GRANTEE

Network of Care Sessions Proceedings Report

Funded in part by First 5 LA, a leading public grantmaking and child advocacy organization.

June 28, 2021

acesaware.org

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. ACEs Aware offers Medi-Cal providers training, screening tools, clinical protocols, and payment for screening children and adults for ACEs. Screening for ACEs, assessing for toxic stress, and responding with evidence-based interventions can significantly improve the health and well-being of individuals and families. The ACEs Aware initiative is part of a statewide effort, led by the Office of the California Surgeon General (CA-OSG), to decrease ACEs and toxic stress by half in one generation. ACEs and toxic stress represent a public health crisis that has been, until recently, largely unrecognized by the health care system and society. By screening for ACEs and responding with evidence-based interventions, and implementing trauma-informed care, we can significantly improve the health and well-being of individuals and families.

In January 2020, CA-OSG 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 providers and organizations that serve Medi-Cal beneficiaries. The ACEs Aware initiative seeks to support the training and engagement of a wide range of health providers and other professionals as well as encourage collaboration among organizations to build networks of care through Provider Training, Provider Engagement, Communications, and Convenings.

First 5 LA and joint applicants, the American Academy of Pediatrics – California Chapter 2 (AAP-CA2) and the Los Angeles County Department of Mental Health (LACDMH)-UCLA Prevention Center of Excellence (COE), were awarded a Provider Engagement grant from CA-OSG and DHCS to promote the ACEs Aware initiative among the Medi-Cal provider community in Los Angeles (L.A.) County. Specifically, First 5 LA partnered with key stakeholders in L.A. County to implement three Provider Engagement activities:

1) Network of Care activities for multiple types of providers;

2) Peer-to-Peer Learning amongst primary care providers; and

3) a Practice Paper to inform large scale systems change for screening alignment, treatment and referrals/care coordination.

Network of Care Sessions

Los Angeles County is the nation's largest county by population and is one of the most socioeconomically diverse regions in the country.[1] Nearly half the population identifies as Latinx (49%) followed by 26 percent white, 15 percent Asian, and 8 percent Black or African American. In 2019, one-third of the population were covered by Medi-Cal, 42 percent by private insurance, 15 percent by Medicare, and 10 percent were uninsured. L.A. County is also home to a diverse, rich, and complex system of healthcare providers, social service providers and community-based organizations (CBOs). Increasingly, these organizations are working together to create a seamless screening, referral, and response process to support families in mitigating toxic stress and promoting optimal growth and development for children. At this important stage, when many initiatives are finalizing their design and structure, the ACEs Aware Network of Care (NoC) sessions were designed to provide an opportunity for those involved in these different networks to come together in conversation. The following callout box highlights three key coordination efforts emerging in Los Angeles that are well-aligned with the objectives of ACEs Aware NoC: Home Visitation, ACEs-LA, and Help Me Grow LA.

Coordinated Systems Strongly Aligned with ACES Aware Objectives

Home Visitation: L.A. County has a cross-agency strategic plan to strengthen 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 Department of Public Health, Department of Mental Health, Department of Children and Family Services, and First 5 LA among others.

ACEs-LA is an effort led by the L.A. County Department of Health Services (DHS) to build community resilience. Through screening, treating, and healing, ACEs-LA aims to improve the health and wellbeing of LA children and families. ACEs-LA provides support within communities to link families with resources to mitigate and prevent early childhood trauma. DHS was awarded a $3 million implementation grant from ACEs Aware, with First 5 LA as a convening partner, to 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 as served through DHS.

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[1] https://www.chcf.org/wp-content/uploads/2021/01/RegionalMarketAlmanac2020LosAngeles.pdf

Coordinated Systems Strongly Aligned with ACES Aware Objectives

Help Me Grow LA helps connect all families to the resources they need to support their child's development and works to increase the coordination of programs and services in local communities. Help Me Grow partners with a large number of community-based organizations and is informed by efforts to improve early identification and intervention services among HMG LA Pathways community collaboratives, First Connections and L.A. Care Health Plan. Help Me Grow affiliates across the country focus on these 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 activities can be found on the Help Me Grow website.

First 5 LA partnered with Health Management Associates (HMA) to plan and facilitate the Provider Engagement NoC sessions. In January 2021, F5LA and HMA convened the Network of Care Advisory Planning Group (NoCAPG) to guide development of NoC sessions. NoCAPG members include ten experts from various LA systems including health services, child development, mental health, ACEs-LA and education (see sidebar).

As part of the NoC design and planning work, HMA conducted planning interviews with all NoCAPG members to solicit input on how they understand the NoC in the context of other ACEs Aware efforts and how best to frame and design the NoC sessions for maximum impact. HMA also conducted planning interviews with persons with lived experience to hear their experiences and needs navigating the NoC in L.A. County and as an intentional way to empower and bring parents into discussions with decision-makers and care providers.

NoCAPG Members

Michael Brodsky, MD, L.A. Care Health Plan

Joel Cisneros, LCSW, LAUSD School Mental Health

Jonathan Goldfinger, MD, Didi Hirsch Mental Health Services

Lisa Fisher, MSW, Community Clinic Association of Los Angeles County

Nancy Wongvipat Kalev, MPH, HealthNet/Centene

Pooja Mittal, DO, HealthNet/Centene

Catherine Mogil, PsyD, DMH-UCLA Prevention Center of Excellence

Adriana Molina, LCSW, Allies for Every Child

Shannon Thyne, MD, L.A. County Department of Health Services

Tomas Torices, MD, American Academy of Pediatrics – California Chapter 2

Yvette Willock, LCSW, MA, L.A. County Department of Mental Health

Key takeaways that emerged from the planning interviews with NoCAPG members included: [2]

- Members most frequently cited the following as unique or significant contributions that could come from this effort: 1) focus on sustainability (especially financing and billing); 2) understand and ensure capacity/competence/consistency of the community service provider network; and 3) effectively engage families in understanding and contributing to the design of a NoC.
- There was significant interest in using the NoC sessions to bring the family lens to ACEs Aware planning.
- There was significant interest in using the NoC sessions to bring the lens of community-based service providers (i.e., those receiving referrals from primary care physicians) to ACEs Aware planning.
- There was concern that the provider focus on implementation of ACEs Aware is so dominant that it overlooks the fact that families don't understand enough about ACEs, their effects on outcomes, and the importance of ameliorating those effects (need for an education campaign).
- There was concern about the number of intake and referral (I&R) platforms – One Degree, Aunt Bertha, UniteUs, etc. – proliferating across the county. The ability to seed and scale networks and to effectively coordinate resources and referrals is hampered by the lack of interoperability across these systems (i.e., the ability for information to flow between those providing services and supports regardless of what platform they use).

Additionally, to plan for the first NoC session and recruit panel members, HMA conducted interviews with family members with lived experience trying to access services.

Drawing on the findings of the NoCAPG and family planning interviews, the NoC sessions were designed to more deeply understand how L.A. County can develop a NoC that prioritizes the family and CBO experience. The first NoC session provided general information about ACEs Aware, an introduction to human-centered design principles, and a chance to hear directly from parents with lived experience navigating the fragmented and complex system of care in Los Angeles to meet the needs of their children. The second NoC session

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[2] HMA conducted, analyzed, and summarized all NoCAPG member planning interviews.

shifted the focus of the discussion to understanding the needs of CBOs to effectively operate within a NoC.

The following sections provide an overview of each NoC session including a detailed description of the content covered, a description of participants, and the key takeaways that emerged from small group discussions.

NoC Session 1 – Designing a Network of Care with Children and Families at the Center

Session 1 Overview

This first NoC session was hosted virtually on April 7, 2021 and focused on designing a NoC with children and families at the center. The objectives of the session were to: (1) Generate understanding, awareness, and support for ACEs Aware, (2) Gain a better understanding of what families want and need from a network of care, (3) Identify design principles for a network of care that are centered on the family experience/perspective and are customer focused, and (4) Identify opportunities to and begin discussion about integration across similar efforts and actors in L.A. County.

The two-hour session facilitated by Health Management Associates (HMA) included a powerful panel discussion where families shared their experiences navigating networks of care in Los Angeles. The family panel was followed by a presentation from Abby Fifer Mandell (see callout box) on the principles of human-centered design as they relate to developing networks of care. The session concluded with small group discussions and large group share out where participants discussed the key features of a network of care that prioritizes the family experience/perspective.

Dr. Karen Hill with HMA kicked off the session by reviewing background information on the ACEs Aware Initiative, the various health risks associated with ACEs, the annual cost of ACEs to the state of California, and how ACEs are related to developmental delays. This foundational context highlighted and underscored the importance of developing networks of care that not only screen children and families for ACEs but connect them to a trauma-informed network of care to treat ACEs and underlying traumas.

Abby Fifer Mandell

Abby Fifer Mandell is the Executive Director of the Brittingham Social Enterprise Lab at USC's Marshall School of Business and teaches human-centered design to more than 100 students each year. She lectures internationally and leads workshops and training for mid-size and large social impact organizations. She won the 2018 Academy of Management Innovation in Entrepreneurship Pedagogy Award for her work with undergraduate students. Abby holds a M.A. in education and received a B.A. in Religious Studies and American Studies from the University of Virginia. She is a Wexner Heritage Fellow and serves on the advisory boards of United Parents and Students and Swipe Out Hunger.

Tara Ficek, Director of First 5 LA Health Systems, then provided additional context on how the ACEs Aware Initiative aligns with various strands of work happening across L.A. County including Help Me Grow LA, ACEs-LA, and other planning work happening among other ACEs Aware grantees.

Following the context setting portion of the session, Dr. Helen DuPlessis, of HMA facilitated a panel discussion among five panelists (see bios on next page)[3], to illustrate family experiences, needs and wants from a network of care. The panelists were all parents who had navigated the fragmented systems in L.A. County to get their children care and shared with the Network of Care participants what their experience was like, the barriers they encountered, and how those barriers could potentially be mitigated.

Key takeaways that emerged from the panel with family members included: [4]

- Families are reluctant to be critical or demanding of service providers when those services are free or greatly needed.

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[3] Three panelists joined real-time and two panelists participated through a pre-recorded video.

[4] HMA conducted, analyzed, and summarized all family planning interviews.

- Customer relationship management (CRM) is sorely needed in Human Services.
    - Voice, manner, and disposition is critical at the first contact and beyond.
    - Scheduling and physical environments should be accommodating to families with children.
    - The best assistance happens when the support staff anticipates family needs besides the specific ones for which a family may have been referred - when staff think and deliver comprehensively/broadly and are solutions-oriented.
    - Assistance and support with broader life goals and trajectory (especially for parents).
    - System navigator or care coordination support.
    - Link to other families/peer support.
- Service providers should operate with the Four "Cs" in mind – competence, capacity, consistency (persistence) and compassion.
- Service entities should provide accurate, timely information about their services online (e.g., current contact information, accurate description of services, eligibility criteria, pre-work required, etc.).
- Having a centralized access point (resource center) or "one stop shop" where multiple services could be accessed at once would be beneficial to families.

Parent Panelists

Ereida Galda has been employed by the Westside Family Resource and Empowerment Center (WFREC) for the last 17 years in many different capacities. She is currently the Early Start Plus Director. Ereida and her husband Robert Sr. are the proud parents of three wonderful young adults: Robert Jr, John and Izel. Johnny is the person who introduced her into the magical world of special needs and brought her along on this journey. Johnny is diagnosed with quadriplegic Cerebral Palsy with a multitude of chronic medical conditions. He is a very happy, smart and positive person who enjoys life to the max. Ereida is a Lend Graduate, she was on the FEC Board of Directors, she helped coach an AYSO Soccer team for children with special needs for 10 years. She was the Facilitator for "Siempre Amigas" a Spanish Support Group for 14 years. She is currently the IHSS Training Facilitator for the WFREC and Westside Regional Center. Her passion is providing parent to parent support and providing parents with the support they need when navigating systems of care. She would love to see all parents have the opportunity to enjoy their children, build memories and cheer the milestones, while reducing the stress and feeling supported.

Queron Hidret is a native of Los Angeles, CA. She is a devoted single mother, a local crusader against homelessness, and an advocate for children with special needs. As a recent graduate from the University of Southern California with a Master's degree in Elementary Education, she hopes to impact the lives of many children and their families through her passion for early childhood education. Through her personal experience of being homeless with a young child, she had to navigate various agencies and community resources to care for her family. Queron serves as an Imagine LA Ambassador and speaks on issues combating homelessness and the negative effects it has on families.

Marissa Lemus was born in El Salvador and moved to the United States in 2015. She is a parent to a four-year-old and is expecting a new baby soon. Marissa has been studying to take a High School Equivalency Credential exam known as the HiSet. Once completed, her next goal will be to continue her education and pursue a career in Ultrasound. In the past year, Marissa has found that taking on-line classes has been beneficial because of her pregnancy and her schedule. As a result, she is currently taking virtual ESL and Computer Literacy classes at Los Angeles Trade Technical College through their ALAS (Avanza Los Angeles) program. Marissa is also an active member in the LIFT-Los Angeles community.

Nancy Lopez Sanchez is a mom to three children, the youngest of whom benefitted greatly from his participation in the Allies for Every Child Early Head Start program. Nancy is in the process of earning her AA degree in sociology and psychology; once completed, she plans to transfer to CSU Dominguez Hills.

LeeAnn Paddock is a longtime resident of La Verne, CA. She has been deeply involved in foster care and special needs children for over 40 years. She has served as a foster parent to many children in Los Angeles County and has legally adopted six children as well as raising three biological children. She has raised five young people to successful adulthood and has three minor children still under her experienced care and guidance. Many of her foster children came from disadvantaged backgrounds and were substance exposed at birth, providing LeeAnn insights into critical health and developmental issues facing her large family. In 1989 she was licensed by the State of California and was selected to accept clients from Los Angeles County Department of Children and Family Services and San Gabriel/Pomona Regional Center to open a small family home which served six children ages birth to eighteen with developmental disabilities and special medical needs. LeeAnn operated her specialized foster home for twenty-five years. LeeAnn worked for over ten years for Citrus College in Glendora as the Kinship Coordinator in the Foster Kinship Education Program. She provided training to foster and relative caregivers on topics such as fetal alcohol syndrome, child development, discipline and bonding. Throughout her career LeeAnn has served two terms on the San Gabriel/Pomona Regional Center Board of Directors and McKinley Children's Center Board of Directors. LeeAnn continues to enjoy collaborating with other professionals and community members who seek to improve the health and wellbeing of young children. As a well-known African proverb states, "It takes a village to raise a child." LeeAnn Keene-Paddock strives to be a key part of that "village."

After the family perspective panel, Abby Fifer Mandell provided a brief presentation on the principles of human-centered design. "Shifting to prioritize a patient-centered approach means deeply exploring the needs, wants, and values of the patient." She stated, "Changing the way we ask questions provides creative opportunities for developing solutions…and often times the solutions families want are much simpler than we think." Historically, most service systems are designed to center 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 felt needs and challenges of families. Some of the questions providers can use to make this shift toward a more family-center approach include:

- What is the family trying to achieve? What is their goal in all of this? What evidence supports that this is their goal? How do I know? Have I asked?
- What's the story under the story? What matters most to the family and why? Can I frame this challenge in any other way?
- Who was involved in developing this decision/design/feature of a program?
- Who benefits?
- Who is harmed?
- Who is left out?

Abby also pointed out how there are six basic emotions – anger, happiness, sadness, loneliness, fear, and shame - which are present during all patient/client interactions. A family-centered approach to care urges providers to reimage how they interact with patients and articulate challenges by tapping into what a parent/caregiver is feeling and using those underlying emotions to bring them joy and happiness. A key question that providers should ask themselves to help shift to this perspective is "What is my patient/client feeling today?

The small breakout discussions that followed provided participants the opportunity to apply principles from the family-centered design presentation with the stories shared during the family panel in order to envision how a NoC could be designed with families at the center.

Session Takeaways

Following the family perspective panel and human-centered design presentation participants were invited to engage in small group discussions for about 30 minutes to discuss the key features of a NoC that holds the family experience and perspective at the center. The guiding questions participants responded to were:

- What is needed in a referral system to make it easier for parents and families to use and move through?
- How should the design account for, and mitigate against, the impacts of institutional and systemic racism and other forms of discrimination.

Each small group prioritized their top two or three features and shared these back during a large group share out. The following section provides a summary of the critical features related to technology and family experiences that should be considered when designing a family-centered Network of Care.

Technology

Interoperable technology platforms. Currently, the technology platforms that providers across L.A. County use to support children and families are independent from one another, yet frequently collect the same information from clients. Participants suggest strengthening the coordination between organizations to utilize the same or similar screenings, data collection, and data sharing procedures to reduce redundancies in client experiences and continued need for families to redescribe their experiences. An interoperable technology platform utilized across providers was regarded as a high priority when designing a family-centered NoC to streamline information sharing and get families connected to services as soon as possible.

Equitable access to platform. Participants highlighted the importance of the technology platform being culturally responsive and addressing the "-isms" that many L.A. County families experience (e.g., ageism, racism, ableism, etc.). For instance, the technology platform should be easy to login to, easy to navigate, include text to speech functions, and forms should be accessible and available in a variety of languages. The design of the technology platform should also acknowledge the many factors that contribute to the digital divide including internet access and computer/device access. Participants acknowledged technology is advancing, but not everyone has access to that technology. According to a 2020 study by BroadbandNow Research, an estimated 42 million Americans cannot purchase broadband internet due to financial, geographic, or service limitations.[5] This points to the need for innovative technology solutions that go beyond an online platform and considers alternative ways to interface with families through technology.

Promising Practices

- Strengthen the coordination between organizations to utilize the same or similar screenings, data collection, and data sharing procedures.
- Establish a technology platform that is easy to login to, easy to navigate, includes text to speech functions, and accessible forms are available in a variety of languages.

Accessible system. Having a user-friendly referral system that is clear and jargon-free was highlighted by participants as a critical feature of a family-centered

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[5] https://www.closethegapfoundation.org/digital-divide?gclid=CjwKCAjwhMmEBhBwEiwAXwFoEZqmjkilfMNzbczVvW2q43a0LX_ap4exRGTlcvVcPLXNyd01fXOGzRoCcvYQAvD_BwE

NoC. They also reiterated the importance of the technology platform providing users with timely and accurate information and feedback regarding available resources, organization contact information, referral status, waitlist information, and connection to services. Participants shared how it is important for families, once in the system, to quickly get information about waitlists and get connected to services versus spending time and energy figuring out how to navigate the system to get what they need. The technology platform should provide users with automatic notifications and the option to call into a designated line when technology support is needed or to get information on the status of a referral. Lastly, participants suggested establishing a universal consent process to enable sharing of information among service providers to make it less work for the families.

Centralized intake and referral. Many of the social service organizations in L.A. County have independent intake processes that capture similar information and data, yet families are continually asked to provide this information at each new organization. Participants highlighted the need for common screening tools to be incorporated into the NoC platform that lift up the most salient needs and can help start conversations already understanding a family's key needs including what has happened in the past and what is currently happening at home rather than asking them to repeat themselves. A centralized intake assessment that allows the family to rank their needs and share with providers their immediate needs was also identified as a key feature of a family-focused NoC.

Family Experience

Staff training. Training staff to value and implement a human-centered, customer service approach across each stage of the screening and referral process is an important step in improving the service experience for families. Such trainings may consider stressing the importance of practicing empathy and showing compassion at each stage of the process, especially the beginning. Trainings could also be framed in the context centering the "Four C's" when interacting with families – competence, capacity, consistency (persistence), and compassion. Participants emphasized the impact of a provider's approach during the first contact with a family. One person shared, "It's critical to have informed, trained, and compassionate

Promising Practices

- Train staff to value and implement human-centered design thinking with clients across each stage of the referral process.

staff when working with parents and families, especially from the first interaction." Similarly, participants noted the need to train staff to be non-judgmental with families to facilitate better interpersonal communication between staff and family members during their service journey. Furthermore, participants indicated that there is a need to have a person available to speak to, in addition to online support, to check on the status of their referral or ask questions. This is important as there are some families with limited access to or comfort with online support and further supports an equitable care system.

Building a unified network. Participants discussed the importance of streamlining the referral process so that families can feel like their support system is a cohesive unit (i.e., a network). This includes incorporating warm handoffs and patient navigators, as well as acknowledging the various barriers families experience when navigating a NoC and actively working to address them. Participants recommended developing a shared care plan and improved communication among NoC agencies and across systems to promote a sense of unity. Furthermore, creating a shared system can help standardize a process that will allow providers and staff to be more transparent with families about what to expect during the referral process. With a shared system and transparent standardized referral process, families may be relieved of the burden of repeating themselves with each new referral. A network that allows for seamless connections and follow-through will alleviate stress and give caregivers more time to focus on loving their children rather than fighting for services.

Culturally and linguistically appropriate services. In addition to providing equitable access to the platform, participants discussed the importance of having trauma-informed and culturally appropriate services within a family-centered NoC. L.A. County is home to a racially and geographically diverse population, thus ensuring services are culturally and linguistically appropriate is an essential component of meeting the needs of LA families. Participants recommended collaborating with grassroot organizations who have existing relationships within communities to meet families where they are at and provide culturally appropriate services.

Session Participants

The first NoC session was attended by 79 participants. The first session targeted ACEs Aware planning and implementation grantees, among others. Of those who completed the post session survey[6] (n=27, 34%), 44 percent of the respondents were Non-Hispanic. Of the Non-Hispanic respondents, 67 percent were White/Caucasian; 11 percent were Other; and 4 percent each for Black, Korean, and Filipino. Eleven percent offered no response.

More than half of the respondents were Hispanic (52%). Of the Hispanic respondents, 37 percent were Mexican, Mexican America, Chicano/a; 11 percent were other Hispanic, Latino, or Spanish; and 4 percent were Salvadoran.

For occupation, nearly three quarters of participants (74%) described themselves as non-clinicians and 26 percent identified as clinicians. Of the non-clinicians, 33 percent were nonprofit/advocacy staff and 22 percent listed their non-clinician occupation as "Other" (including administration of a nonprofit agency, care coordinator specialist, community navigator, and early childhood professional). Of the clinicians, 15 percent of respondents identified as licensed clinical social workers or marriage and family therapists (7.5% each), 4 percent were physicians, 4 percent were psychologists, and 4 percent listed their clinician occupation as "Other." A majority of clinical participants (71%) specialized in behavioral health and the two remaining clinical participants specialized in pediatrics and early childhood mental health, respectively.

Of the 27 respondents, 12 (45%) indicated they serve Medi-Cal beneficiaries; seven respondents or 25% indicated "not applicable." Attendees represented organizations working in all Service Planning Areas in the county, as indicated in Exhibit 1.

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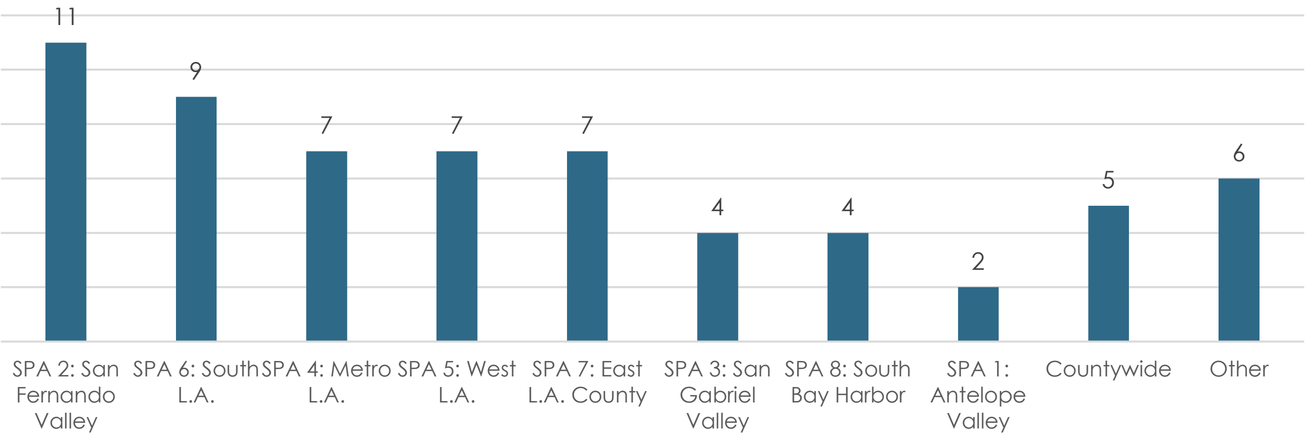
[6] Survey data analysis and summaries were provided by the Health Management Associates (HMA) team.

Exhibit 1. Participant's service planning areas



Follow Up Survey

Following the NoC session, HMA distributed an evaluation survey where participants were asked to reflect on the session. The survey was completed by 27 respondents (34% of attendees). Overall, participants had a positive experience at the first NoC session. Nearly all participants (93%) felt the group discussions made a positive impact on their educational experience and the same amount indicated the NoC session enhanced their current knowledge base (Exhibit 2).[7]

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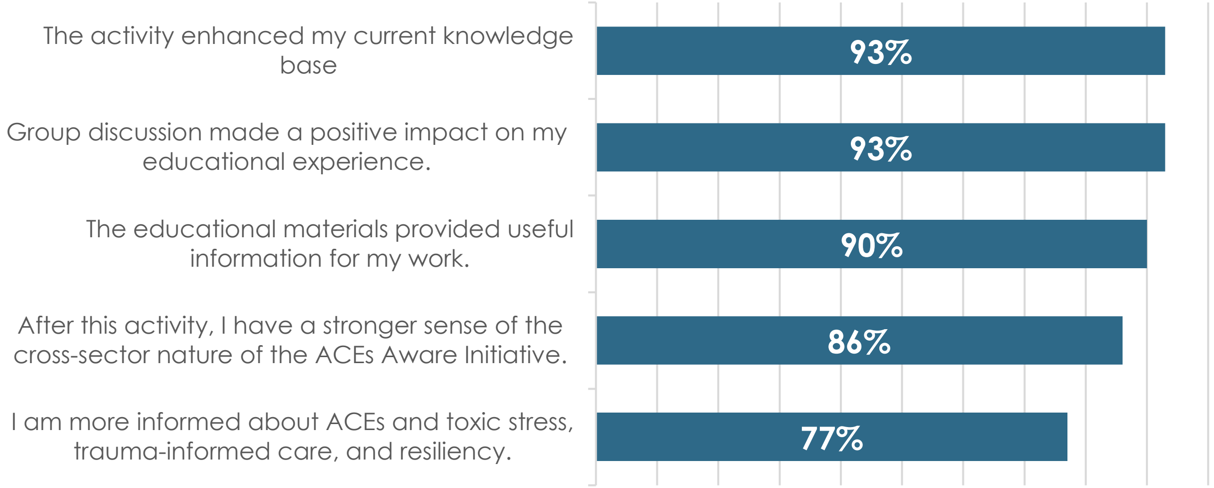
[7] Survey data analysis and summaries were provided by the HMA team.

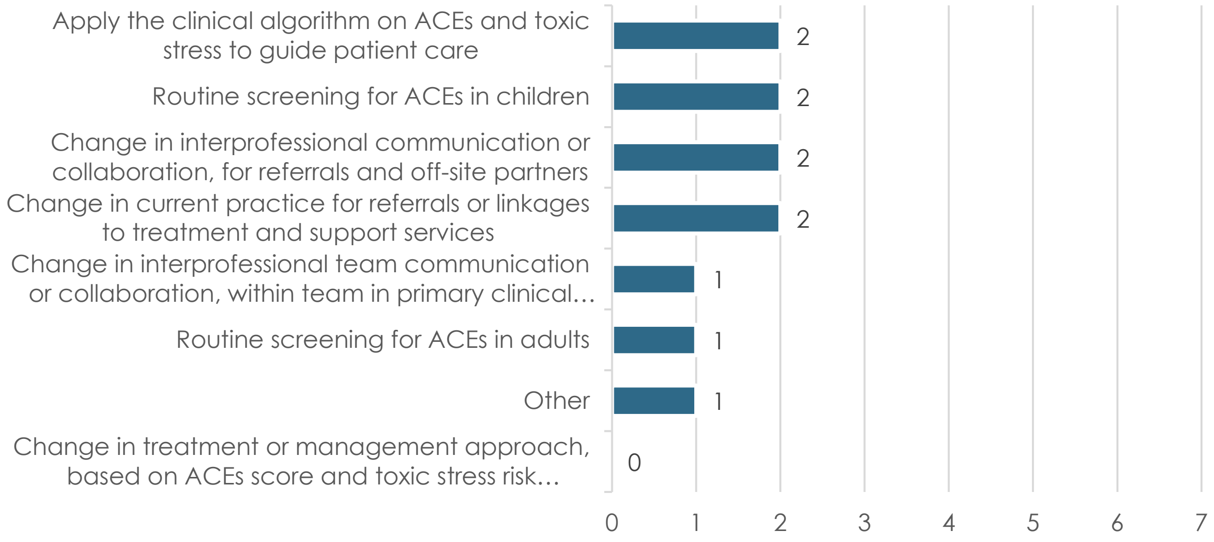
Exhibit 2. Participant's experience at the Network of Care session (percentage of participants who agree/strongly agree)



When asked about how the session might change clinical practice, 26 percent of clinicians indicated that they intend to change their practice behavior and 57 percent indicated they plan to use the information presented to reinforce their current practice. Others plan to change their practice behavior by incorporating a more human/family-centered approach in how they organize their practice and work. One participant stressed the value of hearing the family testimony live and on the recorded videos.

The seven clinical participants indicated the types of changes they intend to make in their practice behavior in Exhibit 3. Other strategies included ongoing improvements to ACEs screening.

Exhibit 3. Number of participants planning to implement practice changes (n=7)



When asked how confident they were about changing their practice behavior, fifty-seven percent of respondents indicated that they are "very" confident; another 29 percent indicated they are somewhat confident. Fourteen percent (14%) were unsure.

The seven clinical participants were asked to weigh in on what they perceive as the primary barrier to implementing changes in their practice (Exhibit 4). Those who noted "other system constraints" cited a lack of funding and an inability to share human/family-centered concepts across the county and state.

Exhibit 4. Barriers to changing practice behavior

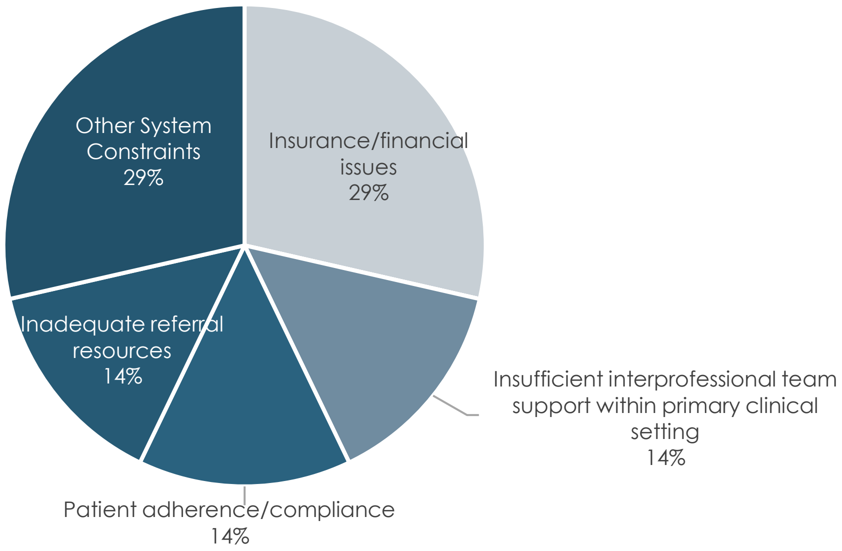
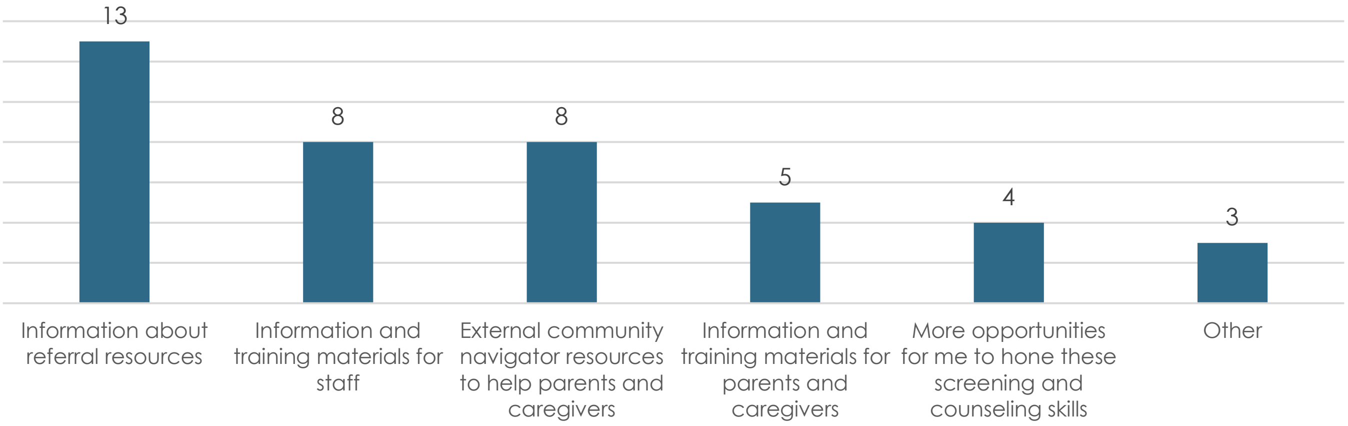


Exhibit 5 indicates the top two information sources or other resources that would assist participants in implementing changes in their practice. Nearly half of participants indicated there is a need for information about referral resources. Additionally, participants indicated a need for strategies to fund ACEs screening efforts for those not eligible for Medi-Cal, toolkits and provider education to support provider behavior changes, and information about referral sources for community-based organizations.

Exhibit 5. Additional information and resources needed to support changes in practice



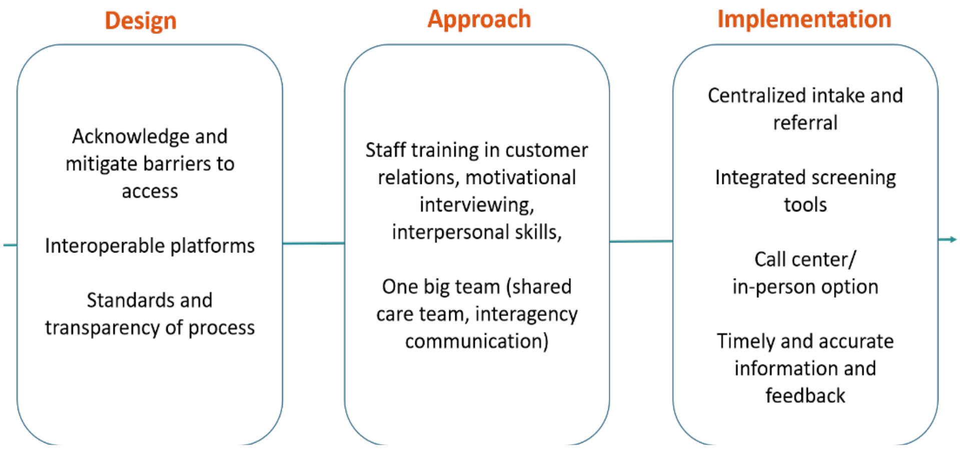
NoC Session 2 – Designing a Network of Care that Works for CBOs

Session 2 Overview

The second NoC session was hosted virtually on April 28, 2021 and focused on designing a network of care that is responsive to the needs of community-based organizations (CBOs). The objectives of the session were to: (1) Generate understanding, awareness, and support for ACEs Aware, (2) Gain a better understanding of what CBOs want and need from a NoC, (3) Identify design principles for a NoC that facilitates CBO engagement, and (4) Further build connections across efforts and actors in L.A. County.

The session started with an overview of how the NoC activities align to related strands of work happening across L.A. County including ACEs-LA and Help Me Grow LA. The takeaways from the first NoC session (Exhibit 5) were also reviewed as a way to ground the conversation and ensure key features of a family-centered NoC were held in mind throughout the second NoC session.

Exhibit 5. Session 1 Takeaways: Key Features of a Family-Centered NoC



Dr. Karen Hill with HMA provided background information on the ACEs Aware Initiative, the various health risks associated with ACEs, the annual cost of ACEs to the state of California, and the role CBOs play in a NoC. She offered the following definition, adapted from ACEs AWARE Roadmap, to establish a shared understanding and to ground the session work. A trauma-informed NoC is "A group of interdisciplinary health, education, and human service professionals, community members, and organizations that support adults, children, and families by providing access to evidence-based 'buffering' resources and supports that help to prevent, treat, and heal the harmful consequences of toxic stress."[8] CBOs are a key component of a trauma-informed NoC and provide supportive services to children and families, yet NoCs can be hard for CBOs to engage in the development of NoCs for a variety of reasons (see page 25). A trauma-informed NoC that seeks to prevent, treat, heal, and reduce toxic stress and ACEs requires cross sector representation and collaboration. Examples of entities that make up a NoC include: primary care physicians, behavioral health providers, other human service providers, child abuse prevention councils, independent practice associations, Medi-Cal managed care plans, law enforcement, housing and homeless services, among others. Lastly, Dr. Hill

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[8] ACEs Aware NoC Roadmap, page 17. https://www.acesaware.org/wp-content/uploads/2020/12/Draft-Network-of-Care-Roadmap-Final-12-14-20-For-Public-Comment.pdf

explained aspirations for L.A. County's NoC including having a fully functional trauma-informed NoC; routine use of clinical and community interventions to interrupt the toxic stress response; strong community provider relationships and infrastructure for assisting families; and a bi-directional IT platform.

Following the background information presentation, Dr. Helen DuPlessis, of HMA, reviewed some of the key features of a family-centered NoC that emerged during the first NoC session before introducing the four panelists (see callout box) who discussed the CBO perspective as it relates to networks of care.

CBO Panelists

Vanessa Mendez, Children's Bureau

Ms. Mendez has over 15 years of experience overseeing, implementing and evaluating community and school-based programs that serve children, youth and families in California, Minnesota and Michigan. She is currently working at Children's Bureau overseeing prevention programming in Metro Los Angeles. Her content knowledge is focused on early childhood development, child abuse prevention, parent-child attachment, family support and community involvement. Ms. Mendez enjoys working collaboratively with community partners to contribute to the development of impactful opportunities for children, youth and families. She has a Master's Degree in Ecological-Community Psychology from Michigan State University.

Dr. Joan Maltese, Child Development Institute

Joan Maltese, PhD, is the co-founder and CEO of the Child Development Institute, a non-profit organization whose mission is to help all children reach their full potential by supporting the relationships and environments that shape early development. Dr. Maltese is a clinical psychologist with more than 40 years of experience working with high-risk infants, toddlers, and their families. She developed an interdisciplinary and community collaboration approach to provide comprehensive care and support to families in underserved communities. Dr. Maltese provided consultation to First 5 LA in designing its new Best Start Program and participates with First 5 LA's Workforce Development Workgroup. She is one of the people responsible for the vision and oversight of CDI's Early Learning Centers in Canoga Park and Reseda, volunteer-run, nature-based drop-in centers for children and families to play, grow, and learn about child development. Recently, Dr. Maltese opened the CDI/Providence Tarzana Medical Center Child Development Center providing in home and center-based support for medically fragile infants and their families.

Denise Gee, Public Health Foundation Enterprises WIC Program

Denise C. Gee is a Deputy Director at the Public Health Foundation Enterprises WIC Program (PHFE WIC) managed by Heluna Health, located in Southern California and the largest local agency WIC program in the nation. She has enjoyed working with the WIC Program for over 27 years in a variety of roles and special projects. Her work spans from being on the front lines to program management and leadership in the areas of program integrity, data analysis, streamlining and maximizing participant care and services, as well as focused attention on public health and maternal and child health efforts including pre- and interconception health promotion, prematurity prevention activities, and nutrition and food security promotion. She most recently led the agency in transitioning the WIC benefits delivery system from paper checks to electronic benefits. As a dedicated public health advocate, she has served as a member on numerous committees, collaboratives and advisory councils. Denise has had the privilege to learn from many mentors, experts and colleagues and formally earned her Bachelor's degree in Nutritional Science from Pepperdine University, Master's degree in Public Health from UCLA, and completed her dietetic internship from the Greater Los Angeles VA Healthcare System and is a Registered Dietitian Nutritionist. She finds great joy in helping others and seeing one another do the same.

Christine Mirasy-Glasco, Upward Bound House

Christine Mirasy-Glasco leads Upward Bound House (UBH) with over twenty years of experience in the field of homelessness. Prior to joining UBH, she was the Chief Programs Officer at PATH where she oversaw programs of four organizations operating temporary shelters, interim housing, service centers, and permanent supportive housing projects. She also served as Chief Executive Officer of Beyond Shelter, a leading provider of housing and services for homeless families. Her nonprofit experience is complemented by many years of leading the Contracts and Grants Management department of the Los Angeles Homeless Services Authority (LAHSA). Christine sits on two County-wide groups charged with advising and formulating policies for people experiencing homelessness – the Los Angeles Regional Advisory Homeless Council (RHAC) as well as the Continuum of Care (CoC) Board. Christine Co-Chairs of the Family Caucus, a subgroup of the Provider Alliance to End Homelessness, an alliance of nonprofit agencies united by a shared commitment to serve the needs of all who experience homelessness and to break the cycle of poverty. She is also the former Co-Chair of the Westside Coalition, an alliance of forty-five organizations, public agencies and faith communities committed to working collaboratively on issues of housing, hunger and health through service coordination, public education and advocacy onthe Westside of Los Angeles County. She holds a Bachelor's degree in International Law from the University of Nice, Sophia-Antipolis, Nice, France, a Master's degree in International and European Law from the University of Paris II – Panthéon-Assas, Paris, France and a Pre-doctorate degree in International Economic Law from the University of Paris I – Panthéon-Sorbonne, Paris, France.

The panelists each described their unique experiences working at a CBO providing services to children and families and responded to the following questions:

- What do you see as the design principles needed to enable these organizations [CBOs] to effectively interface with clinicians and support consumers in these networks of care?
- What kind of perceived barriers are there to participation?
- What other considerations have you contemplated in your decision to participate in a NoC?
- Is there other important information you would like to offer?

Vanessa shared her experience with conducting family assessments through diverse programs. She shared that essential ingredients to successfully screening families includes tapping into compassionate and trauma-informed approaches while interacting with families. This is a critical component of connecting with families and establishing a trusting relationship. She reiterated how important it is for CBO staff trainings to include content that covers not only the technical work, but also covers the human pieces of CBO work. Examples of trauma-informed approaches to conducting screenings include verbalizing the purpose of the screening in way that parents can understand and highlighting that the purpose of the screening is to help the CBO support the family in a tailored way based on their needs.

Joan shared how families on the receiving end of CBO services often don't feel heard or seen by providers. When engaging in services, families sometimes experience confusion, shame, guilt, and are overwhelmed with trying to take care of their child's needs but not having a place that understands their needs. After reflecting on her organization's practices and acknowledging the CBO was not approaching service delivery in a family-centered way, Child Development Institute (CDI) shifted their approach to collaborate with other service provider supporting the family and providing early intervention support as a team with the family at the center. CDI also recognized the implicit and systematic discrimination and inequality that prevented many families from accessing services. In response, CDI set up free drop-in-to-play, nature-based spaces in low resourced communities for families to come everyday to play. While there, 150 volunteers are available to provide support and resources. This shift in service delivery highlighted the importance of community collaboration and underscores the importance of a NoC being accessible and neighborhood-based.

Denise shared her experience working with other CBOs across the county and reflected on the fact that folks often have a misunderstanding of what her organization does. She explained that CBOs need other providers to have a clear understanding of who their organizations serve and what their organizations can offer clients. There are about 40 percent of families who are eligible for WIC services, but are not accessing resources. Often, families who are eligible for services are simply not aware of the services for which they quality or don't know how to access them. Consequently, they do not receive needed and available supports. Because L.A. County is home to many CBOs, as we develop NoCs it will be important to create mechanisms to inform each other about the services each provides and how to access them.

Christine explained that a NoC that works for CBOs includes taking a teaming approach to service delivery. Additionally, it is extremely important that a NoC provides opportunities for providers to educate one another on what they have to offer for families and open doors to those additional or expanded systems of care. Additionally, a trauma-informed NoC needs to include warm handoffs between CBOs and more streamlined referral pathways. Currently, families are asked to navigate various complex systems that can feel like "they are going from one country to another."

All panelists agreed there are existing networks and structures in L.A. County with which the ACEs Aware NoC can interface. This work should not be another standalone structure or network but should be designed in a way that complements and adds to existing networks. Additionally, the CBO panelists shared that whatever technology is developed as part of the NoC needs to be very simple to ease the burden of data entry and administrative work. The panelists also shared that families have been successful in shifting to 100 percent virtual interactions during the pandemic but acknowledged many families do not have access to reliable broadband through a computer, thus a NoC should keep mobile-friendly options top of mind when it comes to NoC technology. Lastly, CBO panelists explained that the NoC needs to include real-time access to up to date information about CBO services. This includes a description of the services, eligibility criteria, and the first step to begin getting families services. Providing CBOs with technical support to ensure up to date information and websites are connected to the NoC technology was also a high priority for panelists.

Session Takeaways

Effective partnerships between health care organizations or providers and CBOs are critical for improving the overall health and well-being of the community. CBOs are the holders of important programs and services that support and address the needs of community members. According to the National Academies of Sciences, Engineering, and Medicine, CBOs provide direct assistance to patients to address health-related social needs and implement innovative processes to integrate their work with other providers and improve scalability of efforts.[9] CBOs are an essential component of a NoC that supports families with children 0-5, however, they often face a variety of challenges that prevent them from entering into mutually beneficial partnerships with other organizations. Effective partnerships are important in urban settings to aid in

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[9] https://www.nap.edu/resource/25467/Social_Care_CBOs_FINAL_05192020.pdf

building coalitions, sharing resources, and partnering to avoid service duplication.[10,11]

The second NoC session included two small group activities. The first small group discussion focused on identifying the gaps and barriers that prevent CBOs from meaningfully engaging in a NoC and were guided by the questions: What resonated for you from the panel? What are the gaps and barriers to meaningful participation? The second small group discussion focused on identifying opportunities and key features of a NoC that work for CBOs and was guided by questions: What's needed in a NoC to support CBOs to meaningfully engage and contribute? What are the key features?

Following each activity, each small group prioritized their top two or three features and shared back with the larger group. The following section provides a summary of the gaps and barriers CBOs experience, followed by the key features of a NoC that works for CBOs.

Gaps and Barriers

Capacity and Funding. Participants frequently highlighted how CBOs 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 engage in a NoC. One person 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." Participants highlighted the need for additional resources for CBOs to participate in a NoC and the potential for specific staff members whose job description is dedicated to what may be required of the NoC. Participants also shared the need to develop shared criteria and expectations at the organizational level of what it means to be part of the NoC. This includes shared expectations related to being represented at NoC convenings, referral processes, training requirements, collaboration with other network partners, etc. Participants

Promising Practices

- Provide additional resources or incentives to allow CBOs to participate.
- Develop shared criteria and expectations at the organizational level of what it means to be part of the NoC.

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[10] Butterfoss FD: Coalitions and partnerships in community health. 2007, San Francisco, CA, US: Jossey-Bass

[11] Mitchell SM, Shortell SM: The governance and management of effective community health partnerships: A typology for research, policy, and practice. Milbank Q. 2000, 78: 241-289. 10.1111/1468-0009.00170.

flagged how important leadership buy-in and support is critical for establishing these shared expectations and prioritizing involvement in the NoC.

Technology Challenges. Participants identified several technology challenges associated with establishing a trauma-informed NoC from the CBO perspective. Currently there are multiple IT platforms used by 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 in information sharing, and no centralized location for updated resource information. Some participants described their experience with different platforms as "time consuming" and even "paralyzing." Participants highlighted the critical need to develop a technology system that is easy to use, captures critical information CBOs need to report to funders, and provides real-time functionality to keep resource information up to date.

Promising Practices

- Develop a technology system that is easy to use, captures critical information CBOs need to report to funders, and provides real-time functionality to keep resource information up to date.

Data Reporting Challenges. Additionally, participants discussed the relationship between technology platforms, data collection, and funding. Many CBOs are invited to sit at various tables, take part in multiple initiatives, and have different contracts with different funders, all requiring different data reporting. Often times funders require very specific and stringent data reporting requirements of CBOs, which makes it challenging to develop a universal platform/process for CBOs to collect data. This points to the need for a larger culture and system shift where CBOs share what data are helpful for them and then funders adapt to the CBOs' needs, rather than the other way around.

Key Features

Connections and Relationships. NoC participants highlighted the importance of building connections and relationships among medical providers and CBOs when developing a NoC. This could include the use of local primary care provider champions who have existing relationships with CBOs to bridge the gap between medical providers and CBOs.

Streamlined Processes. Additionally, as CBOs have limited resources, participants reiterated the importance of establishing a streamlined process for connecting patients to resources. This includes the need for NoC processes to be integrated into the existing work structures that have already been established, as opposed to creating new processes or workloads.

Case Managers and Resource Navigators. Participants also highlighted the need for a NoC to incorporate the use of case managers or resource navigators to support connections to referrals as a way to increase CBO capacity and participation in a NoC. Participants mentioned these roles can be adopted by current staff if explicitly built into their job descriptions or by hiring staff specifically for these roles.

Establish MOUs. Participants shared that having an MOU that clearly outlines the expectations and role the various NoC partners play would be extremely helpful. This included a clear understanding of funding sources and additional considerations tied to funding.

Sustainable Funding. Discussions indicated the need for sustainable funding as a critical feature of a NoC. As previously mentioned, CBOs are often strapped for resources, and fundraising takes significant staff time and effort. Thus, the availability of sustainable funding sources to support ongoing engagement were highlighted as a key feature of a NoC that works for CBOs. Recommendations included utilizing existing funding sources such as Medi-Cal and/or leveraging collaborative funding efforts to alleviate the responsibility for individual CBOs to secure consistent funding.

Technology and Data Sharing. NoC participants stressed the critical need to have interoperability between IT platforms and electronic health records (EHRs) as there is currently no system in place to alleviate this barrier. This includes ensuring the platform allows for CBOs to make referrals to other CBOs. Similarly, having a single, outward-facing site with straightforward search functions, and reliable system maintenance that providers and clients can access are critical technology needs in a NoC that works for CBOs. Lastly, participants indicated that the data provided on a shared platform should not be owned by the tech system, rather, all data and information should be accessible from one system to another and owned by the patients/clients. Participants also highlighted the need for high quality and consistent technical assistance, both for providers using the platform and families navigating the platform.

Promising Practices

- Establish a technology platform that supports interoperability with EHRs.

Allow Time for an Authentic Community-Driven Planning Process. When considering other key features of a NoC, participants warned to "pump the breaks" to support envisioning long-term goals for the NoC and have sufficient time to carefully plan. Participants used the analogy of putting on their own oxygen mask before helping others. The NoC partners must first work together to build relationships and define the larger, long-term vision of the NoC before integrating families. Furthermore, it is imperative to listen to underserved populations and subgroups to ensure their voices are elevated to the forefront of planning work and clearly outlines the incentives for participation in the NoC.

Session Participants

The second NoC session was attended by 52 participants. For those who completed the post session survey[12] (n=24, 37%), 58 percent of the respondents were Non-Hispanic. Of the Non-Hispanic respondents, 63 percent were White/Caucasian; 8 percent each for Black, Samoan, and Other; 4 percent each for Chinese and Filipino; and 8 percent offered no response. Additionally, 45 percent of the respondents were Hispanic. Of the Hispanic respondents, 40 percent were Mexican, Mexican America, Chicano/a and 5 percent were other Hispanic, Latino, or Spanish.

In terms of occupation, approximately 74 percent of participants described themselves as non-clinicians and 22 percent as clinicians. Of the non-clinicians, 35 percent each were nonprofit/advocacy staff and "other" non-clinicians (e.g., patient navigator, program operation supervisor, Medi-Cal health plan staff, strategy and innovations, program coordinator, Director of Community Health, and health plan strategy and programming) and 4 percent each were research and office staff. Of the clinicians, 9 percent were marriage and family therapists, 9 percent were psychologists, and 4 percent were licensed clinical social workers. Thirteen percent specialized in behavioral health and four percent each specialized in early intervention and maternal mental health.

Of the 23 survey respondents, 14 (60%) indicated they serve Medi-Cal beneficiaries and seven respondents indicated "not applicable." Attendees represented organizations working in all service planning areas in the county, as indicated in Exhibit 6.

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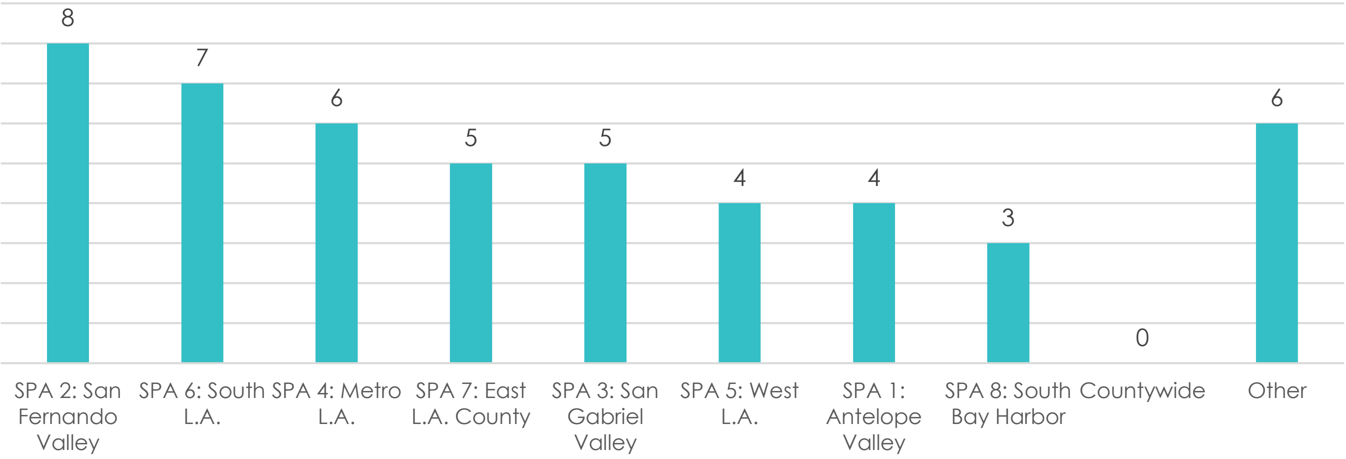
[12] Survey data analysis and summaries were provided by the HMA team.

Exhibit 6. Participant's service planning areas



Follow Up Survey

Following the NoC session, HMA distributed an evaluation summary where participants were asked to reflect on the session. The survey was completed by 24 respondents (37% of attendees). Overall, participants had a positive experience at the second NoC session. The vast majority of participants (96%) felt the NoC activity enhanced their current knowledge base and following the session 91 percent of participants indicated having a stronger sense of the cross-sector nature of the ACEs Aware Initiative (Exhibit 7).[13]

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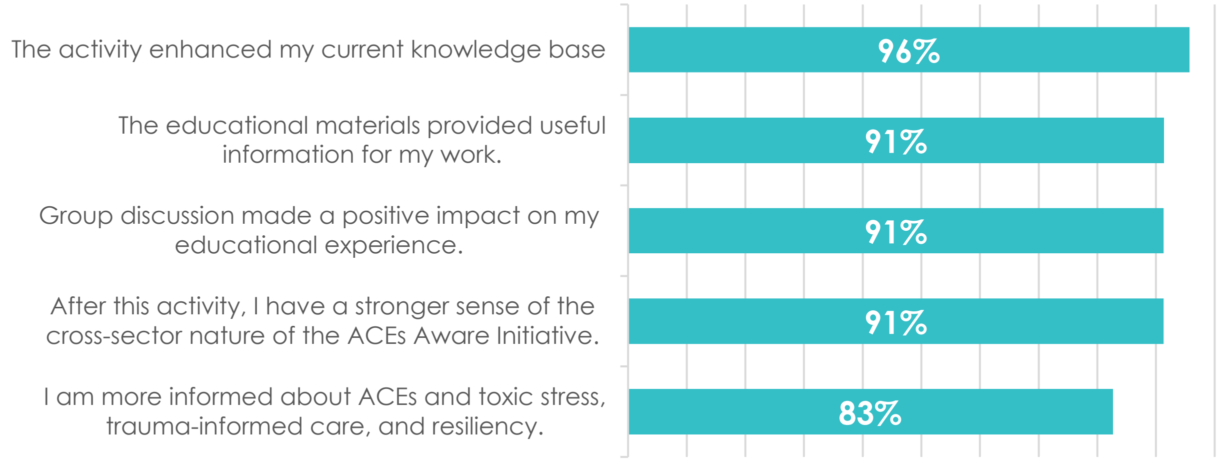
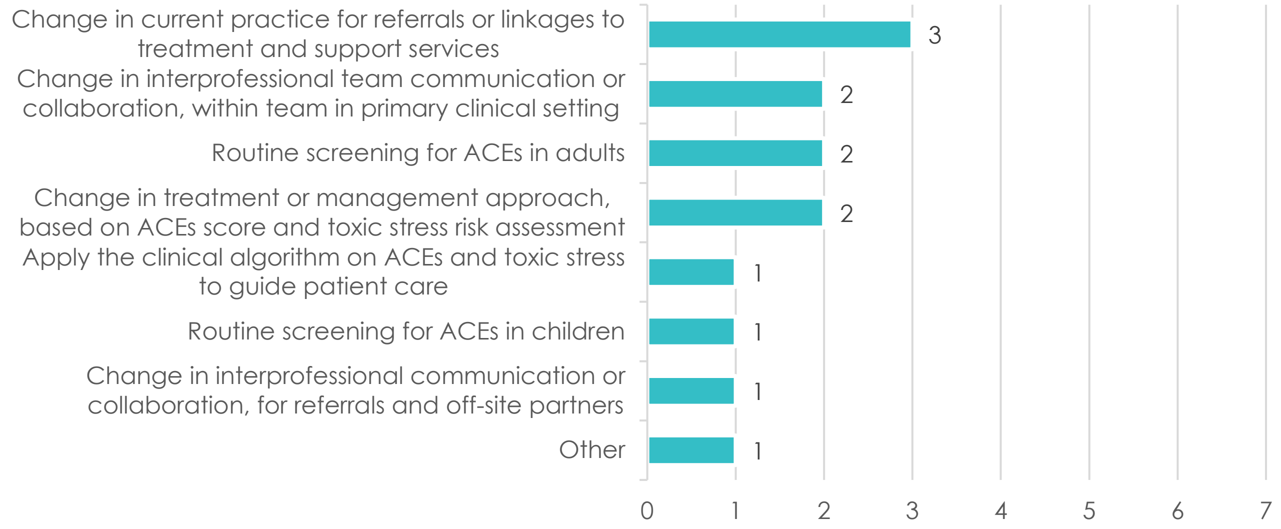
[13] Survey data analysis and summaries were provided by the Health Management Associates (HMA) team.

Exhibit 7. Participant's experience at the Network of Care session (percentage of participants who agree/strongly agree)



When asked about how the session might change clinical practice, 17 percent of clinicians indicated that they plan to use the information presented to reinforce their current practice. Exhibit 8 highlights changes the five clinical participants intend to make in their practice behavior. Other strategies included ongoing improvements to ACEs screening.

Exhibit 8. Number of participants planning to implement practice changes



When asked how confident they were in changing their practice behavior, 40 percent of respondents indicated that they are very confident, another 40 percent indicated they are somewhat confident and 20 percent were unsure. The five clinical participants were asked to weigh in on what they perceive as the *primary* barrier to implementing changes in their practice (Exhibit 9). Forty percent of them identified insurance/financial issues and time constrains as the primary barriers to implementing practice change.

Exhibit 9. Barriers to changing practice behavior

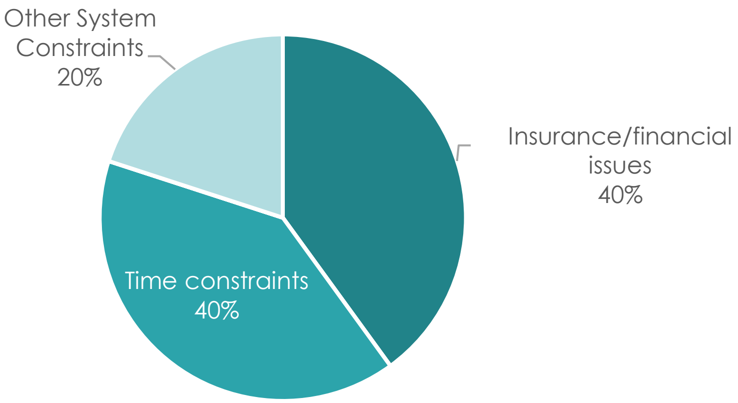
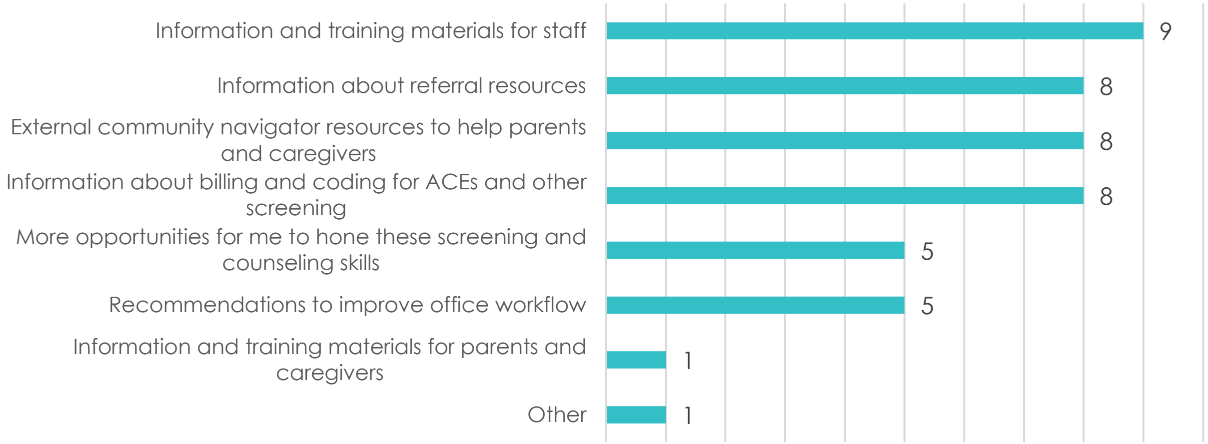


Exhibit 10 indicates the top two information sources or other resources that would assist participants in implementing changes in their practice. Nine participants indicated needing information and training materials for staff and eight participants indicated there is a need for information about referral resources. Additionally, participants indicated a need for strategies to fund ACEs screening efforts for those not eligible for Medi-Cal, toolkits and provider information about billing and coding for ACEs and other screening and referral resources, and external community navigator resources to help parents/caregivers.

Exhibit 10. Additional information and resources to support changes in practice



Conclusion and Next Steps

The NoC sessions were effective at bringing together providers from across L.A. County to begin conversations about what it means to have a family-centered NoC that is inclusive of CBOs. Participants walked away from the sessions feeling more informed and knowledgeable about session topics but were not sure how to act on these discussions and need more trainings and information for their staff to incorporate actual behavior change into their work. Instituting systems change and developing a comprehensive trauma-informed NoC is a complex task that requires establishing a shared vision, respect among all partners, and an amenable technology backbone that enables bi-directional referral processes among the medical community, CBOs, and other critical systems. The NoC sessions were tasked with being a springboard for these conversations and were successful at surfacing important elements to be considered as L.A. County works toward implementing a NoC.

While each NoC session surfaced valuable insights specific to family and CBO needs, some commonalities emerged including the need for a NoC to have an interoperable and accessible technology platform, streamlined intake and referral processes, resource liaisons or coordinators, and trauma-informed trainings available to all provider staff.

Throughout both sessions, participants offered a wide range of recommendations and key features that are needed to establish an effective NoC that prioritizes family and CBO needs. The first set of recommendations that follow have been previously highlighted in above sections of the report and are provided in summary format below. The second set of recommendations are more process-driven and focus on engaging families and providers in conversations about a NoC. Both sets of recommendations are intended to provide suggestions as L.A. County continues to work toward establishing a NoC that includes a seamless screening, referral, and response process to support families in mitigating toxic stress and promoting optimal growth and development for children.

Family-Centered NoC Recommendations

Interoperable technology platforms. Establish an interoperable technology platform and strengthen the coordination between organizations to utilize the same or similar screenings, data collection, and data sharing procedures to reduce redundancies in client experiences and continued need for families to redescribe their experiences.

Equitable access to platform: The NoC technology platform should be easy to login to, easy to navigate, include text to speech functions, and forms should be accessible and available in a variety of languages to ensure equitable access for providers and families.

Accessible system: Establish a user-friendly referral system that is clear and jargon-free and provides users with timely and accurate feedback regarding available resources, organization contact information, referral status, waitlist information, and connection to services.

Centralized intake and referral: Integrate a common screening tool into the NoC platform that lifts up the most salient needs and allows the family to rank their needs and share with providers their immediate needs.

Staff trainings. Train all provider staff to value and implement a human-centered approach across each stage of the screening and referral process, especially during initial interactions.

Use patient navigators to build a unified network. Work to establish a streamlined referral process so that families can feel like their support system is a cohesive unit (i.e., a network). This includes incorporating warm handoffs and patient navigators, into the referral process and developing shared patient-care plans with other agencies.

Culturally and linguistically appropriate services. Collaborate with grassroot organizations who have existing relationships within communities to meet families where they are at and provide culturally responsive services.

CBO NoC Recommendations

Connections and relationships among CBOs. Strengthen connections and relationships among medical providers and CBOs through use of champions who can bridge the gap between the two systems.

Streamlined processes. Establish a streamlined process for connecting families to resources and integrate into the existing work structures that have already been established.

Case managers and resource navigators. Integrate case managers or resource navigators into the NoC to support connections to referrals as a way to increase CBO capacity.

Establish MOUs. Establish an MOU among NoC partners that clearly articulates expectations, roles, and funding considerations.

Sustainable funding. Identify existing and sustainable funding sources that CBOs can leverage to alleviate the responsibility for individual CBOs to secure consistent funding to participate in the NoC.

Technology and data sharing. Establish a single technology platform that is easy to use and interoperable with electronic health records. Consider providing technical support for both providers and families navigating he platform.

Allow time for an authentic community-driven planning process. Empower NoC planning efforts to take a step back, strengthen relationships, and envision the long-term goals for the NoC.

Process Focused Recommendations

While building the NoC, incorporate time for participants to network and share information. During both NoC sessions, participants highlighted the importance of communicating with other services providers about the services available to families, eligibility criteria, etc. More intentionally creating space for networking and connection among NoC members may help educate providers on additional resources available in the community for families. The opportunity to share information would help providers stay informed about what is happening around the county and help providers connect families they serve to additional resources.

While building the NoC, incorporate time and structured activities for members to develop action plans. Establishing a shared understanding is a key objective of a NoC, but without actionable next steps, practice change is unlikely. Future efforts would benefit from dedicated time and supportive activities for participants to develop action plans or blueprints together on how different sectors could work together to begin moving towards change.

Next Steps

Information gathered from the Peer-to-Peer Learning sessions and Network of Care sessions will inform the development of a practice paper as part of First 5 LA's ACEs Aware provider engagement work. Key informant interviews and a literature review will also further explore the role of CBOs in a NoC and the specific needs and circumstances of smaller CBOs. Lastly, in January 2021, the Los Angeles County Department of Health Services was awarded an ACEs Aware Network of Care implementation grant, which First 5 LA is a convening partner on, to continue their work building and strengthening robust networks of care to effectively respond to ACEs and toxic stress. Much of the information surfaced through the NoC sessions will inform this work. Simultaneously, various other LA based organizations received Network of Care planning grants that will contribute to the development of effective Networks of Care to support L.A.'s children and families. First 5 LA looks forward to supporting the alignment of similar collaboratives and networks such as the various ACEs Aware efforts and Help Me Grow in L.A. County.

Report developed by Taylor Anderson, Ashlyn Dadkhah, Joelle Greene, Sophia Lee, and Madeline Rayon of Harder+Company Community Research.