ACEs LA

Screening and Response FAQs

WHAT DOES THE ACEs-LA TEAM DO?
ACEs-LA oversees ACE screening and response activities at DHS clinical sites and specialty clinics, that includes training clinic staff on trauma informed care, ACE screening, documentation in ORCHID, tracking and monitoring all implementation activities, and developing and strengthening referral pathways and partnerships with community stakeholders focused on addressing ACEs and toxic stress.

TRAINING

WHAT TRAINING DO I NEED TO START SCREENING AND RESPONDING TO ACEs AT DHS?
Required Trainings:

- Becoming ACEs Aware:
  - Click HERE and follow the steps to begin the training
- ACEs-LA Introduction
  - Email aces.lacounty@gmail.com to schedule an introduction training
- One Degree CLR Training
  - Your ACEs-LA coach can help coordinate an in-depth One Degree training with one of our Community Navigators.

Recommended:

- ACEs Aware Learning Center
  - Click HERE to browse ACEs Aware's training library
- WellBeing for LA TIC
- TRIADS
  - Click HERE for a framework to talk with patients about ACEs and creating healing relationships
- Lunch and Learns
  - Click HERE to browse ACEs-LA Lunch & Learn Webinars. These take place on the third Thursday of every month. Reach out to aces.lacounty@gmail.com to receive notifications on upcoming webinars.

SCREENING

WHAT IS THE EVIDENCE SUPPORTING ACEs, THEIR IMPACT ON HEALTH OUTCOMES, AND THE NEED FOR SCREENING?
Kaiser Permanente's pivotal study revealed a direct correlation between the number of ACEs, chronic disease risk, and negative health outcomes. Screening is crucial for identifying individuals with high ACE scores or at risk of ACEs, facilitating targeted support to mitigate their effects.

CAN SCREENING BE EFFECTIVELY CONDUCTED DURING BRIEF VISITS THAT ARE ALREADY TIME-CONSTRAINED?
Absolutely! The screening process typically requires less than 5 minutes. A preliminary study conducted at Olive View-UCLA Medical Center demonstrated that incorporating screening at intake in the primary care clinic actually led to decreased cycle times.

We recognize that integrating additional steps into the clinic workflow can pose challenges, but the evidence suggests that screening is a manageable and valuable addition. Please reference the published articles below on screening acceptability:

- *Patient and Caregiver Perspectives on Implementation of ACE Screening in Pediatric Care Settings: A Qualitative Evaluation*
- *Clinician and Staff Perspectives on Implementing Adverse Childhood Experience (ACE) Screening in Los Angeles County Pediatric Clinics*

IS IT ACCEPTABLE TO PROVIDE PATIENTS WITH A PAPER FORM FOR COMPLETING THE SCREEN?

Yes, this is a common practice in many clinics. Please note that regardless of how you are administering the screening tool, it is crucial to introduce the form in a trauma-informed manner, ensuring that patients feel comfortable and supported during the process. For guidance on screening practices and access to the current screening tool, please visit s://aces-la.org/screening-for-aces/.

AT WHAT AGES ARE THE SCREENS MANDATED?
There is no one-size-fits-all approach. You have the flexibility to determine the ages at which to administer the screens based on the unique dynamics of your clinic. Consider factors such as the number of forms distributed during specific appointments and the clinic's overall workload to determine the most suitable screening ages for your setting.

SHOULD WE UTILIZE A SPECIFIC PROBLEM LIST FOR SCREENING?
All information pertinent to the ACE screen, including subsequent actions to be taken, is encompassed in the Ad hoc form, notably in the Provider section.

WHAT HAS BEEN THE EXPERIENCE FOR RESIDENTS WITH THE ACEs ROLL OUT?
At Olive View-UCLA Medical Center, a large teaching hospital, faculty members guided residents during the ACE screening process. They were instructed to recognize the ACEs screening tool when reviewing paperwork with attending physicians, and faculty coached residents on appropriate responses to the results. Regular clinic operation reminders, including charting issues, are sent to residents every 1-2 weeks.

CHARTING AND RECORDING ACE SCREENS

ARE NOTES IN AD HOC DISCOVERABLE IN THE PATIENT PORTAL?
No, all Ad Hoc notes are hidden. Only the score documented in the Ambulatory Tab in Results Review can be seen on the portal. Information added in the designated note box will be visible in the patient's portal.

CAN A SUPERVISOR SIGN THE PROVIDER PORTION ON BEHALF OF ANOTHER PROVIDER AND/OR RESIDENT?
Yes, definitely! However, the supervisor must have a provider NPI and be ACEs Aware certified for the signature to be valid for billing.

HAVE THERE BEEN ANY PROBLEMS WITH DOCUMENTING?
*There have not been any significant issues with documentation. Like all forms of documentation that take place, it is imperative that the charter **AND** the provider who signs off on the screening tool ensure that all information is **complete and accurate**. We have taken steps to reduce incomplete screens by transitioning to a **universal de-identified screening**.*

WHY IS DEIDENTIFIED PREFERRED OVER IDENTIFIED?
Deidentified screening offers significant benefits for both patients and the care team. Providing a deidentified screening tool ensures that patients don't need to disclose their ACE(s), creating a sense of ease and comfort. Additionally, using deidentified data helps streamline the charting process, reducing the time spent on documentation and minimizing potential data discrepancies. This approach prioritizes privacy and efficiency in the screening process.

DO WE CHART THE IDENTIFIED VERSION IF THEY ANSWER YES/NO, AND ONLY CHART DEIDENTIFIED IF THE PATIENT ADDS THE SCORE?
Yes! If the patient was handed a deidentified form but discloses any ACEs, it's important to chart that information as identified. However, if the patient only adds the total score at the bottom without providing specific details, proceed to chart it as de-identified. This approach ensures accurate and appropriate documentation based on the patient's responses.

IF A PATIENT LEAVES PART 1 BLANK BUT ANSWERS PARTS 2-4, SHOULD WE INPUT A "0" WHEN CHARTING?
No, if the patient does not complete PART 1, please do not add a "0". A blank form does not necessarily imply that the patient does not have an ACE. It's important not to assume or input

information that hasn't been provided by the patient. Charting accurately reflects the patient's responses without making assumptions.

BILLING

IF A PATIENT DECLINES TO FILL OUT THE ACEs SCREENING TOOL, DO WE STILL GET REIMBURSEMENT?

No, reimbursement is not provided for patients who decline the screening. Additionally, unsigned screens cannot be reimbursed. To ensure eligibility for reimbursement, it's essential that patients complete the screening tool and an eligible provider signs it.

IS THERE A TIME LIMIT FOR WHEN THE FORM HAS TO BE ENTERED INTO ORCHID FOR BILLING PURPOSES?

Yes, screens must be "signed" or "finalized" by an eligible Provider within 21 days of the screening date to ensure timely and accurate billing. It's crucial to adhere to this timeline for efficient billing processes.

IS THERE A BILLING CODE THAT WE SHOULD BE USING?

Yes, for the PEARLS ad hoc form, a HCPCS code is automatically generated after the screen is signed/finalized by an ACEs Aware-certified/attested provider. HCPCS codes are required by Medi-Cal for reimbursement. A patient with a score of 4+ is coded as G9919, and a score between 0-3 is coded as G9920. It's important to note that reimbursement is not provided for patients who decline the screen, and unsigned screens cannot be reimbursed. Ensuring accurate coding and completion of the screening process is essential for reimbursement.