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Community Information Exchange: Leveraging Collaborative Infrastructure to Assess and Address ACEs

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This paper was produced with grant funding support from the California ACEs Aware initiative, a first-in-the-nation effort to screen children and adults for Adverse Childhood Experiences (ACEs) in primary care, and to treat the impacts of toxic stress with trauma-informed care. The bold goal of this initiative is to reduce ACEs and toxic stress by half in one generation. For more information, visit the ACEs Aware website.

2-1-1 San Diego · Community Information Exchange · San Diego Accountable Community for Health · the YMCA · Partners in Prevention

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Table of Contents

Community Information Exchange: Leveraging Collaborative Infrastructure to Assess and Address ACEs 2
Introduction 2
Community Information Exchange 3
San Diego Community Information Exchange 3
Application of Community Information Exchange to Address ACEs 4
Core Components of CIE San Diego 6
Shared Governance of Network Partners 7
Shared Language 7
Resource Database and Bi-Directional Referrals 7
Technology Platform and Data Integration 8
Community Care Planning 9
Use Cases & Opportunities for Community Information Exchange Models 10
Partner Feedback 10
Opportunities 14
Challenges 15
Recommendations 16
Appendix: CIE ACEs Listening Session Guide

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Introduction

According to the National Pediatric Practice Community on Adverse Childhood Experiences (ACEs), screening for ACEs can improve clinical decision making and health outcomes.[1] As more organizations incorporate ACE screening into their clinical care, ACEs standards for the administration and implementation within workflows continue to be developed. Additionally, as the correlation between social and health needs grow, healthcare providers are grappling with practical ways to address social needs in the context of care.

In California, the recent Medi-Cal (Medicaid) payment for providers to complete ACE screening creates new opportunities to identify, respond, heal and support those who are most vulnerable. This has resulted in counties in Northern California, such as Fresno, and Southern California, such as Orange County, to leverage the roll out of ACE screening as a use case to build a Community Information Exchange (CIE). Similarly, throughout California and across the nation, CIEs are being built by communities to support cross-sector collaboration and coordination to address the needs of overlapping target populations, such as youth, homeless youth, LGBTQ+ youth, and the education sector. Lessons learned from this brief will be helpful to share promising practices as various organizations and institutions are looking to implement bidirectional referral platforms and comprehensive CIEs.

Recommendations for utilizing CIEs to improve ACE screening and response

System Implementation
Adopt and leverage CIE as infrastructure for systemic, cross-sector coordination for ACE screening, prevention, and intervention.

Assessment & Referral
Use the CIE shared record to assess clients' strengths and needs and create closed-loop referral pathways.

Funded Coordination
Increase government investment and policies that support adoption of trauma-informed care coordination practices and systems.

Healthcare Training & Support
Provide training of healthcare staff and inclusion of navigation services in healthcare settings to support those who screen positive for ACEs.

Trauma-Informed Best Practices
Support standards for trauma-informed services and ongoing training, program evaluation, and implementation of interventions that are aligned with these standards.

Paired Screening & Assessment
Support pairing of strengths-based and resiliency screening and assessment with ACE screening.

Data Integration
Fund and support data integration of electronic health record systems and client record management with a CIE to maximize opportunities for adoption and reduce barriers to utilization.

[1] Center for Community Health and Evaluation. (2019, December). *Screening for adverse childhood experiences (ACEs) in pediatric practices*.

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Community Information Exchange

A Community Information Exchange (CIE) is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make closed-loop, bi-directional referrals to create a shared longitudinal record. By focusing on these core components, a CIE enables communities to shift away from a reactive approach to providing care toward proactive, holistic, person-centered care. CIE is an emergent concept and practice. (See the CIE Toolkit for more information.)

San Diego Community Information Exchange

In San Diego, the CIE was established in 2011, using technology to connect social and healthcare providers to improve care for those most disconnected. In its infancy, the CIE was a coordinating platform between social services, law enforcement, and healthcare organizations to streamline and improve care. The first use cases involved addressing the needs of people experiencing homelessness, older adults, and veterans. The CIE has evolved into a network of health and social service providers collectively using this community-driven tool to provide informed and coordinated care using a universal client/patient record, a shared language and line of sight to a person's engagement with past and current service providers, and an essential resource database for closed loop electronic referrals.

Currently, CIE San Diego is an ecosystem comprised of a growing network of 105+ partner organizations across health, behavioral services, and social service sectors (health plans, hospitals, federally qualified health centers [FQHCs], community-based organizations [CBOs], housing providers, food banks, etc.) with over 200,000+ consented individuals. Agencies use Social Determinants of Health (SDoH) screenings and assessments, a resource database, and an integrated technology platform to deliver enhanced service delivery, community care planning, and innovative program design. CIE San Diego offers local healthcare partners and community resource providers a rich set of data points to better understand individual and population interactions within health and social service systems. The CIE enables closed-looped referrals between network partners, offers the ability to view past and current referrals and program enrollments, and provides various search functionality as well as an integrated, longitudinal client record that holds SDoH information relevant to the services each organization provides.

An example of how the CIE has been leveraged to share information for individual care coordination and communitywide planning is the Homelessness Prevention Collaborative (HEAP). HEAP is a network of service providers collaboratively using the

CIE for uniform screening, shared data for collective analysis and program evaluation, and facilitating connection to services for clients via the CIE's closed-loop direct referral process. The CIE also facilitates HEAP partners' rapid response to evolving needs of community members and the ever-changing resource landscape that includes healthcare, food, housing, and mental health services.

Application of Community Information Exchange to Address ACEs

Not only does CIE have the capacity to be the shared infrastructure to link partners and activities within a collaborative, but it also has the capacity to link distinct yet aligned collaboratives. For instance, the utilization of CIE was identified as a component in two community-wide, cross-sector ACEs-focused collaboratives: Partners in Prevention and the San Diego Accountable Community for Health (ACH) ACEs Aware Network of Care Learning Collaborative. Partners in Prevention (PiP) is a collective impact initiative spearheaded by the YMCA of San Diego County with the goal of cultivating a connected community that nurtures caring, strong, safe and healthy families in order to reduce the likelihood of child neglect and abuse. CIE San Diego is the shared space for cross-sector providers to increase protective factors through shared assessments of family strengths and needs, as well as to directly link families to supportive services through CIE and improve coordination between services, programs, and agencies (see Figures 1 and 2 below).

Figure 1. Partners in Prevention Theory of Change

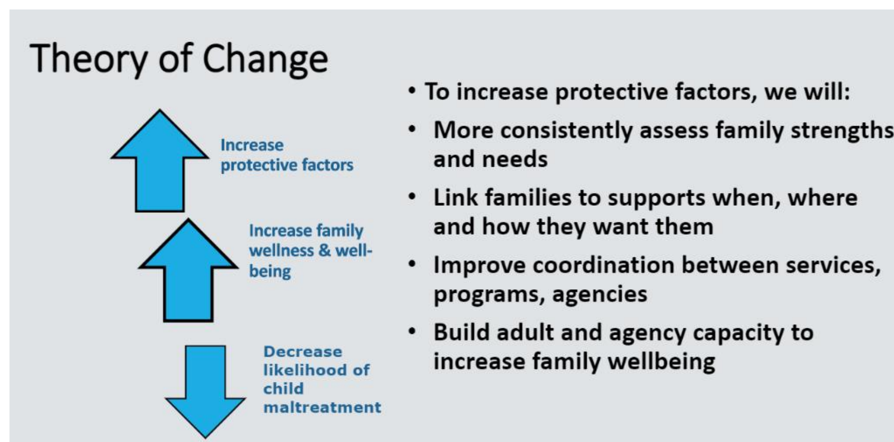

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Figure 2. Partners in Prevention Key Activities

Improve Systems Alignment, Access to Care & Coordination	Provider Capacity Building	Increase use of CIE	Early Childhood Mental Health Consultation
• Mobilize cross-sector partners to align and leverage shared prevention strategies and activities via strategic partner engagement • Expand and enhance continuum of prevention services and supports • Increase access to resources via Community Information Exchange • Gather input from those with lived experience to inform program design and implementation plans	• Develop and implement a shared, community-wide Integrated Learning Plan to support partner integration of service delivery best practices • Provide evidence-based trainings on Protective Factors, Culturally Responsive Practice, Trauma Informed Care, Strengthening Families Quality Standards of Implementation and more • Provide technical assistance to partner agencies as needed	• Integrate shared use of Protective Factors screening tool via CIE • Build family protective factors via linkages to direct services and resources • Provide partner education and technical assistance to support the utilization of CIE	• Provide quality, evidence-based Early Childhood Mental Health Consultation services for children ages 0-5 and their caregivers (families and early care and education providers)

The San Diego ACH ACEs Aware Network of Care Learning Collaborative goal is to support development of a functional trauma-informed network of care. To achieve this goal, the ACH Learning Collaborative developed objectives that include cultivating the conditions for collaboration across sectors, creating an inventory of community resources that increase protective factors, creating a shared vision for the network of care, increasing the awareness of the roles and strengths of each sector, and identifying best practices and potential systems of change for each sector.

The Learning Collaborative was comprised of over 50 individuals from multiple sectors including healthcare providers, health plans, behavioral health, child welfare, legal and justice system, early care and education, academia, social service providers, community-based organizations, community residents with lived experience, and others. Over multiple sessions and small group meetings, Learning Collaborative partners developed 18 shared vision statements, eight strategies, and 30 related action steps recommended for advancing a trauma-informed network of care. One of these strategies is specifically related to advancing technology (see Figure 3 below).

Figure 3. ACH Learning Collaborative Strategy 8 and Related Action Steps

Strategy 8: Advance technology to support connections and person-centered approaches
• Create and participate in bidirectional referral systems • Support data systems that are owned and informed by clients • Share data to support systems improvements

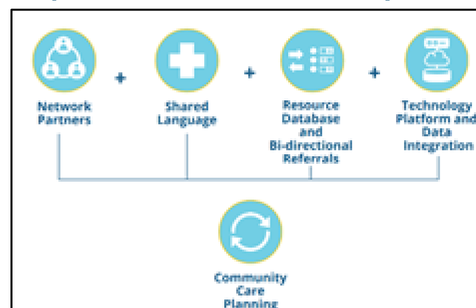
Because the two collaboratives had many shared goals, activities, and service providers, leveraging the shared CIE infrastructure helped achieve far greater collective impact than if they had each worked alone. In addition, service providers were able to adopt a single platform, avoiding duplication of effort and the collaboratives are able to produce and leverage a richer data set, including information from both collaboratives that also accommodates for the iterative nature of platform adoption and systems change being done in concert rather than in a siloed manner.

As we look to best practices for implementation and intervention, CIEs can become a mechanism to support ACE screening and responsive interventions. This brief summarizes the opportunities for using CIE and provides recommendations and feedback from CIE San Diego and its partners, who are actively implementing these best practices into their efforts to screen, assess strengths and address ACEs-related needs for supportive services.

Core Components of CIE San Diego

Core components of CIE San Diego support community needs from individual, agency, and community level perspectives and create opportunities for coordination between health and social services. A description of these components, along with suggestions for how they can enhance a community's capacity to effectively address ACEs, are presented below.

Figure 4. Core Components of a Community Information Exchange



Shared Governance of Network Partners

CIE San Diego's community-led initiative is stewarded by multi-sector community-based organizations, including healthcare and government entities, which are involved in prioritizing community members' needs and allocation of resources. This multi-sector, shared governance is fundamental to establishing the holistic approach needed to collectively address ACEs prevention and resiliency. While screening may often take place in a healthcare setting, many of the supportive services needed to reduce ACEs risk factors and increase protective and resiliency factors include service providers and informal and formal family supports across all sectors.

Shared Language

The shared language incorporated into CIE San Diego's data integrated technology platform includes translating and summarizing key information across health and social services to identify an individual or family's comprehensive situation by domain (food, housing, social connection, etc.). This includes information about the immediacy of a need, barriers to services, available supports, and a person's knowledge and ability to utilize resources. With this information, providers can engage in a more person-centered patient approach, as well as more impactful care planning and interventions that support a person's goals and wellbeing. This component is critical to meaningful implementation of ACE screenings completed in a healthcare setting.

While an ACE screening may identify risk factors, its deficit-oriented framework becomes more meaningful or actionable when paired with screening and assessment tools that identify a person or family's existing strengths and protective and resiliency factors, as well as their expressed goals for supportive services and understanding of their own situation. In the shared space of a CIE platform, service providers across service domains can leverage the integrated data of CIE from other technology platforms and collaboratively contribute to a holistic understanding of a person or family's unique situation, strengths and needs. For instance, using the screening tools embedded in a CIE, a pediatrician can screen for ACEs during a clinic visit and refer to a counselor with a school-based community-based organization (CBO). This counselor might use a strengths-based tool such as the Brief Resiliency Scale or the Protective Factors Survey 2 (PFS-2) while working with the family members to connect them to even more tailored supportive services. In this case, providers are able to view previously completed screenings and assessments for informed care and engagement, and also have access to such tools for client/patient shared decision making and direction to supportive services.

Resource Database and Bi-Directional Referrals

CIE San Diego used a bi-directional, closed loop referrals enable partner organizations to streamline the delivery of person-centered care, monitor individuals' progress, and capture outcomes in real-time. Using the CIE technology platform, network partners

can use detailed information about a client's needs to match them with appropriate healthcare, social, and other services in the resource database. Partners can send, accept, and decline referrals to and from each other based on their program expertise and geographic areas served. Partners can also provide information about referral status, program enrollment, and outcomes, closing the loop. This component is particularly important for service providers partnering with clients or patients seeking services related to ACEs. When addressing need using a trauma-informed lens that accounts for a person's lived experience and individual identity, it is important to not only be able to identify services that address a specific need, but also to assure that services are delivered with appropriate cultural sensitivity, expertise, and contextual understanding that previously accessed services may have been traumatizing or dehumanizing for that person. For instance, a service provider working with a transitional-aged-youth who is queer and experiencing homelessness is able to use information from CIE to engage that youth about the types of services they would like help accessing and review program enrollments to inquire about previously accessed services and whether previous experiences with specific service providers were helpful. This will help the service provider make appropriate direct referrals for services with the individual's consent, while limiting the need for the receiving provider to collect information already available in the CIE.

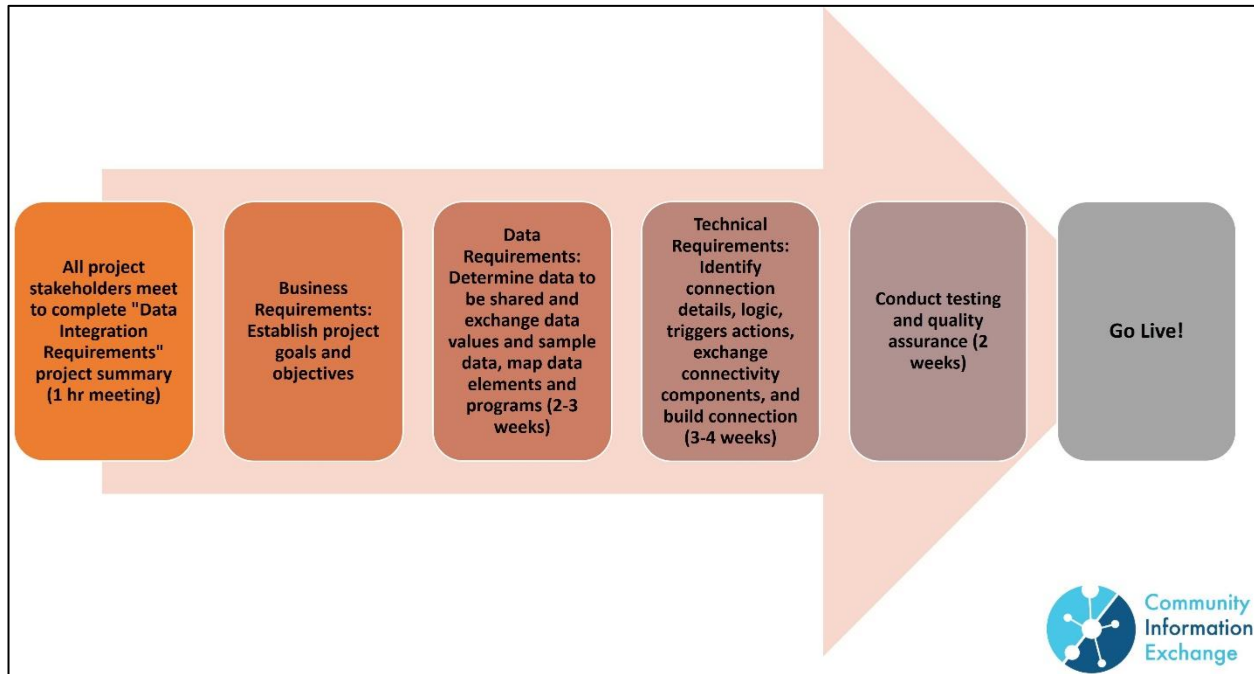
Technology Platform and Data Integration

CIE San Diego is an interoperable, customizable technology platform that allows for data sharing with other platforms or portals accessible to providers and CIE participants. This allows for proactive alerts based on field-level changes and insights to help make client information actionable. Using an integrated data model, the CIE combines data from multiple individual electronic health records (EHRs) or client record management (CRM) systems to create a single, master longitudinal record. This model provides the CIE with infrastructure that both creates uniform data across health and social systems without dual-data entry, and preserves the diversity of data sets used by specialized service providers.

With regard to ACE screening and subsequent interventions, the integrative nature of the CIE makes possible a systems-level ability to reduce over-assessing and potential re-traumatization of patients being screened for ACEs. By integrating data from various systems into a comprehensive, longitudinal record, service providers outside of the screening agency are able to view and build on previous patient engagement. For example, a pediatrician at a clinic might administer an ACE screening which is integrated into the CIE through a real-time Application Programming Interface (API) connection. The ACE screening and identified need would be accessible in the CIE and only visible to those who would be using that information to provide better care through a specific role-based permission. That pediatrician may also then use the CIE to directly refer their patient to a youth and family service provider for counseling. Not only will the counselor receiving that referral be able to view and avoid re-administering an already

completed ACE screening, the counselor may also engage with the patient and gain information such as family strengths, protective factors, resiliency factors, etc. This approach will result in a more humanizing and person-centered understanding for future engagements and care coordination.

Figure 5. Community Information Exchange Data Integration Process



Community Care Planning

CIE San Diego includes an embedded longitudinal record with a unified community care plan that promotes cross-sector collaboration. The CIE promotes holistic, trauma-informed and equitable access to care, inclusive of family needs and strengths. Service providers doing the work of community care planning can leverage ACE screening and other SDoH assessment tools to understand the comprehensive needs of the individual/family and provide support in a meaningful way. Additionally, CIE allows for referrals to non-traditional providers that are based on client's individual characteristics and are culturally appropriate, providing more intersectional resources and supports. The aggregate data from these activities can also demonstrate the capacity of service providers and availability of existing resources for individuals impacted by ACEs, as well as data that articulates what resources are missing. This information can inform systems-level filling of gaps through reallocation of resources or the development of new resources to meet the needs in an equitable way. The CIE is a responsive tool and with the appropriate resources can be expanded to better shape a community's system of care.

Use Cases & Opportunities for Community Information Exchange Models

Locally, many case studies within CIE San Diego have shown success and are examples of how larger initiatives like ACEs Aware can be adopted within similar workflows. For example, a local FQHC used the CIE to implement standardized SDoH screening and referrals across its patient navigation department. Multiple organizations have also used shared screening tools in the CIE to assess for client strengths and resiliency factors to improve trauma-informed care. For example, Building Resilience is a collaborative project funded by the Office of Minority Health (OMH) that aims to provide coordinated support services, increase protective factors, and strengthen economic supports for people at risk of ACEs. Led by United Way of San Diego, this collaborative partnership is comprised of direct service providers, an ACEs and trauma-informed training expert, a research evaluator, and the CIE as the infrastructure to achieve the grant-funded collaborative goals. For evaluation, the CIE is being used as the shared source of uniform data sets regarding the families being served, as well as the means of capturing activities of intensive case management such as sending and receiving direct referrals, program enrollments and care teams. Additionally, the CIE is the shared space for direct service providers to capture baseline and follow up strengths and needs assessments, using validated screening tools such as the Protective Factors Survey – 2nd Edition, Brief Resilience Scale, and the Financial Capability Survey.

Partner Feedback

To support this brief, we received feedback from a total of 52 organizations, 18 representatives from Medi-Cal health plans and healthcare organizations like Federally Qualified Health Centers, 32 CBOs, three collective impact organizations, end-user listening sessions, CIE Advisory Board and Network Partner Meetings, and stakeholder interviews (see example listening session guide in Appendix). Through interactive feedback questions such as interviews, presentations, and group discussion, the above stakeholders were asked to identify opportunities for healthcare and social service providers to leverage the CIE when working with individuals screened for ACEs. Table 1 summarizes the input gathered including primary use cases, examples, potential challenges in using CIE to support ACE screenings and responsive interventions, and recommendations.

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Table 1. Partner Input

Primary Use Cases	Description	ACEs CIE Use Case Examples	Challenges	Recommendations
Informed Care	Viewing an individual or patient to see historical use of social or healthcare services and tailoring services accordingly and/or reaching out to an existing organization working with that individual.	Add the ACEs Aware outcomes into CIE, in which organizations with appropriate role-based permissions are able to view the completed screening to understand history of accessing services to support providers in a trauma informed approach, including avoiding triggers.	• Providers may not receive appropriate training on how to use ACEs information to provide trauma-informed interventions. • Reimbursement is often specific and limits capacity for tailored interventions or services.	• In addition to the ACE screening, add strengths-based resiliency screenings to CIE so that care is informed by a holistic and humanizing lens of both strengths and risks. • Leverage the notification and communication functions of CIE to enable increased coordination among providers. • Include trauma-informed training and support for clinical staff to adopt clinical workflows that support responding to ACE screening. • Expand payment models beyond screening to support healthcare and community-based service providers' time to coordinate referrals and use CIE effectively and routinely.
Referrals	Ability to make closed loop referrals between healthcare and social service organizations, including outcome information.	Healthcare providers can determine appropriate community supports (e.g., home visiting, parent support or education, etc.) based on identified needs of the individual and/or family screened and the ACE score.	• Lack of standardization for trauma-informed services and resources. • Lack of clinician training and	• Establish community-curated resources related to each ACE screening question. • Identify ACEs-related resources

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Primary Use Cases	Description	ACEs CIE Use Case Examples	Challenges	Recommendations
		Additionally, the CIE provides the ability to identify organizations that have established trauma-informed competency.	understanding of non-traditional community-based resources with billable time/capacity. • May not have the resources in the community to adequately respond to needs (early childhood mental health, geographic reach, eligibility criteria, etc.). • May not have the capacity or ability to respond to barriers to services.	that specialize in intersectionally serving the unique needs of vulnerable populations.
Prioritization of Care	Ability to identify immediate and long-term needs of an individual, which enables tailored intervention and care planning.	Coupled with ACE screening, use CIE to understand historical access to services and program enrollment to foster shared decision-making with client/patient in creating a care plan based on individual patient needs, expressed goals, situational context and to communicate patient readiness and interests.	• Patients may not be ready to or have interest (stage of change) in accessing resources. • Service providers may not engage and assess client stage of change or client's goals and priorities. • Providers may not have knowledge of or context of community resource capacity, regional resources, and	• Leverage and expand CIE's ability to capture client readiness, goals, and priorities for care planning that include shared decision making.

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Primary Use Cases	Description	ACEs CIE Use Case Examples	Challenges	Recommendations
			eligibility for programs. • Lack of expertise among traditional providers (e.g., primary care) rather than specialized providers (e.g., LGBT Centers) that can provide more tailored social and healthcare care plans.	
Shared Intake, Screening and Assessment	Ability for one provider to complete an intake, screening or assessment that is accessible to providers working with a family or individual across organizations to inform client/patient care without duplicative capturing of Information.	Use CIE to host the ACE screening tool as well as strengths-based assessments that can be completed and viewed across the partner network. The completion of these tools can also be used to inform interventions such as populating referral suggestions based on screening outcomes.	• Strength-based resiliency screening is not part of ACEs, but is necessary. • Intakes are typically program-centered rather than person-centered.	• Identify who would need access to ACEs score (role-based permissions).
Support System	Ability to understand an individual or family's existing support system (family, care team or case managers).	Use the CIE historical record of information, relationship linkages, and care teams to identify supports based on an individual or family's situation and connect them with support to reduce ACEs risk factors.	• Healthcare receives limited training on how to use holistic client/patient records as part of care or interventions. • Health and social service providers do not often capture information about informal support systems (e.g., friends, family, faith community, etc.).	• Providers use CIE to engage in the best practice of tailoring communication with individual based on historical record • Include payment models and standards that incorporate community-care coordination use.

Primary Use Cases	Description	ACEs CIE Use Case Examples	Challenges	Recommendations
Community Reporting (Aggregate Data and Needs)	Ability to aggregate data from multiple sources to better understand community needs and available resources.	Use CIE as a shared place to collect ACE screening and intervention activities to share common needs and identify gaps and resource needs in our community.	• Disparate data sources are not integrated into CIE.	• Enhance financial and human resources to develop data sharing and interoperability between electronic health records and social service agencies to host ACE screening with CIE.

Opportunities

CIE has many components of its existing infrastructure that would allow for adoption of shared tools and processes. For example, the existing SDoH screening and the CIE assessments measure 14 domains of SDoH with indicators showing change over time on a crisis to thriving scale. This scale, called the Comprehensive Social Assessment Continuum can be used to support the various responses to ACEs that may arise with families. In addition to ACE screening aligning with core CIE functionality and use cases as outlined above, CIE was identified through key stakeholder meetings as a key opportunity for patient engagement after an ACE screening to support an individual or family to access supports and address their needs. Examples include:

- With the comprehensive longitudinal record, providers can leverage the CIE to better understand a person's unique experience and further their ability to build on strengths and work collaboratively with them when establishing a care plan. Specifically, ensuring a more asset-based approach to care vs. a more traditional deficit-based model may also increase participation in and completion of support services and programs.

- CIE can serve as a shared space for providers to utilize validated screening and assessment tools such as ACEs and enable them to view assessments previously completed by other providers, thereby reducing duplication of screening and potential re-traumatization, and truly building upon their patient's or client's strengths and the work patients are already doing with other organizations.

- CIE utilization can reinforce consistent practice of shared principles or service delivery best practices across organizations, which allows for greater trust and coordination between agencies responding to ACEs-related identified needs.

- CIE establishes standardized coordination between organizations and reduces a person's barriers to access, which can increase ACEs resiliency and protective factors.

Challenges

There are some considerations and challenges related to incorporating an ACE screening into CIE. These include:

- Participation in CIE for healthcare providers requires capacity, understanding of community resources, and value. Healthcare providers' need to be able to identify and trust in the services available, which has not been a traditional part of healthcare training. Existing training often does not include non-traditional or population-specific community-based resources, or awareness that ACE screening alone does not indicate need areas or readiness to access services.

- Ensuring that patient information is shared ethically, meaningfully, and aligned with HIPAA standards is another consideration. For instance, who should be able to view a person's ACE screening information? While visibility of ACEs information by providers across systems can reduce potentially harmful duplication of screenings, such sensitive information should also be limited to a need-to-know basis.

- Standards of cultural competency and trauma-informed use of ACEs information must be upheld. It is therefore necessary to establish community competency training to understand the realities and protective factors that go into interventions and care.

- Financial resources are required to support this work in Medi-Cal settings as well as among community-based organizations, which are not typically funded by Medi-Cal.

- Resources continue to be invested into healthcare to address social needs, rather than supporting connections to community-based organizations that are rooted in the community and frequently have more expertise in addressing unique challenges.

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Recommendations

The following recommendations are the primary themes of the feedback and information from the listening sessions and interviews for addressing the above-mentioned challenges and utilizing CIEs to enhance a community's ability to improve ACE screening and response:

1. System Implementation
   Adopt and leverage CIE as infrastructure for systemic, cross-sector, and coordinated implementation of strategies and practices for projects such as ACE screening, prevention, and intervention.

2. Assessment and Referral
   Use the CIE shared record to assess a person or family's strengths and needs to create meaningful, person-centered, closed-loop referral pathways that enable trauma-informed care coordination and interventions.

3. Funded Coordination
   Increase government investment and Medicaid policy that support community capacity to respond to referrals by allocating resources for staff training and adoption of trauma-informed care-coordination practices and systems such as a CIE.

4. Healthcare Training and Support
   Provide systemic training of healthcare staff and/or support inclusion of navigation services in healthcare settings to further assess and triage those who screen positive for ACEs.

5. Trauma-Informed Best Practices
   Support the development of standards for trauma-informed services and ongoing training, program evaluation, and implementation of interventions that are aligned with these standards.

6. Paired Screening and Assessment
   Fund and implement structured pairing of strengths-based and resiliency screening and assessment with ACE screening to provide trauma-informed and effective interventions.

7. Data Integration
   Fund and support data integration of electronic health record systems (EHRs) and client record management (CRMs) with a CIE to maximize opportunities for adoption and reduce barriers to utilization such as dual data entry.

Appendix

Adverse Childhood Experiences (ACEs)

Listening Session: How Might CIE Support Community Responses to ACEs

November 17, 2020

Welcome & Introductions

In the chat: Type your name and organization

- **When you were a kid, what did you want to be when you grew up?**

2-1-1 ®
SAN DIEGO/IMPERIAL

Context to ACES

- **Increasing ACEs awareness**
  - Opportunity expedite and catalyze on ACEs screening and response
    - What do ACEs tell us?
    - What do we do about it (within programs, agencies, systems and sectors) and how?
  - Health and social service alignment around ACEs as an opportunity to provide better care- important step towards person-centered care
  - Existing and aligned work
    - ACES Aware Grantees: supplemental training, communications, networks of care, peer to peer learning, white papers
    - Partners in Prevention
    - 2Gen work

2-1-1 ® SAN DIEGO/IMPERIAL

CIE as an support

- **What is the Community Information Exchange?**
- **Goal is to better understand how CIE can be leveraged as a supportive tool to the existing work**
- **Learning from you about opportunities to use the network and technology for ACEs related activities**

2-1-1 SAN DIEGO/IMPERIAL

Goal of Today:

- Current use and value of ACES
- Considerations and challenges with ACES
- Opportunities with CIE and other ACES Support Networks
- Reference ACES: https://www.acesaware.org/wp-content/uploads/2019/12/PEARLS-Tool-Child-Parent-Caregiver-Report-Identified-English.pdf

- You have shared access to this PowerPoint
- We will ask a question
- Respond with name or organization in a box
- Allows you to go back and make changes, updates or add ideas throughout the presentation

Karis, yes I agree!	

2-1-1 SAN DIEGO/IMPERIAL

Share your agencies ACEs goals?

1. Enter your Name
2. Provide context

In Application

Example: 211 San Diego: We may screen in specialty programs	

In Strategic Planning

Example: 211 San Diego: Could be used to inform referrals	

2-1-1 SAN DIEGO/IMPERIAL

What are the benefits and challenges of assessing for ACEs?

1. Enter your Name
2. Provide context

What are the benefits of knowing client ACEs scores?

Example: Understand the patient	

What are challenges with knowing ACE scores?

2-1-1 SAN DIEGO/IMPERIAL ®

What do you/ would you like to do with ACES scores?

1. Enter your Name
2. Provide context (service delivery)

2-1-1 SAN DIEGO/IMPERIAL

Should strengths and assets assessment be part of ACES screening? Why or Why not?

1. Enter your Name
2. Provide context

Yes, why?

No, why?

2-1-1 SAN DIEGO/IMPERIAL

Should ACES scores or need areas be shared with community providers within the CIE? Why or why not?

1. Enter your Name
2. Provide context

ACES Score(s)

Just identified needs

2-1-1 SAN DIEGO/IMPERIAL

How could/ should ACES scores or needs be used for patient/client care?

1. Enter your Name/Org
2. If there is another use of ACES scores or needs, please provide in chat box

Referrals	Inform Care	Other

What things should be considered when making referrals in response to ACEs screening? How could CIE help?

1. Enter your Name/Org

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What other ways could CIE or other ACES support networks be helpful around ACES screening and response efforts?

1. Enter your Name/Org

THANK YOU!