom: We spend a lot of time within the sub committee defining who is in the network of care. And if you look at the roadmap, you'll see that we have pages of categories of different types of organizations, service providers that provide very different services across the board, all of which contribute to the idea that there are resources in the community that can really mitigate the effects of toxic stress. So for example, the list in the table and the network of care roadmap is not comprehensive, but it's pretty detailed.

Carol Backstrom: For example, primary care providers really encompasses a lot more beyond pediatricians, for example, we talk about family medicine, nurse practitioners, school based health clinics, behavioral health providers are definitely a part of this network of care as well, including psychologists, county mental health services, social workers, and FQHCs. We have talked about schools and education in terms of offices of education at the county level, superintendents and of course, family resource centers, school lunch programs. I mean, these are all those components that encompass those buffering supports.

Carol Backstrom: So, we spent a lot of time making sure that we were inclusive, and in fact, that was one of the areas of feedback that we received, when the document was out for public comment that we really wanted to make sure that different service providers and community service organizations and community benefit organizations, or community based organizations, really were able to see themselves in all of this network of care activity, and so that includes social service programs, early intervention services. Certainly, the role of counties is so important in the state of California, so both local and county government programs are included here.

Carol Backstrom: We have a listing out of examples of community based organizations, and tribal organizations, of course, legal in the justice system, including ... One of the things I think was really interesting that we talked quite a bit about is this whole idea of collaborative divorce teams, I mean, the idea that you can bring in people who can help mitigate those effects of toxic stress in situations where families are coming apart or separating. So we also talk about digital health technology platforms and provider networks, and managed care plans also playing an important role in our network of care. Next slide.

Carol Backstrom: So, I'm going to just really at a very high level, talk about the overall content of the Trauma-Informed Network of Care Roadmap. As you may know, the first two sections really focus on a lot of the background material. So we have the background on ACEs and toxic stress. I think it's a really good ACEs and toxic stress 101, in terms of what the importances of screening for ACEs. We talked about that definition of a Trauma-Informed Network of Care, and being able to respond to the idea that there are ACEs and toxic stress identified in a primary care clinic, what happens next? Well, here are the services that can really wrap around that.

Carol Backstrom: We talked about what we just talked about already, which is, who should be involved in this network of care? And then section two of the roadmap talks a lot about ACE screening clinical workflows and tools. This gets into what I think is a really good summary of the clinical response, the biological stress response, the clinical algorithms and workflows and really the response that primary care providers can take in assessing for toxic stress risk for both children and adults. So you'll find some really good primer material in that section two of the roadmap that will help shape how the clinical responses is developed and planned for. Next slide.

Carol Backstrom: We'll talk a little bit more about the milestones when we get into some of the concrete examples that grantees are in terms of how they are taking the network of care roadmap and applying it to their grant work. But at a high level, the milestones are as follows, and it's really around building and committing to cross sector partnerships, and establishing that formal leadership and accountability structure. Again, we'll talk about that again. Understanding and documenting all available resources, such as healthcare resources and services, community based services and social services.

Carol Backstrom: We talk a lot about, in the milestones, establishing referral and response workflows, again, that clinical aspect of all of this work across sectors and holding each other accountable for the follow up and using technology actually to facilitate those connections. We also talk about, really the PDSA cycle and

really in terms of evaluating, refining and proving network of care activities. So there's a lot more detail in the roadmap about those things. Next slide.

Carol Backstrom: So, how are we bringing the roadmap to life. This, as you know, has been out. The document has been out in draft form for several months. Some changes were made, I think they're all additive. Nothing really structurally changed between the draft roadmap and the final roadmap. In the meantime, as many of you know, we've had grants that were awarded in California, which really has allowed us to practice bringing that roadmap to life.

Carol Backstrom: So next slide. So, again, as some of you or all of you may know, California has been very fortunate in the sense of being thoughtful and planful, around how we can build network of care, Trauma-Informed Networks of Care. We have had and made available $30.8 million in ACEs Aware grant funding that were awarded to 35 communities across the state. These grantees are separated into two different buckets. One is the 27 grantees that we have that are really focused on planning around developing networks of care. In this case, they might be just kind of stepping out into the new experience of what this means, they're partnering with clinical providers who are starting to screen and refer out for services as part of an ACE screening, but they may not be, at this point, really well versed or really well experienced in what it means to create that network of care.

Carol Backstrom: And this grant funding is intended to be startup funding for them to really pull together partnerships, start exploring who it is in their community who can play a role in network of care, a lot of it has to do with being able to identify the right services, getting the commitments on the part of partners, and really starting to think about what this leadership structure for a network of care might look like. We also have eight network of care implementation grants, and these were awarded over the course of 18 months at $3 million a piece for communities that really demonstrate a significant level of collaboration and coordination already across Medi-Cal providers and the community services that are the follow up services as well.

Carol Backstrom: Grant funds, in this case were intended to be distributed across partners, but it really helps to account for the time that it takes to have conversations about building a network of care, it accounts for the clinical time that's needed to build out workflows and clinical protocols. This is really to try to bring communities to the next level in terms of implementing a robust network of care community. Next slide.

Carol Backstrom: This visual, I think, is interesting, and it is in the roadmap, we wanted to be able to describe how we would define the steps of building a network of care along a

continuum. So here, you can see what we think are five different levels. And again, this had a lot of input from the subcommittee as well as other subcommittees that are involved in ACEs Aware. Level one, for example, is a community that might just be starting to screen for ACEs, there may not be a lot of community connections between physical health providers and community services.

Carol Backstrom: Level two brings that up to the next level where we talk about, there's some ACE screening occurring, there are some protocols in place for what happens when there's an ACE screening that indicates the potential for toxic stress and thinking about what the protocols might be for interrupting that toxic stress response. And that community structure is starting to get built up around those services, but not really formalized at that point.

Carol Backstrom: So you can see that just goes all the way up to level five, where we think we have a fully functional, really pretty robust Trauma-Informed Network of Care in place that has shared accountability in governance structures, for example. The clinical and responses to the toxic stress response are utilized right away, but it's pretty robust on that front as well, and that there's a strong community provider relationships that exist with the community service providers, and importantly with closed loop opportunity in terms of having information circles in a bi directional way.

Carol Backstrom: So one of the ways that we wanted to have grantees, think about the milestones was for us to create what we called a discussion tool, really, to think about how the network of care of both the planning grantees and the implementation grantees might be thinking about where they are along that continuum per milestone. So for example, milestone number one here is conducting a readiness assessment. Again, we have milestones for community ... Sorry, for clinical teams, and that's what you're seeing here, and we have milestones for communities. That's the next slide.

Carol Backstrom: But milestone one for clinical teams is really around conducting that readiness assessment. What does it mean to start screening for ACEs, and what are we going to do when we need to have some kind of response? What do we do in the case of needing to respond to those ACEs and the potential for toxic stress? So what we have here is step by step guides for how clinical care teams, could step by step figure out what their readiness was or is in preparation for entering into this work. For an example on this one, some of or many of the network of care grantees are actually using this first milestone, and asking their clinical care teams who are doing the screenings to make sure that they have gone through that step by step process in evaluating their readiness.

Carol Backstrom: Milestone number two talks about defining clinical roles and tasks. It has a lot of discussion in the roadmap around the role of a care coordinator. We have a description of all the tasks or the functions of care coordination in the roadmap, no matter what you call the role, for example, if you call it a community health worker, or care navigator, patient navigator, et cetera, those descriptions of what the functions are as it relates to ACEs and the response to ACEs, these functions or these tasks could actually be used in a position description for the future, and really talking about what that care coordination function is going to look like, within the primary care clinic.

Carol Backstrom: So the county of Glenn, one of our network of care planning grantees, is actually piloting the use of Canadian health workers as referral coordinators in two clinics. So this is an example of a grantee, being able to take the network of care roadmap, thinking about that function of the clinical roles, right, and what that looks like in defining what it looks like for their particular network of care. So, this is why we are so excited to have the opportunity to have the network of care roadmap, be something that can be used for our grantees in defining, again, sort of having those step by step definitions of what it means to build this network of care.

Carol Backstrom: So milestone three, is talking about gathering resources and getting to know your network of care. Again, keep in mind, this is from a clinical care team perspective. So, let's say you are part of a clinical care team in a primary care clinic and you're thinking about maybe starting the ACE screening process, you're thinking about what the workflows might need to be, that kind of thing. And certainly what the referrals might be, if it's appropriate to refer outside of the clinic.

Carol Backstrom: So, there are examples there about how clinical care teams can branch out and become familiar with the community resources, including the fact that we have a couple of case studies here that talk about really how some communities have actually gone out and figured out who the resources are, what the community services are, and then actually visited with them in person and kind of lived at themselves to figure out what might be possible.

Carol Backstrom: In the case of AltaMed, we talked about the fact they are in this process of creating a workflow, that is including information for their screeners that talks about referring patients to internal departments, for example, the services that AltaMed might have in house, there may be ways that primary care providers can respond to the potential for toxic stress within the services that AltaMed already provides. But then they're also providing resources that are external with partnering organizations. For example, this is an example of where the grantee is actually going ahead and using the suggestions from the roadmap and

building it out to create those resources and make it very hands on and actionable.

Carol Backstrom: Milestone four for clinical care teams talks about financing and technology needs. I just want to highlight here that the appendix of the roadmap provides specific examples of those considerations. There's consideration for how ... ensuring for example that the clinical care providers know who can bill for ACE screenings and how that process actually takes place. There are also a lot of suggestions about technology, and my colleague Lauren Block's going to talk a lot about this in a few minutes, in terms of being able to really build up on technology or using technology as a tool to make the connections when it relates to referrals.

Carol Backstrom: Milestone five, I just want to highlight here again, I talked a little bit about the PDSA process, and several grantees are not necessarily at the place where they're able to do a Plan-Do-Study-Act process yet as it relates to their screening and referral process. But we do have step by step examples of how that might work when that clinical care team is at that point. Next slide. All right, here we are talking about the milestones for communities. Again, we have several grantee examples of where grantees are really bringing this to life. Milestone one for communities is about building out a leadership and accountability structure.

Carol Backstrom: This has really been a major consideration for network of care grantees, we are really encouraging grantees to be thinking about what leadership and accountability looks like for their particular network of care, in part, because we really have to think about sustainability, what's going to happen beyond the life of a grant, we want to have that strong leadership and accountability structure defined right now as they are doing their planning. The roadmap discusses what is meant by shared accountability, and I think that is a really important component when we talk about leadership and accountability. Many of our grantees are ... Sorry [Chelsea 00:26:53] I think we need to go back one ... There we go. Thank you.

Carol Backstrom: We are helping grantees think through what is meant by shared accountability. This is where grantees are thinking about things like scopes of work, partnership agreements, perhaps even data use agreements, shared information, shared resources, but really being able to like account for those and document those, is part of what we're describing when we talk about shared accountability, really having that expectation laid out in terms of delineating roles, responsibilities and expectations. I just wanted to highlight Mind OC right here, they are a network of care implementation grantees, and they are defining accountability through sub grantee agreements with each of their funding partners.

Carol Backstrom: And again, that offers that opportunity to lay out, so what happens when you get this piece of information? How do you act on it? What does that look like, and how does it come back to us in terms of the information coming back to us? That's what we mean by the shared ... Sorry, the strong leadership and accountability structure. Milestone two talks about connecting with the clinical care teams in the community. So for example, just as in the milestones for the clinical care teams, these milestones are really coming from that community lens.

Carol Backstrom: So, we are encouraging communities to think back to, do we have providers in our community who are screening for ACEs and ready to help mitigate that toxic stress response? If we're interested in a building out a network of care, and we are community providers in our community, how do we link up with the physical health or the primary care providers in our community to think about how to partner, what does it look like et cetera?

Carol Backstrom: So, what we have here in the roadmap is the description of what that looks like, and again, concrete examples of the types of organizations that can provide the buffering supports, and how best to connect with them. In this section of the roadmap, we also talk about a gap analysis. So for example, if you are a housing provider, or you are one of the first five organizations, but you really want to build out a network of care, how do you start looking at those buffering supports and thinking about who else needs to be added to your community, who else needs to be added to your network of care?

Carol Backstrom: So in this case, we'd love to highlight St. Agnes, which is a network of care implementation grantee. They have discussed the fact that they have begun working with an LGBTQ resource center in their community after conducting a gap analysis in terms of what was missing in services as recommended in milestone two. Milestone three has some advice for how to break down silos, which we all know is a challenge and to create bi directional referrals, and that's something that Lauren, my colleague, Lauren will be talking about a little bit more from that IT perspective. Again, here we have examples in milestone four, again, around those financing and technology needs. Again, this relates so much to sustainability planning.

Carol Backstrom: The roadmap has considerations for how communities might use health information technology to aid in making referrals. And we have a great example here from First 5 Contra Costa, which is one of our implementation grantees, who has created categories by which they are sorting resources in their database, identifying needs of their patients based on the stress clusters, and then looking to these mapped categories to create referrals. And Lauren, will be talking a little bit more, like I said about the use of technology in the next slide.

Carol Backstrom: Milestone five, again, I just want to talk about the PDSA stuff one more time, and that is because there's a difference between what we're asking clinical care teams to do in terms of PDSA, improving that referral process, right, improving those internal workflows within the primary care clinic. And in this case, we talk about PDSA as it relates to the network of care as a whole. So if a network of care community has identified goals, what does it take to actually get to those goals?

Carol Backstrom: So let's say you want to reduce the impact of or the toxic stress created by ACEs, what is it going to take to be able to demonstrate that that has happened in our community? We do actually take on some of those stretch goals as examples in the roadmap. So with that, I do want to turn it over to Lauren Block for just a moment because Lauren is heading up our health information technology and referral platform work with all of our grantees.

Carol Backstrom: I just want to say at the outset, one of the things that we've noted in working with all of our grantees is how frequently the topic of health information technology and exchange of information comes up. It is a constant, and so we actually have Lauren on our team who's worked on these issues in a number of states, as well as others on our team who are really focused on this work. So, Lauren will say a little bit more about that, because it's a really important component to the work that we do. Thanks, Lauren.

Lauren Block: Thanks, Carol. So I'm just going to briefly talk a little bit about the process that the grantees have been going through, and thinking about how to leverage digital resource platforms, and then also go through a couple of workflows to just show you how it might work. So, as communities are contemplating leveraging platforms across health, social and other sectors to optimize the referral process, there are a few key steps that they're taking. And again, all of our grantees have been going through these steps.

Lauren Block: The first is, in addition to broader stakeholder engagement, as others have spoken about to really build, maintain and sustain the network of care, stakeholder engagement is really critical when adding information technology to the equation, because the reality is, the technology alone cannot solve your problems. Just by having a referral platform doesn't mean that it will be used. So, you have to make sure that your participants are agreeing with the goals, the data that's going to be shared, the general workflows are going to be essential as well, because in the long run, IT can make it easier to refer and certainly to track, but if everyone isn't comfortable with it, they may not end up using it.

Lauren Block: So, after that initial stakeholder engagement, you'll hear me say that stakeholders come in a lot to this process, you really have to determine the desired functionality. So, that's an important first step, will the system facilitate closed loop referrals? Will there be single sign on? Will there be different user roles? Will there be interoperability with other platforms? So, all important considerations. It's also really important to think about your data governance model and the infrastructure that you want surrounding that. So, who in the network is making decisions? What is the data? What are the data that will flow? What's the consent model that you'll be using for the participants in your network? So all really important decision points.

Lauren Block: And so, it's important to have a governance model for continuously looking at these things, what's working, what's not. Then there is the decision, communities have to decide, are they going to buy, build, integrate or have a hybrid model? They can buy an off the shelf product. Many of you have heard of many of these referral platforms that are out there just to name a few. There's Aunt Bertha, Unite Us, NowPow, and there are many others as well. Many 211s have taken a role in this and community information exchanges as well. So, there are a lot of different models out there, and that system selection will depend on a couple of different things including what systems are already in use in the community if any?

Lauren Block: And that is something that all of our grantees have been doing. They've been assessing and understanding what is your experience with the various platforms that are out there? What do you like? What do you not like? To help decide what's going to make more sense for the community, and I could spend hours just talking about this particular process. But for now, I'll leave it at that. Finally, it's important to continuously engage your data governance body to evaluate how things are going and what adjustments might be necessary along the way for quality improvement, so to have that continuous evaluative process. Next slide.

Lauren Block: This slide really shows what a generic closed loop referral process might look like. It is very high level. This one starts with the health care provider. Many of the grantees are implementing or working towards more detailed versions of these flows that operate somewhat like this one. So in this case, you start with the ACE screening clinical workflow or the algorithm and identify what supports are needed. And so, both of those documents are referred to in section two of the roadmap. So you can look to this specific there.

Lauren Block: But assuming we're talking about a scenario where the provider does want to make referral. The provider, other clinical staff that might be a community health worker, it might be a patient navigator, it may be the physician or nurse

practitioner, or other eligible provider themselves, who is actually going and making that referral. And so they will access that referral platform to find the service they're looking for. It is important to note that, and I'm not going to get into the details here, but each platform has slightly different functionality. Many communities within our network of care are building their own resource directories within the network, and some are leveraging directories built by referral platforms.

Lauren Block: So even if you're using an off the shelf product, some of them do allow you to build your own network for referrals, in others, you can leverage information that's out there, and there are different pros and cons and benefits to each strategy. So, just something to think about. So anyway, once the provider logs in, it might be through a single sign on or it might be another way, depending on how the system works, they can make the referral through the platform. So they might have to enter some information about the patient or it may transfer over again, it depends on levels of interoperability that might exist within electronic health record, and other decision points the networks will have to make.

Lauren Block: The recipient of the referral will then receive and acknowledge it in an ideal state, they'll reach out to the prospective client, schedule and render the services. What ultimately makes this a closed loop referral process is that the support service provider is notifying the healthcare provider that the services have been rendered. And again, this is just one flow and one way to look at it. Within each step here, there are other workflows and decision trees for considering how to proceed. Let's go to the next slide, and I'll show a slightly different way of looking at things.

Lauren Block: So one of our grantees Mind OC, they're an implementation grantee in our network of care grant program, and they are coordinating with more than a dozen different organizations to provide a cross sector network of services and coordinating across existing resources to build a closed loop referral process in Orange County, California. The community which currently leverages more than one referral platform has decided to take an integration and build approach. So in doing this, they have multiple workgroups with Mind OC, really serving as the backbone to this network, but others participating and being key representatives. And they are working towards creating a clearinghouse, what you see here in the middle of the visual that can take referrals from different referral platforms.

Lauren Block: And they're also exploring whether to build a basic level of information sharing for CBOs who might not be on one of the existing platforms or not interested in one of the existing platforms. So, that decision has not quite been made yet, but you can see that option in here. The idea is that, the different entities can really

use the platforms that they're already on, rather than having to change, but this is a good model to potentially look at to see how you can leverage existing resources and not starting over again. This is a different approach from if you were to say just pay for a single platform and use that. So, neither approach is right or wrong, these are just different models that we are seeing among our various grantees. With that, I'm going to turn it over to ... I'm not sure who we're going back to. But next presenter. Thank you.

Jennifer Ryan: I think I'm next. If someone could just turn my camera back on, that would be great. Okay. Hi, I'm back. Thank you, Lauren. That was really helpful and interesting. I know we've got a few questions coming in as well. So we will definitely save time to make sure we can have some discussion and questions before we finish here today. So, there's been a lot of information, it's a big document, that roadmap. What do we do? What do we do next? Right? How do we get started. Next slide, please.

Jennifer Ryan: So, of course, the first thing we want everyone to do, and you do not have to have an MD behind your name to take this training, we want everyone to take the ACEs Aware training, and attest to having completed the training, which means you're then certified. There is a list of different provider types, that is pretty long, who is eligible to receive that Medi-Cal payment for screening prices and check that out here. The slide deck, it's on the ACEs Aware website. I've taken the training, I think that it's very valuable just in terms of building that understanding of the importance of understanding ACEs and toxic stress and the health effects that can follow. And also understanding the role that screening and practice change can play in helping families heal.

Jennifer Ryan: So, I can't encourage you enough, the training is free. It's available nationwide, internationally, anyone who wants to use it at no cost, it does also qualify for CME and maintenance of certification credits. All right, so next up. We also just recently in May relaunched our website for ACEs Aware, we really feel excited and good about all of the great resources that are there, everything ranging from a compilation of the research on ACEs and toxic stress to specific toolkits and strategies, information about our grantees and their work. There's just a whole wealth of information available on that ACEs Aware website. So I encourage you to check that out.

Jennifer Ryan: Then when you're finished reading the roadmap, the network of care roadmap, you should also check out the surgeon general's report. One of the really important things about this very important report is that it talks a lot about the importance of that cross sector collaboration. So the report is organized actually by sector, so it addresses the pay, if you're a person in the education sector, here are some things that you need to know that you can do. If you're a person

in the child welfare sector, here are some things that you can do. So, I would encourage you all to peruse that report as well.

Jennifer Ryan: Next up. Then, of course, this webinar and about 18 that have come before, we've been doing monthly webinars since we launched the initiative, you can find some really, really rich information and some passionate presentations about the importance of the science of ACEs and toxic stress, and actually hear a lot from practicing providers who are screening for ACEs and sharing their experiences. That is excellent. And then I think the last piece that we always can't resist is to just really encourage everyone to join the movement.

Jennifer Ryan: We have been talking about joining the movement for a long time, but in May, we launched what we're calling the State of Care campaign. And hopefully, those of you in California, at least are seeing some of that out in social media and perhaps even in the newspaper, there's a whole large campaign underway, that's going to go on for about six months, with the goal of really reaching those of you who are new to this topic, or new to this work, and those of you who might have needed more information to be convinced that this should be a priority for you and your practice. So we're really excited to see, hopefully, the reach of the campaign will really expand as we go forward.

Jennifer Ryan: Numberstory.org is, instead of a provider focus campaign, a campaign around helping individuals understand the role that ACEs play in their lives, the role that the toxic stress that can lead from ACEs may be having on them even today, even if it's something that happened 20 years ago. We know that there are long standing effects of ACEs, and so now our story is really trying to meet people where they are and helping them understand what their number means and also helping them understand that their number is not everything, that we have the ability to change our futures. With that, I'm going to stop and open the floor for some questions. I think we have some questions in the Q&A here, here I see. I'm going to take through some of those and maybe call on a few of you to help me answer.

Jennifer Ryan: One of the questions, and I don't know who's the right person to answer this, maybe we can all chime in, is sort of, when we're talking about these referral platforms, how does it actually play out in reality? If there's anyone here who is on the line and is actually screening and using a referral platform, we'd love to hear from you directly. But what happens? You do the screening, and you realize that the person does, in fact, perhaps need a referral outside of the clinic, and you're going to turn to that platform, and what do you do?

Jennifer Ryan: The first thing that Dr. Burke Harris would say is apply your clinical algorithm to the patient, and think through, conduct a full health assessment of that patient,

and think about what their risks are based on associated health conditions, and also identify any other social needs that seem to be apparent, and then go from there. Does anyone else want to chime in on this, or Frank, I know you probably have a lot more real world experience than some of us here. I want to put you on the spot.

Frank Mecca: Thank you. I don't have a lot to add, I don't have a lot of direct experience. But I know my members or the people that I used to represent that participated in several, and they can range from very basic to very robust. There's people that have had a lot of success with multiple different kinds. So I guess one of the takeaways that I had from talking to my members was that, as long as there's an easy way for bi directionality, and prompts and alerts, that a lot of information can go back and forth to help both the clinical care team and the community support providers who may be serving those clients and their programs pretty robustly.

Frank Mecca: So, it can be automatic, there can be ticklers that are sent back and forth. It doesn't have to be a complicated extra application that requires another computer monitor to be open on your screen. They can be pretty user friendly, and at least the people that I know who've been involved in using them have found that they can pretty seamlessly incorporate them into their everyday responsibilities with those individuals who have suffered from the toxic stress.

Jennifer Ryan: Very helpful. Thank you, Frank. There is a couple of questions about grant funds. And Lauren, there's a question here about referral platforms. So I want to give you a second to look at that before I call on you. But I want to go ahead and address the question that seems to be the question of the hour about the future of network healthcare grant funds. We have been so pleased with enthusiasm and strong response that we received for the first two rounds of grants. What is happening at the moment is that the state is under deep conversations about how best to leverage future grant funds out in the community.

Jennifer Ryan: So, while I don't have an answer for you immediately, we will absolutely keep everyone informed as more information becomes available, and please do stay tuned. But I will share that the announcement is not imminent. Okay, so Lauren, can I just turn to you for a minute? We have someone asking about when using a referral platform, how our consents and ROI is covered? Can you just tackle that as best you can?

Lauren Block: Sure. I can say that there is not a single universal answer, and that each of the platforms work a little differently. Assuming that the screening is starting in a healthcare provider's office, which isn't always the case, they may have processes in place already for managing consent that might need to be modified

to make sure that people are comfortable. I will say that in some cases, grantees are really interested in making sure that patients themselves have access to platforms. And so there's what's called self referrals that can happen as well.

Lauren Block: So, there are a lot of different ways. I mean, I showed what a closed loop referral can look like, but there's also bi directional referrals where the referral might be starting perhaps in a CBO. And so an important part of the data governance model is really for that network of care within each community to think about what data are moving, and the decisions that they're making, because they may not be sharing a whole lot, there may be some basic demographics to facilitate the referral, and not much more, but the individual does need to provide necessary consent. Because this is a national audience, and not just in California, it's also worth noting that every state has slightly different requirements.

Lauren Block: So, it's important to understand not only the federal requirements might be depending on what you have to adhere to, with regard to 42 CFR in addition to HIPAA, and FERPA and other laws with lots of acronyms, but also what applicable within your state.

Jennifer Ryan: Thank you, Lauren. We have a couple of questions about, "Is it possible for folks who are not Medi-Cal providers to do the ACEs Aware training?" Yes, it is. The platform is publicly available on the ACEs Aware website, and anyone can sign up and register for the training at no cost. Obviously, if you are a Medi-Cal provider, and you're taking the training, we do strongly encourage everyone who completes the training to complete that attestation form to let us know that you are in fact now certified to build Medi-Cal first screening for ACEs, even if you're not ready to screen, still worthwhile to submit that attestation form for future use.

Jennifer Ryan: I've had a number of questions come up around sort of, "How come my type of organization isn't included in the list of who's in the network of care?" I'm going to have to answer it generally. But I just want to say that ... and Carol, please jump in here. But the intention of the network of care roadmap was to really open the conversation about who should be involved in the network of care, it's absolutely not meant to be exclusive to any type of organization. I think each community has certain resources that are most available [inaudible 00:52:11] that can participate in a network of care. So it really is a community specific question. But I would very much encourage folks who are interested to just check out our website, find out if your community is involved in network of care.

Jennifer Ryan: We have contact information on the website for the folks who are leading the grant work, and you are absolutely encouraged to reach out directly to them and see how you can get involved. So, it really is intended to be an open invitation. Carol, do you want to add anything to that?

Carol Backstrom: Just acknowledging that a lot of our information that we're sharing today is California focused, it has a California lens. But I do want to also just encourage folks who are not from California, to think about how you can partner with others in your community who are interested in ACEs and trying to mitigate the toxic stress response, to partner together, to think about how you can use the roadmap, again, as that step by step tool to think about how you might create your own network of care within your community.

Carol Backstrom: It is designed as a response to support providers who have gone through the training and attestation for getting reimbursed under Medi-Cal for screening for ACEs. But certainly there's nothing to stop any other community from thinking about this in the context of your specific community, and we would be happy to talk to you about even some suggestions for how some of our grantees got started, we can share with you what we're seeing in California in terms of the development of networks of care. I hope that this is information that will give you hope and encourage you to think about what it looks like in your state or in your community.

Jennifer Ryan: Yes. We had a couple of other questions as well about what's the future look like for ACEs Aware? Is the state going to further express its commitment to the initiative and also to additional benefits that are out there, or that could be out there and be covered by Medi-Cal? I think the governor's budget that I think is still not quite fully signed yet, but is looking promising from the ACEs Aware perspective. Both provides additional funding for the initiative to do a public education campaign, to develop a training for educators, which is one of the really important things, I think, that we have been talking about, is what other target audiences should have training curricula developed for them so that it's more directly applicable to their work.

Jennifer Ryan: There's also, as you may have read in the paper, the Medi-Cal program is undergoing a huge transformation to really focus more on meeting the comprehensive needs of folks with complex care situations, at risk of homelessness, all of those different things, including Behavioral Health Initiative. There are things like coverage of community health workers under Medi-Cal that are now going to be available in '22. That's a really exciting, I think, sustainability strategy. Right? If folks are using community health workers right now to help facilitate that network of care process, in the future, we'll be

able to build Medi-Cal directly for that. Carol and Frank, did you all want to jump in?

Carol Backstrom: Frank, do you want to take the question about the future of ACEs?

Frank Mecca: Yes. Thank you. I think it's important to point out that one of the precipitants anyway of the ACEs screening movement in California was legislation that actually predated governor Newsom. It was AB 340, and it was a bill authored by Assemblyman Arambula, from Fresno, and it required DHCS ... and it's the law of the land. It required the Department of Health Care Services to develop protocols for screening children for ACEs. When the governor came into office, and the appointment of the surgeon general, they obviously enthusiastically embraced that legislation, and they've done a lot to move that ball further than, I think, many in the legislature might have even imagined.

Frank Mecca: But they've had a strong and willing and enthusiastic partner in this movement in the legislature. And it dovetails with a lot of other things that are happening in state government with respect to juvenile justice reform and child welfare reform and homelessness initiatives and the [inaudible 00:56:59] Medicaid waiver. So, it is my very strong belief having been involved in the original legislation that the ACEs movement is here to stay, and it's just going to get more and more and more embedded, and the standard way, we in public and private helping businesses, help people that have experienced traumatic adversity.

Jennifer Ryan: Thank you so much, Frank. We are at time now. So, I'm going to turn it over to Carol for one last closing remark, and then I will thank you all for joining today, Carol.

Carol Backstrom: Thanks, Frank, I love how you refer to people as being in the helping business. Right? I think we all like to think about ourselves as that. We are at time, so many questions that we didn't get to, and I also want to just acknowledge that many of you submitted questions in advance of the webinar. We saw them, we heard you, we will be hard at work over the coming weeks trying to prepare answers to those questions and the questions that we didn't get too today, which will inform future materials and resources that we will be putting out coming up and of course, when those questions or whatever form it takes, we will be sure I communicate that through our ACEs Aware distribution list.

Carol Backstrom: So, thank you all for joining us today. We so appreciate it and look forward to continuing our work together on ACEs Aware and mitigating the toxic stress effects. Thank you, everyone.

Jennifer Ryan: Thanks, everyone.