

# Community-Based Organization Experiences in ACE Screening and Treatment of Young Children

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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.<sup>iii</sup> 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 wellbeing 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.<sup>1</sup>

## 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.”<sup>iii</sup>

**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, 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-resource 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.

<sup>1</sup> 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.

**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." 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.

## 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

fundors, 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.”





“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*

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.

**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 screening 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.

### 1. 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.<sup>iv</sup>
- **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.<sup>vii</sup> Health plans and systems leaders should consider how best to leverage the Enhanced Care Management (ECM) component of CalAIM 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.<sup>vii</sup>
- **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.

### 2. Create an accessible and interoperable referral infrastructure.

- **Strengthen standardization:** California Department of Healthcare Services (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.
- **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.

### 3. 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.

### 4. 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.

### 5. 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.



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- Peer-to-Peer Learning and Network of Care peer engagement activities.
- 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 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.

## REFERENCES

- <sup>i</sup> Butterfoss, F. D. (2007). Coalitions and partnerships in community health. Jossey-Bass.
- <sup>ii</sup> Mitchell, S. M., & Shortell, S. M. (2000). The governance and management of effective community health partnerships: A typology for research, policy, and practice. *The Milbank Quarterly*, 78(2), 241-289. doi: 10.1111/1468-0009.00170
- <sup>iii</sup> Houshyar, S., Sanchez, D., & Thompson, N. (2019). Helping our children grow and thrive: leveraging the health care system to prevent and mitigate adverse childhood experiences and advance equity in childhood. [https://familiesusa.org/wp-content/uploads/2019/08/FamiliesUSA\\_Help-Our-Children-Grow-And-Thrive\\_Report.pdf](https://familiesusa.org/wp-content/uploads/2019/08/FamiliesUSA_Help-Our-Children-Grow-And-Thrive_Report.pdf)
- <sup>vi</sup> Verbitsky-Savitz, N., Hargreaves, M. B., Penoyer, S., Morales, N., Coffee-Borden, B., & Whitesell, E. (2016). Preventing and mitigating the effects of ACEs by building community capacity and resilience: APPI cross-site evaluation findings. *Mathematica Policy Research*. [https://www.mathematica.org/api/sitecore/MediaLibrary/ActualDownload?fileId=%7B97EBD175-3145-43D2-ABC3-455EC5012E36%7D&fileName=APPI\\_Final%20Report\\_Full%20Report.pdf&fileData=APPI\\_Final%20Report\\_Full%20Report.pdf%20-%20%7B97EBD175-3145-43D2-ABC3-455EC5012E36%7D&fileMime=application%2Fpdf](https://www.mathematica.org/api/sitecore/MediaLibrary/ActualDownload?fileId=%7B97EBD175-3145-43D2-ABC3-455EC5012E36%7D&fileName=APPI_Final%20Report_Full%20Report.pdf&fileData=APPI_Final%20Report_Full%20Report.pdf%20-%20%7B97EBD175-3145-43D2-ABC3-455EC5012E36%7D&fileMime=application%2Fpdf)
- <sup>v</sup> Prevention Institute. (n.d.). Minimizing the impact of adverse childhood experiences through a focus on adverse community experiences. <https://www.preventioninstitute.org/sites/default/files/publications/Minimizing%20the%20Impact%20of%20Adverse%20Childhood%20Experiences%20through%20a%20Focus%20on%20Adverse%20Community%20Experiences.pdf>
- <sup>vi</sup> RYSE Center Research. (2015). Expanding beyond the traditional approaches to ACEs. [https://static1.squarespace.com/static/58ece61644024383be911a95/t/593e579b37c58172ed51340c/1497257886219/ACEs\\_social-location\\_2015.pdf](https://static1.squarespace.com/static/58ece61644024383be911a95/t/593e579b37c58172ed51340c/1497257886219/ACEs_social-location_2015.pdf)
- <sup>vii</sup> Dhaliwal, K. (2016). Reflected, rejected, altered: Racing ACEs revisited. [http://www.bmsg.org/wp-content/uploads/2016/10/racing\\_aces\\_memo\\_october2016.pdf](http://www.bmsg.org/wp-content/uploads/2016/10/racing_aces_memo_october2016.pdf)

