



Family and Community-Based Organization Experiences in ACE Screening and Treatment of Young Children: An ACEs Aware Practice Paper

Report Prepared for First 5 LA
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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](#).

Executive Summary

Background

ACEs Aware offers health care providers training, screening tools, clinical protocols and payment for screening for Adverse Childhood Experiences (ACEs). ACEs refer to the 10 traumatic categories experienced in childhood that were evaluated in the landmark 1998 Centers for Disease Control and Prevention (CDC) and Kaiser Permanente study.ⁱ Screening for ACEs, assessing for toxic stress and responding with community-defined practices and evidence-based interventions can significantly improve the health and well-being of individuals and families. In January 2020, First 5 LA and its joint applicants, the American Academy of Pediatrics – California Chapter 2 and the Los Angeles County Department of Mental Health-UCLA Prevention Center of Excellence, were awarded a Provider Engagement grant to promote the ACEs Aware initiative in Los Angeles (L.A.) County. This report expands on existing best practices around ACE screening, with a focus on the **family and local CBO experiences**, to inform large-scale systems change of incorporating ACE screening into systems of care for children and families in L.A. County and other similar jurisdictions.

Key Findings

Family Experience. The literature reviewed and content experts, providers, and families interviewed provided examples of successful integration of family-centered ACE screenings into family health care. These include the use of trauma-informed anticipatory guidance, the validation of family strengths in addition to ACEs, a two-generation approach to care, the implementation of care coordination practices, alignment of ACE screening with other screenings and well-child visits and the implementation of anonymous screening processes. Despite some early success integrating ACE screening into family health care while prioritizing the family experience, challenges still exist. Common challenges include addressing the psychological and emotional toll of ACE screening; mitigating the effects of stigma; ensuring linguistic and cultural considerations; implementing power sharing; countering the system complexity and geographical expanse of L.A. County; and addressing challenges with informed consent and privacy.

Community-Based Organization Experience. Establishing a family-centered, trauma-informed Network of Care (NoC) with effective and efficient referral pathways and care coordination is essential for treating ACEs. Content experts

and parents reflected on areas where they have seen success in establishing cross-sector referral pathways and improving care coordination, including being intentional during the planning stages of implementation, being responsive to families' needs, promoting active communication between health care providers and CBOs, and establishing efficient and effective information-sharing infrastructures. Although much enthusiasm surrounds building a family-centered NoC in L.A. County, various challenges exist that should be considered as clinicians and providers work to strengthen referral processes and cross-sector relationship building with families and organizations. Common barriers include the various technology platforms used across L.A. County and their missing interoperability; the lack of shared culture, values, and language among systems of care; the limited number of resources; and limitations on who can be reimbursed for screening and follow-up services.

Call to Action

The following are call to action items for state and county systems, health plans and other family- and child-serving providers as L.A. County works to incorporate ACE screening and treatment into family-centered systems of care.

High-Quality Supports
<ul style="list-style-type: none"> • Normalize screenings in practice to mitigate stigma experienced by families. • Consider cultural congruence and address implicit biases between health care providers and patients. • Take a family-centered, shared decision-making approach to interacting with families that is strengths-based.
Aligning Systems
<ul style="list-style-type: none"> • Start with education and preparation to build relationships and shared expectations between organizations. • Ensure cross-sector partners develop a shared language and understanding of the framing of ACEs in a historical and systems context, rather than as an individual experience. • Create an accessible and interoperable referral infrastructure that integrates into electronic health records and other data systems.
Improved Access
<ul style="list-style-type: none"> • Build resource hubs where multiple services can be accessed at once.
Sustainable Supports
<ul style="list-style-type: none"> • Grow the workforce through meaningful inclusion of doulas, peer support staff such as community health workers and others in care coordination. • Expand access to reimbursement for screening and care planning to other providers who serve Medi-Cal patients.

Background

The ACEs Aware initiative seeks to change and save lives by helping Medi-Cal providers understand the importance of screening for Adverse Childhood Experiences (ACEs) and training them to respond with trauma-informed care. The term ACEs refers to 10 specific categories of adversity experienced by age 18 that were the focus of the 1998 CDC and Kaiser Permanente study. These categories fall into three domains: abuse (physical, emotional, or sexual), neglect (physical or emotional) and household challenges (such as growing up in a household with incarceration, mental illness, substance use, or instability due to parental separation/divorce, or intimate partner violence). ACEs Aware offers Medi-Cal providers training, screening tools, clinical protocols, and payment for screening children and adults for ACEs. By screening for ACEs, responding with evidence-based interventions and community-defined practices, and implementing trauma-informed care, we can significantly improve the health and well-being of individuals and families.

In January 2020, the Office of the California Surgeon General and the California Department of Health Care Services (DHCS) released a Request for Proposals to fund organizations to help extend the reach and impact of this initiative to Medi-Cal beneficiaries through provider trainings and reimbursement. First 5 LA and its joint applicants, the American Academy of Pediatrics – California Chapter 2 (AAP-CA2) and the Los Angeles County Department of Mental Health and UCLA Prevention Center of Excellence (DMH + UCLA COE), were awarded a Provider Engagement grant. Specifically, First 5 LA partnered with key stakeholders in L.A. County to implement three provider engagement activities:

- 1) [Peer-to-Peer Learning sessions](#) with primary care physicians and other health providers;
- 2) [Network of Care \(NoC\) activities](#) for a cross section of providers, including organizations selected as ACEs Aware planning and implementation grantees; and
- 3) A practice paper to inform large-scale systems change for incorporating ACE screening alignment, treatment, and referrals/care coordination.

Purpose and Methods

This report focuses on the **family and CBO experience** of lessons learned and best and promising practices to inform large-scale systems change of incorporating ACE screening into systems of care for children and families in L.A.

County and other similar jurisdictions. The findings of this report are intended to inform coordination with other ACEs Aware efforts across the state and complementary efforts (such as the California Advancing and Innovating Medi-Cal [CalAIM] initiative¹ and other changes to Medi-Cal). Understandably, screening for and treating ACEs has typically been approached with an emphasis on the health care provider perspective since ACE screenings are recommended in health care settings. However, family and CBO experiences must also be prioritized in the design of systems to provide the holistic and efficient care and support needed to treat ACEs.

“ACE screening must be tied to specific, new access to care that shifts agency and power away from the health system to beneficiaries and community-based organizations.”

- Alex Briscoe, Principal, The California Children’s Trust

The learnings and recommendations presented in this report are based on the following data sources:

- Peer-to-Peer Learning and NoC activity session observations.
- Key informant interviews with subject matter experts representing pediatricians, managed care plans, L.A. County Department of Mental Health, L.A. County Department of Health Services, and more.
- A focus group with the Help Me Grow LA’s Community and Family Engagement Council (CFEC), an advisory group of 10 parent champions who help ensure early childhood services and resources are centered around the needs of children and families.
- A literature review of the existing body of research.

Equity and ACEs

Integrating ACE screening into family health care and connecting families with a NoC cannot be discussed without considering equity. The challenges of navigating the complexity of the U.S. health care system are amplified for low-income and marginalized families who often have less time and access to the resources and connections needed to successfully navigate systems of care for themselves and their children. The historical and ongoing pathologizing of Black, Indigenous, and other people of color (BIPOC); Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Gender Non-Conforming (LGBTQGN))

¹ Led by DHCS, California Advancing and Innovating Medi-Cal (CalAIM) seeks to promote whole-person care to address many of the complex challenges California’s most vulnerable populations face including homelessness, behavioral health access, complex health needs, and the growing aging population. CalAIM will enable the system of care in L.A. County to approach care coordination in a new, more family-centered way.



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individuals; people with disabilities; and low-income people highlight the need to repair the health care system. ACEs are one example of traumatic experiences that are systemically influenced and can span generations.

The extent to which trauma-informed principles are put into practice varies within and across programs. Many of the resources for trauma-informed efforts focus on interventions for individuals and families rather than communities or systems, ignoring that traumatic experiences impact individuals, families and entire communities. Too often, individuals and communities who have experienced trauma are seen as just their trauma, without having their whole selves, identities and strengths honored.

A systems perspective of trauma prioritizes healing at the systems level and addresses the root causes of trauma that are structurally embedded in our society. To provide culturally responsive and trauma-informed care to families and communities, health care and service providers need a keen awareness of the effect of historically harmful medical practices and systemic oppression on the communities they serve, how those inequities are held in place, and what their role is in perpetuating inequities. Across all areas, health care and non-health care providers must understand how systemic racism has impacted and continues to impact the well-being of marginalized communities. Local CBOs can help health care providers understand the histories of, and impact of systemic racism on, the communities they both serve.

Family Experience in ACE Screening and Treatment



ACEs and toxic stress are common phenomena across communities. Data show that 62 percent of California residents have experienced at least one ACE and 16 percent have experienced four or more ACEs.ⁱⁱ Research demonstrates that cumulative adversity, especially when experienced during critical and sensitive periods of development, is a root cause of some of the most harmful, persistent, and expensive health challenges facing our state and the nation, including nine of the 10 leading causes of death in the United States.ⁱⁱⁱ By screening for ACEs, health care providers can better determine the likelihood an individual is at increased risk for health challenges and can respond with evidence-based, trauma-informed care and referrals that will improve the health and well-being of individuals and families.^{iv}

Engaging families in conversations about the adversities they have faced is a delicate task. Historically, approaches to patient care have been deficit-based and diagnostically focused. However, the field is currently shifting towards a more patient-centered and trauma-informed approach. Following the key principles of trauma-informed care is a critical component of screening for and treating ACEs and toxic stress in a family-centered way. Principles of trauma-informed care in the health care setting include:

- Establishing the physical and emotional safety of patients and staff.
- Building trust between providers and patients.
- Recognizing the signs and symptoms of trauma exposure on physical and mental health.
- Promoting patient-centered, community-centered evidence-based care.
- Ensuring provider and patient collaboration by bringing patients into the treatment process and discussing mutually agreed-upon goals for treatment.
- Providing care that is sensitive to the patient's racial, ethnic and cultural background and gender identity.⁹

Without trauma-informed, healing-centered and patient-centered approaches, health care providers risk doing more harm than good by triggering recollections of traumatic experiences and reinforcing deficit narratives about vulnerable and marginalized communities when implementing ACE screenings.

The following sections highlight promising practices, challenges and anticipated barriers, and a call to action for integrating ACE screenings and treatment into patient health care in a family-centered way.



Promising Practices

Although the practice of integrating ACE screenings into patient care is relatively new for many clinicians across L.A. County, the literature reviewed and content experts, providers and families interviewed provide examples of successful integration of family-centered ACE screenings into family health care. This includes using trauma-informed anticipatory guidance, validating family strengths in addition to ACEs, taking a two-generation approach to care, implementing care coordination practices, aligning ACE screening with other screenings and well-child visits, and implementing anonymous screening processes.

Trauma-informed anticipatory guidance is the act of having a proactive conversation with families to discuss their child's physical, emotional, psychological or developmental growth.^{vi} The literature recommends the use of anticipatory guidance as “most parents/caregivers are new to ACE screenings, so setting the stage with effective anticipatory guidance can help address questions and relieve possible worries.”^{vii} Additionally, this provides space for providers to implement trauma-informed communication strategies with families (e.g., active listening, motivational interviewing, empathic and nonjudgmental interaction, supportive care, reflective supervision) to convey their shared goal of wanting to help the family “not just survive, but thrive.”^{viii}

Having a conversation about ACEs and toxic stress prior to conducting a formal screening is another method the literature suggests clinicians implement to gain foundational knowledge about a person's history of ACEs. “Having a focused conversation provides education about the effects of toxic stress regardless of disclosure. The intent of this conversation is *not* to elicit disclosure of ACEs history or to screen, but rather to provide foundational knowledge and share resources for resilience building at routine well-care visits.”^{ix}

Family strengths validation is a critical practice when screening and treating ACEs. Providers are shifting away from deficit-based models to focus on family strengths, Benevolent Childhood Experiences (BCEs), and resilience or protective factors in addition to ACEs when screening. Providers have found that framing protective factors in contrast (or as a complement) to ACEs has shown stronger associations with future outcomes among Indigenous/Native American youth than ACE screening alone.^x “The concept of BCEs provides an alternative opportunity to assess positive early life experiences and the impact these experiences may have on building resilience and wellbeing....” Higher levels of BCEs have been shown to predict lower odds of psychological distress.^{xi} Content experts agree that identifying and understanding a family's strengths are just as important as understanding ACEs. Individual and family strengths are critical for buffering the negative impacts of ACEs and toxic stress and should be considered alongside ACEs when treating a patient.

“We always do the Adverse Childhood Experiences with the Benevolent Childhood Experiences. We always look for ‘What else was happening at the same time that may have been a buffer in terms of the impact?’ It has to be looked at with other information in addition. We cannot make assumptions. I know there's trends when you see a specific number of ACEs endorsed, but **we can't use trends to determine individual service needs** [emphasis added].”
- Adriana Molina, Allies for Every Child

Two-generation approaches are one way to interrupt the intergenerational cycle and impact of trauma. Findings from the National Pediatric Practice Community on their ACEs Screening Pilot suggest “effectively addressing ACEs involves a two-generational approach to reduce the dose of adversity and enhance the ability of the caregiver to buffer their child's stress.”^{xii} Two-generation approaches ensure both children and caregivers receive the support they need. When caregivers’ needs are met, they are better able to support their child’s emotional development and build a positive relationship with their child that can buffer the impacts of toxic stress. Additionally, when caregivers’ needs are met, children are likely to experience positive physical, mental and behavioral health outcomes.^{xiii} The inclusion of doula services, family therapy and dyadic services as Medi-Cal covered services supports the two-generational approach by providing physical, behavioral and mental health services to the whole family simultaneously. This dyadic model of care has been proven to improve access to preventive care for children, immunization rates, care coordination, children’s social-emotional health and safety, developmentally appropriate parenting and maternal mental health.^{xiv}

Examples of two-generation approaches in pediatric practice include embedding maternal screenings during well-child visits on behavioral health, family planning and basic needs, particularly during the postpartum period. [HealthySteps](#) is an evidence-based two-generation program from ZERO TO THREE. In the program, a HealthySteps Specialist joins the pediatric primary care team to strengthen the relationships between families and providers, ensure universal screenings and provide interventions, referrals, and follow-up to the whole family. Research shows that HealthySteps leads to more families receiving early preventive services and pediatric practice benefits through increased efficiency of the medical system and supported team-based comprehensive care.^{xv}

Home visitation is another strategy that promotes a two-generation approach to care. L.A. County has a cross-agency strategic plan to strengthen voluntary home visiting services that includes efforts to increase access, build the workforce, create common data to convey shared impact and expand funding. The plan encompasses the work of L.A. County Departments of Public Health, Mental Health, and Children and Family Services, and First 5 LA, among others. The [Welcome Baby program](#), First 5 LA’s universal home visiting model, is deeply integrated into 14 hospitals in high-needs communities across the county. Through Welcome Baby, all babies born in the 14 hospitals and their families are eligible for home visitation services prenatally and for the first nine months of life. Families with higher needs can be referred to longer-term

programs like [Healthy Families America](#) or [Parents as Teachers](#) for up to 5 years. Through home visitation programs, both caregivers and children are connected to the supports and services they need.

Care coordination practice integration in pediatric settings. Ensuring a shared understanding of a family's case between providers is critical to eliminating the need for families to continually retell their story and risk potential re-traumatization in doing so. The literature highlights the promising practice of integrating a care coordinator model into a referral network to support families. This model features one go-to person that families can depend on who actively coordinates their referrals between organizations.^{xvi} Examples of innovative care coordination models include the above referenced HealthySteps, as well as the Developmental Understanding and Legal Collaboration for Everyone (DULCE). In [DULCE](#), a Family Specialist is folded into a pediatric care setting and attends well-child visits with families. In this role, they provide peer support to families and work with the pediatric care team to connect families to resources and services. Both HealthySteps and DULCE designate a single person to be responsible for the care coordination of a family.

One content expert shared another type of coordination process that their team uses internally to help warm handoffs run more smoothly and to ensure that families who were identified with behavioral, social and/or trauma-specific service needs are connected to the appropriate providers. Dr. Michael Brodsky, medical director at L.A. Care Health Plan, explained:

“In order to have handoffs occur smoothly between the mild to moderate system of providers and the severe mental illness system of providers, we have a weekly meeting. It's attended by experts in mental health and substance abuse case managers from both sides [behavioral and physical health]. At these meetings, we try to problem-solve about cases where it's a little unclear what would be the best setting for treatment.”

Additionally, CalAIM, the statewide initiative created to reform Medi-Cal program delivery and payment, provides an opportunity for health care and service providers to think differently about the care coordination system in L.A. County and develop a more robust, family-centered system that better serves young children and their families.

Screenings and well-child visits alignment. The charge of participating in additional screenings impacts both health care providers and patients. From the patient perspective, one content expert shared how integrating ACE screening with other screening processes can give patients a sense that they

are participating in a more holistic effort. Participation in several screening processes simultaneously gives patients the opportunity to elaborate on responses and discuss underlying trauma that may be contributing to other aspects of their health. Content experts interviewed who have integrated ACE screening into their workflow or programs have mainly done so by building on existing developmental screening processes. Dr. Adam Schickedanz, MD, Ph.D., AAP-CA2 ACEs Committee chair, explained:

“The fact that we're sort of doing ACE screening in the same way that we're deploying developmental screening and social risk screening means that there's sort of a ready-made pathway, ready-made set of workflows that we can piggyback on to make it easier for practitioners to digest this change and understand what it entails.”

“Embedding ACE screening in behavioral health screening practices has helped educate primary care physicians about ACEs and helped them to understand more about the experiences of their patients.”

- Dr. Catherine Mogil, PsyD, Co-Director, DMH + UCLA COE

Another approach to incorporating ACE screening in a clinical workflow – and preventing form fatigue related to completing a lot of paperwork– is identifying well-child visits that do not typically include any other screenings and using that time to screen for ACEs. Dr. Shannon Thyne, MD, director of pediatrics at the L.A. County Department of Health Services, shared, “We got one clinic to screen at the three-year visit because that was the only visit where there were no shots and no other screens.”

During well-child visits, primary care providers have a unique opportunity to engage parents and caregivers in conversations about a child's development and wellness while simultaneously exploring and addressing stressors parents may be experiencing. One content expert shared how they have seen a culture shift around well-child visits at a federally qualified health center (FQHC), such that they are screening for ACEs in a way that celebrates a family's success. They explained how the well-child visit day was fun because the center flipped the power dynamic by taking a strengths-based approach to well-child visits and celebrated the beauty and wisdom of parents versus discovering and focusing on pathology. Alex Briscoe, principal of The California Children's Trust, explained:

“The waiting room is like a party. It's awesome, it's so fun. And that's unique in the health care system that's out there hunting pathology and dysfunction. In this case, we're well-child visiting. You're leveling people

up. That's a perfect moment to leverage resilience and grow access to social and emotional support, and human capital, social capital, and other human services.”

Though there are mixed reports among content experts on being able to build ACE screenings into well-child visits, those who are able to integrate them find the strengths-based approach helpful in engaging families.

Anonymous screening processes.² Content experts discussed the pros and cons of anonymous ACE screening procedures. In this workflow, patients are provided with the screener along with instructions to complete and return it at your leisure. No identifying information is collected at the patient level; the resulting ACEs data are used to understand the needs at the clinic level. Conducting anonymous ACE screening has been critical for building trust and ensuring patients' psychological safety and confidentiality; however, maintaining confidentiality for smaller programs can be a challenge.³ Content experts also explained how this approach has provided information on the number and type of ACEs their patient population and community have experienced overall but doesn't elicit rich information that can inform individual patient care.



Challenges and Anticipated Barriers

Despite some early success integrating ACE screening into family health care while prioritizing the family experience, challenges still exist. Common challenges include the psychological and emotional toll of ACE screening, the effects of stigma, the lack of linguistic and cultural considerations, limited power sharing, the system complexity and geographical expanse of L.A. County, and issues with informed consent and privacy.

Psychological and emotional toll of ACE screening. Although the literature suggests that ACE screening can lead to better provider and patient satisfaction,^{xvii} screening can take a psychological and emotional toll on families, as well as providers. When screening for ACEs, patients can be re-traumatized by the retelling of their traumatic experiences to multiple providers.

² Anonymous ACE screenings are not reimbursed at the state level as the screener is not linked to a Medi-Cal patient and therefore does not follow the [Medi-Cal billing and documentation requirements](#).

³ Another screening process option is to use the de-identified version of the ACE screening in which parents provide only the total score of ACEs experienced by child without identifying the specific ACEs experienced. Families may be more comfortable providing a number than disclosing specific experiences. ACEs Aware has both de-identified and identified screening tools that are reimbursable.

This points to the need for strategies and resources that can be leveraged to minimize harm. Examples include training health care providers on how to conduct screenings in a trauma-informed way, incorporating more time in the screening process or providing parent support groups for families to debrief and discuss their feelings about completing an ACE screening with a health care professional. Training in trauma-informed care should also include coping techniques so providers know how to cope with the trauma they are exposed to.

Mitigating stigma. Providers, content experts and parents acknowledged that many families experience stigma or the fear of being stigmatized when it comes to screening and treating ACEs. This includes patients fearing that responding to the ACE screening may result in a diagnosis or that they will be treated differently based on their ACE score. When screening and treating ACEs, health care providers must take steps to destigmatize screening procedures, including establishing creative ways to encourage patients to open up about their lives (e.g., drawing, storytelling, etc.) and establishing rapport and quality relationships with the patient before asking them to disclose sensitive information. One parent highlighted the importance of destigmatizing screenings through clear communication. They stated, “To destigmatize is not to find something wrong. It is to explain.”

“The issue of destigmatization is critical and explaining that [the screening] is being done for the benefit of families as opposed to a way of uncovering what the parents are doing wrong. I think that makes a huge difference.”
- Parent, Help Me Grow LA CFEC member

Lastly, physicians have often inadvertently contributed to patient stigma by being unaware of their own biases toward a particular group or community.^{xviii} Implicit biases can lead to prejudicial or discriminatory behaviors when treating patients, which can ultimately lead to the victimization or oppression of marginalized communities.^{xix} Effective and ongoing trainings on implicit bias, trauma-informed care and healing-centered practices – combined with institutional shifts that support the learning and implementation of these practices (e.g., scheduling trainings when providers are not overly stressed, exhausted or hungry) – may alleviate stigma as health care providers learn to mitigate their own biases in interactions with patients.

Lack of linguistic and cultural considerations. The reading level of the patient population is an important factor to consider when designing ACE screening workflows and public-facing documents. The U.S. Department of Education estimates that 54 percent of U.S. adults read below a sixth-grade reading level.^{xx}

There are 14 threshold languages⁴ in L.A. County, underscoring the need to offer ACE screening in a variety of languages, simplifying text and prioritizing necessary information. Dr. Adam Schickedanz, AAP-CA2 ACEs Committee chair, stated, “I think one thing that’s really important is using language that is not jargony and aligns with the patient’s language preference.” For both literacy and language barriers, offering patients different ways to complete the screening (e.g., by oneself or with support from a peer advocate or a provider) can help promote inclusivity, reduce bias and mitigate barriers to screening.

Content experts also highlighted the importance of cultural congruence between the health care provider and patient when screening for ACEs. The unique experiences of Black, Indigenous, and other people of color (BIPOC), low-income, and other historically marginalized populations accentuate the importance of cultural congruence between the health care provider and patient and the need to deliver patient care in a culturally appropriate and responsive way. This would necessitate improving education and employment pipelines to support the hiring and success of culturally congruent staff. Dr. Michael Brodsky of L.A. Care Health Plan, the largest publicly operated health plan in the country, explained: “The need to keep an eye on the concordance – the cultural congruence between the provider and the patient and caregiver – is really important. That includes not only language factors but cultural factors, to try to minimize discomfort.”

Limited power sharing. Content experts explained how reporting on ACEs runs the risk of becoming a tool for the professional class to generate intervention justification versus a mechanism for patient-driven transformation. This is related to the culture of the health care system, where power and information are held by the doctors or professionals, not the patients. Content experts cited the need to shift this power dynamic so that screening for ACEs becomes a patient-centered process. Alex Briscoe with The California Children’s Trust shared, “Without the required transformation of the central practice and reimbursement model, ACEs [screenings] is just going to create more damage.”

Most service systems are designed around the needs and challenges of the provider rather than the family. Additionally, even when providers are trying to prioritize families, they base solutions on their own well-intentioned assumptions rather than understanding and responding to the currently felt needs and challenges of families. This results in added burden and confusion on the

⁴ A threshold language indicates the language is the primary language for 3,000 or five percent of the Medi-Cal beneficiary population.

patients' side in order for providers to gather the information they need to make decisions for the family. Adriana Molina with Allies for Every Child explained:

"The first thing I think about is the experience of the person having to go to five different service providers and answering the same question because the professionals all want ACE screening, without knowing the 'why' or 'how' it will change my services or change my care. I think the redundancy could actually make it seem less important to families because it creates a feeling of 'everybody's asking me, but nobody's doing anything about it.'"

System complexity and geographical expanse. L.A.

County's size and scale introduce certain geographical implications and challenges for families navigating referral pathways.⁵ People living on the outer edges of the county often experience the most difficulty accessing services (see box at right). Largely due to its size, L.A. County's systems of care are complex and fragmented. With multiple clinical systems, urgent care facilities, emergency departments, subspecialist care providers, health coverage options and other factors to contend with, many families end up having touch points with various systems that are not connected. As such, one expert shared that there appears to be less of an expectation for continuity of care among primary care providers in L.A. County. The fragmented system creates communication barriers among families, primary care providers and agencies receiving referrals. There is often limited information sharing across agencies, restricting providers from monitoring whether families have received the services they were referred to or getting progress updates for families that were connected to services. Continued telehealth services and improved transportation support may help families on the outer edges of the county access services. Moreover, a shared or integrated information-sharing platform would allow providers to be more effective in making and following up on referrals, closing referral loops and tracking patients' care.

"The folks on the outer edges [of the county] face a double gap. Because if they try to refer for services, sometimes they're either going to be not close but in L.A. County, or really close and in another county. That becomes a big challenge for L.A. County, just because it's so big and vast."

- Adriana Molina, Allies for Every Child

Informed consent and data privacy. Technology platforms have become important tools for organizing health information. But before implementing an

⁵ L.A. County covers 4,084 square miles and includes 88 incorporated cities and 120-125 unincorporated communities. There are currently over 10 million residents, of which 7 percent are children ages 0-5.

integrated information-sharing platform across providers, there is a need to review the confidentiality, privacy and security of electronic health information.^{xxi} Establishing a process and form for families to provide universal informed consent to release information to multiple providers – along with guidance to providers on how to safely and appropriately share information – would be helpful for sharing data and reducing the burden on families to repeat their stories.

The literature also suggests that families should have more control over their health information, including the ability to access, amend and delete identifiable information and to have knowledge of and control over how their data are disclosed, including any participation in de-aggregated data sets used for research purposes.^{xxii} Also, given the historical racism and misuse of health data for research and experimentation within BIPOC communities, information being shared must be appropriately protected and consent meaningfully sought to rebuild trust and collective partnership.



Call to Action in L.A. County

Incorporating ACE screening into patient care is a complex, nuanced and sensitive process. Patient well-being, provider well-being, and cultural considerations are just a few of the many factors that must be considered. The following recommendations emerged from First 5 LA's ACEs Aware provider engagement activities and should be utilized as a guide for practices integrating ACE screening and treatment into patient-care workflows and policies.

Normalize screenings to mitigate the fear of stigma.

- **Improve communication practices:** Health plans and health care practices can provide the structure for health care providers with the necessary training and tools to meaningfully engage families in an empathetic and nonjudgmental way. These include establishing engagement strategy practices like anticipatory guidance and developing creative ways (e.g., drawing, telling a story) to gather more information on ACEs. At a practice level, providers can benefit from guidance on developing a standardized process for explaining and preparing families for an ACE screening. Essential to this process is transparency with families on how the information will be used to inform patient care and what the next steps will entail. Lastly, in partnership with

parents, practices can develop culturally responsive materials that families can reference to get additional information on an ACE screening.

- **Align screening workflow:** Pediatric practices can incorporate ACE screenings with existing social risk screens, developmental screenings and perinatal or postpartum mood and anxiety disorder (PMAD) screenings as a way to signal to families that ACE screening is a common practice. Engaging ancillary supports such as other medical staff or peer navigators in the screening and treatment process will help develop rapport and trust and increase the amount of time health care providers are able to engage with patients.
- **Leverage changes to Medi-Cal:** Systems leaders and health plans should consider how to leverage new and innovative insurance benefits to sustain supportive ACE screening implementation. For instance, the Population Health Management strategy of CalAIM⁶ may provide an opportunity to integrate screenings. This will prepare managed care organizations to better manage member risk and subsequently improve quality and health outcomes. In addition, the new dyadic care Medi-Cal benefit will integrate physical and behavioral health screening and services so that parents and children can be treated together.

Consider cultural congruence and address implicit biases.

- **Examine hiring policies:** Pediatric practices should ensure there are staff who share similar cultural backgrounds and lived experiences with the patients and the community they serve. Cultural congruence can help with delivering care in a culturally responsive way in the patient's preferred language and can minimize discomfort patients may have with the screening.
- **Infuse training:** Health care systems need to acknowledge the implicit biases providers bring and how that impacts the treatment of patients. To better equip health care providers to address their bias and increase equitable treatment of their patients, practices can integrate more implicit bias training and learning around power, privilege and cultural responsiveness in health care. Practices can also provide the infrastructure for ongoing reflection and supports to change implicit bias, such as regular self-assessments. At a pediatric practice level, developing equity-focused goals and metrics will serve to support continuous quality improvement. One local resource is the DMH + UCLA Prevention Center of

⁶ To learn more about CalAIM strategies, visit: <https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx>

Excellence (COE) – their Wellbeing for LA Learning Center has recorded trainings and educational materials, including resources on implicit bias, that are free to providers.

- **Align county efforts:** Practices should identify and leverage county initiatives focusing on diversity, equity and inclusion. For example, the Anti-Racism, Diversity, and Inclusion (ARDI) Initiative, a motion approved by the L.A. County Board of Supervisors, is tasked with developing a strategic plan and policy platform for the county, in coordination with local systems and agencies. There should be consistent messaging and activities across county systems.

Integrate a family-centered, shared decision-making approach.

- **Enhance care teams:** Practices should consider expanding health care teams to include care coordinators, behavioral health providers, social workers, family therapists, psychologists and others to facilitate relationship building and whole-family approaches to care and treatment. The new dyadic care benefit through Medi-Cal may provide opportunities to enhance care teams to intentionally implement a two-generational approach to ACEs.
- **Pair with strengths:** It is important to acknowledge and promote strengths when counseling children and families. Practices can consider incorporating the BCE Questionnaire or other strengths-based/resiliency tools into workflows alongside the ACE screening. Providers should co-develop treatment plans with the family and integrate the family's strengths into the plan to promote successful implementation. Understanding how family strengths and resiliency factors can buffer the effects of toxic stress is an important component of treating ACEs.
- **Hold collaborative conversations:** Engaging in conversations with families will help practices to better understand their needs; identify their challenges in accessing referrals, the ways they can work together to address them, and the referral processes that have worked for them in the past; and incorporate shared decision-making into the family's service experience. This entails the health system prioritizing providers having access to the knowledge, tools, and resources to hold space for collaborative conversations and meeting patients where they are at. One essential resource needed is **time**, as patients may express doubt, hesitation or worry, need more time to understand the referral, or have questions about the service provider's recommendations.

Community-Based Organization Experience in ACE Screening and Treatment



Cross-sector referral pathways and partnerships between health care providers and CBOs are critical to effectively screening and treating ACEs and improving the overall health and well-being of L.A. County communities. These partnerships are especially important in large settings to aid in building coalitions, sharing resources and partnering to avoid service duplication.^{xxiii,xxiv} L.A. County is home to a diverse, rich and complex system of health care providers, county systems, and CBOs. Increasingly, these organizations see the value in working together to create a more streamlined screening, referral and response process to support families in mitigating toxic stress and promoting optimal growth and development for children. In California, there is momentum surrounding the alignment of efforts across various systems (e.g., health, child

welfare, behavioral health) to screen children and families for various risk factors – including ACEs, developmental delays and adverse social determinants of health – and to establish resource and referral systems of care to support them. The ACEs Aware initiative is an example of one statewide effort to do so. The table below highlights two key coordination efforts emerging in L.A. County that are aligned with the objectives of ACEs Aware: ACEs-LA and Help Me Grow LA.

Coordinated Systems Efforts in L.A. County

ACEs-LA is a multi-sector coordination effort led by the L.A. County Department of Health Services (DHS) in collaboration with L.A. County and state stakeholders to build community resilience. ACEs-LA uses the “Screen, Treat and Heal” framework to address the health impacts of ACEs identified in DHS pediatric practices, build referral linkages to service partners, and improve the health and well-being of L.A. County children and families. ACEs-LA builds the relationships for care coordination and infrastructure, linking DHS families with resources to prevent and mitigate the health harms of early childhood trauma. DHS was awarded a \$3 million implementation grant by ACEs Aware to build the ACEs-LA Network of Care, with First 5 LA, Help Me Grow LA, One Degree from Alluma, LIFT-LA, Antelope Valley Engagement Network United in Equity (AVENUE), and the Safe Healthy & Resilient Kids (SHARK) Clinic as convening partners, along with dozens of additional service partner organizations. Together, these partners build and strengthen robust networks of care to effectively respond to ACEs and toxic stress with community-based health and social supports that meet the needs of the children, adults, and families. For more information, visit the ACEs-LA [website](#).

Help Me Grow LA (HMG LA) helps connect all families to the resources they need to support their child’s development, while working to increase the coordination of programs and services in local communities. In partnership with a large number of community-based organizations, HMG LA is informed by other First 5 LA efforts to improve early identification and intervention services. HMG affiliates across the country focus on four core components meant to improve developmental screenings, help service providers with coordination of services and connect families to services that support their child’s development: Centralized Access Point, Family and Community Engagement, Child Health Provider Outreach, and Data Collection and Analysis. More information about Help Me Grow LA and its activities can be found on the Help Me Grow LA [website](#).

The following sections highlight promising practices, challenges and anticipated barriers, as well as a call to action to connect health care providers and CBOs to create a NoC.⁷

⁷ A network of care is defined as a cross-sector group of organizations with intentionally interconnected service delivery, within and between systems in a defined region, that creates continuity of care for those accessing services.



Promising Practices

Content experts, CBO staff and parents reflected on areas where they have seen success in establishing cross-sector referral pathways and improving care coordination that can be replicated to establish a family-centered, trauma-informed NoC in L.A. County. Successful strategies include being intentional during the planning stages of implementation, being responsive to families' needs, promoting active communication between health care providers and CBOs, and establishing efficient and effective information-sharing infrastructures.

Pre-implementation steps. The literature recommends that clinic settings start their education and preparation for ACE screening implementation by looking at inequitable community conditions as underlying sources of ACEs and toxic stress. Additionally, there are several pieces of literature that highlight the importance of taking a systems-level approach to ACEs prevention and mitigation. Partnerships between health care providers and CBOs can help to “address the root causes of early adversity, toxic stress, and trauma, and to develop strategies that can support children and families who experience compounding stressors, can improve systems and change community conditions so that all children and families can thrive.”^{xv}

Responsive to family's needs. Due in part to the complexity and intricacies of L.A. County's current NoC (e.g., lack of a coordinated NoC) as well as larger systemic issues, families may become overwhelmed with trying to take care of their child's needs and are unable to find a place that understands and accommodates their needs. One CBO acknowledged that the NoC for families was not approaching service delivery in a family-centered way. For example, families were being asked to drive to multiple offices across the county in order to access services. In response, the CBO shifted its approach and began collaborating with other service providers supporting their families by providing neighborhood-centered and team-based early intervention support – creating, in essence, a one-stop shop that focused on meeting family needs and reducing barriers to access by offering speech and occupational therapy, developmental, mental health services and more. This organization also recognized the implicit and systemic discrimination and inequities that prevented many families from accessing services. In response, they set up free drop-in-to-play, nature-based spaces in low-resourced neighborhoods as a strategy to meet families in their communities. While the children play, volunteers

are available to provide caregivers with resources, free screenings, learning lunches and other supports. This shift in service delivery highlighted the importance of community collaboration and underscored the importance of a NoC that is both accessible and family-centered.

Active communication between health care providers and CBOs. To build effective referral pathways, it is imperative that health care providers and CBOs keep each other informed and updated on their respective services and resources, eligibility requirements and application processes. Taking the extra step of providing warm handoffs between organizations can also make a big impact on a family's experience. Currently, families are asked to navigate various complex systems that can feel, as one parent noted, like "they are going from one country to another." L.A. County is already home to multiple community collaboratives and structures through which certain providers can interface, so ACEs-related referral pathways should be designed in a way that complements and strengthens existing systems.

Information sharing infrastructures that are efficient and effective. In addition to a shared understanding among health care providers and CBOs of each other's services, eligibility criteria and referring practices, efficient and effective information sharing infrastructures must be in place to help improve families' experiences as they navigate the NoC. Once referrals are made, it is critical for health care providers to be able to track referrals and transitions to ensure families are successfully connected to the organization receiving the referral. Developing a closed-loop information transfer process between providers from different systems of care, via electronic (e.g., e-referral system, shared electronic health resources [EHRs], health information exchange) or other means (e.g., shared Excel spreadsheet or telephone), promotes timely and effective information flow. This connectivity and information sharing enables all providers who come in contact with a family to have a common understanding of the important landmarks in the referral process (e.g., referral appointment made, patient information received, appointment completed).

To begin developing a shared tracking system, the literature suggests "recording basic information about each referral or transition, and then developing strategies for assessing and recording whether key milestones (e.g., appointment made, organization received information, appointment kept, report received by primary care) were reached."^{xxvi} Once a shared tracking process is in place, establish a quality improvement plan among collaborating partners to ensure families are being supported and both partners are making progress toward meeting shared goals.^{xxvi}



Challenges and Anticipated Barriers

Although much enthusiasm surrounds building a family-centered NoC in L.A. County, various challenges exist that should be considered as clinicians and providers work to strengthen referral processes and cross-sector relationship building with families and organizations. Common barriers include the missing interoperability due to differing technology platforms used across L.A. County; the lack of shared culture, values and language among systems of care; limited resources; and limitations on who can be reimbursed for screening and follow-up services.

Missing interoperability across differing technology platforms. The literature highlights the importance of shared referral systems when designing a NoC to ensure families are receiving the support they need. Currently, there are multiple information and referral platforms used by health care and service providers across L.A. County; however, the platforms are not interoperable – they do not “talk to each other.” This lack of interoperability leads to duplication of efforts, delays and gaps in information sharing, and the absence of a centralized location to maintain updated resource information; more importantly, it may increase instances where families are falling through the cracks.

Some service providers described their experience with different platforms as “**time-consuming**” and even “**paralyzing**.” There is a critical need to develop a comprehensive technology system that is family-centered and easy to use, captures critical information CBOs need to report to funders, provides real-time functionality to keep resource information up to date, and minimizes administrative burden. There also needs to be buy-in and commitment from all parties involved to input information in a timely manner. In terms of essential attributes, a family-centered technology platform is equitable, accessible and jargon-free, with features that include centralized intake and referral processes.

Lack of shared culture, values and language. Content experts, providers and families highlighted the misalignment among systems of care with different organizational cultures, disparate languages, insufficient time or capacity to understand one another, and limited willingness to adjust and meet each other where they are at. This misalignment results in more burden on the families to navigate and figure out how to work with different organizations within the same NoC. One content expert stated:

“I think an unfortunate thing is that people are so coupled to their organizational culture that they don't take the time to say, ‘Just let me make sure: when you're asking about assessment, are you asking about this?’ And if the response is, ‘No, that's not what I'm saying,’ that there's time taken to get to that common language of understanding so that we know what the needs are. And that organization can say, ‘Oh, yes, we do that all day long. Please make a referral and we'll be able to provide the needed services.’ I don't know that that is consistently done. And that is a challenge.”

NoC session participants highlighted the need for additional resources, as well as the importance of developing shared criteria and expectations at the organizational level of what it means to be part of a network of care with other service providers. This includes shared expectations related to referral processes, training requirements, collaboration with other network partners, representation at various meetings, etc. Participants flagged how leadership buy-in and support are critical for establishing these shared expectations and for prioritizing involvement in a care network.

“We need to have people from different disciplines learn together and train together, so that we can keep the perspective of others in mind and help make this process more efficient for everyone.”
- Adriana Molina, Chief Program Officer, Allies for Every Child

Limited resources. CBOs coordinating with health care providers are often resource-strapped and have multiple competing priorities, which reduces their capacity to actively participate in a NoC. Similarly, CBOs often lack the staffing and resources needed to build relationships with various networks. One participant at a First 5 LA NoC session shared: “CBOs do not have the capacity [to participate]. CBOs don't have enough staffing or funding; their staff are too busy putting out fires and dealing with community crises.”

During the NoC convenings and key informant interviews, CBOs discussed the relationship between technology platforms, data collection, funding, and competition. CBOs have different contracts with different funders. Often, funders impose very specific and stringent data reporting requirements, which limits their ability to develop a universal platform or process for CBOs to collect data. This points to the need for a larger culture and system shift – where CBOs share what data are meaningful for them and funders then adapt to the CBOs' needs, rather than the other way around. In the meantime, having a data-sharing agreement that clearly outlines the expectations and roles the various partners

play within the NoC would be extremely helpful. CBOs are often strapped for resources and fundraising often takes significant staff time and effort. Thus, providing CBOs with a clear understanding of and access to funding sources is critical. One strategy includes leaning on existing funding sources such as Medi-Cal and/or leveraging collaborative funding efforts to alleviate the responsibility of individual CBOs to secure consistent funding. Lastly, content experts and providers also explained that because there is rarely enough funding to pay for services, it perpetuates a culture of scarcity and places CBOs in direct competition with one another because they are all vying for the same funding. This prevents intentional relationship building and collaboration, which ultimately has a negative impact on families.

Limitations on who can be reimbursed for screening and follow-up services. Institutions outside health care – including community-based providers such as child care centers, schools, and family-serving agencies – may have trusting relationships with families and be better positioned to access services required to meet the needs surfaced by screening. Paraprofessionals within the health care system, such as promotoras and peer navigators, may also be better positioned to save health care providers' time by conducting and discussing the screenings with patients. However, non-health care agencies and paraprofessional staff are currently ineligible for reimbursement through Medi-Cal for the screenings and follow-up services they perform. As a result, this leads to fewer screenings for uninsured individuals and an increased burden on medical staff and primary care providers.



Call to Action in L.A. County

Families, providers and content experts who participated in the various First 5 LA ACEs Aware provider engagement activities shared recommendations to better support CBOs when developing a NoC across L.A. County to screen and treat ACEs.

Start with education and preparation to build relationships and shared expectations.

- **Start with relationship building:** Health plans and other systems leaders create opportunities for cross-sector relationship building (e.g., coffee talks, recurring round table discussions, networking events, etc.) on a regular basis to break down silos between systems of care. These

opportunities serve to engage and educate non-health care organizations on how to work with the health care delivery system and Medi-Cal, and vice versa. Engaging in cross-sector partnerships creates more effective service delivery systems; builds trust and reciprocity between leaders and organizations working across lines; and can result in mobilizing assets, changing policies and practices, and making investments that are critical for population health.^{xxvi}

- **Develop shared language and understanding:** Similarly, health plans and systems leaders could provide opportunities for cross-sector development of shared language and organizational practices, which are essential to reducing the burden families face when navigating the intricacies of L.A. County's various systems. Expanding the definition to include neighborhood-, community-, and societal-level ACEs, as well as integrating local context, race, oppression and historical trauma, provides a fuller picture of ACEs and how they have impacted – and continue to impact – communities.^{xxvii,xxviii} Health plans and systems leaders should consider how best to leverage the Enhanced Care Management (ECM) strategy of CalAIM⁸ to create the space for NoC cross-sector talk and training. Such a space could support the creation of a robust network for care with a shared understanding of shifting responsibility from individuals to systems.^{xxix}
- **Establish a repository of updated resources:** A centralized source of information can help counter misperceptions that there are not enough places to send families with high ACE scores or that the NoC will not be able to hold the numerous referral pathways. Such a repository would provide up-to-date information to health care providers about the various specialist, community-based, and other social services available for patients. The success of both ACE-LA and HMG LA rely on their abilities to stay abreast of community resources, so there may be opportunities to build upon these complementary efforts.

Create an accessible and interoperable referral infrastructure.

- **Strengthen standardization:** DHCS could provide guidance and infrastructure for organizations to implement universal consent procedures and utilize the same or similar screenings, data collection, and data sharing procedures. This would reduce redundancies in client experiences and lessen the need for families to redescribe their traumatic experiences.

⁸ To learn more about CalAIM strategies, visit: <https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx>

- **Demand interoperability:** Develop a cross-network interoperable data platform that allows collaborative tracking of EHRs, treatment plans and referrals, to ensure all NoC providers are informed of a family's history and that they are connected to the services they need. Or, as health care providers and CBOs have existing platforms, facilitating convenings of the various platforms and their payors can help determine opportunities that support interoperability.
- **Make it accessible to families:** Systems and practices must integrate a patient-facing portal in the data platform(s) that provides families with timely and accurate information and feedback regarding available resources, organization contact information and referral status. The platform should be culturally responsive and address the "-isms" that many L.A. County families experience (e.g., ageism, racism, ableism, etc.), while taking into account the many factors that contribute to the digital divide, including internet access, computer/device access and/or broadband reliability. This platform must also be easy to log in to and navigate, include text-to-speech functions, and be accessible and available in multiple languages. The establishment of a designated line should be considered so families can talk to a human when technology support or information on the status of a referral is needed.
- **Get funders on the same page:** Funders must have a common understanding regarding data expectations. This coordination and alignment between funders will make it easier for CBOs to communicate with each other and health providers and will also make communication easier between funders so that they can best compare the impact and determine how best to pool resources.

Expand resource hubs where multiple services can be accessed at once.

- **Support existing resource hubs:** Across the county there are limited number of hubs where a variety of services can be accessed in one place to determine best practices. Due to the vast geography of L.A. County, families would benefit from being able to go to one centralized location for all the services their family needs in their region, especially families living in the more rural parts of the county with less access to services.
- **Leverage changes to Medi-Cal:** There is the potential for health plans to advocate that the narrow focus of Community Supports (formerly called In Lieu of Services) or ECM strategies be expanded for increased community-based coordination of services. ECM is a core strategy of CalAIM and a whole-person, cross-sector approach to comprehensive

care management (both clinical and non-clinical needs) for high-cost, high-need Medi-Cal beneficiaries. Another core strategy of CalAIM is Community Supports, which offers medically appropriate and cost-effective optional alternatives to services for managed care members.

Grow the workforce and strengthen access through meaningful inclusion of doulas, peer support staff such as community health workers and others in care coordination.

- **Redefine who does care coordination:** Practices identify key staff who can serve as point people for patients seeking support with referrals and/or overall care navigation. These staff could also support the tasks of troubleshooting logistical and other challenges that families may encounter in accessing services; going into the community with them to make sure they are able to keep appointments; and advocating on the family's behalf. In addition, they can establish relationships with local resources and CBOs to aid in care coordination.

Expand access to reimbursement for screening and care planning.

- **Involve paraprofessionals:** DHCS could expand reimbursement and provide infrastructure and specialized training to paraprofessionals in primary care settings, such as promotoras or community health workers, to develop care plans. If the goal of ACEs Aware is to expand access to ACE screening, then leverage trusted paraprofessionals in the screening and care planning process. Their involvement recognizes those with lived experience may be better suited to work with families as they are more reflective of the community families come from and acknowledges the limited time medical providers have to spend with families to build a trusting relationship.
- **Partner with other trusted providers:** DHCS should consider expanding reimbursement for screening and care planning to others outside of health care that typically develop trust and empathy with families, such as with a child care provider, family-serving agencies or other community-based service providers. Professionals in these settings are usually familiar with and trained in conducting assessments and might be better positioned to do so than health care providers in some cases.

Conclusion

This report presents the data available to date and the early-stage recommendations focused on family and CBO perspectives. Enacting widespread ACE screening and treatment is a complex and intricate task that takes thoughtful and intentional planning. Data were limited for some topics such as equity, culturally responsive screening processes and innovative funding; these topics should be explored further in future research before moving to widespread implementation.

This report highlights the importance of transparency and family-centeredness, trauma-informed approaches, and adequate preparation before moving to widespread ACE screening implementation.

Transparency and family-centeredness in all stages of the screening, referral and treatment process are essential. Transparency is an integral component of establishing trust between families and providers. Research suggests there is a positive relationship between patient-provider trust, health outcomes, and patient satisfaction.^{xxx} Transparency entails being clear and open about why the information is being collected and how it will inform care. It is also important to design a family-centered process that provides a choice in how to complete the screening and sends information about the screening ahead of time. Clinicians and service providers should also be transparent and collaborative with families about their treatment plans and referral process by explaining what the referral process is, how the referral fits into their treatment plan and what to expect once the receiving agency receives the referral.

Screening for and treating ACEs in a trauma-informed and culturally responsive way is critical. Clinicians, service providers and family members reiterated the importance of taking a trauma-informed approach to screening and treating ACEs to reduce potential harm. This means ensuring screening procedures prioritize the family's experience, results are discussed in a nonjudgmental and empathetic way, and the referral network is also trained to approach patient care in a trauma-informed way. This includes taking a strength-based approach to care and acknowledging and building upon family strengths at all points of the screening and treatment process. One way to promote trauma-informed approaches and build staff capacity is to jointly train health care and other providers on trauma-informed approaches to care and practical methods for using those approaches in ACE screening. Stakeholders used terms like "foundational" and "non-negotiable" when describing the importance of approaching ACE screening and treatment in a trauma-informed way,

underscoring the importance of building a trauma-informed culture across L.A. County systems of care. Shifting the network of care in L.A. County toward a trauma-informed paradigm has been a goal of First 5 LA; additional information on this effort can be found in the [Year 2 L.A. County Trauma and Resiliency-Informed Systems Change Initiative Report](#).

Cultural congruence and language preferences are also critical components of delivering trauma-informed care. Ensuring there are staff in health care settings that share similar cultural backgrounds and lived experiences with the patients they serve is an important aspect to consider when screening for ACEs. Cultural congruence can help with delivering care in a culturally responsive way, in the patient's preferred language, and can minimize discomfort patients may have with the screening.

Clinicians and other providers need education and training on how to respond to screening results and refer for treatment prior to implementation. While it is important for providers to understand a family's trauma history in relation to their health, it is vital to ensure providers have the training to address the trauma they may unearth and the ability to connect families with needed services and resources if appropriate. Without preparation on how to respond to a high ACE score and connect families to services and supports that can treat their underlying trauma, screening for ACEs alone can re-traumatize families and cause psychological harm. ACEs Aware has various efforts underway to better support and prepare health care providers – beyond the two-hour training required to qualify for reimbursement – so that they are able to conduct an ACE screening and respond to the results appropriately. Additionally, ACEs Aware has awarded grants to build the capacity of health care providers to screen and treat ACEs, and several of these grants were awarded to L.A. County organizations. The largest ACEs Aware investment in the county is in ACEs-LA, which is looking to transform how DHS clinicians refer to CBOs. Other grantees, such as AltaMed, Children's Hospital Los Angeles and L.A. County Department of Public Health, are developing provider trainings and materials.

Relatedly, health care professionals must also have a strong understanding of the impact systemic racism has had on their patients, as well as how the implicit biases they hold influence their patient care. It is essential that health care systems – from leadership to front-line staff – undergo trainings and self-assessments that focus on mitigating the impact of systemic racism and implicit bias on the decisions and recommendations they make for their patients; this will help prevent them from administering inappropriate treatment plans and

perpetuating the victimization of marginalized communities. This would require ongoing institutional support and commitment.

Organized by critical features required for systems change, the following call to action items should be considered by state and county systems, health plans and other family- and child-serving providers as L.A. County works toward incorporating ACE screening and treatment into family-centered systems of care for children and families.

High-Quality Supports

- Normalize screenings in practice to mitigate stigma experienced by families.
- Consider cultural congruence and address implicit biases between health care providers and patients.
- Take a family-centered, shared decision-making approach to interacting with families that is strengths-based.

Aligning Systems

- Start with education and preparation to build relationships and shared expectations between organizations.
- Ensure cross-sector partners develop a shared language and understanding of the framing of ACEs in a historical and systems context, rather than as an individual experience.
- Create an accessible and interoperable referral infrastructure that integrates into EHR and other data systems.

Improved Access

- Build resource hubs where multiple services can be accessed at once.

Sustainable Supports

- Grow the workforce through meaningful inclusion of doulas, peer support staff such as community health workers and others in care coordination.
- Expand access to reimbursement for screening and care planning to other providers who serve Medi-Cal patients.

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