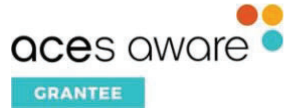

How Accountable Communities for Health Can Lead Multi-Sector Partnerships to Address the Effects of Adverse Childhood Experiences

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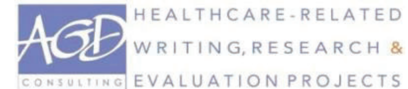
This paper was produced with grant funding support from the California ACEs Aware initiative, a first-in-the-nation effort to screen children and adults for Adverse Childhood Experiences (ACEs) in primary care, and to treat the impacts of toxic stress with trauma-informed care. The bold goal of this initiative is to reduce ACEs and toxic stress by half in one generation. For more information, visit the ACEs Aware website.



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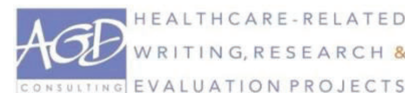

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Introduction

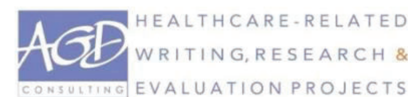
The California Office of the Surgeon General (CA-OSG) and the Department of Health Care Services (DHCS) have set a goal to reduce adverse childhood experiences (ACEs) and toxic stress in California by half in one generation. This will require the long-term commitment of partners from multiple sectors – health, social services, community-based organizations, government, early care and education, child welfare, and the legal/justice system. Systemic changes cannot be made by one organization or sector on its own. Instead, an infrastructure is needed to foster collaboration among disparate groups to address ACEs in a more coordinated and effective manner.

Accountable Communities for Health (ACHs) are ideally positioned to provide the necessary leadership over the long term to create a community ACEs network of care. ACHs are community-based partnerships formed across multiple sectors that develop a shared vision and take action to improve the health and wellbeing of a community. With over 125 ACHs or ACH-like organizations nationwide, this is a proven model defined by certain essential elements, including a formal governance structure, a backbone organization, a multi-sector approach, interventions, data collection and evaluation, consumer engagement and finances.

The purpose of this practice paper is to describe how California ACHs can leverage their experience leading multi-sector partnerships to support the *Network of Care Milestones for Communities* set out in the *ACEs Aware Trauma-Informed Network of Care Roadmap*. The roadmap offers guidance on key elements and milestones for establishing an effective system for responding to ACE screenings and mitigating the toxic stress response in a community. The document outlines five milestones for clinical care teams and five for communities. The community milestones are as follows:

Milestone #1: Identify or establish a strong leadership and accountability structure.
Milestone #2: Connect with health care clinical teams and other resources.
Milestone #3: Achieve community and health care integration.
Milestone #4: Consider financing and technology needs.
Milestone #5: Evaluate and improve the strength of the trauma-informed network of care.

The history and strengths of the ACH model are explained below. This is followed by a description of how ACHs can utilize their ability to lead and convene multi-stakeholder initiatives to address each of the five community milestones. Case highlights are included for each milestone that illustrate relevant successes the San Diego ACH and other ACHs have already demonstrated.



San Diego Accountable Community for Health

The San Diego Accountable Community for Health (SDACH) is a multi-sector initiative established in 2016 to create community health and wellness. It builds new relationships between clinical and community partners to redefine the local health system and advance a wellness system that prioritizes community well-being and equity. Its partners include community members, clinical providers, public health professionals, social service agencies, health plans, community-based organizations (CBOs), and many others. The backbone organization is the San Diego Healthcare Quality Collaborative, doing business as the San Diego Wellness Collaborative. The SDACH mission, vision and values are shown in the **sidebar**.

The **SDACH Stewardship Group** provides governance and strategic guidance for the initiative. Stewardship Group members are diverse leaders and influencers from multiple sectors, organizations, and communities who demonstrate passion and commitment to the vision and to working in collaboration with a broad range of partners.

The SDACH is an incubator for initiatives that support healthy communities, individual wellbeing, and health equity. SDACH's core initiatives are co-designed and implemented by stakeholders who share its mission. The aim of the SDACH is to support ideal cardiovascular health across the lifespan with a focus on the health, behavioral, social, and environmental factors that protect individuals from cardiovascular disease. This broad approach with a focus on cardiovascular protective factors has led to the creation of several priority focus areas and initiatives:

- **Neighborhood Networks** addresses the health and social needs of community residents using a network of community-based solutions with highly trained community health workers (CHWs), known as Neighborhood Navigators, at the center. In this model, Medi-Cal managed care health plans identify high-need patients and the SDACH links them to the Neighborhood Navigators, who are hired by local community-based organizations. Neighborhood Networks is a revenue-generating social enterprise that helps sustain backbone functions of the SDACH, as well as contributes to interventions that meet SDACH goals.
- **North Inland Nutrition Security Portfolio of Interventions:** The SDACH convenes stakeholders in the North Inland region of San Diego County to create cross-sector solutions to assure that all residents have access to nutritious foods. This network of solutions, known as a portfolio of interventions, includes efforts to assess and address nutrition insecurity among children, families, and adults across the region. The group uses Results-Based Accountability to measure and report program-level progress on shared population indicators.

San Diego
Accountable Community for Health

Mission
To create a "wellness system" that ensures individuals, families, and communities in San Diego have access to all they need to create a lifetime of health and wellness.

Vision:
Health, wellness and equity for all of our communities, regardless of zip code.

Values:
- Equity
- Inclusivity
- Neutrality
- Accountability

- **ACEs Aware Network of Care Learning Collaborative:** The SDACH received a one-year provider engagement grant from the California ACEs Aware Initiative to enhance cross-sector collaboration to address ACEs in San Diego County. With these funds, the SDACH launched an ACEs Aware Network of Care Learning Collaborative. This multi-sector Learning Collaborative works to improve cooperation and coordination across systems to prevent, treat, and heal ACEs and toxic stress. Stakeholders from healthcare institutions, public agencies, community-based organizations, education, and other sectors come together with community members to conceive and realize a shared vision for a trauma-informed network of care designed to improve health and wellbeing for children, families, and communities.
- **Stakeholder Convenings**: Several times each year, the SDACH convenes a broad range of partners to engage in deep, meaningful, and sometimes difficult conversations. Topics have included racial equity and justice, trauma-informed care, building equity into COVID-19 response and relief efforts, and addressing the impacts of toxic stress and ACEs.

Background

Adverse Childhood Experiences

Almost two-thirds (62%) of California residents experience at least one ACE by the age of 18, but the health care system is not as well equipped as it could be to identify ACEs in their patients, to address the resulting toxic stress, or to link patients with community buffering services. Toxic stress refers to the prolonged activation of the biological stress response and associated changes to brain development, as well as immune, hormonal, metabolic and genetic regulation (ACEs Aware Initiative, 2021). ACEs were first described in a landmark 1998 study by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente in a study published by Vincent J. Felitti and others. It identified 10 types of ACEs and grouped them into three categories: abuse, neglect and/or household dysfunction (see **Figure 1**) (ACEs Aware Initiative, 2020).

Figure 1: 10 Categories of Adverse Childhood Experiences

Abuse: physical, emotional and sexual abuse

Neglect: physical and emotional neglect

Household dysfunction: parental incarceration, mental illness, substance use, parental separation or divorce, and intimate partner violence

Source: ACEs Aware Initiative, 2020

Scientific research has found that cumulated adversity for growing children and young people is the root cause of some of the most harmful, persistent and expensive health challenges facing California and the nation, and it contributes to at least 9 of the 10 leading causes of death in the United States. Adults with four or more ACEs are 11 times more likely to die of Alzheimer's or dementia, three times more likely to die of chronic lower respiratory diseases, and more than twice as likely to die of accidents (unintentional injuries), cancer and heart disease. They are 37 times more likely to attempt suicide (Bhushan et al., 2020). Poor parent-child attachment due to past or current toxic stress most likely cause disturbances in child development (Gillespie, 2019).

The ACEs Aware Initiative

The ACEs Aware Initiative is a statewide effort to prevent and address the impact of ACEs and toxic stress led by Dr. Nadine Burke Harris, California Surgeon General, and Dr. Karen Mark, Medical Director of the Department of Health Care Services. The initiative's goal is to reduce ACEs and toxic stress in California by half in one generation. ACEs Aware offers training, screening tools, clinical protocols, and payment for screening children and adults for ACEs.

ACEs Aware is also supporting establishment of robust and effective networks of care for responding to ACEs screenings and mitigating the toxic stress response by bringing together healthcare providers, clinics, community-based organizations, and social service agencies in communities across California. The initiative has awarded 185 grants totaling $45.1 million to organizations statewide in two rounds of funding, commencing in July 2020 (see **Table 1**). A round one Provider Engagement grant was awarded to San Diego Healthcare Quality Collaborative, the backbone organization for the SDACH, as well as to the Imperial County

Local Health Authority. A round two Trauma-Informed Network of Care Implementation grant was awarded to Saint Agnes Medical Center, with whom the Fresno ACH, called the Community Health Improvement Partnership, is a lead partner.

Table 1: ACEs Aware Grant Categories

Grant Type	Purpose
Provider Training	To educate Medi-Cal providers about incorporating ACE screenings into their clinical practice.
Provider Engagement	To share lessons learned and best practices about ACE screenings tailored to specific geographic areas, patient populations, practice settings.
Communications	To promote provider training and engagement opportunities and increase awareness about ACEs Aware.
Network of Care Planning	To support organizational planning for a network of care in communities with a high prevalence of ACEs.
Network of Care Implementation	To fully execute trauma-informed networks of care.

Source: ACEs Aware Community Grant Program Information, https://www.acesaware.org/grants/grant-program-information/

Accountable Communities for Health

ACHs are community-based partnerships formed across multiple sectors that develop a shared vision and take action to improve the health and wellbeing of a community (Levi et al., 2021). Involvement of the community is one of the elements that make this model unique.

Another definition of ACHs put forward by the California Accountable Communities for Health Initiative (CACHI) (see **sidebar**) expands on the above description by mentioning the importance of working toward health equity among a community's residents (CACHI, 2016). This is especially important for communities of color and those who are economically disadvantaged.

> **What is an Accountable Community for Health?**
>
> An Accountable Community for Health is a multi-payer, multi-sector alliance of major health care systems, providers, and health plans, along with public health, key community and social services organizations, schools, and other partners serving a particular geographic area. An ACH is responsible for improving the health of the entire community, **with particular attention to achieving greater health equity among its residents**."
>
> ~ California Accountable Communities for Health Initiative

The Funders Forum on Accountable Health, a collaborative that brings together philanthropic and public sector funders of multisector partnerships, has been tracking the development of ACHs across the country. It has identified over 125 ACHs or ACH-like organizations nationwide (i.e., accountable health communities, accountable care communities, and coordinated care organizations). These organizations have diverse titles, funding sources, and organizational structures, but they all share several essential elements – most importantly being able to bring people and organizations to a table to solve community-wide challenges. The states of Washington and Minnesota began funding ACH initiatives in 2015 using funding provided by the Centers for Medicare and Medicaid Innovation (CMMI) through the State Innovation Model Initiative. Descriptions of the CMMI AHCs and Washington State ACHs are provided below.

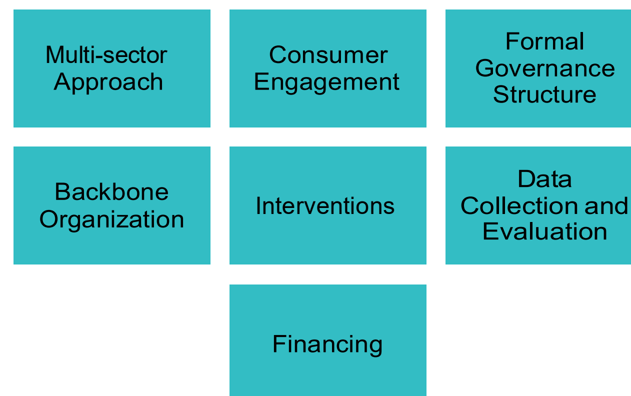
- **CMMI Accountable Health Communities**. CMMI funded the Accountable Health Communities model in 29 sites across 22 states. CMMI invested a total of $157 million into this five-year project that began in 2017. The model's goal is to address Medicaid and Medicare beneficiaries' health-related social needs related to housing instability, food insecurity, utility needs, interpersonal violence and transportation needs. This program includes 29 AHCs across the country (CMS website).

- **Washington State Accountable Communities of Health**. The Washington State Health Care Authority established the Medicaid Transformation Project to improve quality of care, reduce barriers to care, and connect clinical care and social services for their Medicaid beneficiaries (those enrolled in Apple Health). They established nine regional accountable communities of health through a Section 1115 Medicaid demonstration waiver that allocates $1.5 billion in federal funds to develop projects, activities and services. The ACHs earn incentive payments by implementing projects that improve enrollee health (Washington State Health Care Authority, 2020).

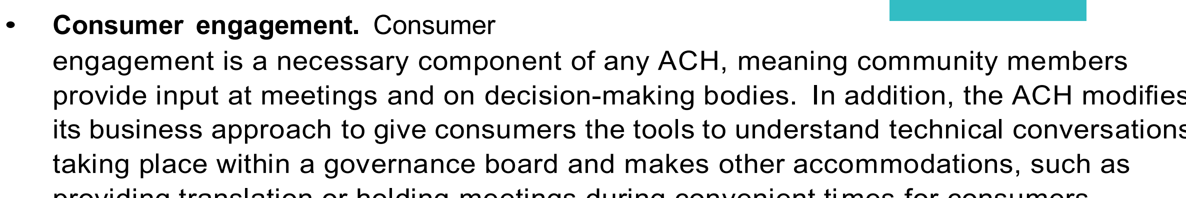
Essential Elements of ACHs

Organizations have slightly different ways of depicting the essential elements of ACHs, but there are commonalities among all of them. A literature review (Mongeon et al., 2017) describing the fundamentals of ACHs found the following essential components (see summary in **Figure 2**).

Figure 2: ACH Essential Elements



- **Multi-sector approach**. ACHs engage multiple sectors to create mutually reinforcing interventions rather than focusing solely on a health care delivery system.



- **Consumer engagement.** Consumer engagement is a necessary component of any ACH, meaning community members provide input at meetings and on decision-making bodies. In addition, the ACH modifies its business approach to give consumers the tools to understand technical conversations taking place within a governance board and makes other accommodations, such as providing translation or holding meetings during convenient times for consumers.
- **Formal governance structure**. A formal governance structure is established, often as part of the funding application, to reflect multi-sector engagement and to establish processes for collaborative decision-making regarding interventions, financial obligations, the evaluation, and conflict management.
- **Backbone organization**. A trusted backbone organization convenes multi-sector partners, guides the vision and strategy development process, and ensures activities are aligned and support mutually reinforcing interventions. The backbone organization may be a community-based organization, public health department, or health care delivery system and may also serve as the fiscal agent.
- **Interventions**. A diverse network of interventions, also known as a "portfolio of interventions," addresses immediate physical and behavioral health needs, as well as interventions requiring longer-term commitment, such as those addressing health-related social needs and equity.
- **Data collection and evaluation.** Formal data collection and evaluation methods assess the impact of the interventions. Identifying outcome measures is a part of the ACH process, as funders and governance leadership expect to see how an intervention is impacting the intended population. Some ACHs are also involved in linking disparate data sources, such as health system data and social services data.
- **Financing**. A financing or sustainability plan identifies opportunities to secure ongoing funding for the backbone and ACH interventions. ACHs blend payments from multiple funding sources to cover costs, and look for creative ways to secure funding, whether through foundations, government funders, payment system reform, hospital partnerships or health plan contracts.

California Accountable Communities for Health Initiative

The California Accountable Communities for Health Initiative (CACHI) represents California's version of ACHs. CACHI is a public-private partnership that was established to build a healthier California by creating cross-sector collaborations to improve the health of communities. The five-year initiative was established in 2016 in response to recommendations from the State Health Care Innovation Plan and the Let's Get Healthy Task Force, which promoted health system transformation (CACHI, 2019).

CACHI Funding Partners

Blue Shield of California Foundation

The California Endowment

The California Wellness Foundation

Kaiser Permanente

Sierra Health Foundation

Social Impact Exchange

Well Being Trust

CACHI was founded on the principle that improving health requires going beyond the walls of traditional health care providers to include other sectors that can influence health, such as public health departments, schools, social service agencies, community-based organizations and others. From their perspective, it will take a broad range of partnerships to improve individual health status, population health and health equity. CACHI funding partners are shown in the **sidebar**.

The 13 CACHI ACHs throughout California (see map in **Attachment 1**) were funded in two phases, with each ACH addressing different target conditions (see **Table 2**) in a specified region or neighborhood. As shown in the table, several California ACHs address trauma, violence prevention, resilience, or children's health and wellbeing, and others address some of the manifestations of ACEs, such as substance misuse and cardiovascular disease. More detail about California ACHs is provided in **Attachment 2**.

Table 2: ACHs and Target Conditions

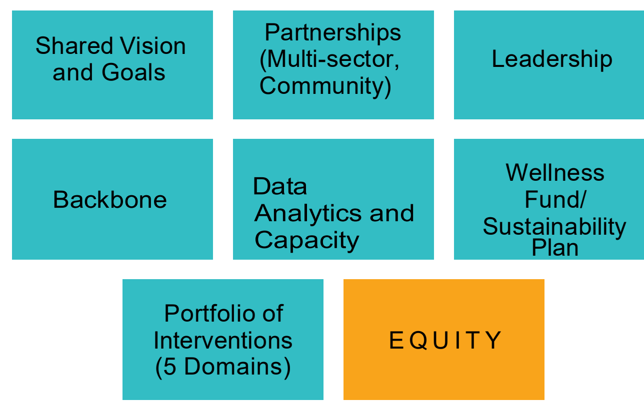
ACH Name/Region	Target Condition(s)
All Children Thrive Long Beach	Children's Health and Wellbeing
Boyle Heights Health Innovation Community Partnership	Trauma/Community Resilience
East San Jose PEACE Partnership	Trauma/Violence Prevention
Fresno Community Health Improvement Partnership	Trauma-Informed Nutrition/Food Insecurity
Health Action Sonoma	Cardiovascular Disease
Healthy San Gabriel Valley	Violence Prevention/Community Resilience
Hope Rising Lake County	Homelessness/Substance Use Disorder
Humboldt Community Health Trust	Substance Use Disorder

ACH Name/Region	Target Condition(s)
Imperial County Accountable Community for Health	Asthma
Merced County All In for Health	Chronic Diseases, Food Security, Access to Care
Reinvent South Stockton Coalition	Trauma, Healthy Lives, Early Childhood Education, Workforce
San Diego Accountable Community for Health	Cardiovascular Disease
West Sacramento Accountable Community for Health	Health Inequities, Heart Disease, COVID-19

Source: California Accountable Communities for Health and Desert Vista Consulting

CACHI's Essential Elements of Success are shown in **Figure 3** (CACHI, 2017). These elements are very similar to the national ACH essential elements, with only a couple of differences. Equity and health equity considerations are incorporated into all aspects of California ACHs. The goal is for ACH participants to gain a common understanding of how equity issues permeate everyday life, and how they could be manifested in the microcosm of the ACH.

Figure 3: CACHI Essential Elements



The CACHI model encourages development of a mutually reinforcing "portfolio of interventions," (POI) or group of strategies and actions, across five domains (Community Partners, 2016). An effective POI reinforces existing activities or services in a community, and utilizes multiple domains, for example by combining clinical screening with policy changes. The POI draws on a range of strategies that are evidence-based or emerging best practices, as well as existing programs that could be better coordinated. **Table 3** lists the domains and gives examples of programs that could be included in an ACEs portfolio.

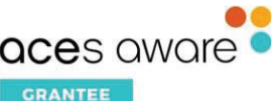


Table 3: Portfolio of Intervention Domains as Applied to an ACEs/Resilience Portfolio of Interventions

Domain/Description	Examples for an ACEs/Resilience Portfolio of Interventions
Clinical Services Services delivered in the health care setting	Work with federally qualified health centers to develop a trauma-informed ACEs screening process
Community and Social Services Programs Programs taking place in community settings	Identify trauma-informed and trauma-sensitive buffering services in defined geographic regions
Clinical-Community Linkages Programs that connect clinical services with community programs	Implement a community health worker program to link individuals and families with needed buffering supports
Environment Changes in environment that support healthy behaviors	Improve the safety of parks to encourage encounters with nature leading to improved mental health
Policy and Systems Change Public policy or regulatory changes, as well as organizational policy changes	Increase access to school mental health services for children and families

Description of Domains by Community Partners, 2016

Summary

Reducing the impact of ACEs in a generation in California will require multi-sector partnerships throughout the state to support ACE screenings conducted by Medi-Cal providers, and to ensure individuals or families needing support are connected with trauma-informed community-based services. ACHs have a track record nationally and within California for convening multi-sector partners to improve health in a community. The model uses certain “essential elements” (shared vision and goals, partnerships, leadership, backbone, data analytics and capacity, sustainability plans and a portfolio of interventions) to lend stability to the organization and contribute to improved community health and wellbeing. California further expands upon what is needed in a POI by denoting five domains to maximize the potential impact of their programs (clinical, community, clinical-community linkages, environment, and public policy and system change). As will be described in the next section, **these foundational characteristics point to what ideal partners ACHs are to support the community milestones mentioned in the *ACEs Aware Trauma-Informed Care Roadmap*** and described further in the next section.

Mapping ACH Infrastructure with the *ACEs Aware Trauma-Informed Network of Care Roadmap* Community Milestones

> *To reduce the impact of ACEs it is necessary to "…work together across the health, human services, education and non-profit sectors to prevent and address the impact of Adverse Childhood Experiences and toxic stress to significantly improve the health and wellbeing of individuals and families."*
>
> *ACEs Aware Trauma-Informed Network of Care Roadmap, p.2*

In a paper by JSI about developing a trauma- and resilience-focused ACH, Cantor & Haller (2016) described how an ACH, with its ability to convene multi-sector partners and lead community health improvement efforts, could apply its strengths to addressing ACEs. ACHs are good candidates to carry out ACEs work because an ACEs POI would include a defined population and a clear set of potential partners with shared motivations and understanding. In addition, the strategies used to address ACEs and increase resilience would have long-term, cross-generational impact in a community. A POI could be built around this defined target population, and the community's many partners could coalesce around a defined set of strategies and actions. The ACH could ensure the efforts reach underserved populations and that they support health equity. ACHs could also raise recommendations in a community to make policy changes and advocate for other upstream changes.

Table 4 maps the Community Milestones from the *ACEs Aware Trauma-Informed Network of Care Roadmap* with the ACH essential elements and portfolio of intervention domains. For example, Milestone #1, to identify or establish a strong leadership and accountability structure, aligns with the ACH essential elements of leadership, backbone, partners, and shared vision and goals. The table shows additional ways in which the milestones and ACH components reinforce one another.

The remainder of this paper describes in more detail how ACHs can support each of the Community Milestones.

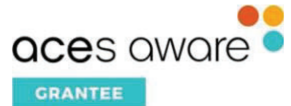
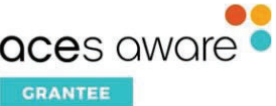


Table 4: Roadmap Milestones Mapped to ACH Components

***ACEs Aware Trauma-Informed Network of Care Roadmap*:** **Community Milestones**	**ACH Essential Elements**	**ACH Portfolio of Intervention Domains**
Milestone #1: Identify or establish a strong leadership and accountability structure - Include leaders from a variety of participating entities and community, patient and family representatives. - Identify shared goals.	Leadership, Backbone, Shared Vision and Goals, and Partnerships	Clinical Services Community and Social Services Programs Clinical-Community Linkages Environment Policy and Systems Change
Milestone #2: Connect with health care clinical teams and other resources - Reach out to health care clinical care teams and identify where there are gaps and areas for improved connection with clinics and other buffering services. - Ensure primary care clinics have strong referral linkages with mental health and substance use disorder treatment, and that they know how to support families in need with food and housing assistance.	Leadership, Backbone, Partnerships	Clinical Services Community and Social Services Programs Clinical-Community Linkages
Milestone #3: Achieve community and health care integration - Break down silos between health care clinical teams and community-based organizations. - Assist physicians and health centers in asset mapping their communities and forming the interpersonal relationships needed to integrate health care and community-based services. - Engage in bi-directional information sharing.	Leadership, Backbone, Partnerships	Clinical Services Community and Social Services Programs Clinical-Community Linkages

ACEs Aware Trauma-Informed Network of Care Roadmap: Community Milestones	ACH Essential Elements	ACH Portfolio of Intervention Domains
Milestone #4: Consider financing and technology needs - Be aware of what services can be reimbursed through Medi-Cal and other state- and federally-funded programs. - Consider technology solutions that can support the referral network. - Identify possible sources of long-term funding. - Identify entities that can work together to explore funding options.	Leadership, Backbone, Partnerships, Sustainability Plan	Clinical-Community Linkages Policy and Systems Change
Milestone #5: Evaluate and improve the strength of the trauma-informed network of care - Provide evidence-based buffering services to adults, children and families that mitigate the toxic stress response and make process improvements as needed. - Use the Plan-Do-Study-Act framework to improve the trauma-informed network of care referral process.	Data Analytics and Capacity, Leadership, Backbone, Partnerships	Clinical Services Community and Social Services Programs Clinical-Community Linkages



Milestone #1: Identify or establish a strong leadership and accountability structure

- **Include leaders from a variety of participating entities and community, patient and family representatives**

- **Identify shared goals**

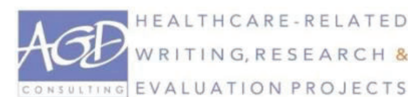
ACHs are known for their ability to bring people and organizations to a common table to solve complex health problems in their communities (Levi et al., 2021). Further, they are sensitive to changing how a community creates health and incorporates multiple viewpoints of diverse individuals to improve outcomes and advance equity. ACHs develop relationships across sectors to better address health priorities in the communities they serve. They bring together health care providers, public health, social service providers, CBOs and residents. The SDACH's ability to convene leaders from multiple sectors has resulted in several important initiatives and many accomplishments over the last five years. One recent example is the San Diego ACEs Aware Network of Care Learning Collaborative (see Case Highlight #1).

Several of CACHI's essential elements support this milestone, including leadership and governance, shared vision and goals, partnerships, and data analytics and capacity (CACHI, 2017). **An ACH must establish a sound governance structure to support effective decision-making, accountability to the community, representation of stakeholder interests, and fiscal and fiduciary accountability.** Leadership is also responsible for establishing roles and responsibilities, creating, or identifying a backbone organization, and involving high-level leaders from partner organizations as well as community representatives. Leaders need to identify and secure funding, and attempt to ensure the long-term viability of the ACH.

Establishing a shared vision and goals is important in the early stages of a collaboration. Once these are put in place, the leadership structure has a framework for moving forward. In addition, these components create a foundation for collective action. When new opportunities arise, partners can compare them against the vision and goals, and focus on those that support the ACH's intent. As partner organizations increase their involvement in a particular initiative, ACHs can consider "shared leadership," in which the partner gains prominence and uses its own experience and network in continuing to advance the work. Shared leadership recognizes the strengths of community partners and builds capacity.

Accountability is achieved by setting goals and using data to demonstrate the level of success in meeting those goals. This process takes time and metrics are not always clear. As described later under Milestone #5, ACHs are working hard to secure data and use it to measure success. The leadership structure can periodically revisit an ACH's ability to demonstrate results and recommend course corrections as needed.

Several ACHs have been able to leverage their infrastructure and partnerships to take more prominent roles under initiatives such as Whole Person Care or California Advancing & Innovating Medi-Cal (CalAIM) (Desert Vista Consulting, Year 4 Interim Report, 2021). ACHs also found their infrastructure enabled them to respond quickly to COVID-19 to convene partner organizations and community stakeholders, and to mobilize response plans to meet immediate community needs (Desert Vista Consulting, COVID-19 Quarterly Report, 2020).



CASE HIGHLIGHT #1: SDACH ACEs Aware Network of Care Learning Collaborative

The SDACH convened the ACEs Aware Network of Care Learning Collaborative meetings from February to May, 2021 with more than 50 partners from a variety of sectors, including health care, social services, community-based organizations, child welfare, public health, early care and education, and others. The Learning Collaborative's objectives were to:

- Cultivate the conditions for collaboration across sectors
- Create an inventory of buffering and protective factors that includes traditional and non-traditional community resources
- Create a shared vision for an ideal network of care
- Increase awareness and understanding of the roles and strengths of each sector
- Identify best practices and potential system changes for each sector

Over the course of three meetings, and two additional work group meetings that took place between them, participants worked together to understand the current ACEs network of care, identify opportunities for improvement, create a shared vision, develop strategies and action steps for an ideal network of care, and determine what changes needed to be made to accomplish this.

The "***Ideal Network of Care Vision,***" which captured the richness of diverse viewpoints and a passion for trauma-informed care, is included as **Attachment 3**. The strategies are summarized in the **sidebar** and detailed action steps are provided in **Attachment 4**.

San Diego ACEs Aware Network of Care Learning Collaborative Strategies and Actions

Strategy 1: Engage youth and families with lived experience in co-designing solutions*

Strategy 2: Develop and support a diverse, trauma informed and trauma-sensitive workforce

Strategy 3: Deliver services in a trauma-informed and trauma-sensitive manner*

Strategy 4: Ensure that all communities have equitable access to formal and informal healing supports

Strategy 5: Cultivate trauma-informed and trauma-sensitive systems

Strategy 6: Raise public awareness about the impact of ACEs and formal and informal healing supports

Strategy 7: Address upstream determinants of childhood trauma and adversity

Strategy 8: Advance technology to support connections in person centered approaches

*** Priority Strategies**

The SDACH's ability to convene and garner the support of such a broad group of multi-sector partners was the result of the ACH's history of leadership in the community and the trust that has been developed among partners over time. The result was a clear sense of direction of where to go next to continue to advance the trauma-informed network of care. New partnerships and collaborations were formed, and partners expressed a strong desire to continue the work together. The strategies and action steps identified by the ACEs Aware Network of Care Learning Collaborative could easily set the stage for development of a portfolio of interventions to address ACEs.

Milestone #2: Connect with health care clinical teams and other resources

- **Reach out to health care clinical care teams and identify where there are gaps and areas for improved connection with clinics and other buffering services.**

- **Ensure primary care clinics have strong referral linkages with mental health and substance use disorder treatment, and that they know how to support families in need with food and housing assistance.**

Milestone #2 describes the importance of ensuring that the community network of care has linkages to the clinical setting, and that outpatient clinics can connect individuals and families with buffering supports and services such as behavioral health, food assistance and housing.

Desert Vista Consulting's Health Care Sector Quarterly Report (2021) found that federally qualified health centers (FQHCs) participate in all ACHs; and hospitals, health plans, and mental health and substance use disorder providers participate in most ACHs (see Case Highlight #2). This participation has created strong ties between ACHs and clinical providers. Several hospitals collaborate with their local ACHs and community-based organizations to conduct their health needs assessment, and work with the community to develop response plans.

FQHCs are more experienced than most outpatient providers in connecting patients with buffering services. For example, many offer integrated behavioral health services on site, and as a result, doctors can offer a "warm handoff" of an individual to mental health services and be confident that their colleague will provide the necessary support services to the patient. In addition, because community health centers are so community-based, staff are more likely to be familiar with available resources, such as food and housing assistance. This is especially true because over 90% of clinic patients are below 200% of the federal poverty level, and therefore are regularly in need of supportive services.

Private doctor's offices, which are rarely involved in ACHs, tend to be less familiar with community resources either because referring families is not a routine part of their work with patients, or they don't have designated staff to do so. In San Diego, efforts are underway to address this concern. The American Academy of Pediatrics (Chapter 3) is working with smaller practices to make them aware of available buffering services. In addition, through the Neighborhood Networks program, the SDACH is launching a pilot program funded by a health plan to embed a community health worker within a pediatric practice whose patients have demonstrated high ACEs screening scores. The CHW will work with families and serve as the link between the clinical practice and community resources.

Experience with clinical providers and community-based organizations put ACHs in a good position to facilitate connections between the two. ACHs can create a forum for clinical and community providers in which they can share information about their respective services, and develop new relationships for the benefit of patients and clients. Getting people together to meet each other and share information creates new collaboration, relationships and opportunities to work together.

CASE HIGHLIGHT #2: California ACH Health Sector Linkages

CACHI statewide evaluator Desert Vista Consulting conducted a health care sector survey of ACHs in April 2021via Qualtrics that was completed by a backbone leader from each of 11 ACHs statewide (all except Merced and San Gabriel Valley; see **Attachment 2**). Results showed that health care sector partners play a vital role in California ACHs by supporting portfolio of intervention activities, sharing data, offering in-kind support, and making financial contributions. Primary care clinics, including FQHCs, as well as hospitals, health plans and community-based substance abuse treatment providers were the most involved (see table below).

Predominant Health Care Sector Members of ACHs
☑ Primary Care Clinics, including FQHCs (n=11 ACHs)
Health Plans (n=10)
Mental Health/Substance Use Disorder Providers (n=10)
☑ Hospitals (n=9)
Additional Health Sector Participants*
Community-Based Organizations
Community Clinic Consortium
County Public Health Clinics
Family Medicine Residency Program
Home Health Program
Hospital Community Benefit
Medical Society
Pharmacy
Rural Health Clinic
Tribal Health

** Mentioned by at least one ACH responding to an open-ended question; n=11*

ACHs mentioned multiple benefits of having these partners at the table. They appreciated **primary care providers/FQHCs** because, as one ACH mentioned, *"they consistently invest leadership, staff and resources in the ACH."* Others praised FQHCs for the number of patient lives they touch, as well as their ability to represent the needs and perspectives of the community. Another ACH commented on primary care providers' ability to share their electric health record (EHR) data. One ACH described **substance use disorder treatment providers** as being especially valuable in contributing their content expertise. **Medicaid health plans** were cited by two ACHs for their potential role as funders, as well as the possibility of shared financial activity and innovation. In praising their **hospital partners**, one ACH said *"they have been the longest and most consistent partners. They have championed work and offered funding and leadership."* Others appreciated that their local hospital offered *"influence, resources, staffing and financial support,"* as well as their steering committee role and contribution of POI funding.

The relationship is reciprocated in that ACHs bring value to health care sectors as well. They convene partners, lead POI development and implementation, promote health and racial equity strategies, and report data, among other functions. **This mutual support benefits communities and in the long term creates the opportunity to make lasting improvements in any ACH or POI focus area, including initiatives to address ACEs.**

Milestone #3: Achieve community and health care integration

- **Break down silos between health care clinical teams and community-based organizations.**
- **Assist physicians and health centers in forming the interpersonal relationships needed to integrate health care and community-based services.**
- **Engage in bi-directional information sharing.**

Milestone #3 goes beyond the knowledge of services available in a community and the involvement of clinics described in Milestone #2. It points to the next step of breaking down silos and better integrating clinical and social services for the benefit of individuals needing services related to trauma or toxic stress. Improved integration includes bi-directional information sharing about the services an individual or family receives.

The language around making referrals is something that participants in the SDACH ACEs Aware Network of Care Learning Collaborative meetings discussed at some length. Partners felt that the term “referral” sounds unidirectional in that it refers to the sending aspect of a referral but does not connote whether or not someone was successfully received. Further, they pointed out that the term “referral” is clinical in nature and is not a word that is used or well understood by community members. Participants felt it would be better to talk about “linking” or “connecting” families with resources because these words imply the referral was successful.

More detailed information about community and health care integration needs was obtained through pre- and post-session surveys (see **Attachment 5 and Attachment 6**) that were implemented via SurveyMonkey prior to SDACH’s first ACEs Aware Network of Care Learning Collaborative meeting and after the third (and final) one. The pre-session survey responses **(n=48)** captured people’s knowledge about ACEs concepts, cross-sector collaboration, and referral processes. The post-session survey responses **(n=26)** provided feedback about the impact of respondents’ involvement in the Learning Collaborative on their organizations and what they suggested as next steps for the ACEs network of care. The surveys were sent to the total invitee list of 91 individuals.

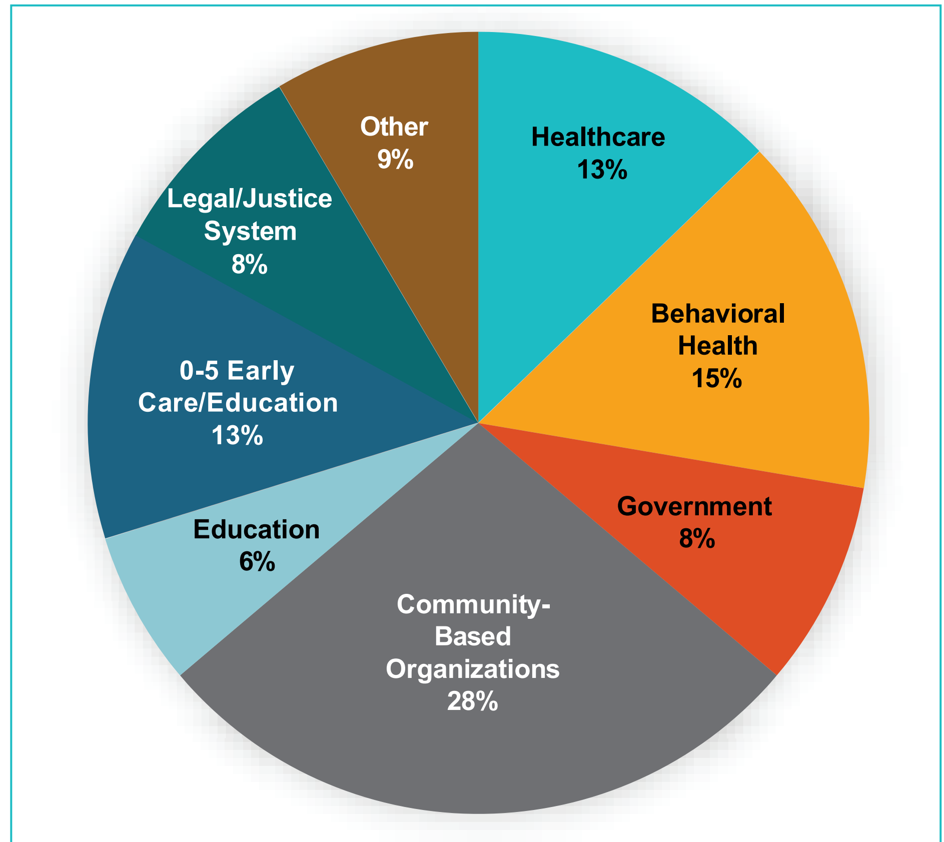
Invitees from different sectors responded to the survey, with just over a quarter (28%) representing community-based organizations (see **Figure 4**). Participants were a mix of higher-level leadership and front-line staff. At least two-thirds considered themselves to be “very” knowledgable about ACEs, and the concepts of resiliency, protective factors, and trauma-informed care. Almost half (48%) indicated their organization had integrated ACE concepts into their work “quite a bit.”

How to Successfully Link Families with Buffering Services

To successfully link families with needed buffering services, three components need to be in place. First and most importantly, the relationships need to be established in which the person helping to connect a family to services feels confident the receiving organization will meet the family’s needs and will do so in a trauma-sensitive way. Leadership and staff from different organizations need to trust one another and feel confident that a family will be treated well. A

family in turn needs to trust the organization they are connected to. Successful linkages are much less likely to happen as the result of a cold call where the staff involved have never met, or if a client is simply given a resource list with phone numbers. ACHs are ideally positioned to facilitate relationships between organizational leadership and staff, and to create opportunities to build trust.

Figure 4: Percentage of Pre-Session Survey Respondents by Sector



n=48. Source: Pre-Session Survey, SDACH ACEs Aware Network of Care Learning Collaborative

Second, organizations need to establish referral processes for linking individuals to other agencies. This means agreeing on how people should be connected to the agency, and what kind of information should be shared. FQHCs use referral coordinators who are familiar with these processes and who are much more accustomed to connecting patients with food and housing support, for example, but this is not the case with all service providers.

In San Diego, participants in the pre-session survey felt that referral processes that connect children and families with community services related to ACEs could be improved. Two-thirds of respondents (67%) said referral processes were "somewhat" effective, but 13% said they were "not at all" effective. When asked in an open-ended question what changes needed to be made to the referral process, respondents identified several solutions:

- More formalized referral partnerships between organizations
- More information sharing between organizations
- Clear connections of the client to the services, for example through warm handoffs

- Navigators to help individuals and families access support services
- The ability for individuals to self-refer to a service without being limited by eligibility restrictions or having to wait for approval
- Improved care coordination and communication between agencies

Third, organizations need to be familiar with the full range of services offered in a community, especially in sectors other than their own. According to the pre-session survey (see **Figure 5**), more than half of respondents said they had already collaborated "a great deal" with community-based organizations, behavioral health, and early care/education for ages 0-5. A high percentage also collaborated a great deal with government programs and healthcare. Respondents were less experienced working with the legal/justice system, with just under one-third saying they did not work with this sector, and another third saying they worked with the sector "somewhat" to address ACEs.

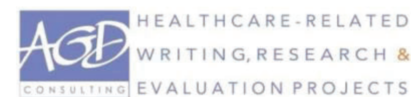
Figure 5: Pre-Session Survey Responses: To what extent have you or has your organization collaborated with the following sectors address ACEs?

	Not at all	Somewhat	A Great Deal	Don't know	Weighted Average (3-point scale)
Community-Based Organizations	2.1%	31.9%	61.7%	4.6%	2.72
Government Programs	8.9%	33.3%	46.7%	8.9%	2.69
Behavioral Health	6.4%	31.9%	55.3%	4.3%	2.66
Education and Training	4.3%	48.9%	40.4%	6.4%	2.55
Ages 0-5 Early Care/Education	17.0%	23.4%	53.2%	6.4%	2.55
Healthcare	10.7%	40.4%	42.6%	4.3%	2.49
Legal/Justice System	29.8%	31.9%	31.9%	6.4%	2.21

n=47. Source: Pre-Session Survey, SDACH ACEs Aware Network of Care Learning Collaborative.
Note: Not all respondents answered all questions.

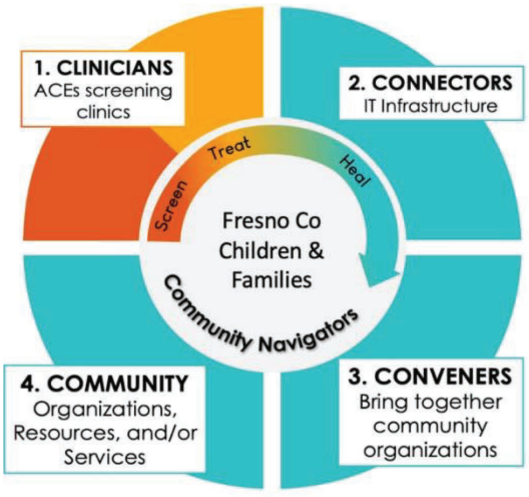
Although these respondents had experience working with other sectors, they were not as familiar as they could be with buffering services. Half of respondents (50%) said they were "somewhat" familiar with community services for children and families needing support related to ACEs, and 44% were "very" familiar.

ACHs are ideally positioned to convene partners, enhance relationships between organizations and sectors, and develop processes to improve individual and family connections to buffering services. Technical aspects of sharing information through a technology platform will be discussed under Milestone#4.



CASE HIGHLIGHT #3: Fresno Community Health Improvement Partnership's Network of Care Implementation

The Fresno County ACEs Aware Trauma-Informed Network of Care has developed a workflow in which community health workers are used to connect individuals scoring high on an ACE screening in a clinical setting with community-based buffering services.



The Fresno Community Health Improvement Partnership (FCHIP) ACH is part of a collaboration that received a Network of Care Implementation grant from ACEs Aware for $2.6 million in February 2021. Saint Agnes Medical Center serves as the fiscal agent and FCHIP oversees the pilot program, including deliverables, marketing and communication, and staffing.

As shown in the figure in the **sidebar**, the ACEs screen takes place in a clinical setting. A patient identified as high risk is then linked to a community health worker who serves as a care coordinator and works with the client to create a plan and set goals. The CHW uses a technology-based platform to enter the client's information and send an email to the receiving organization to log in to the IT platform. The organization then retrieves the client's information and schedules an appointment to discuss services. The CHW stays in touch with the client to ensure the linkage was successful, or to troubleshoot as needed. The receiving agency then indicates when the client has been connected and eventually, when services are complete.

To increase organizational capacity, the project will train over 20 community-based organizations on trauma-informed services and will coach over 100 Medi-Cal healthcare providers who conduct ACEs screenings. Multiple sectors are represented in the pilot program, including health, mental health, social services, education, local government, legal, and managed care networks.

FCHIP's work with ACEs began in 2017 with the Trauma and Resiliency Network. There are 40 partner organizations/agencies/health systems involved in the grant, including over 100 medical providers, three community health workers, 24 community-based organizations, data and technology staff, trainers, and community engagement contractors.

Milestone #4: Consider financing and technology needs

- **Identify possible sources of long-term funding.**
- **Identify entities that can work together to explore funding options.**
- **Be aware of what services can be reimbursed through Medi-Cal and other state- and federally-funded programs.**
- **Consider technology solutions that can support the referral network.**

Financing

Funding to create an ACEs Aware Network of Care would need to come from a variety of sources, as is the case with most not-for-profit ventures. In fall 2020, California ACHs reported receiving about $5 million collectively in non-CACHI funding, with just over half from private sources (Desert Vista Consulting, Year 4 Evaluation Report, 2021). About 80% of committed and projected funding was for programs and 20% for backbone functions.

When the CACHI initiative was established, one of the core elements was a Wellness Fund, which they defined as (CACHI, 2017): *"a vehicle for attracting resources from a variety of sources to support the infrastructure, goals, priorities and strategies developed by the ACH, with particular attention to upstream prevention."* The vision was for the Wellness Fund to be comprised of flexible funding received from multiple sources that could be used to fund programs or backbone functions. Imperial Health developed a contractual partnership between Imperial County and the locally selected managed care organization, California Health and Wellness, to establish a Local Health Authority (LHA) Commission in 2014 to provide oversight of a Wellness Fund. The LHA also receives funding from the Imperial County Public Health Department and CACHI (Heinrich et al, 2020).

With CACHI funding slated to end in early 2022, California ACHs are actively pursuing funding to continue their programs and to support their backbone functions. As one California ACH leader said in response to the CACHI Year 4 Evaluation survey (Desert Vista Consulting, 2021), *"Figuring out sustainable funding for this work has been challenging. Defining the right project and right funder combination is more key than anything else."* **ACHs are blending payment from multiple funding sources to cover costs, and looking for creative ways to secure funding, whether through foundations, government funders, payment system reform, hospital partnerships or health plan contracts. Multi-sector partnerships increase the likelihood an ACH can access diverse funding streams for infrastructure support.**

San Diego has secured an innovative source of funding by adopting the Pathways Community HUB model through partnerships with local Medicaid health plans (see **next page**) through its Neighborhood Networks program. This initiative challenges health plans to redirect funding to ACHs as a new way of improving the health of its members. Other California ACHs are considering adapting this model as well. ACHs that can carry on with sustainable funding are in a position to support their partners to ensure they are maximizing reimbursement from Medi-Cal for eligible services related to supporting individuals and families and linking them to buffering supports. ACHs can also assist with identifying funding sources for community-based

organizations, and work with them to partner on proposed grant programs, support their grant writing efforts, and offer letters of support.

Technology

Many communities have a health and social service information and referral management system, whether a community information exchange (CIE), health information exchange, or some other type of system. These systems can provide the solutions needed to ensure providers from multiple organizations can view a single record containing all of an individual's most important information, such as their ACE screening information, the services they have already received, what kind of additional health-related social needs they have, and in some cases, assets or protective factors they can build upon.

Advancing these systems past the development phase and into implementation can take years. It can be challenging for community stakeholders to agree on the most important components of the system, and how to implement it locally. Who will have access to it and how will organizations ask for and document patient consent? What information will be included in the shared record? Who will monitor the system to be sure the data is accurate? And perhaps most importantly, how much will it cost? Health care organizations that have already invested in electronic health records will be hesitant to make any additional substantial investment into another information technology system and may bristle at the idea of their staff having to access multiple systems.

As an example, San Diego's CIE is comprised of over 100 partner organizations across health, behavioral services, social service sectors, community-based organizations, housing providers, food banks, and others that can exchange information on over 200,000 individuals who have consented to have their information shared.

CIE San Diego offers local healthcare partners and community providers a rich set of data points to better understand individual and population interactions within health and social service systems. The CIE also enables closed-looped referrals between network partners and offers the ability to view past and current referrals and program enrollments.

More information about how the CIE can be used to support bi-directional referrals of individuals with high ACEs scores is provided in the CIE San Diego practice paper entitled:

Community Information Exchange: Leveraging Collaborative Infrastructure to Assess and Address ACEs.

Importantly, the CIE has a social determinants of health tool that is used to screen patients for their needs and calculate a score reflecting whether they have low, medium or high need. The CIE could use the same infrastructure to embed the ACE screening into their tool. This would prevent a person with trauma from having to tell their story over and over again. In addition, it would allow organizations to identify clients with high scores and link these individuals with buffering services. The CIE's goal is to create a more holistic view of what is happening with the client, rather than keeping certain information hidden from other providers. CIE San Diego developed a toolkit in 2018 to assist communities interested in learning how to develop a community information exchange.

The Humboldt Community Health Trust, through its backbone, the North Coast Health Improvement and Information Network (NCHIIN), is also developing a CIE to serve as a centralized, comprehensive source of information for individuals and families seeking treatment for substance use disorder (NCHIIN webpage). A primary function of the system will be referral management. They are continuing to work with partners to ensure the system meets their needs and to identify next steps for implementation.

A number of competing referral tracking software packages have also entered the market, such as UniteUS, Aunt Bertha, and info.com. These software packages generally have information about various community-based providers and allow for searches using certain criteria as well as referral tracking. Some also provide for closed-loop or bi-directional referrals. It is challenging that the space has become so crowded with so many options. Some health plans or providers require the use of certain systems, so an organization can find itself in the position of having to use two different systems to please two different funders or health plans.

In terms of using technology to support linkages with outside organizations for buffering services, and to marry multiple EHR systems, **ACHs can set the table for convening partners and reaching agreement on important aspects of such a system to support person-centered care.** Until such platforms are running smoothly, ACHs can work on the less technical aspects of connecting individuals to services through relationship-building between agencies and agreement on procedures on how to link individuals and families to services, as described in earlier sections.

CASE HIGHLIGHT #4: SDACH Neighborhood Networks HUB

The Neighborhood Networks HUB was conceived by the SDACH as an intermediary organization to allow a network of San Diego County's community-based organizations to receive subcontracts from Medi-Cal health plans for community-based workforce solutions. CBOs have the trust of the community, have a deep history of working in the neighborhoods they serve, and are experts at hiring community-based workforces in the same areas that serve Medi-Cal members.

Although CBOs are well positioned to provide services to Medi-Cal members, they are often not equipped to meet the challenges of contracting directly with Medi-Cal managed care plans. San Diego's Neighborhood Networks contracts directly with managed care plans, then subcontracts with CBOs to provide services. In this way, Neighborhood Networks serves as an intermediary, or HUB, between managed care plans and CBOs. This model has multiple benefits, such as it:

- Allows managed care plans to have one contract that coordinates care across an entire region and addresses multiple health and social needs of its members.
- Provides CBOs with a new funding source to build the workforce of well-trained community health workers.
- Offers community residents one-on-one relationships with trusted community health workers, who conduct personalized assessments of health and social needs and provide curated connections to available resources.
- Creates new financial partnerships, which redirect funds from healthcare delivery to community-based services to address the impacts of the social determinants of health.

Using the Neighborhood Networks HUB to Address Trauma and Toxic Stress

A pilot is underway to test the Neighborhood Networks model to have community health workers assist families who have received an ACE screening to address the impact of trauma and toxic stress.

This funding model is innovative because it challenges health plans to think differently about which organizations they contract with. First, contracting with a HUB is a smart way to support CBOs, which don't necessarily have the infrastructure to contract directly with health plans on their own. Second, it helps the community address the impacts of the social determinants of health, including for those individuals who may be impacted by trauma. Third, it invests dollars "upstream" to create new systems that focus on prevention rather than waiting until a member's health has suffered. **The SDACH uses Neighborhood Network revenues to support ongoing SDACH backbone activities.**

Milestone #5: Evaluate and improve the strength of the trauma-informed network of care

- **Provide evidence-based buffering services to adults, children and families that mitigate the toxic stress response and make process improvements as needed.**

- **Use the Plan-Do-Study-Act framework to improve the trauma-informed network of care referral process.**

More formal evaluation studies need to be conducted to learn more about how ACHs have impacted the health of their communities, but some ACHs have demonstrated their success based on traditional health outcome measures (Levi, 2021). The Imperial County ACH reduced ER visits for children with asthma and improved school attendance by creating lines of communication between schools, primary care settings, emergency departments and home visiting services. The Staten Island Performing Provider System in New York (an ACH-like model) reduced opioid overdose and deaths by 35% by creating treatment protocols and sharing data between police, EMS first responders, hospitals and homeless shelter providers. The Collaborative Cottage Grove ACH in Greensboro, North Carolina increased local housing investments, resulting in improved housing in Black and other minority neighborhoods (Levi, 2021). Additional studies are needed to formally measure ACH success, but these show a few examples.

"Data analytics and capacity" combined are included in CACHI's essential elements of ACHs, recognizing that they are necessary to evaluate the impact of interventions in a POI. The Desert Vista Consulting health sector survey (described in Case Highlight #2) found that health plans, mental health/substance use disorder treatment providers, primary clinics/FQHCs and hospitals share data to a subset of ACHs. When health care sector partners share data, it is usually population-level, aggregate data on health needs in the region (e.g., information from community health needs assessments, health disparities, COVID-19-related data, and general health-related statistics). The same health sector survey found that in some ACHs, partners share performance data relevant to the ACH's target conditions(s) or POI (e.g., hypertension control measures, asthma encounters, clinical quality control, or opioid prescribing).

Readiness and Willingness

Improving the strength of the trauma-informed network of care can be influenced by several factors. First, organizations must be willing to participate in the network of care. In a pre-session online survey (n=47), the SDACH found that organizations participating in the ACEs Aware Network of Care Learning Collaborative were both ready and willing to train staff on trauma-informed care and resilience (weighted average of 3.74) (see **Figure 6**). This is an important first step in changing or enhancing organizational culture to be more trauma informed. Respondents also said their organizations had leadership buy-in to participate in an ACEs network of care (3.66 weighted average) and were willing to work with cross-sector partners (3.64 weighted average). A few respondents had concerns that their organization did not have sufficient support staff with the time and resources to participate in an ACEs network of care (19%).

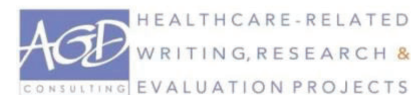


Figure 6: San Diego Organizational Readiness and Willingness to Address ACEs

	Strongly disagree	Disagree	Agree	Strongly agree	N/A	Weighted Average (4-point scale)
Is willing to train staff on trauma-informed care and resilience	0%	2%	28%	64%	6%	3.74
Has leadership buy-in to participate in an ACEs network of care	0%	0%	36%	62%	2%	3.66
Is willing to work with cross-sector partners on an ACEs network of care	2%	0%	30%	68%	0%	3.64
Has adequately trained staff on trauma-informed care and resilience	4%	23%	30%	36%	6%	3.17
Has sufficient support staff with time and resources to participate in an ACEs network of care	2%	17%	49%	28%	4%	3.15

n=47. Source: Pre-Session Survey, SDACH ACEs Aware Network of Care Learning Collaborative. Note: Not all respondents answered all questions.

Enhanced Education and Training Resources

In an open-ended question in the pre-session survey, respondents said they believed more education and training were needed to improve referrals and strengthen the trauma-informed network of care. More providers need to access the ACEs Aware trainings about trauma-informed care and social/emotional development. Teachers and parents also need to be educated about the impact of ACEs and toxic stress, as well as resources they can access to address them. Trainers who have themselves been exposed to ACEs or toxic stress should be used as much as possible. Examples of ACH trainings are described in the next case highlight.

Evidence-Based Buffering Services

ACEs network of care providers may currently provide care that they feel is helpful to individuals experiencing toxic stress, but they may not be aware of evidence-based services with a proven track record. As described in the California Surgeon General's *Roadmap for Resilience* (Bhushan, et al., 2020, p. 87), it is important to screen for ACEs and provide buffering services as early as possible. Patients need to be educated on toxic stress as well as strategies that can help regulate the stress response (see **Figure 7**).

There are many resources through California ACEs Aware, as well as national organizations such as PACES (Positive and Adverse Childhood Experiences). Providers may benefit from learning about best practices in the literature, as well as promising practices experienced in a local

community. ACHs could curate a summary of evidence-based practices and create a change package of effective interventions so that community partners would not have to do this research on their own. Partners could then commit to certain actions and metrics to measure their success, with the ACH backbone supporting them in the process.

Figure 7: Stress Busters

Source: ACEs Aware website, Clinical Assessment and Treatment: Identifying ACEs and risk of toxic stress.

Continuous Quality Improvement

To take it a step further, ACHs could facilitate a continuous quality improvement learning community in which a small number of community-based providers would commit to rapid cycle improvements in serving individuals with toxic stress or trauma. Organizations would commit to certain interventions, assess their effectiveness, and quickly make any necessary improvements. The partners would also commit to tracking and reporting metrics as part of the process. The role of the ACH in this type of leadership position would be to lead the quality improvement effort, convene and support partners, and measure and report outcomes.

CASE HIGHLIGHT #5: ACH Trainings on Trauma and Toxic Stress

Fresno Community Health Improvement Partnership: FCHIP implemented two training strategies to support a trauma-informed approach in organizations and communities. FCHIP project staff participated in the **Community Resilience Initiative's train-the-trainer courses** for organizational team building. Over 1,200 individuals were trained in an 18-month period. In addition, FCHIP adopted the milestones in the **PACEs Connection community resilience tracker**, which delineates steps organizations can take to become more trauma informed. The tracker enables them to see how well they are doing on a continuum. All partners in the Fresno County Trauma Informed Network of Care participated in the milestone survey to see where their organization placed and received individualized consultations on what steps they needed to take to become more trauma-informed organization. This process helped build awareness among leadership and team members and identified an action plan for moving through the milestones to change current practices, systems and internal policies (S. Kincaid, personal communication, February 24, 2021).

NEK Prosper! – Vermont: The NEK Prosper! Caledonia and Southern Essex Accountable Health Community ("NEK Prosper AHC") in Vermont, supports the state's *"Building Flourishing Communities"* initiative to improve intergenerational health by building community capacity and disseminating NEAR (neuroscience, epigenetics, adverse childhood experiences and resilience) science. Building Flourishing Communities is a re-branding of the concept of **self-healing communities**, described in a paper commissioned by the Robert Wood Johnson Foundation (Porter et al., 2016) as a *"transformational process model for improving intergenerational health."* This is done not only by supporting communities in identifying their own problems and solutions, but importantly, by improving parenting skills and creating circles of trustworthy people to help and support parents and families (K. White, personal communication, February 3, 2021).

Greater Columbia ACH - Washington State: The Greater Columbia ACH (GCACH) is one of nine accountable communities of health in Washington State. It has a community resilience educational initiative called ***"Cope, Calm and Care,"*** which provides skills models and resources designed to help people recover from trauma, build personal resilience and engage in healthy living. These steps apply to many types of trauma, including the trauma experienced as a result of COVID-19. In addition to this program, GCACH created a "Build Community Resilience" webpage with resources and information on resilience and ACEs (C. Moser, personal communication, March 3, 2021).

Cascade Pacific Action Alliance - Washington State: The Cascade Pacific Action Alliance Accountable Community of Health held a half-day training in 2019 entitled, ***"Staff Retention through a Trauma-Informed Lens."*** The focus of the training was how to support staff who are working with clients with trauma and are experiencing secondary trauma. Staff members learned how to protect themselves so they could provide the services and manage any emotional response they might have. To encourage participants to take action, they created "change plans" that partners could complete on their own to document milestones and action steps they could take (see **Figure 8**) (J. Clark, personal communication, February 17, 2021).

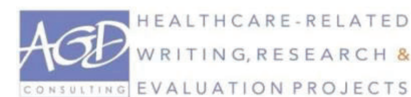


Figure 8: Staff Retention Project Worksheets

Roundtable Discussion: Imagining a Trauma Informed Workplace - PART 1

Goal: *Identify ideas and strategies that will help your organization become more trauma-informed.*

DIRECTIONS:

1. **Individually**, use the white boxes below to brainstorm as many ideas as possible to the questions within each category (10 minutes).
2. **Discuss** as a table your individual ideas, and continue to fill out your worksheet based on your group discussion (20 minutes).

CATEGORIES	What is working about your current workplace culture and systems?	What barriers/challenges exist that prevent your organization from being more trauma informed?	If your organization became fully trauma informed overnight, what would be different?
1. Organization Practices & Policies (e.g. maternity leave, wellness program)			
2. Staff Supervision & Service Delivery (e.g. reflective supervision, caseload management)			
3. Education & Training (e.g. monthly training, internal workgroup)			

Roundtable Discussion: Imagining a Trauma Informed Workplace - PART 2

DIRECTIONS:

1. **Move** to a table based on the three categories from Part 1 (Organization Practices & Policies, Staff Supervision & Service Delivery, Education & Training) that you are most interested in discussing further.
2. **Discuss** as a group and document how you can take action for your own organization to become more trauma-informed. (15 minutes).
3. Be prepared to share.

Circle Your Topic Area: Organization Practices/Policies Staff Supervision/Service Delivery Education/Training

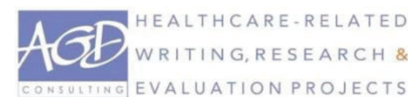
	WHAT ACTIONS WILL YOU TAKE?		
How do you...	Action 1	Action 2	Action 3
...ensure there is leadership buy-in at all levels?			
...build knowledge and understanding about trauma-informed concepts amongst your staff?			
...provide time and resources to develop/maintain a trauma-informed workplace?			

Source: Cascade Pacific Action Alliance AHC, Washington State

Conclusion

Accountable communities for health are expert conveners and facilitators that have strong connections with multi-sector partnerships. Essential elements of ACHs -- which in California include leadership, partnerships, shared vision and goals, backbone, portfolio of interventions, data analytics and capacity, and wellness fund/sustainability – can be leveraged to support the community milestones described in the *ACEs Aware Trauma-Informed Network of Care Roadmap.* ACHs have a strong leadership and accountability structure. Clinical and community partners actively participate in ACHs, and they work together to streamline linkages between the two. ACHs are strong funding partners looking for innovative ways to secure financing for programs and backbone services. They have created a culture of accountability by identifying program outcomes and measures to demonstrate success, and by looking for ways to make quality improvements. They are involved in conversations about CIEs and referral technology. In other words, ACHs are ideally positioned to use their experience and expertise to advance California's goal to reduce the impact of ACEs by half for the next generation.

***About the Author**: Alaina Dall, M.A., is a consultant based in San Diego, California. She provides writing, research and evaluation services for health-related organizations focused on mission-driven community health improvement. Alaina has over 20 years of experience working with integrated health care delivery systems, community clinics and health centers, and other community-based nonprofit organizations. She currently works with the San Diego Accountable Community for Health and with the CACHI statewide evaluator, Desert Vista Consulting.*



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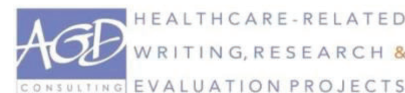


Attachments

Attachment 1: Map of California Accountable Communities for Health

Humboldt Community Health Trust
Hope Rising Lake County
Health Action Sonoma County
West Sacramento Accountable Community for Health Initiative
Healing South Stockton
East San José PEACE Partnership
All in for Health Merced County
Fresno Community Health Improvement Partnership
Health Innovation Community Partnership
Healthy San Gabriel Valley
All Children Thrive Long Beach
San Diego Accountable Community for Health
Imperial County Accountable Community for Health

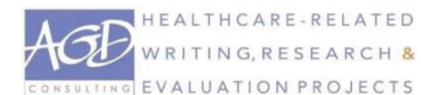
ACH COMMUNITIES

- Fresno County
  - West Fresno
- Humboldt County
- Imperial County
- Lake County
- Los Angeles County
  - Boyle Heights
  - Long Beach
  - San Gabriel Valley
- Merced County
- San Diego County
- Santa Clara County
  - East San José
- Sonoma County
- San Joaquin County
  - South Stockton
- Yolo County
  - West Sacramento

Attachment 2: Descriptions of California Accountable Communities for Health

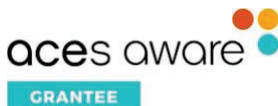
ACH Name	Backbone	Backbone Type	Geography	Target Condition
All Children Thrive Long Beach	City of Long Beach Public Health Dept	Public Health Department	Long Beach	Children's Health And Well-Being
Boyle Heights Health Innovation Community Partnership	The Wellness Center at LAC & USC Medical Center Foundation	Health System/ Foundation	Boyle Heights Neighborhood	Trauma/ Community Resilience
East San Jose PEACE Partnership	Santa Clara Public Health Department	Public Health Department	East San Jose	Trauma/Violence Prevention
Fresno Community Health Improvement Partnership	Fresno Metro Ministry	Nonprofit Organization	Fresno	Trauma Informed Nutrition/Food Insecurity
Health Action Sonoma County	Ceres Community Project	Nonprofit Organization	Sonoma County	Cardiovascular Disease
Healthy San Gabriel Valley	YMCA of San Gabriel Valley	Nonprofit Organization	San Gabriel Valley and City of Azusa	Violence Prevention/ Community Resilience
Hope Rising Lake County	Adventist Health Clear Lake	Hospital/ Health System	Lake County	Homelessness/ Substance Use Disorder
Humboldt Community Health Trust	North Coast Health Improvement and Information Network	Nonprofit Organization	Humboldt County	Substance Use Disorder
Imperial County Accountable Community for Health	Imperial County Public Health Department	Public Health Department	Imperial County	Asthma
Merced County All In for Health	County of Merced	Public Health Department	Merced County	Chronic Diseases, Food Security, Access to Care
Reinvent South Stockton Coalition	Reinvent South Stockton Coalition	Nonprofit Organization	South Stockton	Trauma, Healthy Lives, Early Childhood Education, Workforce
San Diego Accountable Community for Health	Be There San Diego	Nonprofit Organization	San Diego County; North Inland San Diego	Cardiovascular Disease
West Sacramento Accountable Community for Health	Health Education Council	Nonprofit Organization	West Sacramento	Health Indequities, Heart Disease, COVID-19

Adapted from Desert Vista Consulting and CORE Center for Outcome Research and Education; Updated July 2021



Attachment 3: SDACH "Ideal" Vision for a Trauma-Informed Network of Care in San Diego

1. Children and families are connected with both formal and informal healing supports.
2. Public, private, and communitywide systems work together to promote healing and resiliency.
3. Intentional relationship structures that benefit children and families are built and nurtured across all sectors.
4. Factors that may impact trauma and resiliency, including community context and public, private and community systems that families are involved with, are known and considered.
5. Exposure to racism and discrimination is recognized as a risk factor for toxic stress and ACEs.
6. Healing and trauma-informed care are incorporated across all policies, programs, and practices.
7. Common language, workflows, lines of sight, and no wrong door policies help to create seamless, person-centered care and help families to connect with needed resources.
8. ACEs aren't "treated" like a medical condition using traditional medical models, although ACEs are identified in medical settings. Practitioners agree that it is important for us not to "medicalize" all responses to ACEs.
9. Families have choice and voice; they lead and partner with healthcare and service providers in determining their own needs and supports.
10. Families' cultural approaches to healing and wellness are honored.
11. Joint assessment of resiliency and positive childhood experiences (PCEs) along with ACEs better identify needs and supports and enable a focus on building strengths to promote wellbeing.
12. Existing policies, programs, and practices are enhanced to better support children and families.
13. All service providers acknowledge race and power dynamics in their interactions with children and families. They do things withfamilies, not forthem or tothem.
14. Children are respected as being creative, resourceful, and whole, not damaged or deficient.
15. Communities are places that promote healing and resilience, not places of adversity.
16. Support is available for families before they reach a crisis point.
17. Follow-up is provided to assure that families receive the supports they want and need.
18. The NOC is incomplete unless/until we work together with affected families and people with lived experience as thought partners



Attachment 4: SDACH ACEs Aware Network of Care Strategies and Actions

ACEs Network of Care Strategies & Actions

The following strategies and actions are recommended by the ACEs Network of Care Learning Collaborative to create an "ideal" network of care for children and families.

Strategy 1: Engage youth and families with lived experience in co-designing solutions

- Connect youth and families with advocacy opportunities including meeting with policy makers and decision makers
- Provide opportunities for community residents to build new relationships and greater trust with systems they interact with

Strategy 2: Develop and support a diverse, trauma-informed and trauma-sensitive workforce

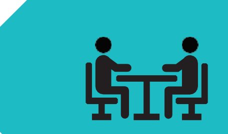
- Create trauma-informed care standards and a recognition program for organizations that meet standards
- Provide ongoing trauma-informed care training
- Adopt organizational policies that support trauma-informed care
- Adopt policies that recognize and address secondary trauma
- Create educational and employment pathways for people with lived experience and diverse backgrounds

Strategy 3: Deliver services in a trauma-informed and trauma-sensitive manner

- Acknowledge race and power dynamics in all interactions with children and families
- Adopt policies and conduct training for providers that support cultural humility
- Support families in directing their own needs and supports
- Use person- and family-centered language that is gentle and non-judgmental
- Measure and address assets and resiliency factors
- Recognize and support protective factors available to each family

Strategy 4: Ensure that all communities have equitable access to formal and informal healing supports

- Support community health workers to support and connect families with healing supports
- Increase behavioral health services
- Increase integration of physical and behavioral health services
- Build capacity of community members to be informal healing resources



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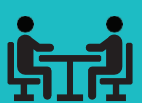
ACEs Network of Care Strategies & Actions

Strategy 5: Cultivate trauma-informed and trauma-sensitive systems

- Create, continue, and/or participate in multi-sector partnerships
- Create and/or participate in a "Network of Networks" to create awareness and shared leadership among systems
- Identify and address barriers to systems integration



Strategy 6: Raise public awareness about the impact of ACEs and formal and informal healing supports

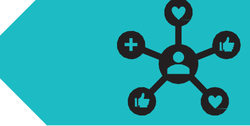
- Create and implement an awareness campaign and disseminate it with the same messages across all systems and sectors
- Provide information on how community members can be trauma-sensitive informal supports to children and families
- Engage trusted messengers in all communities
- Utilize language that is culturally appropriate, affirming and empowering

Strategy 7: Address upstream determinants of childhood trauma and adversity

- Adopt policies that support improved community conditions
- Support community residents in efforts to improve community conditions
- Create opportunities for building trust and healthy relationships between children/families and systems

Strategy 8: Advance technology to support connections and person-centered approaches

- Create and participate in bidirectional referral systems
- Support data systems that are owned and informed by clients
- Share data to support systems improvements



The ACEs Network of Care Learning Collaborative encourages agencies, organizations, and individuals to implement these strategies and actions to support children and families to heal, develop resiliency, and thrive.

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Attachment 5: SDACH ACEs Aware Network of Care Learning Collaborative Pre-Session Survey

San Diego Accountable Community for Health
ACEs Aware Network of Care Learning Collaborative
Pre-Session Survey – February 18, 2021

1. Your name:
2. Your organization (if applicable):
3. Your title (if applicable):
4. Which of the following best describes your work? (If you work in multiple areas, check the box that reflects the majority of your work.)
   - ❐ Healthcare (e.g., medical groups, health plans, FQHCs, hospitals)
   - ❐ Behavioral health (mental health and/or substance use services)
   - ❐ Government program (e.g., child welfare, family resource centers, nurse family partnerships)
   - ❐ Community-based organization (e.g., non-profit providers of food, housing or financial assistance)
   - ❐ Faith-based organization
   - ❐ Education and training (e.g., elementary, secondary and postsecondary education; parent education; workforce development or training)
   - ❐ Ages 0-5 Early care/education (childcare resources, preschool, early childhood education)
   - ❐ Legal/Justice system (law enforcement; courts, corrections or legal services; juvenile justice services; probation)
   - ❐ Other: (please describe:_____________)

5. How knowledgeable are you about the following:

	Not at all	Somewhat	Very
Adverse childhood experiences (ACEs)			
Resiliency			
Protective factors			
Protective factor services/support			
Community buffering supports			
Toxic stress			
Trauma-informed care			
Healing practices/services			
"Stress buster" services/supports			
Impact of toxic stress			

6. To what extent has your organization integrated adverse childhood experience concepts into its work?
   a. Not at all

1

b. Somewhat
c. Quite a bit
d. Not applicable

7. How familiar are you with community services for children and families needing support related to ACEs? (This means that you are familiar with a number of resources, and you know the types of services offered, where the organization is located, and the populations they serve, for example.)
   a. Not at all
   b. Somewhat
   c. Very
   d. Not applicable

8. Based on your experience, how effective are **current referral processes** that connect children and families with community services related to ACEs? (This means that children and families are connected with appropriate services in a timely manner.)
   a. Not at all effective
   b. Somewhat effective
   c. Very effective
   d. Not applicable

9. How could current referral processes that connect children and families with ACEs services be improved? (open ended)

10. Rate the degree to which you believe cross-sector partners in San Diego County have:

	Not at all	Somewhat	A great deal	Not applicable	Don't Know
a. Created strategic, cross-sector partnerships to address ACEs (such as education, health, juvenile justice and social services)					
b. Developed a deep trust in each other to work together to address ACEs					
c. Demonstrated a shared ongoing commitment to address ACEs					

2

d. Organized a strong network of care to address ACEs					
e. Developed open communication with partners to address ACEs					
f. Developed a clearly defined community action plan to address ACEs					
g. Engaged residents as leaders to address ACEs					

11. To what extent have you or has your organization collaborated with the following sectors to address ACEs?

	Not at all	Somewhat	A great deal	Not applicable	Don't know
Healthcare					
Behavioral health					
Government programs					
Community-based organizations					
Faith-based organizations					
Education and training					
Ages 0-5 early care/education					
Legal/justice system					
Other (please describe): __________					

12. Please answer the following questions related to agency or organizational readiness and willingness to address ACEs. My agency or organization…

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Has leadership buy-in to participate in an ACEs network of care.					
Has sufficient support staff with the necessary time and resources to participate in an ACEs network of care.					
Has adequately trained staff on trauma-informed care and resilience.					

Is willing to train staff on trauma-informed care and resilience.					
Is willing to work with cross-sector partners on an ACEs network of care.					

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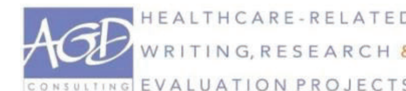


Attachment 6: SDACH ACEs Aware Network of Care Learning Collaborative Post-Session Survey

San Diego Accountable Community for Health
ACEs Aware Network of Care Learning Collaborative
Post-Session Survey - May 21, 2021

1. Your name:
2. Your organization (if applicable):
3. Your title (if applicable):
4. Which of the following best describes your work? (If you work in multiple areas, check the box that reflects the majority of your work.)
   - ❒ Healthcare (e.g., medical groups, health plans, FQHCs, hospitals)
   - ❒ Behavioral health (mental health and/or substance use services)
   - ❒ Government program (e.g., child welfare, family resource centers, nurse family partnerships)
   - ❒ Community-based organization (e.g., non-profit providers of food, housing or financial assistance)
   - ❒ Faith-based organization
   - ❒ Education and training (e.g., elementary, secondary and postsecondary education; parent education; workforce development or training)
   - ❒ Ages 0-5 Early care/education (childcare resources, preschool, early childhood education)
   - ❒ Legal/Justice system (law enforcement; courts, corrections or legal services; juvenile justice services; probation)
   - ❒ Other: (please describe:_____________)

5. How knowledgeable are you about the following:

	Not at all	Somewhat	Very
Adverse childhood experiences (ACEs)			
Resiliency			
Protective factors			
Protective factor services/support			
Community buffering supports			
Toxic stress			
Trauma-informed care			
Healing practices/services			
"Stress buster" services/supports			
Impact of toxic stress			

6. To what extent has your organization integrated adverse childhood experience concepts into its work?
   a. Not at all

1

b. Somewhat
c. Quite a bit
d. Not applicable

7. How familiar are you with community services for children and families needing support related to ACEs? (This means that you are familiar with a number of resources, and you know the types of services offered, where the organization is located, and the populations they serve, for example.)
   a. Not at all
   b. Somewhat
   c. Very
   d. Not applicable

8. Rate the degree to which you believe cross-sector partners in San Diego County have:

	Not at all	Somewhat	A great deal	Not applicable	Don't Know
a. Created strategic, cross-sector partnerships to address ACEs (such as education, health, juvenile justice and social services)					
b. Developed a deep trust in each other to work together to address ACEs					
c. Demonstrated a shared ongoing commitment to address ACEs					
d. Organized a strong network of care to address ACEs					
e. Developed open communication with partners to address ACEs					
f. Developed a clearly defined community action plan to address ACEs					

2

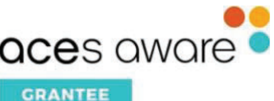
g. Engaged residents as leaders to address ACEs					

9. To what extent have you or has your organization collaborated with the following sectors to address ACEs?

	Not at all	Somewhat	A great deal	Not applicable	Don't know
Healthcare					
Behavioral health					
Government programs					
Community-based organizations					
Faith-based organizations					
Education and training					
Ages 0-5 early care/education					
Legal/justice system					
Other (please describe): __________					

10. Please answer the following questions related to agency or organizational readiness and willingness to address ACEs. My agency or organization…

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Has leadership buy-in to participate in an ACEs network of care.					
Has sufficient support staff with the necessary time and resources to participate in an ACEs network of care.					
Has adequately trained staff on trauma-informed care and resilience.					
Is willing to train staff on trauma-informed care and resilience.					
Is willing to work with cross-sector partners on an ACEs network of care.					



Post Survey Only:

11. To what extent has your involvement in the ACEs Network of Care Learning Community influenced your agency or organization in the following areas:

	Not at all	Somewhat	A great deal	Not applicable	I don't know
Enhanced **collaboration** with other organizations in multiple sectors					
Integrated ACEs into **organizational practices and procedures**					
Increased staff **training** about ACEs					
Facilitated **community awareness** about ACEs					
Improved **policy or advocacy** efforts					

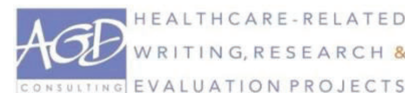
12. What sectors did you develop new or enhanced relationships with as a result of the ACEs Network of Care Learning Collaborative?
    - ☐ Healthcare
    - ☐ Behavioral health
    - ☐ Government programs
    - ☐ Community-based organizations
    - ☐ Faith-based organizations
    - ☐ Education and training
    - ☐ Ages 0-5 early care/education
    - ☐ Legal/justice system
    - ☐ Other (please describe): ____ _

13. Please describe any new or **enhanced relationships** with other organizations that have occurred as a result of the ACEs Network of Care Learning Collaborative? *(open ended}*

14. Does your organization plan to make any changes on how it addresses ACEs as a result of the ACEs Network of Care Learning Collaborative? *(open ended}*

15. What did you find most valuable about the ACEs Network of Care Learning Collaborative? *(open ended)*

16. Describe any additional ways your involvement in the ACEs Network of Care Learning Collaborative has been beneficial. *(open ended)*



17. What do you suggest for next steps to improve cross-sector collaboration on ACEs?

    a. Continue the learning collaborative
    b. Further build out and implement the action plan
    c. Engage new partners and/or sectors
    d. Share best practices and lessons learned
    e. Other (please specify): _________

18. If we continue the learning collaborative, would you be willing to participate?

    a. Yes
    b. No

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