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IMPROVING HEALTHCARE ACCESS AND QUALITY IN LA COUNTY:

# The ACEs-LA Network of Care Case Study

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

UCLA | UCSF ACEs Aware Family Resilience Network

OFFICE OF THE CALIFORNIA SURGEON GENERAL

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# EXECUTIVE SUMMARY

ACEs Aware funding supported the creation of the ACEs-LA Network of Care, a collaboration between the Los Angeles County Department of Health Services (LA DHS), local community-based organizations (CBO), and Medi-Cal managed care plans (MCPs) designed to prevent, identify, and respond to Adverse Childhood Experiences (ACEs) and toxic stress. Since 2019, ACEs-LA has supported progressive implementation of ACE screening and response activities across LA DHS primary care clinics, resulting in more than 40,000 screens and more than 10,000 internal and external social services referrals at the time of screening.

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As one of the largest implementation sites for ACE screening and response activities in California, LA DHS provides a real-world setting to rigorously examine the impact of ACE screening and response and systems transformation on the health status of individuals, health care quality across clinics, and health care access across Medi-Cal managed care systems and state programs. Early evaluation data from ACEs-LA clinics (LA DHS clinics with well-established ACE screening and response activities) have identified improvements in access to quality primary care, referrals for mental and behavioral health services, and increased identification of individuals who are eligible for enrollment in new state programs designed to improve the health and well-being of Medi-Cal members when compared to LA DHS clinics that have not yet implemented routine ACE screening and response activities.

Encouraging findings from ACEs-LA demonstrate that ACE screening and response activities can improve quality of care and can help achieve DHCS Quality Metrics and Bold Goals for 2025 and suggest that a continued focus on ACE screening and response activities can be an important tool for achieving targets to improve health for California's 15 million Medi-Cal members.

## DHCS Quality Strategy Goals

- **Engaging members as owners of their own care**
- **Keeping families and communities healthy via prevention**
- **Providing early interventions for rising risk and patient-centered chronic disease management**
- **Providing whole person, equitable care for high-risk populations, addressing social drivers of health**

## Quality Strategy Guiding Principles

**Eliminating health disparities through anti-racism and community-based partnerships**

**Data-driven improvements that address the whole person**

**Transparency, accountability, and member involvement**

## Bold Goals

**Close racial/ethnic disparities in well-child visits and immunizations by 50%**

**Close maternity care disparity for Black and Native American persons by 50%**

**Improve maternal and adolescent depression screening by 50%**

**Improve follow up for mental health and substance use disorder by 50%**

**Ensure all health plans exceed the 50th percentile for all children's preventative care measures**

## Early Findings:

- ACEs-LA clinics (LA DHS clinics with well-established ACE screening and response activities), when compared with LA DHS clinics that do not screen, have experienced:
  - **Increased referrals to social services on the day of screening** for both children and adults (those with higher scores are more likely to be referred).
  - Significant **improvements in quality metrics** for behavioral counseling and preventive health screening.
  - **Higher on-time childhood and adolescent well care visits**.
  - Overall **higher childhood and adolescent immunization rates**.
- Two ACEs-LA programs that provide care for children and families at risk for toxic stress have identified:
  - **Increased access** to Community Health Worker (CHW) and non-specialty mental health services.
  - **Improved linkage** to mental health, school services, and regional center services.
  - **Fewer missed primary care visits** and **fewer missed vaccines**.
  - **Reduction in physical symptoms**, **depression scores**, and **anxiety scores**.
- **Screening for ACEs doubles the number of children identified** as eligible for Enhanced Care Management (ECM).

# Leveraging ACEs Aware Grant Funding to Build and Strengthen the ACEs-LA Network of Care

LA DHS is the second largest municipal health system in the country, serving more than 600,000 individuals annually for primary care, specialty care, and acute care services. More than 250,000 adults and 55,000 children and youth ages 0-20 receive primary care through LA DHS networks of community and hospital-based clinics. Clinical care, including outpatient encounters, inpatient, and emergency care, as well as specialty referrals are all tracked through a systemwide medical record system (ORCHID) that has been in place since 2015. Through the ORCHID system, all elements of patient care, including utilization, medical care, and specialty referrals, can be tracked across all LA DHS sites and settings.

LA DHS received funding in all three ACEs Aware grant cycles and used this funding to create and strengthen the ACEs-LA Network of Care, a collaboration across health clinics, community partners, and health plans. The progressive funding has been important for building infrastructure and capacity for ACE screening and response, enabling teams to support scaling activities across LA DHS through streamlined clinical workflows, improved internal referrals, and increased engagement with CBO and Medi-Cal MCPs. Funding from ACEs Aware was instrumental in the implementation of a bi-directional online referral platform (One Degree) that allows communication between clinic providers and CBO providing services to patients and families. ACEs Aware funding also promotes increased engagement from MCPs in ACEs Aware Networks of Care, with the goal of improving care coordination and supporting access to new Medi-Cal funding streams to expand the workforce and services needed to address ACEs.


The ACEs-LA Network of Care is a collaboration between LA DHS, local CBOs, and MCPs (Health Net, LA Care, and Molina) designed to prevent, identify, and respond to ACEs and toxic stress and promote community resilience. Since its launch in 2019, ACEs-LA has supported implementation of the state's ACEs Aware initiative in LA DHS primary care clinics.

More information at www.ACEs-LA.org

one degree

One Degree is a technology-driven non-profit supporting the 1degree.org website. This website is free to everyone and provides users with web-based connections to health, housing, family and household, employment, legal, financial, and educational resources. LA DHS has partnered with One Degree, hosting the website on its electronic health record system to allow on-line referrals to supportive services during health visits.

**1degree.org**

Grant funding supported expansion of two LA DHS clinical programs supporting the needs of children and families impacted by ACEs and ACE-Associated Health Conditions: the Strong, Healthy, and Resilient Kids (SHARK) program and the Resilience Bridge program. The ACEs-LA Network of Care now includes 15 LA DHS clinics, more than 500 CBOs (40 of which engage in the bi-directional, closed-loop referral program), three local MCPs, and the One Degree online referral platform. Overall, implementation has supported training more than 500 medical providers in ACE screening and response activities, and more than 40,000 ACE screens conducted. Responding to screens has resulted in more than 1,600 internal referrals (within the LA DHS consult system) and 8,400 external referrals (through the One Degree platform) on the date of screening.

# Early Findings: Impact on Quality of Care and Access to Services

The ACEs-LA Network of Care offers an important opportunity to examine the impact of ACE screening and response activities among children and adults who receive primary care services within LA DHS clinics.

The LA DHS electronic medical record platform, which has embedded ACE screening tools and an internal referral system, and its connection to the One Degree community referral platform, allow comprehensive tracking of clinical conditions, referral patterns, utilization, and community connections for the expansive LA DHS population. Partnership with MCPs also allows assessment of billing and external referral practices.

**Observations at a high level include:**

- Despite the large volume of screens in ACEs-LA clinics, particularly in pediatric primary care settings, screening and response activities have not resulted in prolonged clinic visits or increased wait times for appointments.
- Increased referrals resulting from screens have not led to longer wait times for specialty medical care or social services.
- Both providers and patients have expressed satisfaction with screening and response activities in LA DHS primary care clinics. (See published findings from RAND evaluation.[1] )

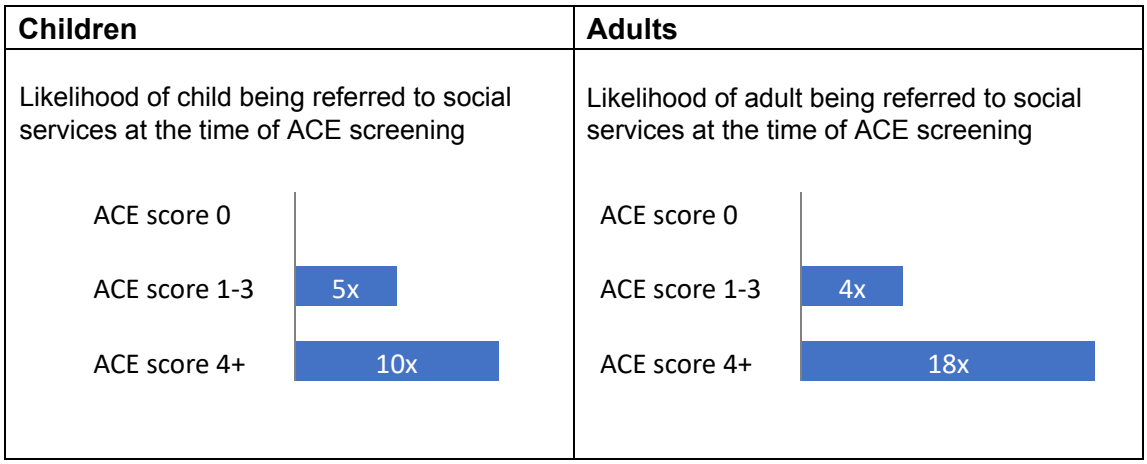
1 Patient and Caregiver Perspectives on Implementation of ACE Screening in Pediatric Care Settings: A Qualitative Evaluation (Journal of Pediatric Healthcare; August 2023) and Clinician and Staff Perspectives on Implementing Adverse Childhood Experience (ACE) Screening in Los Angeles County Pediatric Clinics (Annals of Family Medicine; September 2023).

## Identifying Unmet Need through ACE Screening

ACE screens are performed during primary care clinic visits, and scores are recorded as Low Risk (0-3), and High Risk (4+). When indicated, licensed providers work with nursing and social service team members to respond to screening results both during the visit and through referrals for additional services. Early examination of referrals generated at the time of ACE screening suggests that screening is identifying unmet patient needs and may contribute to improved access to services.

A review of more than 27,700 ACE screens across LA DHS identified that ACE screening is associated with referrals to social services on the date of screening for both adults and children, with increased referrals when ACE scores suggest higher risk for toxic stress. **[Figure 1]**

**Figure 1.** Social Services Referrals Generated at the Time of ACE Screening in Primary Care




Increased referrals after screening is not an unexpected outcome; however, they highlight unmet need within the LA DHS population and emphasize that asking about toxic stress is an important launch point for addressing its contribution to overall health. The next step will be to examine whether these referrals lead to successful connections to services for patients and, ultimately, to improved health outcomes.

## Higher Referral Rates for Pediatric and Adult Mental and Behavioral Health

Screening for ACEs and implementing trauma-responsive approaches to care can serve as a starting point for extending care beyond the medical visit. At baseline, 4 percent of LA DHS adult and pediatric populations have documented referrals to developmental/behavioral health (children only), mental health, social services, or CBO after primary care visits. However, those screened for ACEs are referred for services at higher rates, regardless of score. Among the more than 27,700 individuals screened for ACEs in the primary care setting, 18 percent of those scoring 0-3 have documented referrals for services at the time of screening, and 63 percent with ACE scores of 4 or more were referred. The comparison between baseline referral rates and rates after ACE screens suggests that trauma-informed inquiry has the potential to better identify patient needs and support connections to appropriate services. Details on the referrals generated at the time of ACE screening are noted in **Table 1**.

**Table 1.** Documented Referrals to Support Services on Date of ACE Screen (Low Risk=0-3 and High Risk=4+)

| REFERRALS – AGES 0 TO 20 | TOTAL PATIENTS REFERRED | ACE 0 TO 3 N=16,437 | ACE 4+ N=1,350 |
|---|---|---|---|
| Developmental/ Behavioral Health | 344 | 307 | 37 |
| Mental Health | 1,796 | 1,197 | 599 |
| Social Services | 1,661 | 1,282 | 379 |
| External Health-Related Social Service Referrals | 372 | 304 | 68 |
| **REFERRALS – AGES 21+** | **TOTAL PATIENTS REFERRED** | **ACE 0 TO 3 N=4,533** | **ACE 4+ N=399** |
| Developmental/ Behavioral Health | 4 | 3 | 1 |
| Mental Health | 287 | 161 | 126 |
| Social Services | 431 | 271 | 160 |
| External Health-Related Social Services Referrals | 42 | 21 | 21 |

**Note: Referrals to social services and mental health services on the date of ACE screening increased for children and adults, regardless of score. (Baseline referral rates are approximately 4 percent for both.)*

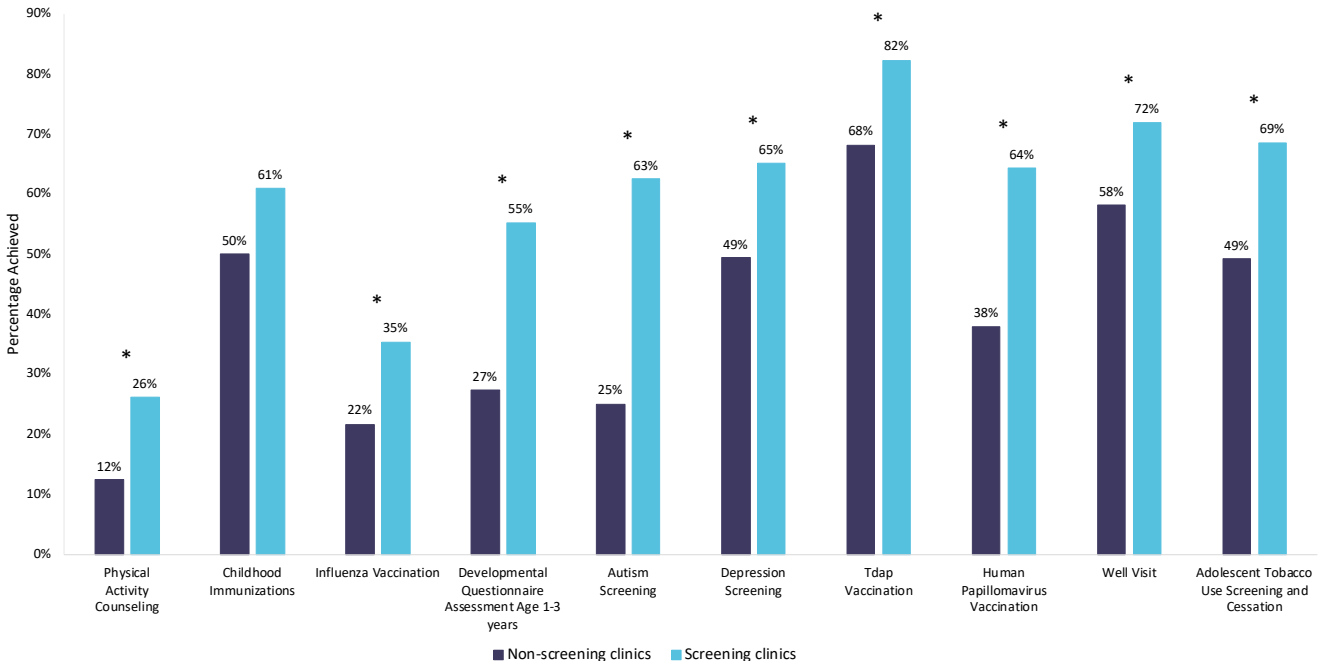
While documentation of referrals is a positive step, it will be important to understand whether referrals result in successful connections, both internally and within the community. The ACEs-LA Network of Care has developed the capacity to track the success of referrals to key community partners through both its electronic medical record (for internal referrals) and through the One Degree closed-loop referral system, which is now active for 40 community partners. The next step will be to identify barriers to successful connection and to determine which types of connections contribute to better health access and outcomes. This process is already underway in several of ACEs-LA's ACEs response programs. [See details related to SHARK and the Resilience Bridge below.]

## Improved Pediatric Health Care Quality Metrics

The staged rollout of screening and response activities across LA DHS clinics created the opportunity to compare screening clinics to those that had not yet started screening. Data from five ACEs-LA Network of Care clinics (LA DHS clinics where ACE screening and response activities have been in place for more than 18 months) were compared with data from four large LA DHS clinics where screening was not yet well established. While not a randomized-controlled trial, comparison across these settings offers early insights into the impact of ACE screening and practice transformation in Medi-Cal clinic settings.

Encounter and referral data from the LA DHS ACEs-LA Network of Care screening clinics and four LA DHS non-screening clinics (representing more than 200,000 primary care visits over the past two years) were reviewed for compliance with several key metrics from the state's Quality Improvement Program (QIP), including immunizations, developmental assessments, and depression screenings. In all instances, LA DHS sites participating in ACE screening and response activities were found to have better QIP metric scorecards. [See **Figure 2**]

**Figure 2.** Compliance with Pediatric Preventive Health Metrics across Screening and Non-Screening Clinics




*Note: * indicates statistically significant changes between screening and non-screening clinics (p <0.05)*

# Improved Clinical Outcomes in Clinics Focused on Addressing ACEs and Toxic Stress

SHARK
STRONG HEALTHY AND RESILIENT KIDS

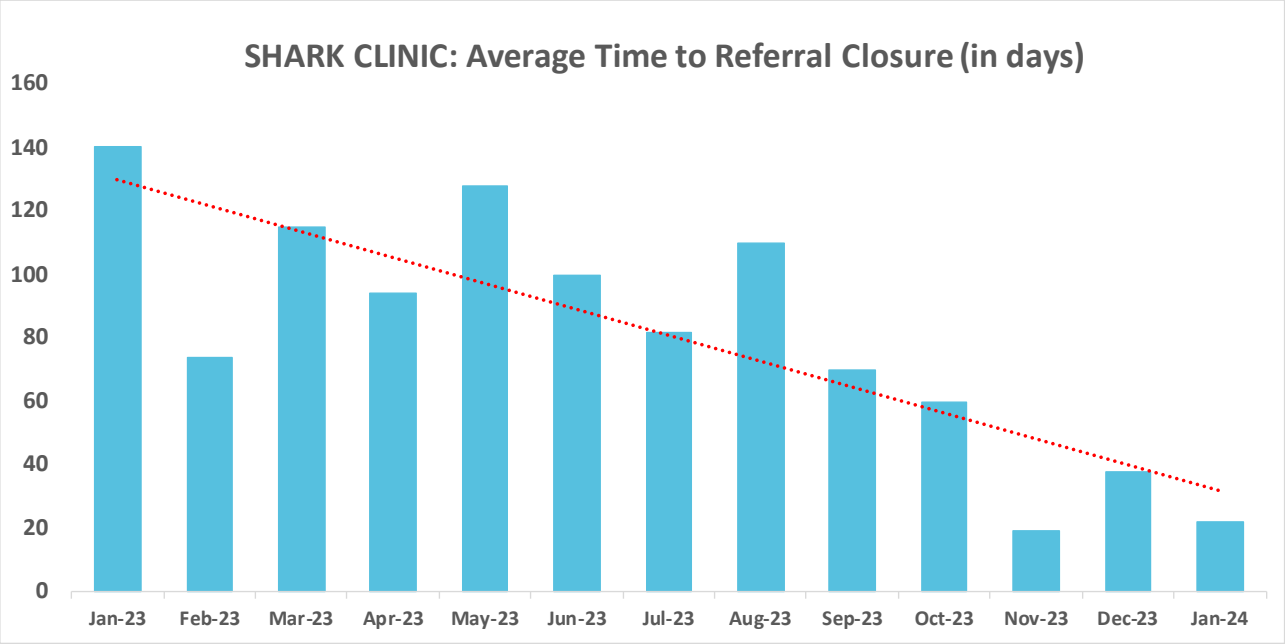
The SHARK program, based at the LA DHS Rancho Los Amigos facility, is a trauma-focused primary care and consultation clinic for children with complex medical, developmental, and behavioral health needs, many of whom have experienced significant childhood adversity.

**ACEs-LA.org/SHARK**

### SHARK Clinic: CHWs Facilitate Successful Connections to Services

ACEs Aware funding supported the addition of community health workers (CHWs) into the Strong, Healthy, and Resilient Kids (SHARK) Clinic to support patients and families in connecting to services. The SHARK Clinic served more than 1,000 children over the past two years, and more than 500 children/families have enrolled in its CHW program. The SHARK team has demonstrated that CHW engagement supports successful connections to services. Program review has identified more than 531 successful connections to the following services: bridge therapy, educational services, mental health services, autism services, and regional center services. Since the launch of its CHW-facilitated referrals and care management program, the time to successful connections with these services has progressively decreased. [see **Figure 3**]

**Figure 3.** SHARK Clinic – Days to Connection with Services or "Closed Referral" since January 2023 Launch of CHW-Facilitated Referrals



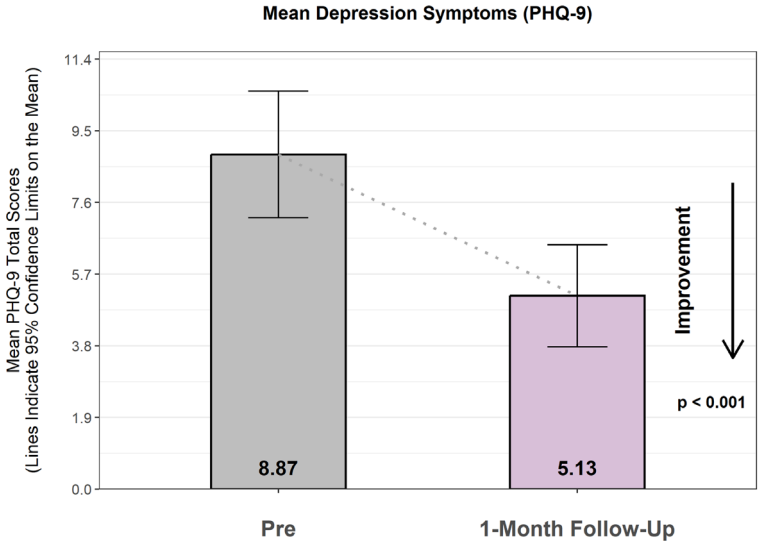

In addition to improving time to connections with services, 25 percent of SHARK patients enrolled in CHW-facilitated referrals and care coordination achieved either treatment goals or a 50 percent reduction in symptoms within eight months of enrollment in the SHARK CHW program.

These early outcomes from SHARK's CHW program are encouraging, and LA DHS is now working to identify more specific outcomes for patients enrolled in SHARK and other programs. For example, its Virtual Meditation as a Response to Adverse Childhood Events (a six-session virtual meditation and mindfulness program for children ages 10-14 with 4 or more ACEs or 1-3 ACEs with significant symptoms) has identified improved clinical status after enrollment. Children experienced a significant reduction in symptoms and improvement in anxiety and depression scores over the course of the intervention. [See **Table 2**, **Figures 4 and 5**]

**Table 2.** Changes in Symptoms Pre- and Post-Intervention (Virtual Meditation as a Response to Adverse Childhood Events)

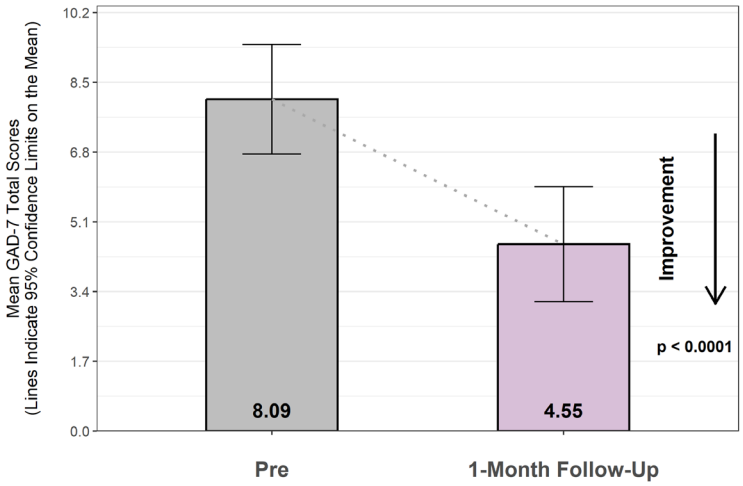
| (N=47) | NUMBER AND PERCENTAGE RESPONDING 'YES' | | | | |
|---|---|---|---|---|---|
| | PRE | | ONE MONTH FOLLOW-UP | | |
| | N | % | N | % | P VALUE |
| Headache/Migraine | 17 | 36 | 11 | 23 | 0.1094 |
| Chronic Abdominal Pain | 15 | 32 | 12 | 26 | 0.5811 |
| Chronic Muscle or Bone Pain | 11 | 23 | 8 | 17 | 0.6072 |
| Chronic Nausea or Vomiting | 11 | 23 | 8 | 17 | 0.5078 |
| Difficulty Eating | 12 | 26 | 11 | 23 | 1.0000 |
| Difficulty Sleeping | 26 | 55 | 19 | 40 | 0.1435 |
| Frequent Dizziness | 9 | 19 | 7 | 15 | 0.7266 |
| Frequent Constipation/Diarrhea | 7 | 15 | 4 | 9 | 0.3750 |
| Chronic Fatigue | 20 | 43 | 15 | 32 | 0.3018 |
| Palpitations/Heart Racing | 8 | 17 | 5 | 11 | 0.4531 |
| Unexplained Shortness of Breath | 9 | 19 | 5 | 11 | 0.4240 |
| | **N** | **Mean** | **Med** | **SD** | |
| **CHANGE IN TOTAL NUMBER OF SYMPTOMS** | **47** | **-0.851** | **-1.000** | **2.236** | **0.0082** |

**Exact McNemar test comparing changes from Pre-Enrollment to One Month Follow-Up*
***Bold** indicates statistical significance ($p < 0.05$)*




SHARK: October 2022 - July 2023
N = 47 Participating Youth
Wilcoxon Signed-Rank Test
≥ 10 Indicates Clinically Meaningful Depression Risk

**Figure 4.** Changes in Depression Symptoms (PHQ-9) Pre- and Post-Enrollment (Virtual Meditation as a Response to Adverse Childhood Events)




SHARK: October 2022 - July 2023
N = 47 Participating Youth
Wilcoxon Signed-Rank Test
≥ 10 Indicates Clinically Meaningful Anxiety Risk

**Figure 5.** Changes in Anxiety Scores (GAD7) Pre- and Post-Enrollment (Virtual Meditation as a Response to Adverse Childhood Events)

Finally, the SHARK team evaluated the feasibility of incorporating CHWs into clinical care and conducted a cost analysis to determine whether CHW services could be adequately reimbursed. The assessment included financial modeling for CHW services, exploration of credentialing for CHWs, detailing of clinical workflows, and creation of training and supervision documents. A toolkit detailing their findings will be ready for dissemination in summer 2024. A similar process is now underway to examine the feasibility of billing for non-specialty mental health services for children and their caregivers.

### Resilience Bridge: Dyadic Services and Non-Specialty Mental Health Services

Based at Harbor-UCLA Medical Center, the Medical Financial Partnership's Resilience Bridge has created pathways to billing for non-specialty mental health services provided in their program. ACEs Aware grant funding supported program expansion and an examination of the efficacy of adding resilience coaches to support new parents through family-centered, community-partnered care.

More than 400 parent-child dyads have enrolled in Resilience Bridge over the past two years. This coaching program is focused on helping families build resilience and access services that will help them improve their socioeconomic status and build resilience. The Resilience Bridge team has identified encouraging improvements in health metrics related to health care access and compliance with childhood vaccines.

## RESILIENCE BRIDGE

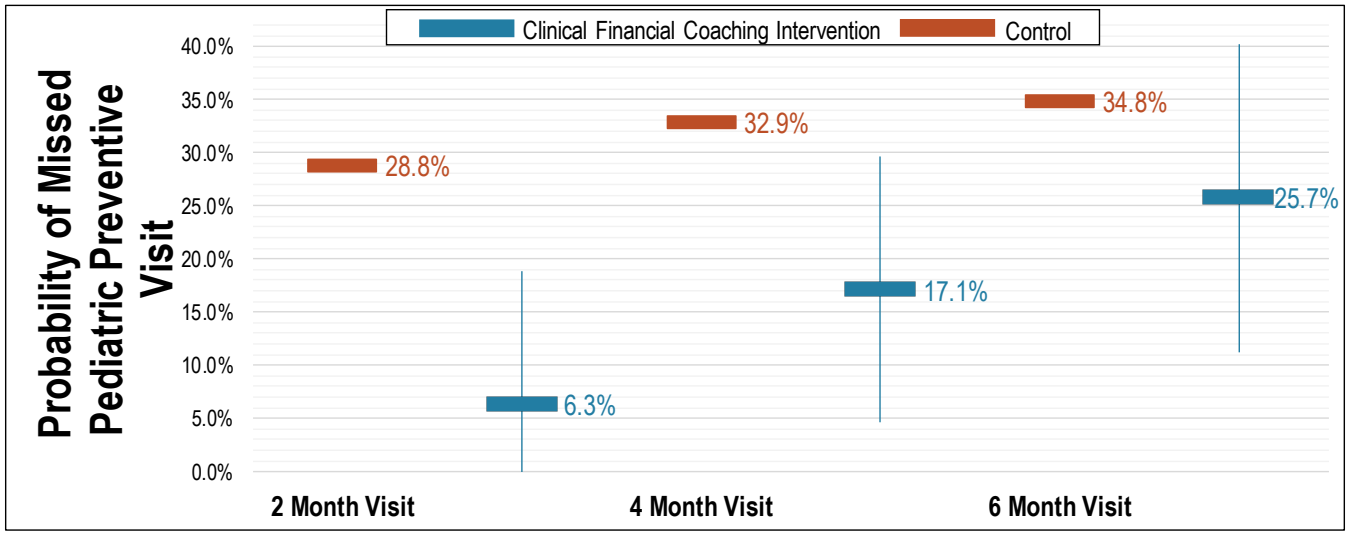
MEDICAL FINANCIAL PARTNERSHIP

Resilience Bridge is a program of the Medical Financial Partnership at Harbor-UCLA Medical Center. This innovative two-generational perinatal program is focused on addressing complex social and financial barriers to optimal child health while supporting family resilience. The program operates within the primary care pediatric clinic at Harbor, enrolling pregnant persons and following parents and their infants over the first two years of life.

**ACEs-LA.org/MFP**

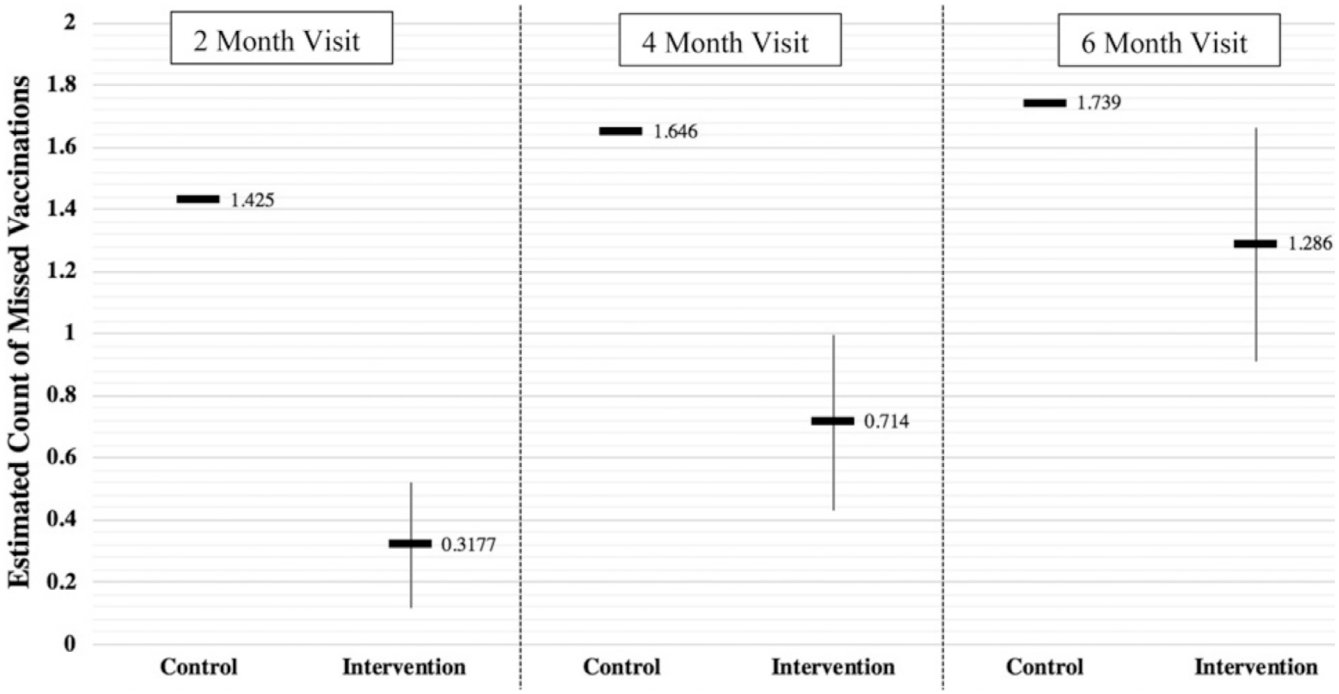
Resilience Bridge patients missed half as many scheduled visits in the six-month period after enrollment and were 20 percent more likely to attend each visit when compared to those not receiving coaching. In addition, enrolled patients were 25 percent more likely to be fully vaccinated by 6 months of age. [See **Figures 6 and 7**]

**Figure 6.** Resilience Bridge: Improved Immunization Rates and Reduced No-Show Rates for Primary Care Visits




**Note:* *0.64 fewer visits missed, and 20% more likely to attend visits (RR1.19, CI 1.004-1.4)*

**Figure 7.** Resilience Bridge: Reduced Missed Vaccines




*Note: 1.45 fewer missed vaccines; 25% more likely to be fully vaccinated by six months.*

The Resilience Bridge team also created workflows that will support capturing reimbursement for non-specialty mental health services delivered during clinic visits.

### Increased Identification of Patients Eligible for Enhanced Care Management

The Department of Health Care Services (DHCS) has implemented Medi-Cal transformation efforts to create a more coordinated, patient-centered, and equitable health system. Through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, patients with complex medical and social needs now have access to the ECM benefit, among other new services and programs.

## CalAIM Goals

**Implement a whole-person care approach and address social drivers of health**

**Improve quality outcomes, reduce health disparities, and drive delivery system transformation**

**Create a consistent, efficient, and seamless Medi-Cal system**

ECM is a statewide Medi-Cal benefit targeting the 5 percent of members with the highest-cost and most complex needs. ECM eligibility is based on pediatric and adult "populations of focus," such as children involved with the child welfare system, individuals experiencing homelessness, individuals with complex medical, mental health, and behavioral conditions, and those transitioning from incarceration. Enrolled members are connected to a lead care manager who coordinates their health and health-related care, with the goal of supporting the right care in the right setting, including beyond the medical visit.

## Medi-Cal Transformation: Enhanced Care Management

### THE ISSUE

Medi-Cal members typically have **several complex health conditions** involving physical, behavioral, and social needs.

Members with complex needs must often engage **several delivery systems to access care**, including primary and specialty care, dental, mental health, substance use disorder treatment, and long-term services and supports.

More than half of Medi-Cal spending is attributed to the **5 percent of members with the highest-cost needs.**

More information: www.dhcs.ca.gov/CalAIM/Documents/CalAIM-ECM-a11y.pdf

ECM-eligible conditions are often associated with childhood adversity and exposure to toxic stress, and the ACEs-LA team has focused on aligning its efforts with CalAIM to maximize access to services for LA DHS patients who qualify.

When ECM enrollment expanded to children in 2023, LA DHS worked with local health plans to identify children and adolescents who may be eligible for the program based on billing diagnoses related to target populations, including the areas noted above. ECM enrollment has been implemented in LA DHS, as well as in other settings, through a collaborative effort between medical clinics and managed care partners. Clinics work with their nursing staff, social services teams, and clinicians to informally identify high-needs patients who may be eligible.

Pursuant to a 2021 DHCS Behavioral Health Information Notice (BHIN-021-073), ACE scores of 4 or more make children eligible for specialty mental health services and, therefore, eligible for ECM, which ACEs-LA documents in its case finding. Using the ACE score for eligibility streamlines the process for Medi-Cal managed care because clinics often do not keep accurate records of their complex patients, and most providers under-code for diagnoses related to mental health and social drivers of health. **Table 3** provides an overview of the key diagnoses used to identify children who might benefit from outreach to encourage ECM enrollment and the number of individuals associated with each of these diagnoses.

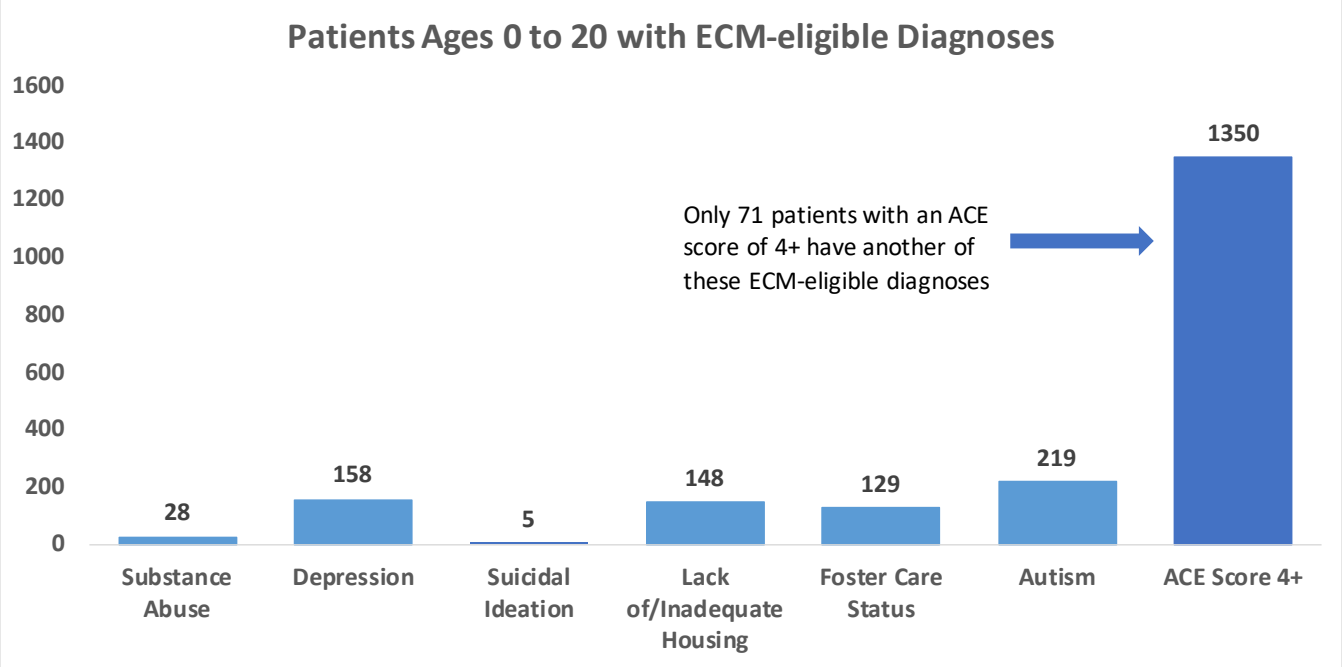
**Table 3.** ECM-Eligible Conditions in LA DHS Pediatric Patients

| ECM-ELIGIBLE DIAGNOSIS | ICD10 CODE | PATIENTS AGES 0 TO 20 WITH 4+ ACE AND ECM-ELIGIBLE DIAGNOSIS CODE | PATIENTS 0 TO 20 WITH ECM-ELIGIBLE DIAGNOSIS CODE IN ORCHID* |
|---|---|---|---|
| Substance Abuse | F10-F19 | 7 | 28 |
| Depression | F32-F33 | 29 | 158 |
| Suicidal Ideation | R45.851 | 2 | 5 |
| Lack of/ inadequate housing | Z59 | 4 | 148 |
| Foster care | Z62-Z63 | 16 | 129 |
| Transfer from correctional facility | Z65.2 | 0 | 0 |
| Autism | F84 | 13 | 219 |
| ACE Screen 4+ | G99210 | N/A | 1,350* |
| **TOTAL ECM ELIGIBLE** | | **71** | **2,013** |

As demonstrated above, adding an ACE score of 4+ more than doubled the number of children and youth ages 0-20 identified for ECM outreach. This likely occurs because the workflows associated with ACE screening and response activities automatically trigger the correct billing code, whereas documentation of other diagnoses related to ECM populations of focus requires the provider to manually select appropriate codes.

This query provides important insights into the challenges of outreach for ECM enrollment. First, coding queries are not currently the best mechanism for identifying those at risk. Second, implementing workflows (such as the ACE screening workflows) that improve documentation and coding has the potential to improve access to services through better case finding and outreach. This is clearly demonstrated in the finding that 64 percent of ECM-eligible children and youth in LA DHS were identified based on ACE score alone. [See **Figure 8**]

**Figure 8.** ECM Eligibility Based on Diagnoses Related to Populations of Focus




As more clinics adopt ACE screening, it is anticipated that the eligibility list for ECM based on ACE score identifying eligibility for serious mental health diagnoses will grow. Additionally, referrals generated on the date of screening for individuals with higher ACE scores may promote earlier engagement with support services such as case management, specialty care, and social services. In turn, successful relationships with support teams are likely to result in higher enrollment rates when ECM services are offered.

# LOOKING AHEAD

Early findings from the ACEs-LA Network of Care demonstrate that ACE screening and response activities are transforming the LA DHS health system for the better. They suggest that ACE screening and response activities are associated with improvements in access to quality primary care, referrals for mental and behavioral health services, and increased identification for eligibility in new state programs designed to improve the health and well-being of Medi-Cal members.

Assessment of ACE screening and response activities across the ACEs-LA Network of Care will continue, allowing for longitudinal evaluation of the impact on health care delivery and patient outcomes in a large, diverse health system. Lessons learned have the potential to improve patient engagement and cross-sector coordination in state initiatives exploring implementation of newly funded Medi-Cal programs, including doula services, community health worker supports, non-specialty mental health services, and dyadic services.

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