



2025

ACE Screening as a Tool for Improving Health Access and Outcomes for Children and Youth in California: Enhanced Care Management

Nina Thompson; Amy Shekarchi, MD; Joshua Parsons, MPH; Ivy Zucaya, PhD
Laura Liévano-Karim, PhD; and Shannon Thyne, MD

ACE Screening as a Tool for Improving Health Access and Outcomes for Children and Youth in California: Enhanced Care Management

Executive Summary

Emergent research suggests that adverse childhood experiences (ACE) screening and response activities – such as patient education or linkage to community resources, social services, and specialty medical services – can help mitigate the impact of toxic stress. In addition, identification of those with the highest risk for toxic stress can uncover unmet needs and provide improved access to services.

California launched ACEs Aware in 2019 to support training and screening activities for identifying and responding to ACEs. Uptake has been steady, with over 20,000 Medi-Cal providers certified to bill for screening activities.

Enhanced Care Management (ECM) is a key component of the state’s Medi-Cal transformation. This program aims to serve Medi-Cal managed care members with the highest medical and social needs by providing improved care coordination, facilitating access to community resources, addressing social determinants of health, improving health outcomes, and decreasing inappropriate utilization and duplication of health care services. When pediatric patients are screened and receive an ACE score of 4 or greater, they become eligible for specialty mental health evaluation services and Enhanced Care Management.

To determine how ACE scores impact the identification of eligibility for specialty mental health and ECM services, we examined ACE scores and other medical and social diagnoses within the ECM “populations of focus” in a managed care Medi-Cal setting in Los Angeles County. This analysis revealed that medical record queries for specific medical and social conditions did not generate adequate outreach lists for ECM enrollment. However, expanding the query to include ACE scores of 4 and higher more than doubled the number of children and youth identified for ECM outreach.

Key Takeaways:

- Screening California’s children and youth for adverse childhood experiences (ACEs) allows for early identification of toxic stress risk, supporting referrals for those at high risk to CalAIM programs, such as ECM, before downstream negative impacts of toxic stress develop.
- Opportunities exist to enhance partnerships between Medi-Cal managed care organizations (MCOs) and affiliated clinical practice groups to leverage ECM and other CalAIM initiatives as part of the clinical response for children and youth at risk for toxic stress.

Recommendations:

1. Policymakers can support MCOs and their affiliated practice groups to amplify and increase focus on activities that identify Medi-Cal recipients who are eligible for CalAIM initiatives designed to reduce gaps in care for high risk populations – including ECM, specialty and non-specialty mental health services, community health worker services, doula services, and dyadic care.
2. As a bridge from ECM eligibility to enrollment, policymakers should consider setting clear expectations for Medi-Cal MCOs regarding ECM and other CalAIM programs: strategies to mitigate the toxic stress response.
 - a. **Identification:** Increase provider training for ACE screening; expand ACE screening in areas with highest health disparities; and facilitate timely reimbursement for screens to support ongoing identification of high risk children and youth who may be eligible for CalAIM programs.
 - b. **Outreach:** Collaborate with practice groups to develop formal protocols for outreach and enrollment in ECM and other funded services.
 - c. **Implementation:** Continue to simplify and streamline pathways for ECM and other CalAIM service providers (community health workers, doulas, and non-specialty mental health providers) to engage in reimbursable activities supporting eligible children and youth.

Suggested Citation: Thompson, N., Shekarchi, A., Parsons, J., Zucaya, I., Liévano-Karim, L., & Thyne, S. (2025). *ACE Screening as a Tool for Improving Health Access and Outcomes for Children and Youth in California: Enhanced Care Management*. ACEs-LA Network of Care; UCLA Pritzker Center for Strengthening Children and Families: Los Angeles, CA.

Background

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are exposures to traumatic events, such as abuse, neglect, or exposure to familial stressors – like divorce, domestic violence, substance misuse, mental illness, and parental death or incarceration – before a person’s 18th birthday.¹ Nearly one in five California adults has experienced 4 or more ACEs.² Cumulatively, ACEs can result in toxic stress that negatively affects a child’s health and development.³ In addition to ACEs, childhood exposure to other adversities, such as housing and food insecurity, poverty, racism, and discrimination, have been associated with poor health outcomes.⁴

Children with high ACE scores (4 or more) have an increased risk of serious health conditions and unmet care coordination needs, particularly among youth also experiencing poverty and discrimination.⁵ These impacts also continue into adulthood. ACEs are associated with several chronic health conditions, including some of the leading causes of sickness and death in the United States, such as heart disease and diabetes.⁶

Increased awareness of the prevalence and consequences of ACEs has prompted several public health responses, including the implementation of routine ACE screening in California to identify and respond to the effects of toxic stress. California’s ACEs Aware initiative is the first statewide effort to promote standardized ACE screening and appropriate responses to childhood adversity among Medi-Cal recipients.⁷

In 2020, Medi-Cal providers caring for children and youth became eligible for payment to conduct ACE screenings in conjunction with a medical visit using the Pediatric ACEs and Related Life-events Screener ([PEARLS](#)). The PEARLS tool includes an age-specific screening for 10 ACEs (Part 1) and other social determinants of health (Part 2).

When screening is performed, providers who have completed a certified ACEs Aware training are eligible to bill Medi-Cal \$29 (on top of any other billing submitted for the encounter) for each screen performed for children ages 0-20 once annually. The state’s Medi-Cal data exchange system tracks these billing and reimbursement processes.

Enhanced Care Management

[ECM](#) is a Medi-Cal benefit intended to support members with the highest healthcare expenses and most complex health needs by integrating social services and community-based resources. The overarching goals of ECM include improved care coordination, facilitating access to community resources, addressing social determinants of health, improving health outcomes, and decreasing inappropriate utilization and duplication of health care services. The program, which launched in 2022, is a critical component of the state’s California Advancing and Innovating Medi-Cal (CalAIM) initiative and is offered to pediatric and adult Medi-Cal managed care members.

Current pediatric populations of focus for ECM enrollment include youth who are experiencing homelessness, face risk for avoidable hospitalization or emergency department visits, have substance use dependency needs, are enrolled in California Children’s Services programs, are involved in the child welfare or probation systems, have serious mental health conditions (including those with an ACE score of 4 or more), or are legally unaccompanied minors.



Identifying and Addressing Enrollment Challenges

Implementing ECM across adult and pediatric populations has been inhibited by low uptake. During a 2022 convening of clinicians, community, and managed care health plan stakeholders, several barriers to implementation were identified, and solutions were explored. One of the key challenges identified was a need to increase ECM enrollment, and suggested solutions from key participants were to expand eligibility for patient enrollment, improve data exchange to identify potential ECM participants, and more effectively engage eligible patients to improve uptake.

Methods for identifying patients have included billing queries, patient self-identification via Managed Care Organizations, and provider identification of individual patients. However, there has not been any universally adopted standard for identification and outreach, which may contribute to inequitable access and poor uptake.

While specific billing codes related to “populations of focus” – including those with medical conditions, housing status, mental health conditions, and history of incarceration – can help identify potential ECM enrollees, several of these codes are not routinely used by managed care providers. Many clinicians practicing in medically underserved communities have not been adequately trained in billing and coding for these conditions. Moreover, there is no significant incentive for optimized outpatient coding in a capitated system where reimbursement is allocated “per member per month” and is not tied to complexity or billing codes. Patient self-identification may exclude individuals who cannot self-advocate or understand the potential value of ECM benefits. Providers may also need more tools to adequately identify and engage their most complex patients.

ACE screening has the potential to support a more standardized, equitable, and feasible approach to identifying children and youth who may be eligible for ECM services for several reasons. First, ACE screens are reimbursable when conducted by trained providers. The connection between screening and reimbursement has helped standardize the identification of heightened risk for toxic stress. As screening expands to more Medi-Cal settings, more children and youth will have the opportunity to be screened, referred, and identified for reimbursable services to manage toxic stress, thus increasing access to ECM. Further, existing research indicates that the process of ACE screening allows pediatric clinicians to elicit important information about a patient’s wellbeing and needs, while building trust between patients and service providers. Building trust in healthcare providers is an important first step in helping pediatric patients (and their caregivers) who are offered ECM understand how the program may directly benefit them and increase the likelihood of ECM uptake.

This brief describes the results of an analysis conducted to assess the effectiveness of using ACE screening to identify children and youth eligible for ECM using patient electronic health records (EHRs) for Medi-Cal Managed Care members in the second largest health system in the country, Los Angeles County Department of Health Services (LA DHS), and describes implications for improving uptake of ECM in Medi-Cal managed care health systems throughout the state.

Methods

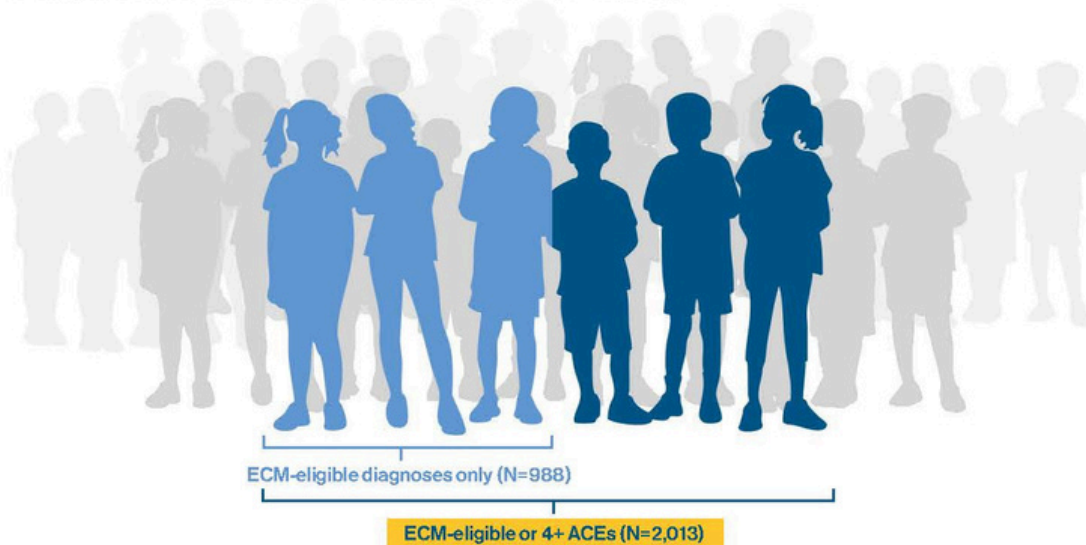
The LA DHS electronic health record (EHR) was queried to determine how many of its 36,092 unique Medi-Cal managed care members ages 0-20 were eligible for ECM using ICD-10 and billing codes entered in pediatric patient charts.

Diagnoses that are (a) commonly associated with elevated medical needs, mental health, social needs, and toxic stress and (b) used by health plans to identify ECM eligibility were extracted from medical records in the health system’s EHR and linked with [ACE screening](#) data to identify those with ACE scores of 4 or more performed between January 2020 and November 2023. Diagnoses and ACE screening data were matched by date of service.

Findings

- ▶ Of the 36,092 pediatric patients (ages 0-20 years) with Medi-Cal managed care at Los Angeles County Health Services clinics, over half (57.8%) received one ACE screening over a three-year period through standardized screening procedures.
- ▶ One in 15 screened youth (6.5%) reported 4 or more ACEs on their ACE screening.
- ▶ Of the 36,092 pediatric patients with Medi-Cal managed care at LA DHS clinics, only 988 youth were eligible for ECM based on billing codes associated with “populations of focus” – housing instability, mental health conditions, CCS diagnoses, contact with juvenile justice, and affiliation with child welfare services.
- ▶ Expanding inclusion of youth who had a documented ACE score of 4 or more increased the number of ECM-eligible youth to 2,013 – more than doubling the potential reach of ECM services (Notably, only 71 of those identified through ACE scores had any other indication of ECM-eligible conditions on their billing diagnosis lists).

Figure 1. ECM-Eligible Conditions in LA DHS Pediatric Patients (N=36,092)



Discussion

This evaluation began as a local outreach project and ultimately led to changes in local outreach for ECM within the LA DHS health system. Data on ECM-related diagnoses were pulled initially in preparation for ECM implementation for children and youth. The initial yield uncovered gaps in outpatient coding that limited outreach opportunities to children and youth with specific diagnoses in the ECM “populations of focus.” Even when combined with provider identification and patient-self-identification, the outreach list for ECM performed poorly at identifying children and youth at the highest risk for toxic stress and would result in falling significantly short of identifying and subsequently enrolling the intended 5% of children and youth with the highest medical, mental health, and social needs into ECM.

Adding ACE screening of 4 or more to the query resulted in a much larger pool for outreach, more than doubling the eligible list with minimal overlap in diagnostic codes. Only 71 individuals were identified as having 4 or more ACEs and an additional diagnosis code indicating ECM eligibility.

Now that enrollment has been underway for more than 12 months, DHS will begin to examine whether identification through ACE screening leads to a higher yield in enrollment, presumably based on a better understanding of how social factors and toxic stress can impact health.

Looking toward the future of ECM and the integration of other CalAIM programs into the system of care for Medi-Cal managed care members, it will be important to focus on providing broad, equitable access to effective programs that help patients and families engage in a functioning network of care that includes medical providers, case management, community supports, and involves coordination between health plans, clinical care sites, and funding streams. Research has already demonstrated that ACE screening effectively identifies risk for toxic stress,¹⁰⁻¹¹ and ACE response activities have been shown to improve health outcomes.¹² This analysis provides evidence that ACE screening is an effective path toward ECM enrollment.

Key Takeaways

- 1 **Screening California’s children and youth for adverse childhood experiences allows for early identification of toxic stress risk and supporting referrals for those at high risk to CalAIM programs, such as ECM, before downstream negative impacts of toxic stress develop.**

The introduction of routine ACE screening in pediatric care clinics has expanded opportunities to support children and youth at risk for toxic stress and its associated negative health outcomes through better access to specialized services and referrals. Earlier and more equitable identification can lead to individualized, proactive interventions to diminish or prevent downstream impacts of toxic stress.

When done well, ACE screening and response activities support better care for patients. In clinics that have adopted a trauma-informed approach to screening and responding to ACEs, patients may be more likely to engage in support services when offered. As CalAIM expands access to ECM and other programs, incorporating ACE screening and response activities and supporting local networks of care that include managed care plans, clinical teams, and community organizations – with patients and families at the center – reflect a promising pathway for improved access and better health outcomes for children.

- 2 **Opportunities exist to enhance partnerships between Medi-Cal managed care organizations (MCOs) and affiliated clinical practice groups to leverage ECM and other CalAIM initiatives as part of the clinical response for children and youth at risk for toxic stress.**

As more clinical practice groups implement screening and response activities and work to build more robust networks of care, MCOs and practice groups must partner to identify and enroll patients into CalAIM programs such as ECM. While the MCO infrastructure is needed to administer and monitor programs, including ECM, dyadic services, specialty and non-specialty mental health services, doula services, and community health worker supports, the trusted relationship between patients and their medical providers is a key component of successful engagement in these programs.

The MCO infrastructure also has the potential to support healthcare providers through improved reimbursement streams for ACE and other screens and to support access to reimbursable services such as ECM and other CalAIM-funded programs.

Recommendations

- 1 As ACE screening increasingly identifies people eligible for ECM services, policymakers can support MCOs and their affiliated practice groups to improve the implementation of CalAIM initiatives that address gaps in care for high risk populations – including ECM, specialty and non-specialty mental health services, community health worker services, doula services, and dyadic care.
- 2 As a bridge from ECM eligibility to enrollment, policymakers should consider setting clear expectations for Medi-Cal MCOs regarding ECM and other CalAIM programs for the purposes of:
 - a. Identification: Increase provider training for ACE screening; expand ACE screening in areas with highest health disparities; and facilitate timely reimbursement for screens to support ongoing identification of high risk children and youth who may be eligible for CalAIM programs.
 - b. Outreach: Collaborate with practice groups to develop formal protocols for outreach and enrollment in ECM and other funded services.
 - c. Implementation: Streamline pathways for ECM and other CalAIM service providers (community health workers, doulas, and non-specialty mental health providers) to engage in reimbursable activities supporting eligible children and youth.

References

1. Felitti, Vincent J., Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, and James S. Marks. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." *American Journal of Preventive Medicine* 14, no. 4 (1998): 245-58. [https://doi.org/10.1016/s0749-3797\(98\)00017-8](https://doi.org/10.1016/s0749-3797(98)00017-8).
2. Tan, Sean., Courtney S. Thomas Tobin, Ángela Gutiérrez, Nicole Pereira, and Lucas Oh. "California Adults With Adverse Childhood Experiences (ACEs) Are at Greater Risk for Serious Psychological Distress and Report Perceived and Unmet Need for Mental Health Care Services." *UCLA Center for Health and Policy Research*. (2024). <https://healthpolicy.ucla.edu/our-work/publications/adult-adverse-childhood-experiences-policy-brief-2024>
3. Ashwood, J. Scott, Nipher Malika, Stephanie Williamson, Charles Engel, Edward Machtinger, Nina Thompson, Amy Shekarchi, Shannon Thyne, Bridig McCaw, Marguerita Lightfoot, Anda Kuo, Eric Fein, Darcy Benedict, Lisa Gantz, Raymond Perry, Nancy Yap, and Nicole Eberhart. "Clinician actions in response to Adverse Childhood Experience (ACE) screening." *Preventive Medicine Reports* (2024): 102887. <https://doi.org/10.1016/j.pmedr.2024.102887>
4. Trinidad, Stephen, and Meera Kotagal. "Social determinants of health as drivers of inequities in pediatric injury." *Seminars in Pediatric Surgery* 31, no. 5 (2022): 151221. <https://doi.org/10.1016/j.sempedsurg.2022.151221>
5. Anyigbo, Chidiogo, Beth A. Tarini, Jichuan Wang, and Paul Lanier. "Clusters of adverse childhood experiences and unmet need for care coordination." *Child abuse & neglect* 122 (2021): 105334. <https://doi.org/10.1016/j.chiabu.2021.105334>
6. Merrick, Melissa T., Derek C. Ford, Katie A. Ports, Angie S. Guinn, Jieru Chen, Joanne Klevens, Marilyn Metzler, Christopher M. Jones, Thomas R. Simon, Valerie M. Daniel, Phyllis Ottley and James A. Mercy. "Vital Signs: Estimated Proportion of Adult Health Problems Attributable to Adverse Childhood Experiences and Implications for Prevention – 25 States, 2015–2017." *MMWR Morbidity and Mortality Weekly Report* 68, no. 44 (2019): 999–1005. <https://doi.org/10.15585/mmwr.mm6844e1>.
7. Negriff, Sonya, Margo A. Sidell, and Mercie J. DiGangi. "Adverse childhood experiences screening in healthcare settings: a focus on pediatric primary care." *Child Abuse & Neglect* (2024): 106709. <https://doi.org/10.1016/j.chiabu.2024.106709>.
8. Boyd-Barrett, Claudia. *CalAIM Perspectives: How to Improve Enrollment in Enhanced Care Management*. CHCF Perspectives from the Field. (2023). <https://www.chcf.org/wp-content/uploads/2023/11/CalAIMPerspectivesImproveEnrollmentECM.pdf>
9. Alvarado, Gabriela, Ryan McBain, Peggy Chen, Ingrid Estrada-Darley, Charles Engel, Nipher Malika, Edward Machtinger, Brigid McCaw, Shannon Thyne, Nina Thompson, Amy Shekarchi, Marguerita Lightfoot, Anda Kuo, Darcy Benedict, Lisa Gantz, Raymond Perry, Indu Kannan, Nancy Yap, and Nicole Eberhart. "Clinician and Staff Perspectives on Implementing Adverse Childhood Experience (ACE) Screening in Los Angeles County Pediatric Clinics." *The Annals of Family Medicine* 21, no. 5 (2023): 416–23. <https://doi.org/10.1370/afm.3014>.
10. Koita, Kadiatou, Dayna Long, Danielle Hessler, Mindy Benson, Karen Daley, Monica Bucci, Neeta Thakur, and Nadine Burke Harris. "Development and Implementation of a Pediatric Adverse Childhood Experiences (ACEs) and Other Determinants of Health Questionnaire in the Pediatric Medical Home: A Pilot Study." *PLoS ONE* 13, no. 12 (2018): e0208088. <https://doi.org/10.1371/journal.pone.0208088>.
11. Tutko, Holly, Felicity Bernard, Corina Chao, Delitha Watts, Michelle Capozzoli, Jeanne Ryer, and Josephine Porter. "Lessons learned from a quality improvement intervention to support implementation of childhood adversity screening in pediatric primary care." *Journal of Family Trauma, Child Custody & Child Development* (2024): 1-23. <https://doi.org/10.1080/26904586.2024.2324758>
12. ACEs Aware. *Screen. Treat. Heal. Improving Healthcare Access And Quality In La County: The ACEs-LA Network of Care Case Study*. (2024). https://aces-la.org/wp-content/uploads/2024/05/UCAAN_ACEsLARReport_CP4_050724.pdf

This work was funded by the UCLA/UCSF ACEs Aware Family Resilience Network (UCAAN) and Olive View-UCLA Education and Research Institute.