Advance Member Health Through Adverse Childhood Experiences Screening

REFER ELIGIBLE MEMBERS TO CALIFORNIA'S MEDI-CAL PROGRAM INITIATIVE

Screening for Adverse Childhood Experiences (ACEs) can help you know how likely a patient is at increased health risk due to a toxic stress response and provide trauma-informed care. Identifying and treating cases of trauma in children and adults can lower long-term health costs and support the well-being of individuals and families.

The California Department of Health Care Services (DHCS) has identified and approved specific screening tools for children and adults for the 10 categories of ACEs grouped under three sub-categories: abuse, neglect, and household dysfunction. Providers should retain all completed screenings in the member's medical record, as the forms will be subject to audit.

For children and adolescents, use pediatric ACEs and related life events screener (PEARLS)

PEARLS is designed and licensed by the Center for Youth Wellness. Providers can screen once during a 12-month period, per member. The PEARLS screening tools are also available in additional languages. There are three versions of the tool based on age:

- **PEARLS for children ages 0–11, to be completed by a caregiver.**
- **PEARLS for teenagers ages 12–19, to be completed by a caregiver.**
- **PEARLS for teenagers ages 12–19, self-reported.**

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For adults, use the ACE assessment tool

The ACE assessment tool is adapted from the work of Kaiser Permanente and the Centers for Disease Control and Prevention (CDC). Other versions of the ACEs questionnaires can be used, but to qualify, questions must contain the 10 categories.

Ages	Use this tool	To receive directed payment
0–17	PEARLS	Not given more than once during a 12-month period, per provider, per member.
18 or 19	ACEs or PEARLS	Not given more than once during a 12-month period, per provider, per member.
20–64	ACEs screening portion of the PEARLS tool (part 1) can also be used.	• Not given more than once during a 12-month period, per provider, per member under age 21. • Not given more than once per lifetime, per provider, per member ages 21 and older.

Take these steps after screening

As part of the clinical workflow, providers should be prepared with a treatment plan and referral process so patients who have identified behavioral, social or traumatic experiences can be connected to trained professionals and resources. Building a strong referral network and conducting warm hand-offs to partners and services are vital to the treatment plan. In addition, it is critical to build a follow-up plan to effectively track the patient's progress to ensure they get connected to the support needed.

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Calculating scores

The ACE score refers to the total reported exposure to the 10 ACE categories indicated in the adult ACE assessment tool or the top box of the pediatric PEARLS tool. ACE scores range from 0 to 10 based on the number of adversities, protective factors and the level of negative experience(s) that have impacted the patient. Providers will obtain a sum total of the number of ACEs reported on the screening tool.

For children and adults, two toxic stress risk assessment algorithms based on the score were developed to determine the level of risk and referral needs. According to the algorithm, risk and scores are determined as follows:

Risk: Low
Score: 0
Action: If a patient is at low risk, providers should offer education on the impact of ACEs, anticipatory guidance on ACEs, toxic stress and buffering factors.

Risk: Intermediate
Score: 1–3
Action: A patient who scores 1–3 has disclosed at least one ACE-associated condition and should be offered educational resources.

Risk: High
Score: 1–3 with associated health conditions, or a score of 4 or higher
Action: The higher the score, the more likely the patient has experienced toxic stress during the first 18 years of life and has a greater chance of experiencing mental health conditions, such as depression, post-traumatic disorder, anxiety and engaging in risky behaviors.

Refer members to California Advancing and Innovating Medi-Cal (CalAIM) programs

CalAIM is a multi-year initiative lead by DHCS to improve the quality of life and health outcomes for Medi-Cal members through broad delivery system, program and payment reform across the Medi-Cal program.

Dyadic Services and Family Therapy (DS/FT) can help support child development and mental health by treating children and caregivers together. The child/youth must be enrolled in Medi-Cal. Services are generally provided within the pediatric primary care setting and can help with identifying behavioral health interventions, referrals to services, meeting the family's needs (including addressing mental health and social support concerns) and broadening and improving the delivery of pediatric care.

Enhanced Care Management (ECM) is a statewide benefit to provide a whole-person approach to care that addresses the clinical and non-clinical to Medi-Cal members who have complex needs and challenges that make it hard to improve their health.

ECM providers have experience serving the ECM population of focus (adults, children and youth), and expertise providing the core ECM services that include outreach and engagement, comprehensive assessment and care management plan, enhanced care coordination, health promotion, comprehensive transitional care, member and family support, and coordination of and referral to community and social support services.

Community Supports (CS) are key services that address the social determinants of health to improve health equity. The goal is to allow members to receive care in settings where they feel most comfortable and to keep them in their home or community, as medically appropriate. There are 14 CS services to address the needs of members – including those with the most complex challenges affecting their health, such as homelessness, unstable and unsafe housing, food insecurity and/or other social needs.

Community Health Workers (CHWs) are preventive health personnel who provide health education and navigation services to help members get the care they need. CHWs are members of the community, such as community health representatives and non-licensed public health workers, including violence prevention professionals. Services may include a variety of concerns impacting the member, including but not limited to behavioral health conditions, control and prevention of chronic conditions or infectious diseases, oral health, domestic violence and other violence prevention services, etc.

Referral resources

Use the appropriate sources to make referrals into CalAIM programs

Provider Portal
provider.healthnetcalifornia.com

Findhelp
https://communitysupportsecm.findhelp.com

Provider Directory
https://www.healthnet.com/content/healthnet/en_us/members/medi-cal/provider-directory.html

Fax the member information that supports the member's ECM eligibility
800-743-1655

Member Services
24 hours a day, 7 days a week
800-675-6110

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