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ACE Screening as a Tool for Improving Health Access and Outcomes for Children and Youth in California: Social Work Referrals

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Executive Summary

Research shows that adverse childhood experiences (ACEs) can lead to toxic stress responses, which have lasting effects on physical and social-emotional wellbeing. California launched ACEs Aware to facilitate training on ACE screening and response activities to support healthcare providers in identifying and responding comprehensively to patient experiences of adversity.[1]

Response activities may vary by resource allocation and availability but, generally, are evidence-based and can include relational conversations, universal toxic stress counseling and education, individualized patient assessments, and risk-stratified referrals.

To deepen our understanding of how ACE screening contributes to integrated health care access among youth enrolled in managed care, this brief examines clinician plans to refer children and families for Los Angeles County Department of Health Services (LA DHS) social work services following ACE screening. Nearly 12,000 ACE screenings were conducted on behalf of about 4,000 unique patients ages 17 and under. About 20% of screens had at least one ACE indicated, and 5.5% of all patient visits associated with ACE screening included a plan to refer the patient and/or family to LA DHS social work services, regardless of ACE score.

Key Takeaways:

- Most screened patients (regardless of ACE score) were not referred to LA DHS social work services, demonstrating that referring to social work is not an automatic response to ACE screening.
- Referrals to LA DHS social work services were more common when screening resulted in higher ACE scores, indicating that ACE screening can assist providers in identifying patients at higher risk of toxic stress and unmet needs for social work support.

Recommendations:

1. Managed Care Organizations (MCOs) should support and incentivize ACE screening and training on ACE screening and response for practice groups to help identify those at highest need for supportive services, including social work.
2. Policymakers should support MCOs and affiliated practice groups to leverage existing programs funded through California Advancing and Innovating Medi-Cal (CalAIM) more effectively, equitably, and efficiently by simplifying and defining workflows for organizations to build and receive payment for services and for patients to equitably access these services. Some specific actions to facilitate utilization of CalAIM include:
   a. **Provide** bridge funding for practice groups to create behavioral health or social work teams that can be sustainably maintained through CalAIM funding.
   b. **Support** practice groups to gain the knowledge needed to successfully and sustainably bill for these services.
   c. **Ensure** practice groups have the resources and tools needed to provide all patients in their practice group universal access to toxic stress resources and education.

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Background

Adverse Childhood Experiences (ACEs) are traumatic events during childhood, including abuse and neglect, and exposure to stressful household conditions, such as domestic violence, behavioral health conditions, and parental death or incarceration.[1] Prolonged or compounded exposure to ACEs strain the nervous system and can result in toxic stress responses, which can negatively affect a developing brain and body, impacting a child or adolescent in multiple ways - from physical and behavioral health to literacy and social skills.[2] The consequences of ACEs persist well into adulthood and include elevated rates of physical and mental health conditions, including developmental concerns, depression, asthma, cancers, and especially heart disease.[3]

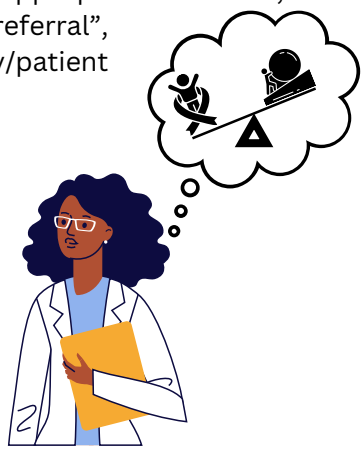
Within integrative pediatric care models, routine ACE screening has been introduced to help healthcare providers detect childhood adversity, intervene promptly and comprehensively, and prevent the medical and social-emotional consequences of toxic stress from developing.[4]

California's ACEs Aware initiative is the first statewide effort to facilitate screening for childhood trauma and response to the impacts of toxic stress across its 13-million-member Medicaid system through reimbursement and comprehensive training.[5] Provider responses to ACE screen findings are intended to be evidence-based and can include universal toxic stress counseling and education, individualized patient assessments, and risk-stratified referrals.[6-7] ACE screening responses may also vary by resource allocation and availability at clinical sites, and several studies demonstrate that relational conversations with patients about their ACE screen results are common and acceptable responses.[8-9]

ACEs Aware has developed evidence-informed algorithms to assist providers in managing response activities.[10] The ACEs Aware ACE screening response algorithm guides clinicians to not only identify a patient's ACE score but to identify the patient's toxic stress risk and determine appropriate interventions.

In 2019, Los Angeles County Department of Health Services began a phased implementation of universal ACE screening across 14 clinics serving pediatric patients throughout Los Angeles County. Providers at participating ACE screening clinics completed the Becoming ACEs Aware in California training and received 1-3 additional training sessions on ACE screening, trauma-informed care, and approaches to ACE screening response. Additionally, providers were invited to optional 1-hour trauma-informed learning sessions monthly over 3 years.

Resources available to respond to ACE screen findings differ at each of the LA DHS pediatric clinical sites. For example, some sites have co-located specialty services or varying levels of social work services. Other clinics instead rely on community agencies to provide additional family support when needs are identified. During patient visits in which ACE screening is performed at an LA DHS clinic, medical providers document patient ACE screen results and patient toxic stress risk assessments, then "check off" what actions were taken to respond to the screening and/or patient's needs. The provider documents ACE screen response actions by selecting one of the following: "none", "family/patient already receiving appropriate services", "anticipatory guidance", "social work referral", "community organization referral", "developmental/behavioral service referral", "mental health referral", "family/patient declined action", or "other".



A social work referral is documented when a social needs assessment, service linkage, and/or social case management that exceeds the capacity of the clinic provider is/are noted at the time of ACE screening. LA DHS social work teams, where available, receive these referrals and assign the patient's case to a social worker, medical case worker, or community health worker, depending on the patient's level of need. When an LA DHS social work team is not available, a clinic provider may refer the patient and family to social service supports outside of the LA DHS system of care, including community-based organizations and other LA County programs.

To advance the understanding of how ACE screening contributes to healthcare access among youth, we examined the relationship between ACE screening and provider referrals to LA DHS social work services.

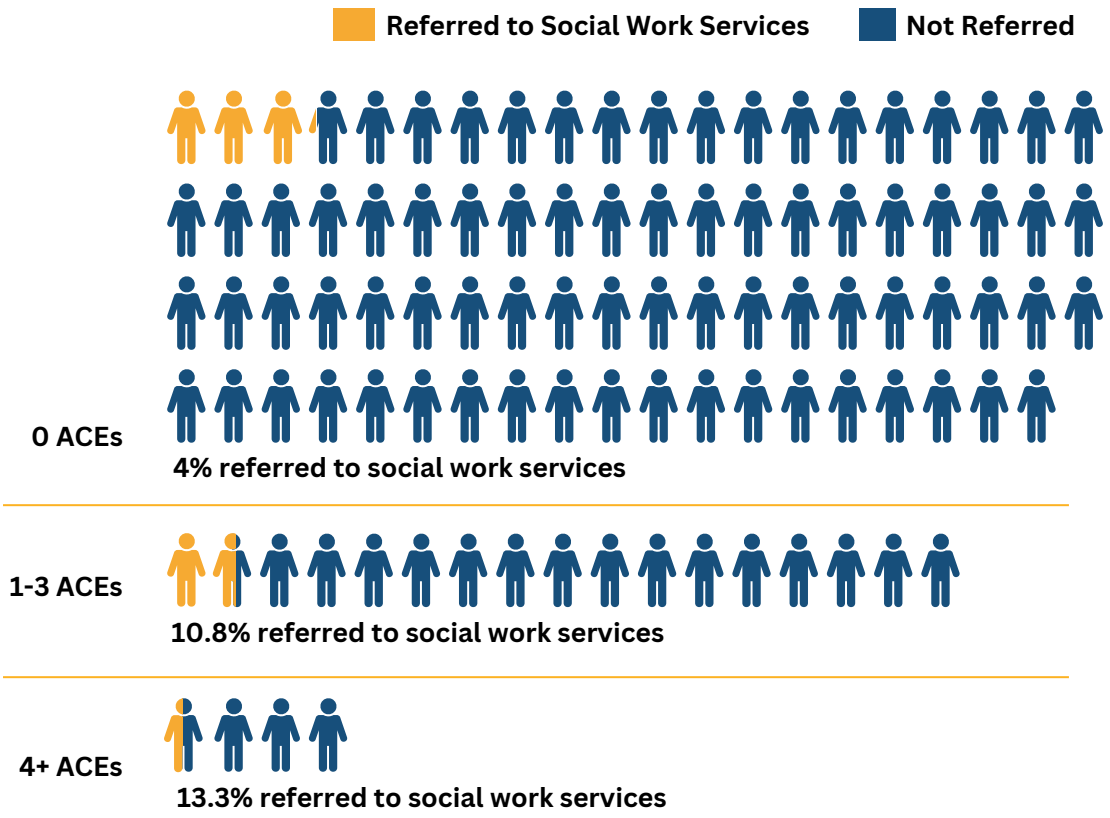
Methods

In this analysis, we reviewed Pediatric ACEs and Related Life Events Screening (PEARLS) and referral data from 4,314 unique pediatric patients aged 0-17 years receiving primary care in 14 LA DHS clinics between November 2021 and June 2023.

Findings

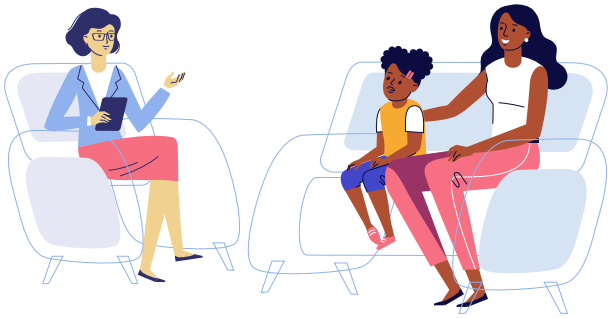
- 11,878 ACE screenings were conducted on behalf of 4,314 unique patients aged 17 years old and under
- ACE screening:
  - Nearly 80 percent of all routine ACE screenings documented an ACE score of zero.
  - About 20 percent of screens reported an ACE score of 1 or more.
- Planned referrals to LA DHS social work:
  - Cumulatively, 5.5 percent of all patient visits associated with ACE screening included a plan to refer the patient and/or family to LA DHS social work services.
  - 94.5 percent of all patient visits associated with ACE screening did not include a plan to refer to LA DHS social work services.
- Social work referrals in response to ACE Scores:
  - Documented plans to refer to LA DHS social work services increased with high ACE scores.

Figure 1. Plans to refer to LA DHS social work services increased with high ACE scores



Discussion

Prior research shows that when ACE screening is utilized effectively, it can ensure that social work is also effectively accessed and utilized.[11] Our findings demonstrate how ACE screening can be a useful tool for developing individualized treatment plans for patients experiencing varying risk levels of toxic stress. Social work services can be a valuable resource for this individualized plan.



It is also important to note that social work services are not equally or widely available across various clinical settings.[12-13] When resources are limited, having a mechanism for triaging to match the type and intensity of patient needs may be an effective tool for optimizing service delivery. Though primary care providers may be able to provide basic social needs assessments, service linkage, and/or social case management, staff trained in social work interventions (community health workers, medical case workers, social workers) may be required when patient or family needs exceed the skillset of the primary care provider.

With California's recent launch of the CalAIM program, more supportive services are now reimbursed beyond the standard capitation rates for primary care. For example, community health workers can now bill for services, and social workers can bill for services through non-specialty mental health benefits.[14-15] These new programs, which are all administered through Medi-Cal Managed Care Organizations (MCOs), have the potential to improve outcomes for children experiencing the negative impacts of ACEs and toxic stress by improving and equalizing their access to these response resources.

Key Takeaways

1. **It is notable that the majority of patients were not referred to LA DHS social work services, regardless of their ACE score. This suggests that referrals to social work are not automatic responses to ACE screening or to a particular ACE score.**

   Our finding that cumulatively, 5.5 percent of ACE screenings resulted in a planned social work referral is fairly consistent with prior research on ACE screening and response activities. In a similar study conducted at Kaiser, just over 1 percent of pediatric patients screened for ACEs were referred to social work after ACE screening.[16] Another study that included data from 48 clinics across California found 21 percent of pediatric patients screened for ACEs received a referral of any kind.[17] In this same study, one provider reflected on the low referral rates, stating, "*We're slowly learning that sometimes it's not that we have to refer people somewhere, we can start a conversation with them about the things they've been through and help them feel heard and understood.*"[18]

   While it is possible to interpret the low referral rates, even in instances where a high ACE score is noted, as provider failure, this consistent finding among ACE screening providers more likely represents the appropriate actions by providers who use the screen results as one component of their decision-making. The positive association between score and referrals we documented reinforces this inference.

   Clinicians may choose not to refer to LA DHS social work services for several valid reasons. First, many patients with high ACE scores are already engaged with supportive services such as case management, mental health services, and engagement with community-based organization.[19] In addition, providers who screen for ACEs have undergone specific training through the state's certification course (Becoming ACEs Aware) to help them develop skills in universal ACE education and relational conversations, a foundational response to ACE screening that builds patient trust.[20] When done well, ACE screening and response activities support better care for patients through relational conversations that build trust, destigmatize ACEs and toxic stress, connect past experiences to current medical needs, and provide universal support and access to resources and education, which may or may not include formal referrals.[21]

2. **Referrals to social work were greater when screening documented higher ACE scores. This finding is consistent with prior research[22] and suggests that routine ACE screening – when utilized as a needs assessment tool in combination with ACES Aware response algorithm - may assist providers in identifying patients at higher risk of toxic stress and in need of social work support.**

In trainings, LA DHS providers learn to utilize relational conversations as both a response to ACE screening and as an opportunity to learn more about the patient, family, and their needs. This approach can help providers better determine the need and appropriateness for a social work referral, and – when indicated – can help identify the level of social work support the patient and family may need. When deciding whether to refer after ACE screening, clinicians may consider the availability of resources, family willingness and readiness to engage, and existing resources connections.

Recommendations

1. M**anaged Care Organizations (MCOs) should support and incentivize ACE screening and training on ACE ACE screening and response for practice groups.** Clinician training on ACE screening and response promotes the inclusion of toxic stress risk assessments and relational conversations in clinical decision making. This can facilitate early identification, early intervention around toxic stress, and coordinated, patient- and family-centered response activities. ACE screening is a useful tool to develop individualized treatment and response plans for toxic stress. ACE screening trainings should include trauma-informed, relational-, and resilience-focused skills that build trust, destigmatize ACEs and toxic stress, and connect past experiences to current medical needs.

2. **Policymakers should support MCOs and affiliated practice groups to leverage existing programs funded through CalAIM more effectively, equitably, and efficiently by simplifying and defining workflows for organizations to build and receive payment for services and for patients to equitably access these services.** As more clinical practice groups implement screening and response activities and work to build more robust networks of care, MCOs have the opportunity to support these efforts. The MCO infrastructure is essential to the successful administration and monitoring of program implementation, including social work services. Optimizing this infrastructure has the potential to support access to reimbursable services such as social work (through the non-specialty mental health benefit) and other CalAIM programs based on patients' identified needs. Social work services can be a valuable response tool for addressing patient and family drivers of health. Utilizing CalAIM funding to improve and equalize access to social work services across health systems can improve health equity and promote the use of important services by patients and families with high risks of toxic stress. Some specific actions MCOs can take – and policy makers can support – to facilitate utilization of CalAIM include:
    a. Provide bridge funding for practice groups to create behavioral health or social work teams that can be sustainably maintained through CalAIM funding
    b. Support practice groups to gain the knowledge needed to successfully and sustainably bill for these services
    c. Ensure practice groups have the resources and tools needed to provide all patients in their practice group universal access to toxic stress resources and education

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