Commission on Trauma-Informed Care: Findings and Recommendations on the Development and Implementation of the Adverse Childhood Experiences (ACEs) Aware Program

Human Services Article § 8-1309(b)(5); Senate Bill 299/Chapter 723, 2021; House Bill 548/Chapter 722, 2021

Submitted by:
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Acknowledgements

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Executive Summary

In accordance with Chapters 722 and 723 of 2021 (House Bill 548/Senate Bill 299), the Commission on Trauma-Informed Care (Commission) is charged to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults.[1] In addition, and in consultation with the Maryland Department of Health, the Department of Human Services, and the Maryland Health Care Commission, the Commission must study and implement an Adverse Childhood Experiences (ACEs) Aware program.[2] The purpose of the ACEs Aware program is to screen for ACEs and toxic stress to provide targeted evidence-based interventions to support individual and family health. As part of the study, the Commission must (1) propose a process to set up training and an accreditation process for program providers and (2) explore the possibility of third-party reimbursement for screenings under the program. Furthermore, and in accordance with § 8-1309(b)(5) of the Human Services Act, the Commission must submit a report to the Governor and the General Assembly by October 1, 2022, and annually thereafter, as it relates to its findings and recommendations regarding the development and implementation of an ACEs Aware program.

Through its charge, and under the leadership of Chairwoman Jessica Wheeler (November 2021-August 2022) and Chairman William Jernigan (August 2022-present), Director of Prevention Strategies and Maryland's Racial and Ethnic Disparities Coordinator, and staff from the Governor's Office of Crime Prevention, Youth, and Victim Services, the Commission began developing a statewide strategy toward an organizational culture shift into a trauma-responsive State government, and a process and framework for implementation of an ACE Aware program in the State. Ms. Wheeler announced at the August Commission meeting that this would be her last meeting and William Jernigan would replace her as Chair. Mr. Jernigan brings his experience as an ACEs Master trainer, Maryland's Racial and Ethnic Disparities Coordinator supporting Maryland's State Advisory Group, and past experience serving system-involved youth and families working in various roles within Baltimore City's Department of Social Services.

To address its charge, the Commission formed the ACEs Aware Workgroup, chaired by Carrie Freshour. The ACEs Aware Workgroup will also be supported by the following workgroups created by the Commission to address related focus areas:

[1] Maryland General Assembly. (2021). *Chapters 722 and 723 (House Bill 548/Senate Bill 299), Human Services - Trauma-Informed Care - Commission and Training (Healing Maryland's Trauma Act)*.
[2] Maryland General Assembly. (2021). *Senate Bill 299 (2021), Human Services - Trauma-Informed Care - Commission and Training (Healing Maryland's Trauma Act) [Fiscal and Policy Note, Third Reader - Revised]*.

- **Metrics & Assessment**: Chaired by Kay Connors and Margo Candelaria, this workgroup focuses on developing metrics to be utilized to evaluate the progress of the statewide trauma-informed care initiative.
- **Training**: Chaired by Amie Myrick and Janie Goldwater, this workgroup focuses on the design and implementation of a statewide trauma-informed training to be provided to State agencies in coordination with the Maryland Department of Health.
- **Operational Implementation & Technical Assistance**: Chaired by Elizabeth Guroff, Dr. Inga James, and Dr. Michael Sinclair, this workgroup focuses on developing recommendations on trauma-informed policies and procedures for State agencies. In collaboration with the Maryland Department of Health, the workgroup will provide technical assistance and guidance on implementing trauma-informed training and operational policy and procedure review.
- **Public Awareness**: Chaired by Ulysses Archie, Jr., this workgroup focuses on developing recommendations regarding a cross-agency and evidence-informed communications strategy that will support Maryland's statewide strategy toward an organizational culture shift into a trauma-responsive state government.
- **Definitions & Core Values**: Chaired by Cherry Price, this workgroup focuses on developing standardized definitions so that the State, across agencies, is using consistent language in legislation, policies, public awareness campaigns, grant applications, training, etc. The group also identified equity as a core value that needs to be present throughout the work of the Commission and its workgroups.

Pursuant to § 8-1309(b)(5) of the Human Services Act, this *Commission on Trauma-Informed Care: Findings and Recommendations on the Development and Implementation on the Adverse Childhood Experiences (ACEs) Aware Program* includes information on the findings and recommendations of the Commission as it relates to the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults. It also provides recommendations to improve existing laws relating to children, youth, families, and older adults in the State.

Adverse Childhood Experiences (ACEs) Aware Program

I. Study Developing a Process and Framework for Implementing the Program

In consultation with the Maryland Department of Health, the Department of Human Services, and the Maryland Health Care Commission, the Commission on Trauma-Informed Care must

study developing a process and framework for implementing an ACEs Aware program in Maryland and implement the program. The purpose of the program is to screen for adverse childhood experiences and toxic stress to provide targeted evidence-based interventions to support individual and family health, in order to improve individual and family well-being and reduce health care costs.

Since November 2021, the Commission has met eleven times and each meeting has had vibrant discussions about what Maryland's strategy should entail. The Commission also invited speakers from national and local organizations with successful trauma-informed care programs and strategies, and continues to gather information about additional programs. In addition, the Commission created the ACEs Aware Workgroup as well as several related workgroups, which include membership from local communities, to accomplish its goals.

A. ACEs Aware Workgroup

The ACEs Aware Workgroup defined its *purpose* in the following way: "The purpose of the ACEs Aware workgroup is to study the ACEs Aware California program, evaluate it as a potential model to be replicated (in whole or part) in Maryland, and ensuring the recommended model includes resources, treatment, and support that are both evidence-based and cost-effective, supporting individual and family health in Maryland." To achieve this, the workgroup will:

1. Review the original ACE study for context and history;
2. Research other states that participate in ACEs-Aware;
3. Research SEEK and other evidence based practices and models that meet the intended purpose; and
4. Assess the budgetary requirements needed to establish and implement a program model that meets the intended needs by screening for ACEs and other toxic stress.

The ACEs Aware Workgroup is made up of over 40 individuals including a legislator, government agency representatives, community representatives, pediatricians, advocates, researchers, therapists, and more. The Workgroup held its first meeting on March 14, 2022, and monthly thereafter. A brief description of each meeting is listed below (*please refer to Appendix 1 for the full meeting minutes*).

March 14, 2022: The Workgroup reviewed the legislative mandate, Carrie Freshour was introduced as the Chair, and Christine Fogle was introduced as providing staff support. The Workgroup discussed the membership and assured members that their views and suggestions would be included. The group also decided to share documents in the Google drive. In addition, the group discussed how to guide future conversations to stay on topic.

April 18, 2022: The Workgroup began drafting a purpose statement. The members expressed the desire to include resilience in the work moving forward. Members also suggested other

individuals in Maryland to share additional perspectives and experiences with the Workgroup to help guide decision-making. In addition, the group discussed alternative programs to compare to California's program.

May 16, 2022: The Workgroup finalized the new purpose statement. The group also discussed membership suggestions and specific speakers to present. Members took responsibility for extending invitations to new members and speakers. In addition, the group agreed to review an article written by Dr. Howard Dubowitz in preparation for his presentation at the next Workgroup meeting.

June 20, 2022: The Workgroup invited Dr. Howard Dubowitz to present on his article, titled *Addressing Adverse Childhood Experiences in Primary Care: Challenges and Considerations*. Dr. Dubowitz discussed the state of the science, what we know and what we are unclear about regarding identifying ACEs, and recommendations for practice. The group discussion following the presentation included a desire to be certain that there are sufficient resources available to treat any issues/concerns that arise as a result of the assessments conducted by providers. Members discussed concerns about the current lack of treatment resources in Maryland and a need to address this before, or simultaneously with, initiating assessment. The group also discussed training providers to play the role completely, not simply completing an assessment, but to create relationships, create a treatment plan, make connections to resources, etc. Finally, the group reiterated concerns regarding utilizing the ACEs questionnaire as an assessment tool because it was never intended by the original researchers to be utilized as a diagnostic tool.

August 15, 2022: The Workgroup debriefed on the Visioning Retreat experience that was hosted by the Commission in July 2022. The primary goal of this meeting was to discuss the California ACEs Aware model and identify the strengths and drawbacks to the model. The members also compiled questions about the California model and the additional components needed for Maryland's program model.

B. California's ACEs Aware Program

The ACEs Aware Workgroup studied California's ACEs Aware Program, [3] to include the following objectives for its program:

1. To inform and empower primary care clinicians with the latest evidence on how to recognize, address, and prevent ACEs and toxic stress.
2. To incentivize early detection and early intervention for toxic stress by reimbursing providers for screening for ACEs, which involves assessing for the triad of adversity

[3] Bhushan D, Kotz K, McCall J, Wirtz S, Gilgoff R, Dube SR, Powers C, Olson-Morgan J, Galeste M, Patterson K, Harris L, Mills A, Bethell C, Burke Harris N, Office of the California Surgeon General. (2020). *Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health*. DOI: 10.48019/PEAM8812. Retrieved from https://osg.ca.gov/sg-report/.

(ACE score), clinical manifestations of toxic stress (ACE-Associated Health Conditions), and protective factors to assess clinical risk for toxic stress and to guide effective responses.

3. To increase awareness and utilization of cross-sectoral, evidence-based clinical and community interventions for preventing and mitigating the toxic stress response.
4. To build clinical capacity for screening for, and responding to, ACEs and toxic stress by investing in the development of clinical protocols and community networks for response.
5. To improve clinical outcomes and health equity by enhancing the quality and specificity of health care provided to individuals exposed to ACEs and/or at risk for toxic stress, through rigorous, evidence-informed methods.

California's ACEs Aware Initiative was implemented in three phases (*as described below*).

The first phase focused on initial training of providers. This free two-hour online training, titled *Becoming ACEs Aware in California*, was adapted from a trauma-informed care curriculum developed by the Office of Women's Health of the U.S. Department of Health and Human Services. The training covered three topics: 1) clinical algorithms to assess for and respond to risk of toxic stress, including formulating appropriately tailored, strengths-oriented, and evidence-based treatment plans; 2) about two screening tools required for reimbursement; and 3) information on obtaining reimbursement for ACE screening of California's medical assistance program.

The second phase of the initiative focused on strengthening provider engagement and capacity. California funded grants for provider training, provider engagement, and communications. The state partnered with Frameworks Institute to work with grant recipients to build capacity, offer technical support, and develop consistent and effective messaging on ACEs and toxic stress that is grounded in the latest science. The provider training grants were designed to deepen the ACEs Aware Core Training Certification criteria and created supplemental training to augment the information provided in the Core training. The provider engagement grants were designed to create opportunities for providers to interact with each other and with other stakeholders to share lessons learned and best practices specific to geographic areas, patient populations, provider types, and practice settings. The communication grants were designed to create strategic communication efforts to disseminate information on provider training and engagement opportunities.

In a second round of grants, ACEs Aware provided funding for Network of Care grants which were designed to create connections between medical assistance providers, social service systems, and community partners to assure that toxic stress in children and adults is addressed properly through clinical and community interventions following an ACE screening, to prevent future ACEs, toxic stress, and intergenerational transmission, and prevent or assist in treating

ACEs Associated Health Conditions (AAHCs). These grants were divided into planning and implementation grants.

In addition to the grants, ACEs Aware invested in provider engagement through monthly webinars and external stakeholder engagement. The monthly webinar promoted ongoing practice improvement and clinical implementation learnings among California providers. The external stakeholder engagement occurred through the Trauma-Informed Primary Care Implementation Advisory Committee (TIPC). The TIPC advises ACEs Aware on promising models, best practices, clinical systems, policy expertise, strategic insights, and the latest science. The TIPC created subcommittees to address specific goals of the TIPC.

Finally, ACEs Aware coordinated with managed care plans (MCPs) to enlist their partnership in engaging providers in screening for ACEs and toxic stress.

The third phase of California's ACEs Aware program is quality improvement. The main mechanism is the California ACEs Learning and Quality Improvement Collaborative (CALQIC) which will generate both qualitative and quantitative data on best practices in ACEs screening and response from 53 clinics in seven California regions over 18 months.

The 53 learning collaborative clinics were provided with virtual coaching and technical assistance, grants, and virtual site visits to exemplary organizations. The clinics will integrate equity and patient/community voice into all aspects and activities of the project team, participating clinicians will be trained, and best practices for the training of health care providers will be developed. Finally, the QI team will be collecting data to identify and respond to any potential adverse events associated with ACEs screening.

C. ACEs Aware Workgroup ~ Initial Assessment of California ACEs Aware Program

Certain themes have remained consistent throughout the conversations of the ACEs Aware Workgroup. The group believes that training providers will be beneficial in Maryland, especially if accredited CME/CEUs can be provided. This training should be broader than simply explaining an assessment tool but rather include a coaching model or in some way enable providers to play this new role competently. The group believes that enabling providers to receive third-party reimbursement for the additional time that it will take to conduct assessment thoroughly will be crucial. This partnership with Maryland Medicaid and potentially other managed care organizations (MCOs) will prove to be pivotal moving forward. The Workgroup is encouraged by California's community involvement model and the partnership with the Frameworks Institute for public awareness. Incorporation of the community, and specifically that of individuals with lived experiences, assures that the program remains vital and responsive to the needs of those it serves. Public awareness strategies employed by the Frameworks Institute

are the model that the Commission's Public Awareness Workgroup feel will be most beneficial in Maryland.

The ACEs Aware Workgroup has concerns about utilizing the ACEs tool as an assessment tool as it was never intended to be utilized in this way. The original ACEs study was an epidemiological study designed to look at ACEs across a population. The ACEs survey can assist a provider in understanding an individual's history, however, it is not a diagnostic tool. Although the Workgroup is not opposed to an assessment in general, it is looking at other assessment tools, such as the PEARLS tool (currently used in California) and other tools that look at ACEs in addition to social determinants of health, positive childhood experiences, and resiliency.

The Workgroup has consistently expressed concerns about beginning a program of assessment when Maryland is lacking resources to treat the extent of trauma in its community. The Workgroup is interested in working with the Operational Implementation and Technical Assistance Workgroup to assure that this need is being addressed. The group is also conducting a survey to assess the level of services that currently exist in communities statewide. Additionally, the group has expressed the critical need for the continued allocation of resources to support both the assessment and the implementation of the program.

Finally, the Workgroup wants to ensure that a program created for Maryland has an element of prevention, not just identification and treatment. Ideally, the program will reach children, families, and communities in a way that prevents ACEs from occurring in children's lives. The Workgroup wants to target efforts at prevention in state agencies and communities.

The ACEs Aware Workgroup has created a template to use to assess the California ACEs Aware Program and other evidence-based programs. This template includes information about the components of the program, to include its strengths, limitations, and recommendations for utilization in Maryland. The table is included in Appendix 2. *It is important to note that, at the time this report was submitted, the information in the table captured individual workgroup members' thoughts and not a group consensus decision.*

D. ACEs Aware Workgroup ~ Survey to Assess the Current Statewide Efforts

As the ACEs Aware Workgroup began their assessment of the ACEs Aware model, members wanted to better understand what is currently occurring at the local level in Maryland to educate the community about ACEs, to screen for ACEs/resilience, and to respond to ACEs. The Workgroup felt this information would be important to gauge Maryland's readiness for an ACEs Aware program. For this reason, the Workgroup distributed a survey to Local Behavioral Health Authorities, Local Management Boards, and community stakeholders to assess the current statewide efforts, based on the following requested items:

1. Name of person completing the form

2. Name of organization
3. What jurisdiction are you reporting on?
4. Are there any initiatives or efforts that you are aware of in your jurisdiction that conduct screenings and/or assessments for Adverse Childhood Experiences (ACEs), trauma? Please list and describe with contact information.
5. Are there any initiatives or efforts that you are aware of in your jurisdiction that conduct screenings and/or assessments for resiliency? Please list and describe with contact information.
6. Are there any programs/workgroups/coalitions that specifically address trauma, trauma-informed care, or secondary trauma in your community? With children? With adults? With families? With communities?
7. Are there individuals you would consider an expert in this area in your community? Please provide name(s) and contact information.
8. Are you aware of any grants or other funding streams that organizations in your community have applied for/received to fund trauma-informed care, ACEs, or resiliency work? If so, please describe.
9. If you have anyone else you would like this Workgroup or the Commission on Trauma-Informed Care to know, please feel free to let us know here.

At the time this report was submitted, 22 surveys were completed representing nine Maryland jurisdictions. The survey results will be shared with the other workgroups to inform other work of the Commission. Please refer to Appendix 3 for the survey results which include the submitted responses.

E. ACEs Aware Workgroup ~ Next Steps

The ACEs Aware Workgroup has developed a list of questions and will request a representative from the California ACEs Aware program to attend an upcoming meeting to address these questions. Examples of these questions include:

- What changes have been made from the original design? Why were the changes made and what was the result of those changes?
- What would you consider the primary successes and lessons learned thus far in the California program?
- What were the main objections to the program from government agencies, providers, and the community? How were these objections addressed?
- Have protective factors or resiliency been added into the model and if so how has that impacted the results?
- Do you have any initial data analysis to report at this time? Are you studying neurotoxicity in patients?

- California is diverse and large; how have you implemented this program in diverse rural and urban settings?
- How was your budget created for each stage of the project and would you be willing to share the budget?

Once the requested information is received, the Workgroup will finalize its assessment of the California program and then begin investigating other evidence-based models in Maryland and in other states. The Workgroup has an initial list of programs/models to review but is continuing to formulate a complete list of similar programs. Two of such programs include the Safe Environment for Every Kid (SEEK) model of primary care and the Child Health Assessment and Monitoring Program (CHAMP).

The ACEs Aware Workgroup is committed to partnering with State agencies and other workgroups of the Commission in the creation of an ACEs Aware program for Maryland. The Workgroup is communicating with these entities and will have representation from each on the Workgroup moving forward. In addition, the group continues to reach out to pediatricians and other providers and community representatives to assure that the Workgroup has a diverse representation of stakeholders and partners.

Maryland Department of Human Services

Through the Integrated Practice Model, the Department of Human Services (DHS) Social Service Administration's (SSA) vision is to transform the social service system in partnership with public agencies, private agencies, courts, and community partners, so that the children, youth, families, and vulnerable adults are:

- Safe and free from maltreatment;
- Living in safe, supportive, and stable families where they can grow and thrive;
- Healthy and resilient with lasting family connections;
- Able to access a full array of high-quality services and supports that are designed to meet their needs; and
- Partnered with safe, engaged, and well-prepared professionals that effectively collaborate with individuals and families to achieve positive and lasting results.

DHS/SSA's ongoing strategies for accomplishing these goals are to:

- Promote safe, reliable, and effective practice through a strength-based, trauma-responsive practice model for child welfare and adult services.
- Engage in a collaborative assessment process that is trauma-informed, culturally responsive, and inclusive of formal and informal family and community partners.
- Expand and align the array of services, resources, and evidence-based interventions available across child welfare and adult services based upon the assessed needs of

children, families, and vulnerable adults, to include additional resources aimed at preventing maltreatment and unnecessary out-of-home placements.
- Invest in a safe, engaged, and well-prepared professional workforce through training and other professional development including strong supervision and coaching.
- Modernize DHS/SSA's information technology to ensure timely access to data and greater focus on agency, individual, and family outcomes.
- Strengthen the State and local continuous quality improvement processes by creating useful data resources to monitor performance, using evidence to develop performance improvement strategies, and meaningfully engaging internal and external stakeholders.

Similar to the ACEs Aware Program in California, Maryland is committed to continued partnerships between DHS/SSA and providers and community partners. In the same way that California provided Network of Care grants, Maryland could benefit from funding to build relationships between Maryland Medicaid providers and public and private community partners to assure that toxic stress in children and adults is addressed properly through clinical and community interventions following an ACE screening, to prevent future ACEs, toxic stress, and intergenerational transmission, and prevent or assist in treating ACEs Associated Health Conditions (AAHCs).

Moving forward, the Child Welfare Medical Director at DHS will be invited to the ACEs Aware Workgroup meetings to assure that DHS involvement is built into the ACEs Aware program plan for Maryland from the beginning.

Maryland Health Care Commission

The Maryland Health Care Commission (MHCC) is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability and improve access in a rapidly changing healthcare environment by providing timely and accurate information on availability, cost and quality of services to policy makers, purchasers, providers and the public. The MHCC will work with the ACEs Aware Workgroup to create a plan for Maryland and will provide data, specifically data related to social determinants of health, that will inform decisions moving forward. Moving forward, the Director of Policy Development and External Affairs will attend the ACEs Aware Workgroup meetings to ensure that MHCC involvement is built into the ACEs Aware program plan for Maryland from the beginning.

II. Establish Training and An Accreditation Process

The Commission on Trauma-Informed Care will propose a process to establish training and an accreditation process for providers in the program. The ACEs Aware Workgroup agreed that training providers is a vital element that must be included in a program plan for Maryland. The

Workgroup is looking to the Maryland Department of Health (MDH), the Training Workgroup, the Core Values and Definitions Workgroup, and the Metrics and Assessment Workgroup to develop the specifics of Maryland's training program. Additionally, in researching accredited training for physicians, the ACEs Aware Workgroup reached out to MedChi as a potential partner. If the Workgroup expands this training to include providers in other professions, the accredited training process will be different. The Workgroup will continue to research this as the program develops further.

Maryland Department of Health: MDH implemented the "Behavioral Health ACEs Data To Action, Training and Technical Assistance Initiative." The purpose of this initiative is to enhance awareness of ACEs and adoption of trauma-informed practices in the State with a focus on the Maryland Public Behavioral Health System (PBHS). Supported by American Rescue Plan Act (ARPA) funding, the proposed work is intended to align with and support the deliverables outlined in the Governor's executive order on ACEs and the Governor's Commission on Trauma-Informed Care. The program of work will provide essential ACEs data surveillance, training, technical assistance, and quality monitoring services to support the adoption of trauma-informed policies and practices and the transition of the PBHS to a fully trauma-informed system of care. MDH/Behavioral Health Administration (BHA) issued an Inter-Agency Agreement (IA) Request for Proposals (RFP) in January 2022, to solicit proposals and select a vendor to perform the work. The contract was finalized in August 2022, and the University of Maryland, School of Medicine was selected to perform this work. Since this time, the University of Maryland team has begun participating on each of the workgroups of the Commission and attended the Commission's Visioning Retreat.

The proposed work includes three core activity areas:

1. ACEs data collection, analysis, and data to action activities to increase awareness of ACEs and trauma-informed approaches to service delivery among State and local behavioral health partners;
2. Identification and implementation of a trauma-informed organizational assessment tool and continuous improvement/technical assistance process for use within MDH-BHA, local behavioral health partners, and PBHS providers ; and
3. Selection, adaptation, and implementation of a trauma-informed training curriculum targeted to PBHS behavioral health partners and providers and implemented statewide.

MDH, in partnership with the University of Maryland is currently working on all three core activities in collaboration with the workgroups of the Commission. While the primary focus of the University's work under this contract is targeted to PBHS behavioral health partners and providers, the University and MDH are open to expanding the focus, where feasible to meet the

needs of the Commission's goals as well. In partnership with the workgroups listed below, the University and MDH will work to develop a program for Maryland.

Training Workgroup: This workgroup, chaired by Ms. Amie Myrick and Ms. Janice Goldwater, has met monthly to discuss training curricula and topics to be included in trauma-informed care training. The group will review the curricula and training information submitted with the agency reports, and partner with MDH and the University of Maryland around trauma-informed care training. In the same way, once the ACEs Aware Workgroup has decided on the foundational elements of the program for Maryland, the Training Workgroup will work with the ACEs Aware Workgroup to create training for providers.

Definitions & Core Values Workgroup: The workgroup, chaired by Cherry Price, has met multiple times and gathered definitions of national organizations for specific terms identified by the Commission and the workgroup. The workgroup has also reviewed the definitions submitted within the agency reports. Following the Commission's Visioning Retreat, the workgroup is developing a set of unified definitions to be reviewed by the Commission and recommended for use across state agencies. These definitions will be utilized in the work of the ACEs Aware Workgroup as well in the creation of Maryland's program.

Metrics & Assessment Workgroup: The workgroup, chaired by Kay Conners and Margo Candelaria, meets monthly. The group was blended with the State ACEs Data Committee, chaired by Dr. James Yoe, Ph.D., at MDH, which started its work as a part of the National Governors Association (NGA) Learning Collaborative. The two groups aligned goals and outcomes and were able to assemble a database of assessment tools, materials, and recommendations for the Commission. As the work of the ACEs Aware Workgroup moves forward, and begins considering specific assessment tools, the partnership with the experts in the Metrics and Assessment Workgroup will be crucial.

Accredited Training Partnership: The ACEs Aware Workgroup is committed to assuring that CME/CEUs are provided with any training for providers. In a meeting with MedChi, an accredited provider of CMEs in Maryland, it was determined that physicians are required to renew their medical license every two years and during those two years are expected to accumulate 50 CMEs to maintain their license. These CMEs must be achieved by attending training that is conducted in partnership with an accredited provider such as MedChi, University of Maryland, Johns Hopkins University, etc. In order for a training to qualify for CMEs, it must comply with the requirements set by the American Medical Association (AMA) and the Accreditation Council for Continuing Medical Education (ACCME), to include: 1) meet a need and/or fill a gap/problem in practice; 2) utilize adult learning practices; 3) be conducted by trainer/speaker that is a subject matter expert; 4) include an evaluation that accurately assesses

the learning of the subject matter covered in the training; and 5) be free of commercial bias or influence.

While it may be important to train providers with different professional certifications, CMEs typically are the most difficult to receive approval. Once the Workgroup has created a full training, and the audiences have been established, the CEU applications for all professions targeted will be completed.

III. Explore the Possibility of Third-Party Reimbursement

On July 14, 2010, the Departments of Health and Human Services, Labor, and the Treasury issued new regulations, building on the Affordable Care Act, requiring private health plans to cover evidence-based preventive services and to eliminate cost-sharing for preventive care.[4] "For new health policies beginning on or after September 23, 2010, preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, co-insurance or deductible for these services when they are delivered by a network provider."[5]

Maryland should follow California's lead and take advantage of this opportunity to leverage the child and adult well visit benefit in both Medicaid, Medicare and private insurance. Since all health plans are required by law to provide services aligned with Bright Futures Guidelines, this makes this a high leverage opportunity. The goal would be to utilize an evidence-based approach to conduct whole child/whole family assessments (whichever the Workgroup and Commission decides is most appropriate) that build trust and partnership between providers and children/families.

In an effort to explore the possibility of third-party reimbursement, including the State Medical Assistance program, for screenings under the program, the ACEs Aware Workgroup reached out to MDH, Maryland Medical Assistance (Medicaid). Maryland Medicaid currently reimburses, or is planning to reimburse, for services in multiple maternal and child health (MCH) programs. While these programs are not specifically focused on ACEs screenings, they address ACEs by supporting both parents and children in all aspects of health. The three MCH programs outlined below aim to prevent and/or address adverse childhood experiences.

1. **Healthy Steps**, a program of ZERO TO THREE, is a pediatric primary care model that promotes positive parenting and health development for babies and toddlers. Under the model, all children ages zero to three and their families are screened by a child

[4] U.S. Centers for Medicare & Medicaid Services. (2010). *Background: The Affordable Care Act's New Rules on Preventive Care*. Retrieved from https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background.
[5] Ibid.

development expert, serving in the role of the Healthy Steps Specialist, and placed into a tiered model of services of risk-stratified supports.

2. **Home Visiting Services (HVS**) in early childhood was established in January 2022, and is a statewide benefit for Medicaid beneficiaries, including the Healthy Families America (HFA) and Nurse Family Partnership (NFP) models. Both models employ specific developmental and depression screenings and have an established track record of improving the health and well-being of both the birthing parent and the child.
3. **Maternal Opioid Misuse (MOM) Model** was launched in January 2020. This multi-prong approach aims to improve maternal and infant health outcomes through a number of targeted initiatives. While the focus of the intervention is on the parent, the MOM intake process incorporates a variety of screenings. The health-related social needs assessment includes questions related to safety. While there is no ACEs specific screening conducted, a variety of questions are related to ACEs and toxic stress, predominantly regarding abuse.

The federally required **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program** benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The comprehensive benefit aims to ensure that children receive critical screening, preventative services, and treatment services to prevent future medical issues. Program components include preventative, dental, mental health, and developmental services, as well as other speciality services. In Maryland, the preventative care component of the EPSDT program is known as the Healthy Kids Program.

The Maryland Medicaid program does not currently reimburse providers for ACEs screenings. To implement coverage for this benefit for both children and adults, a budget initiative would be required. In addition, Maryland would need to amend its State plan and regulations, as well as incorporate the benefit into the HealthChoice managed care organization rate setting process. System changes would also be required to allow accredited/credentialed providers to bill Medicaid for the ACEs screening. The complete description of Maryland Medicaid ACEs Related Reimbursement is included in Appendix 4.

IV. Implementation of the Program

The Commission is still in the process of studying the ACEs Aware program and developing a framework for implementing an ACEs Aware program in Maryland. The Commission is not prepared to implement a program at this time.

Operational Implementation & Technical Assistance Workgroup: This workgroup, chaired by Elizabeth Guroff, Inga James, and Michael Sinclair, has met several times. The workgroup created *The Maryland Way: Trauma-Informed, Resilience-Oriented, Equitable Care and Culture*

(TIROE), a document which is adapted from the Principles of Trauma-Informed Care and 10 Implementation Domains offered by SAMHSA.[6] The workgroup presented this document to the Commission for consideration. The Commission provided comments to be incorporated and will vote on the final document at the September 15, 2022 meeting. Once the ACEs Aware Workgroup is prepared to begin planning for implementation and technical assistance of Maryland's program, the Operational Implementation & Technical Assistance Workgroup will partner with them. The draft of this document being voted on is included in Appendix 5.

Public Awareness Workgroup: This workgroup, chaired by Ulysses Archie, Jr., has met monthly to discuss components of an effective communications strategy to support an organizational culture shift into a trauma-responsive government. This workgroup has identified and begun to examine jurisdictional examples of the use of a two-science approach, applying communication science to the science underlying trauma (neurobiology, epigenetics, ACEs/trauma, resilience). Additionally, the workgroup has begun to examine what messages might be the most effective. As the ACEs Aware Workgroup begins to think about raising public awareness regarding Maryland's program, the Public Awareness Workgroup will assist in creating and communicating messages to providers and then the community.

V. Findings and Recommendations

At this time, the Commission is not prepared to make recommendations regarding the implementation of an ACEs Aware program in Maryland. The ACEs Aware Workgroup is diligently working to investigate this matter and propose recommendations to the Commission. One theme that remains consistent in all the research thus far is the need for significant funding to implement a program similar to the ACEs Aware Program in California.

In reviewing the surgeon general's report, it is evident that California's program required incredible investment from the state. The report does not include a budget for the first phase in which the provider training and Medicaid reimbursement occurred, but it is certain that it required an initial financial investment. The report does state that in phase two, $14.3 million in grants were provided. A second round of grants were distributed up to $30 million in Network of Care Grants. The final stage consisted of a partnership between the state, a university, and a private corporation so it is unclear what the financial commitment of the state was; however, considering the extent of an 18 month project providing training and technical assistance and conducting intense evaluation of 53 community clinics, the budget is presumed to be extensive.

[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf.

Provider Training

Similar to the California program, Maryland is committed to providing quality training to providers. In order to provide such training, the Commission will require financial resources. While the Commission and the community members working diligently on the workgroups are passionate and willingly donating their time to this work, the extent of this task will require hiring a contractor or providing community grants to provide training on this scale.

Third-Party Reimbursement for Medicaid Providers

Similar to the program in California, Maryland will need to include third-party reimbursement for providers providing assessments. In order to implement coverage for this benefit for both children and adults, a budget initiative would be required. In addition, Maryland will need to amend its State plan and regulations, as well as incorporate the benefit into the HealthChoice managed care organization rate setting process. System changes would also be required to allow accredited/credentialed providers to bill Medicaid for the ACEs screening.

Network of Care Investment

Similar to the program in California, Maryland is committed to continued partnerships between DHS/SSA and providers and community partners. In the same way that California provided Network of Care grants, Maryland will benefit from funding to build relationships between Maryland Medicaid providers, local social service systems, and community partners to assure that toxic stress in children and adults is addressed properly through clinical and community interventions following an ACE screening, to prevent future ACEs, toxic stress, and intergenerational transmission, and prevent or assist in treating ACEs Associated Health Conditions (AAHCs).

Conclusion

In accordance with Chapters 722 and 723 of 2021, the Commission will continue to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults; and report its findings and recommendations to the Governor and the General Assembly by October 1 of each year, as it relates to the development and implementation of the ACEs Aware program in Maryland.

Appendix 1: ACEs Aware Workgroup Meeting Minutes

March 14, 2022

In attendance:

Chalarra Sessoms
Diane King-Shaw
Heather Hanline
Michele Solloway
Jessica Lertora
Jennifer Martinez
Stephanie Freeman
Tracey Friedlander
Malcom Augustine
Dara Feldman
Heather McQuay
Jennifer Long
David Brown
Carrier Freshour
Roberta Koomson
Troy Biermann
Jennifer Long
Amie Myrick
Kirsten Robb-McGrath
Doncella Wilson - Minary's Dream Alliance
Erica Waskey
Tiffany Tatem

Discussion Items:

- Workgroup review of legislation ~
    - Study to develop process and framework to implement an ACE Aware program across the state
    - Purpose of program - screen for ACEs and toxic stress
    - Evidence-based interventions
    - ACEs Aware Report ~ October 1 deadline each year
    - March 31 - agency report to commission
    - Commission report to general assembly due June 30
- Carrie - co-chair, Christine as main admin support
- Workgroup Representation ~ Pediatrician representative? Senator Augustine - wants to do a profiling for the workgroup to make sure all appropriate stakeholders are representative
- Meet monthly? - put a doodle poll together for the next meeting, recurring calendar invite
    - Mondays at 10 good for Carrie, not third week
- How do we intersect with the other Workgroups?
- What is our end product and how do we get there?
- ACE Aware - California
    - Nadine Burke Harris
    - Healthcare providers understand ACE fundamentals
    - Benefits of ACE screening (proceed with caution)
    - Link children/adults with most appropriate treatment - need enough providers and services to do this though
- Prioritize target groups - strategy?
- Equity! Circle back to core values workgroup
- Meet people where they want to go not where we think they need to be
- Can't talk about trauma without giving concrete ways to address it in the same conversation
- Need to offer skills for dealing with the activation that comes from talking about trauma

- Connections to implementation and public awareness workgroups

Next Steps:
- Identify next steps
- Start with guiding principles that could guide conversation (framework)
- Have to stay consistent with the legislation
- Document sharing - homework
- Reading the same info and coming back together
- Creating a "parking lot" if things don't necessarily fit we don't lose sight
- Send materials - document sharing, google drive
- Send link to drive

March 30, 2022

In attendance:
Kelly Gorman
Christina Drushel-Williams
Christine Fogle
Carrie Freshour

Discussion Items:
Carrie Freshour has accepted the role of Chair for the ACE Aware Workgroup. She met with Christina, Kelly, and Christi to discuss the purpose of the workgroup, the role of the chair and the direction for the workgroup.

The committee will be having their first meeting on April 18, 2022 at 10 am.

Next Steps:
In preparation, the Chair has sent out a brief form questionnaire to workgroup members with the goals of assuring all pertinent players are at the table and to create direction for the first meeting.

April 18, 2022

In attendance:
Carrie Freshour ~ Chair
Christi Fogle ~ Staff
Christina Drushel~ Williams ~Staff
Kirsten Robb-McGrath
Jessica Lertora
Lisa Dominguez
Joyce Harrison
Veronica Land-Davis
Doncella Wilson
Katelyn Kirby
Katie Speert
Amie Myrick
Claudia Remington
Roberta Koomson

Welcome and Introductions
New members:
- Joyce, Psychiatrist with Young children and trauma-related.
- Veronica -Roberta's House Grief lens youth children.

- Lisa - adoption lens. State and how to integrate without strength

Updates

ACEs AWARE Report due to Governor and General Assembly on October 1, 2022

Results of the questionnaire and filling the gaps

- Claudia and Joyce will help link to pediatricians
- Deb Badowi- is on the commission and is Developmental Pediatrician (or resident)
- Recommendations: Dr. Lamonico, Pilar Olivo (perhaps to consult) Howard Dubowitz (SEEK)

Discussion Items:

Draft Purpose Statement

> This workgroup aims to study the ACE Aware California program and evaluate it as a potential model to be replicated in whole or in part in Maryland. The workgroup will research other states that participate in ACE-Aware, other programs models or options for screening, and the budgetary requirements needed to establish and implement an ACE aware or other program models that screen for ACES and toxic stress to provide evidence-based treatment to support individual and family health and reduce health care costs in Maryland.

Approach to action

- David Brown - make sure we are using resilience tools and strengths
- Dr. Dubowitz article
- Research, process, implementation
- Increase access to support and services and better mental health outcomes
- Look at the Pilar O… (see chat) program
- CHAMPS and SEEK model

Next Steps ~ Action Items

- Invite individuals to fill the gaps
- Invite speaker to present from RE:ACEs AWARE program in CA Challenges, Concerns,k Successes (Christina Bethel ?)
- Review Peds article sent for review
- Review purpose statement and be prepared to finalize wordsmithing
- Future meetings 3rd Monday from 10-11 (May 16th, June 20th, July 25th, August 15th, September 19th, October 17th)

Parking LOT

Concerns with the approach- make sure to incorporate what does not work and look at the articles that do a review and detail all pros cons (SEEK, CHAMP, Wyoming, NJ position statement, Robert Anda,

Resilience Measures

Metrics - Age appropriate tools

May 16, 2022

In attendance:

Carrie Freshour
Christine Fogle
Stephanie Freeman
Lisa Dominguez
Dara Feldman
Jennifer Martinez
Chalarra Sessoms
Jessica Lertora
Ulysses Archie
Kaeshawn Stewart
Amie Myrick
Tiffany Tatem

Discussion Items:

Rewriting Purpose Statement for Workgroup

> The purpose of this workgroup is to study the ACE Aware California program and evaluate it as a potential model to be replicated [in whole or part] in Maryland. Ensuring the recommended model includes resources, treatment, and support that are both evidence-based and cost-effective, supporting individual and family health in Maryland. To achieve this, the workgroup will: 1) Review the original ACEs study for context and history; 2) Research other states that participate in ACE-Aware; 3) Research SEEK and other EBP and models that meet the intended purpose; and 4) Assessing the budgetary requirements needed to establish and implement a program model that meets the intended needs by screening for ACEs and other toxic stress.

Review membership suggestions/invites

> Maryland Behavioral Health Integration in Pediatric Primary Care. They field calls from pediatricians to assess and support mental health needs of their patients. https://mdbhipp.org/

Discuss Peds article -

Brainstorm possible speakers

- Invitation to Dr. Howard Dubowitz on June 20 at 10:00 AM
- Delegate speaker invites

Next Steps:

Create survey & distribute to Local Behavioral Health Authorities and Local Management Boards to gather information about resources that currently exist at the local level

June 20, 2022

In attendance:

Carrie Freshour
Camillia Whitehead
Malcolm Augustine
Katelyn Kirby
Katie Speert
Claudia Remington
Ulysess Archie
Christine Fogle

Presentation/Guest Speaker:
Howard is a professor at the U of MD SOM, and the Division Head of Child Protective Services, where I first met him 12 years ago. He is here to talk with us today about the recently published article we have been reviewing: https://drive.google.com/file/d/1ZK5Da_stOVbGbuHxyYBrYTbC7Zo0VRKW/view
www.Seekwellbeing.org

Howard Dubowitz: ***Addressing Adverse Childhood Experiences in Primary Care: Challenges and Considerations***

- The state of the science
- What we know and what is still unclear regarding identifying ACEs
- Recommendations for practice
- Q & A

Questions/Discussion Items:

- Don't ask a question unless it will benefit the client/patient
- Group feels irresponsible beginning assessment because MD is lacking in treatment resources
- Training not just to complete assessment but to play role competently
- What treatment plans are being evaluated
- Group reminded to remain open-minded when reviewing ACEs Aware
- ACEs assessment not intended to be diagnostic tool but rather provide data for population/community and perhaps learn individual history

Next Steps:

- Reading and Review of current library of articles
- Vision Planning Retreat July 28th
- Delegate speaker invites
- Plan next steps

August 15, 2022

In attendance:
Carrie Freshour
Chalarra Sessoms
Christine Fogle
Dave Brown
Katie Speert
Kirsten Robb-McGrath
Lisa Dominguez
Malcolm Augustine
Stephanie Freeman
Ulysses Archie
Veronica Land-Davis

Discussion:
Reading surgeon general approach detailed in that document

Strengths- what do you like about the model?

1. Layout overall good of implementation - Framework
2. Community asking for the community to be involved and public awareness committee**
3. Video for education and therapist grounding and safety and toxic stress, emotional regulation, etc. Information is good
4. PEARLS as a tool
5. Link with funding for Medicaid and utilization as an assessment tool**
6. Medicaid code- more buy-in if Medicaid funding**
7. Community involvement
8. People served voices involved
9. Community- Provider- Different catches of people
10. Videos and tools
11. Allocation of resources
12. Clear to find information on certified core training- Easy navigate
    a. Training Observation- Coaching afterward and application. Re-certification. *Tennessee model reference*
13. Three-phase approach- Targeted providers first, Relationship connections in Phase 2, and Data-driven phase 3 to look at university-based data collection services.
14. Wraparound care
15. Training conceptual and screening and interaction in TI - Algorithms of trauma and resonance and health impacts of trauma combined. TA provided
16. Government funding and grants process: Provider engagement grants/ Implementations/ building relationships with other agencies (i.e., DSS and Trauma providers to connect relationships)
17. 53 In-community Clinics seem like an impressive
18. Medicaid Assessment and health conditions treated as a result of toxic stress are also paid. Other 3rd pArty coverage.
19. CEUs / CMEs provided

Drawbacks/Opposition- what do you not like about the model?

1. Concerns about training and implementation and ensuring we are connecting with our colleagues
2. Commitment -willingness and financing from the state/ government
3. Concerns that we start and do not have the resources or commitment to the follow-up, treatment, and healing
4. Concern about the stigma attached once identified as an indicator, not another stigma for the score.
5. Capacity building
6. How are you looking at (screening for) protective and resilience factors
7. Resources building for prevention to prevent ACES

What remaining questions do we have [for contributors or about the development or implementation of the model]?

1. What would you see as what went wrong or has not gone as anticipated in California?
2. How has the original design changed from origination, and why did it change? What is the result of those changes?
3. How did you come up with a budget?
4. How have resources and capacity been built once ACES have been identified as an indicator?
5. What were the main objections to the program? And how were they addressed Various stakeholders From the Government Agencies/ Providers and Community?

6. How did you look at prevention infrastructures to midgate the ACES to begin with? Is that considered in the California model?
7. Were protective factors and/or resiliency added into the model?
8. Any data analysis? Neurotoxicity and other data elements in the science?
9. California is diverse and large; how do you implement it in diverse rural and urban settings?

What is missing [that would need to be included in any model we choose or develop]?

1. As we get to recommendations, what groups are already doing the work and are they all speaking the same language? How are we connecting those efforts?
2. Funding trainers and ongoing re-certifications and training the trainer programs. Many are volunteers. Is there consistency in training and offering across the state?
3. Integrating that into the ACE aware framework. The old way of training triggered people.

Other Questions and Concerns, in General, for Maryland Commission: What does that mean if we start with the state government? They are people, too. In community.

ACEs Survey sent to LMBs and Local Behavioral Health

Appendix 2: California ACEs Aware Program Components Assessment Table

ACEs Aware Component	Strengths	Limitations	Recommendations
California's ACEs Aware Components			
Phase ONE ~ Training Providers			
Accredited training for providers (CME's CEUs, etc.) on screening for trauma & recognizing and responding to toxic stress.	~ Trainings about trauma-informed care, vicarious trauma, importance of equity, core ACE training ~ Essential to ensure understanding of the relevance to health and best practices ~ Free Training ~ 2 hours ~ Counts towards CMEs, MOCs ~ Motivates providers to do the training	~ Providers only need to take one of these trainings. ~ It's a little confusing as to which trainings they should take and which are optional? Would be curious if they have data on how many providers went above and beyond the one training. ~ Any training not set in a real life context is limiting. Only screening for ACEs is not likely or recommended. Trainings should focus on how it fits in the flow of broader care and is evaluated in consideration of other data, including positive health, resilience and protective factors. ~ Costs, need an institutional sponsor	~Combine some of these topics into one training series that is a bit more comprehensive. ~ Maryland should offer a free training to providers as well ~ Yes to accreditation
Assessment tool that assesses ACEs and toxic stress. Adapted to utilize Pediatric ACEs and Related Life-Events Screener (PEARLS) tool.	~ Like the community-level questions ~ Tools at every age level ~ The PEARLS assessment has two parts and screens for additional adversities ~ Good to have a tool to recommend.	~ Some of the wording could use work and many of the questions are more complicated than just a yes/no answer. ~ Too many tools can lead to confusion on which to use when ~ Other options should be offered and also integrated assessments. The Well Visit Planner is noted in the Roadmap report as a way to integrate ACEs with the broader well child visit content. I suggest there be recommendations that include an integrated approach. ~ Screening tools have limitations	~ Infuse a HOPE-based approach to these questions and include more SDoH information gathering. ~ Ideally remove the ACEs questions and replace with a validated trauma screener and more SDoH questions. ~ ~ Also collect more data on resilience and HOPE building blocks. ~ Have an array of tools available

ACEs and toxic stress algorithm for pediatrics and adults. Algorithm combines presence of ACEs with presence of health conditions associated with toxic stress.	~ Algorithm is a good way to break down the screening process. ~ The clinical response piece – like that it specifies that the response is to toxic stress (not ACEs specifically – this broadens the scope) Algorithms are important.	~ Screening should not be ACEs focus. ~ ACEs Screening is not currently recommended. ~ No mention of social determinants of health (SDoH) or ACEs beyond the initial 10. ~ The algorithm might not consider positive factors and other elements like family/patient preference. I'd like to see how the algorithm has worked, what referrals are made and how successful they are. ~ Limited utility	~ Prefer to consider SDoH tools, parenting skills, and questions designed to build relationships and understand both strengths and challenges of parents/families ~ unnecessary
Medical Assistance 3rd party payment for screenings	~ The Billing and Payment section is very clear. ~ Buy in from providers if it is reimbursable ~ Yes to reimbursement	~ Not sure why coding is related to ACE score? ~ What about all other payers	~ Clarity as to where some of these questions and ideas can fit into already existing coding. ~ Maryland should strongly endorse reimbursement for screening ~ Work toward all payers reimbursing
Phase TWO ~ Strengthening Provider Engagement and Capacity			
Provider training grants: to help educate Medicaid providers on using screening for ACEs, AAHC, and protective factors; providing trauma-informed care, delivering evidence-based treatment plans to mitigate toxic stress, etc.	~ Appreciate the overall attention to these various issues and the opportunity for providers and organizations to decide where their needs are greatest. ~ Training is needed so providers/public have a good understanding of this program and its impacts. Grants to ensure training is delivered widely is huge!	~ A readiness assessment or needs assessment might help organizations identify their strengths and needs to better equip them to know which grants to apply for ~ Would like to see progress and lessons learned for these recommendations before assessing further. ~ I do think all trainings need to consider the specific broader context and use a "whole person/whole family" assessment approach.	~ Training is a critical component to ensuring that the system works properly, Maryland should consider grants to ensure training is disseminated widely. ~ Yes but where does the money come from? ~ Everything in this section is fantastic but enormous effort and funding is required.
Provider engagement grants: to increase clinical response networks, develop peer-to-peer engagement, enable broad based provider engagement, create papers highlighting best practices.			
Communications grants: to support strategic communications efforts.	~ Ensuring the public understands this program is key. The more people who know about it, the more it will be used.		~ Key to ensuring universal understanding

Network of Care grants: to create, augment and sustain formal connections between Medicaid providers, social services systems, and community partners to effectively address toxic stress.	~ Often in government there is a breakdown between agencies, I think this would be essential to keeping the program running smoothly between the cross-system entities.		
Frameworks Institute partnership: to work with all grantees to build capacity, offer technical support, and develop consistent and effective messaging on ACEs and toxic stress grounded in science.	~ Key to ensuring universal understanding/practice		
Provider engagement monthly webinars: to promote ongoing practice improvement and clinical implementation.	~ Like the message here – that all learning is ongoing and new information is being revealed all the time. Ongoing learning in this topic is important. ~ Key for collaboration ~ Can reduce provider burnout as they can discuss "difficult" cases	~ I think overall, a lot of teams are starting to feel burnt out from webinars.	~ Opportunity for in person connections.
Provider engagement ~ external stakeholder engagement: created Trauma-Informed Primary Care Implementation Advisory Committee (TIPC) to advise program leaders on promising models, best practices, clinical systems, and policy expertise, strategic insights, and latest science for optimal implementation in CA.	~ Really like the ease with which I was able to find the minutes, the members, etc for each meeting. Doing some good surveying on which ACEs Aware communications channels are being utilized. A lot of considerations for clinicians and educators. ~ Helps keep Maryland leadership aware of program implementation from providers who are actually using the tool ~ If the state implements an adult tool we should consider having adults who have been screened by the tool at the table to share their personal experience with it. Can help us understand that lived experience piece and modify if needed.	~ A lot of moving parts and a lot of information, particularly when not accompanied by recording.	~ Early on, narrowed focus to keep initiative from being too big to manage or follow. ~ Ensures state leadership (Maryland Surgeon General) is aware of program implementation from individuals actually using the tool

ACEs Aware managed care plan engagement strategy: coordinating with managed care plans to enlist their partnership in engaging providers in screening.			~ Ensures parity across insurance provider networks/systems (Medicaid, Medicare, Private Ins.)
Phase THREE ~ Quality Improvement (CA ACEs Learning and Quality Improvement Collaborative)			
18-month public-private learning collaborative of 53 clinics in 7 diverse CA regions.	~ Diverse infrastructure capacity; buy-in at multiple levels; encouragement of multiple workflows and flexible approaches. ~ Allows for innovation, learning and collaboration between state partners	~ Of the 14% of clinics that were not screening but the end, what happened? ~ Potentially seen as too long	~ Understand some of the challenges for those 14% in comparison to the capacity of the other 86%. How did ~ ~ 86% overcome barriers and challenges? ~ Strongly encourage Maryland replicates, huge learning and growth opportunity ~ See comment in above section—this would also require enormous effort and funding
Clinics receive virtual coaching, technical assistance, site visits to exemplary organizations and grants.	~ Training addressed all staff, not just providers; integrated EHR prompts were helpful. ~ Providing technical assistance to providers, a safe network for providers to grow during the implementation of this program	~ Equity piece seemed a little weaker than some of the others. Would like to know more about how equity was considered.	
Clinics participate in qualitative and quantitative evaluation activities.	~ I think this is a great idea. Ongoing focus groups, simple quantitative evaluation, and outcome measures.	~ Could be seen as too much administrative work	~ Leaning heavily on outcomes group to determine what is needed here.
Includes an intentional focus on adverse events encountered after ACE screening to test for speculated negative impact of screening.	~ Appreciated this part of the slides/results ~ Important to see the impacts of screening	~ Revealed some equity issues around language and non-parent caregivers. Many respondents did not receive an introduction or explanation, and results were not discussed. ~ Could be seen as too much administrative work	~ Complex reactions should be further explored.
Create trauma-informed practice and patient-centered medical home model			~ Strongly recommend

Encourage and teach self-care for healthcare staff working at clinics to reduce burnout, compassion fatigue, secondary and vicarious trauma.			~ Strongly recommend
Overall ACEs Aware Program Elements			
Large Financial Investment from State government	~ Financial backing from the state will add to buy-in from providers	~ Could be a hard sell in the legislature if there is a large fiscal note	~ While there may be a large fiscal note the legislature should see this as a long-term investment, where the money will be high at the implementation phase but over time there will be a reduction in more costly expenses such as unnecessary hospital stays, out of home placements, etc. ~ Would be essential, but would consider other funding sources i.e SAMHSA, HRSA
The Science of ACEs & Toxic Stress	~ Comprehensive, like the focus on the brain science/toxic stress part, the breakdown of developmental differences ~ Ensures that we aren't just screening about what is happening/ed but looking at the whole picture and future implications of ACEs	~ Only focuses on the brain impacts of negative events. Could be a place to discuss the impact of positives (attachment, belonging, emotion regulation etc) ~ Workflow for screen seems inappropriately placed under this section.	~ Include brain science on the positive ~ Include resources that pediatricians could use to educate parents ~ yes
Trauma Informed Care	~ Good, basic outline of TIC principles ~ Strengthens providers' understanding of trauma and how to better care for patients so as to not re-traumatize them.	~ No mention of focusing on strengths ~ Not a place for a mandated reporting list (that can go elsewhere)	~ Update to include MD's agreed upon approach (implementation workgroup) ~ yes
ACEs Associated Health Conditions (AAHC)			~ less priority for peds
Social Determinants of Health (SDOH)	~ Important to see trends and see how SDOH impacts ACEs ~ Can inform other programming that may benefit from implementing ACEs screening		~ yes

Health Equity	~ Like the idea of addressing stress and ACEs in all children and families in the state ~ Key to ensuring equal screening in differing communities	~ Lacking in comparison to other sections. ~ No thoughts on what increasing equity might look like in practice	~ This could be another place to talk about SDoH ~ yes
COVID-19 & Stress	~ Liked the ACES Aware self-care tool, mindful app, and appreciated resources for caregivers of adults with dementia. ~ Liked the guidance for policy.	~ Nothing jumps out, but of course this would have to look different for a program being developed now	~ Rename as something other than Stress (focus on positive – maybe Self-Care or Taking Care of You and Your Family) and focus on self-care in and out of pandemic situations ~ lower priority

Appendix 3: Survey Results

The ACEs Aware Workgroup created the following *ACEs Aware Survey to Assess Current Statewide Efforts*. The survey was sent to Local Behavioral Health Authorities (BHAs) and Local Management Boards (LMBs). The survey requested the following information:

1. Name of person completing the form
2. Name of organization
3. What jurisdiction are you reporting on?
4. Are there any initiatives or efforts that you are aware of in your jurisdiction that conduct screenings and/or assessments for Adverse Childhood Experiences (ACEs), trauma? Please list and describe with contact information.
5. Are there any initiatives or efforts that you are aware of in your jurisdiction that conduct screenings and/or assessments for resiliency? Please list and describe with contact information.
6. Are there programs/workgroups/coalitions that specifically address trauma, trauma-informed care, or secondary trauma in your community? With children? With adults? With families? With communities?
7. Are there individual(s) you would consider an expert in this area in your community? Please provide name(s) and contact information.
8. Are you aware of any grants or other funding streams that organizations in your community have applied for/received to fund trauma-informed care, ACEs, or resiliency work? If so, please describe
9. If you have anything else you would like this Workgroup or the Commission on Trauma-Informed Care to know, please feel free to let us know here.

At the time this report was submitted, the Workgroup received 22 responses (*as illustrated on the following pages*).[7]

[7] It is important to note that minor changes were made to the responses to show consistency; however, no substantial changes were made.

Results of the ACEs Aware Survey to Assess Current Statewide Efforts								
Name	**Organization**	**Jurisdiction**	**Initiatives/Efforts that Conduct Screenings and/or Assessments for ACEs**	**Initiatives/Efforts that Conduct Screenings and/or Assessments for Resiliency**	**Programs/Groups that Address Trauma in Community**	**Experts in Community**	**Funding Opportunities**	**Additional Information**
Jessica Lertora	ZERO TO THREE	Frederick County	Child Parent Psychotherapy mental health providers (Ellie Bentz at Dagenhart and Associates)	Unknown	ACES Workgroup (Pilar Olivo), FC Safe Babies Court Team (Jessica Lertora), Trauma Responsive Frederick (Rachel Mandel and Inga James)	Inga James, Jessica Lertora, Ellie Bentz, Rachel Harrison (Trauma Specialists of Maryland)	Frederick County Government, Local Health Improvement Plan, ZERO TO THREE, Department of Social Services, Health Department	
Kathleen Allen	Frederick County Public Schools	Frederick County Public Schools Early Childhood	Infants and Toddlers use the screening in Frederick County. FCPS is trauma informed and conducts professional learning for staff. The Judy center is actively involved with the ACEs Workgroup through FC.	Healthy Families Frederick	ACEs Local Health Improvement	Pilar Olivio, POlivo@FrederickcountyMD.gov		
Pat Rosensteel	Children of Incarcerated Parents Partnership	Frederick County	One pediatric practice is screening for ACEs. Frederick Pediatric Center, Dr. James Lee, (301) 882-7489	Unknown	Yes. Frederick County ACEs Workgroup (children), Frederick County Interagency Early Childhood Committee (children), Trauma Responsive Frederick (community level)	Pilar Olivo, ACEs Liaison for Frederick County Government, Polivo@frederickcounty.gov, (301) 471-3400; Dr. Rachel Mandel, Coordinator of Trauma Responsive Frederick, rachelmandelmd@gmail.com; Lynn Davis, Coordinator of Mental Health Services at Frederick County Public Schools, Lynndavis@fcps.org, (301) 644-5306	Frederick County Government (ARPA funds), Maryland State Department of Education	
Kelsey Wetherald	Concerted Care Group	Frederick Co.	Grants are provided by the county for trauma-informed care such as EMDR trainings provided by Trauma Specialists of MD and paid for by the health department and work groups; not aware of any county specific screenings.	Unknown	We have trauma work groups for professionals and then providers that work with the above listed groups individually	Dr. Rachel Mandel, Jamie Sedgwick and Rachel Harrison of Trauma Specialists of MD	Concerted Care Group received some grant funding to train a therapist in EMDR.	In this area there are very few Medicaid therapists that are legitimately trauma-informed or practice any form of evidence-based trauma treatment modalities.

Adrienne Mickler	Anne Arundel County Mental Health Agency	Anne Arundel County	Yes	Yes	Yes. Anne Arundel County Crisis Response System	Several do not have information at hand	Yes, however, I do not know full names, etc.	Convening a meeting with all the LBHA directors and explaining the purpose of this group and requesting data from interested parties in the jurisdictions would provide better information to report to the committee.
Genevieve Engleman MS, OTR/L	The Remote OT	Howard County	TheRemoteOT.com	TheRemoteOT.com	TheRemoteOT.com	Genevieve Engleman MS, CFWE, OTR/L TheRemoteOT.com	Unfortunately no but I would greatly appreciate any resources!	Thank you for all you do for those you serve!!
Jennifer Gauthier	Lead4Life, Inc.	Lower Eastern Shore	Yes, the local management board has contracted with an organization to conduct ACEs.	Yes, I am not sure the name but the local management board contracts out with them for the service.	I am not sure of any workgroups that are addressing trauma on the Lower Eastern Shore.	Local Management Board Tim Palmer	ACEs funding through the LMB.	N/A
Stephanie Freeman	St. Mary's County Health Department	St Mary's County	We conducted Academic Detailing sessions with local primary care providers, in which the providers agreed to ask general ACEs questions (i.e. how was your childhood, how was your relationship with your parents, etc). The providers were also provided a list of mental health professionals, were encouraged to use supportive language when speaking about trauma, and to create a treatment plan with their clients. Please note: providers were not asked to use the ACEs questionnaire, but to have a more general conversation about experienced trauma. POC: Stephanie Freeman, stephanie.freeman@maryland.gov, (240) 577-1391	The Mentoring Connections Program links youth with mentoring organizations around the county. Before and after the youth enters/completes the program, the youth completes a Child and Youth Resilience Measure (CYRM). POC: Stephanie Freeman, stephanie.freeman@maryland.gov, (240) 577-1391	The Healthy St Mary's Partnership is a local health improvement collation that supports 4 Action Teams: Violence, Injury, and Trauma (VIT), Behavioral Health (BHAT), Chronic Disease, and Environmental Health. The VIT Action Team works to address, prevent, educate, and mitigate the effects of violence, injury, and trauma, including but not limited to, ACEs, domestic violence, and community violence. The BHAT is also dedicated to improving behavioral health outcomes, including those related to mental health and substance use prevention and control. The action teams are open to the community, focusing on the entire St. Marys County population - children, families, adults, parents, etc. POCs: Jacquie Wells and Shan Chen, stmaryspartnership@gmail.com	Stephanie Freeman, ACEs Expert; Jennifer Martinez, ACEs Expert, jennifer.martinez@maryland.gov; Angela Cochran, Grant Expert, angela.cochran@maryland.gov; Tammy Loowe, Local Behavioral Health Authority, tammym.loewe@maryland.gov	In December 2020, the St Mary's County Health Department (SMCHD) was awarded the Comprehensive Community Approaches that Address Childhood Trauma to Prevent Substance Misuse (CCAPS) grant from the National Association of City and County Health Officials (NACCHO). This grant was used to create the Violence, Injury, and Trauma Unit which focused on the prevention, education, and mitigation of ACEs, connecting youth with caring adults, early childhood intervention, and education on the impacts of substance use on pregnancy to increase resilience in the St. Mary's County population. In May 2022, the SMCHD applied for the FY2023	

							Title II Formula Grant (JJAC) from the Governor's Office of Crime Prevention, Youth, and Victim Services. Funds are being requested to provide funding to faith based organizations to start their own youth mentoring programs. This would in turn increase the number of youth being connected with caring adults. This funding focuses on ACEs and improving resilience.	
Angela Gray	Office on Mental Health	Harford County	The Teen Diversion program uses the ACE tool.	None	The Harford County Trauma Institute is working to make Harford County a trauma focused community using evidence informed practices and resiliency work (HOPE model)	Jennifer Redding, Jennifer.Redding@umm.edu; Amie Myrick, AMyrick@naccho.org ; Angela Gray, agray@harfordmentalhealth.org	The Harford County LMB was awarded funding related to trauma-informed care and ACEs which was awarded to Springboard Community Services.	
Robin Marie Grove	Child Advocacy Center of Frederick County	Frederick County	The Child Advocacy Center of Frederick County utilizes the PEARLS survey with Caregivers and with Children ages 12>.	The CAC is researching this with the intention to conduct screenings in the future	Yes. ACES Workgroup, Trauma Responsive Frederick, Frederick Trauma Recovery Network	Pilar Olivio, Frederick County ACEs Liaison, polivio@frederickcountymd.gov	Unknown	
Shawn Elizabeth Lattanzio	Montgomery County LBHA	Montgomery	The Lourie Center for Children's Social and Emotional Wellness, (301) 761-2401	Not specifically for Resiliency.	Not that I am aware of.	No	No	
Jessica	Caroline County Behavioral Health	Caroline	We conduct screening for all adults in MH treatment.	None	Yes. Caroline County Public schools has a community campaign as well as the Child Advocacy Center.	Kami Morris, Caroline County Advocacy Center, (410) 819-4500	CCBH has a trauma training grant and there are multiple grants received by the Child Advocacy Center in the past.	
Cindy Green	Talbot County Department of Corrections	Talbot County	Yes	Unknown	Yes	No	Yes	More providers and coalitions to provides the services needed
Robert C Schmidt	Talbot County Public Schools	Talbot County Public Schools	TCPS does not; school mental health contractual providers may complete.	No	TCPS School Mental Health Program - trained in trauma-informed care	Dr. Kathryn Seifert, (443) 754-1001	TCPS Project Aware Grant	Review current curriculum in Maryland Colleges providing Mental Health Degrees to ensure future practitioners receive this training.

April Lynn Adams	Maryland Coalition of Families	Talbot and Caroline County	No	No	Yes	No	No	Spread the word, bring in help and provide resources!
Tanya Camper-Greene	Talbot County Addiction Program	Talbot	I use the ACE's screening at DSS on the TCS/CPS clients.	None	For All Seasons, Mid-Shore Behavioral Health and LEWC	For All Season and Mid Shore Behavioral Health (Lisa Saulberry)	None	None
Nancy Andrew	Talbot Family Network	Talbot	Not at this time.			Beth Anne Langrell, For All Seasons, blangrell@forallseasonsinc.org	Talbot County Public Schools - MD AWARE II (5 year grant)	
Pilar Olivo	Frederick County Office for Children and Families	Frederick County	Screenings: Lisa Jarboe, Frederick County Infants & Toddlers, ljarboe@frederickcountymd.gov; Robin Grove, Child Advocacy Center of Frederick County, rgrove@FrederickCountyMD.gov; Shannon Aleshire, Mental Health Association, saleshire@fcmha.org; Jessica Lertora, Safe Babies Court Team, jlertora@zerotothree.org; Dr. Jim Lee, Frederick County Pediatrics, doclee@fredcokids.com	Not aware at this point in time.	The Frederick County ACEs Workgroup is a workgroup of the local health improvement process overseen by the Frederick County Health Care Coalition in collaboration with Frederick County Health Department, Frederick Health (our only hospital in the County), and Frederick County Office for Children and Families. I lead this workgroup -- we have three areas of focus -- awareness, prevention and treatment and intervention. The workgroup started in 2017 and meets monthly. Safe Babies Court Team has two committees/coalitions that support it. Trauma Responsive Frederick was started by Dr. Inga James during the pandemic and has been focused on meeting transportation needs, interfacing with the business community in response to pandemic caused trauma on adults. All LMB funded programs through the Office for Children and Families require vendor staff to be aware and informed of the impact of ACEs.	Lynn Davis, lynn.davis@fcps.org; Jessica Lertora, jlertora@zerotothree.org; Robin Grove, rgrove@FrederickCountyMD.gov; Jay Hessler, jhessler@FrederickCountyMD.gov; Suzi Borg, sborg@fcmha.org; Shannon Aleshire, saleshire@fcmha.org; Pat Rosensteel, pbrosensteel@aol.com; Shelly Toms, Director, Office for Children and Families, stoms@FrederickCountyMD.gov	The Frederick County budget includes a small amount for ACEs-related initiatives. The ACEs Workgroup develops and recommends projects to the director of the Office for Children and Families. This is not a grant process. The Frederick County Health Care Coalition recently applied for funding for CareFirst for an ACEs-informed behavioral health project and has received county ARPA funding to support ACEs-related initiatives. Frederick Health received $8M in county ARPA funding for a universal newborn home visiting program developed by the Frederick County ACEs Workgroup.	
Katie Speert	Together We Own It	Carroll	Iindividual organizations conduct their own screening. There are no collaborative efforts at this time.	Not sure	TWOI's programs address trauma. Springboard Community Services has a focus on addressing trauma.	None	Not specifically	Please let me know how I can support bringing these initiatives to Maryland and Carroll County.
Erin Gambrill	Frederick County Public Libraries	Frederick County	None	None	None	No one at the library. Children's Services Supervisors and children's librarians	None	N/A

						take professional development courses regarding related issues on a regular basis.		
Beth Anne Langrell	For All Seasons	Eastern Shore	As a Mental Health and Rape Crisis Center we are continually addressing ACEs in our work with the community and with our clients. As the CEO of the organization and an ACEs Masters Trainer for the state I am called upon for presentations and trainings that I provide to schools, community groups, non-profits and the clients we serve. While we discuss the screening it is not used in the trainings.	I do use a resiliency screening in all my presentations.	For All Seasons is the trauma agency for the mid-shore and while we are based on the shore, we serve 21 out of 24 counties across the state with the new tele-health provisions. Our agency leads the region with education and trainings through our Center for Learning and we provide mental health, psychiatry to children, men and women regardless of one's abiltty to pay for our English and Spanish Speaking individuals - and we use an on demand interpretive service for over 500 languages.	Beth Anne Langrell, CEO For All Seasons, blangrell@forallseasonsinc.org; Lesa Lee, LCSW-C, CCO For All Seasons, llee@forallseasonsinc.org; Robin Davenport, Executive Director, CASA of the Mid-Shore	Funds from the Governor's Office of Crime Prevention, Youth, and Victim Services have helped to support our ACEs initiatives as well as local foundations.	
Pam Brown	Partnership for Children Youth and Families	Anne Arundel	I am a certified ACEs trainer. Most recently trained a large community group (100+) on trauma informed response to back to school.		The organization has worked with the Community Foundation over the last year on a trauma/ACEs series for the community.	Pam Brown, srbrow00@aacounty.org, (954) 205-7618		
Jaime Riley	Wicomico Partnership	Wicomico	We currently have a grant for ACE's that includes screening/assessment. It is out for RFP and we have had one program submit a proposal. Once it is awarded, more information can be provided.		We are providing training for area providers to become TF-CBT providers in Wicomico County. The trainings are intensive with a large time commitment. Three agencies have stated their interest. Training should start at the end of October. We also provide TIC training for area agencies for a variety of topics; TIC for LGBTQ+ safe spaces, TIC for adolescent substance use, TIC for teachers, etc. They will be occurring every couple months for this fiscal year with the first one scheduled for September 20. We will also provide some trauma-informed Zoom informational sessions for families and for the community. We are researching more funding opportunities that would allow us to provide FFT and MST training for area providers as well.	Dr. Samantha Scott, The Child & Family Center, (410) 860-8227; Jaime Riley, MS, Wicomico Partnership, (410) 546-5400	I do not know of any other than the ones we are currently funding through the LMB and the ones I am applying for coming up through DHS and SAMHSA.	I would love to be involved in the workgroup if you need additional participation, especially since the Eastern Shore is often underrepresented in state wide workgroups. Please let me know if that is something I can be a part of.

Appendix 4: Medical Assistance

Maryland Medicaid and ACEs Screening

In response to a request made by the Commission on Trauma-Informed Care in regard to the report mandated by § 8-1309(b) of the Human Service Article, titled, *Commission on Trauma-Informed-Care: Findings and Recommendations on the Development and Implementation of the Adverse Childhood Experiences (ACEs) Aware Program*, the Maryland Medical Assistance program (Medicaid) would like to share the following information on ACEs screening and the Medicaid program.

Maternal and Child Health Programs that Address ACEs

Maryland Medicaid currently reimburses, or is planning to reimburse, for services in multiple maternal and child health (MCH) programs. While these programs are not specifically focused on ACEs screenings, they address ACEs by supporting both parents and children in all aspects of health. The three MCH programs outlined below all aim to prevent and/or address adverse childhood experiences.

HealthySteps

HealthySteps, a program of ZERO TO THREE, is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened by a child development expert, serving in the role of HealthySteps Specialist, and placed into a tiered model of services of risk-stratified supports. Supports include care coordination and on-site intervention. The HealthySteps Specialist joins the pediatric primary care team to ensure universal screening, provide successful interventions, referrals and follow-up to the whole family.

While ZERO TO THREE does not require ACEs screening, the HealthySteps screening schedule recommends a parent ACEs screening at newborn visits. Additionally, the overall approach of placing children and their families into risk-stratified tiers enables the practice to support each child and family on an individualized basis. HealthySteps providers screen for maternal depression, food insecurity, housing instability, interpersonal safety, among other screenings. Practices may implement additional screenings, including ACEs screenings, if resources are available and staff is appropriately trained.

The HealthySteps national website also has a resource page dedicated to ACEs to support practices in identifying ACEs. The national body estimates that 30% of HealthySteps practices screen for ACEs at this time.

Maryland Medicaid will begin providing enhanced payments to HealthySteps providers January 1, 2023. Additional information can be found on the MDH HealthySteps webpage once coverage is effective.

Home Visiting Services (HVS)

In 2017 MDH established a Medicaid HVS Pilot to test a service expansion initiative for home visiting services in Maryland. This pilot tested two evidence-based home visiting models, Healthy Families America (HFA) and Nurse Family Partnership (NFP). Beginning in January 2022, Maryland established early childhood home visiting, including the HFA and NFP models, as a statewide benefit for Medicaid beneficiaries. Both models employ specific developmental and depression screenings and have an established track record of improving the health and well-being of both the birthing parent and the child. With factors such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues or domestic violence having a significant impact in the health of the parent-child dyad, this benefit aims to encourage a positive parent-child relationship and maternal, child and family accomplishments.

Maternal Opioid Misuse (MOM) Model

Maryland Medicaid launched its Maternal Opioid Misuse (MOM) model in January 2020. The MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with OUD through a statewide approach involving collaborative work with its nine managed care organizations (MCOs), improved data infrastructure and strengthened provider capacity in underserved areas of the state. This multi-prong approach aims to improve maternal and infant health outcomes through a number of targeted initiatives. MOM model efforts focus on increasing utilization of ambulatory and behavioral health care, such as medication for opioid use disorder, through enhanced MCO case management; improving provider capacity, especially in rural areas, to treat pregnant and postpartum participants with OUD; and ensuring families have access to the community resources that they need by leveraging enhanced care coordination and health information technology infrastructure.

While the focus of the intervention is on the parent, the MOM intake process incorporates a variety of screenings. The health-related social needs assessment includes questions related to safety. While there is no ACEs-specific screening conducted, a variety of questions asked do relate to them, predominantly regarding abuse. Additionally, one pillar of the MOM model, linkages to community and support services, may also prevent some ACEs for participants' children. These services can provide support for issues, including intimate partner violence, and food or housing insecurity. The model does directly address parental SUD. In sum, the MOM model centers upon the prevention of ACEs in working with the parent and their families/companions.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The federally required EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The comprehensive benefit aims to ensure that children receive critical screening, preventative services, and treatment services to prevent future medical issues. Program components include preventative, dental, mental health, and developmental services, as well as other specialty services. In Maryland, the preventive care component of the EPSDT Program is known as the Healthy Kids Program. The preventive health care services allow for early identification and treatment of health problems

before they become medically complex and costly to treat.

Standards for the Healthy Kids Program are developed through collaboration with key stakeholders such as the MDH Family Health Administration, the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School, and the Maryland Department of the Environment. The Maryland Healthy Kids Preventive Health Schedule closely correlates to the American Academy of Pediatrics' periodicity schedule.

The Healthy Kids provider manual and Maryland's EPSDT webpage includes additional information and resources related to the program.

Medicaid Funding for ACEs Screening

The Maryland Medicaid program does not currently reimburse providers for ACEs screenings. To implement coverage for this benefit for both children and adults, a budget initiative would be required. In addition Maryland Medicaid would need to amend its State Plan and regulations, as well as incorporate the benefit into the HealthChoice managed care organization rate setting process. System changes would also be required to allow accredited/credentialed providers to bill Medicaid for the ACEs screening.

Last updated 8.24.22

Appendix 5: DRAFT of The Maryland Way

Up for Vote at September Commission Meeting

The Maryland Way:
Trauma-Informed, Resilience-Oriented, Equitable Care and Culture (TIROE)

The Commissioners on Maryland's Commission on Trauma-Informed Care adopt the following Principles, Definitions, and Implementation Domains to guide our work and recommendations.

Framework:
We define a Trauma-Informed, Resilience-Oriented, Equitable Care and Culture (TIROE) to be composed of this framework:

Trauma-Informed: The 4Rs: A Trauma-Informed Organization/ Culture

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in individual, family, organizational, and systemic levels
- Responds by fully integrating knowledge about trauma, and its effects into policies, procedures, and practices
- Resist re-traumatization and create a healing environment for everyone.

Resilience Oriented: The 4Is: A Resilience-Oriented Organization/Culture

- Identifies programs and best practices proven to build resiliency at individual, family, organizational, and systemic levels
- Inoculates the system culture from the effects of stress and trauma proactively rather than reactively by having a strategic plan
- Instills a shared vocabulary and skills for resiliency into every aspect of life of the system.

Equitable: The 4Cs: In An Equitable Organization/Culture

- Cultural Humility is actively practiced and modeled throughout all relationships
- Cultural Safety is established and maintained throughout the organization and within its partnerships
- CLAS Standards are fully incorporated into policies, procedures, and practices in a meaningful and identifiable manner
- Community is recognized and engaged for its inherent healing practices and honored for the uniqueness and diversity of its members.

TIROE Principles (adapted from SAMHSA):

- **Safety (Cultural, Physical, Psychological, Social and Moral)** *(Bloom, 2013)*

- **Trustworthiness and Transparency**
- **Inclusion of the Voice of Lived Experience (including Peer Support and Mutual Self Help)**
- **Collaboration and Mutuality**
- **Empowerment, Voice, and Choice**
- **Cultural, Historical, and Gender Issues**
- **Anti-Racism**
- **Anti-Bias**
- **Social Justice**

With the following definitions of the principles:

- **Safety** includes cultural, physical, psychological, social, and moral safety. Throughout the organization, staff and the people they serve, whether children, youth, adults or families, feel culturally, physically, psychologically, socially, and morally safe; the physical setting is safe and interpersonal interactions promote a sense of safety
    - **Cultural Safety:** Established principles of practice that include protocols that show respect and ask for permission and informed consent. Through personal knowledge hone critical consciousness of social location and power. Within partnerships engage in relational practices founded in authentic encounters. Throughout the process ensure equity and dignity for all parties. And in developing as Positive Purpose we build on strengths, ensure confidentiality, and do no harm. *(https://ecdip.org/cultural-safety/)*
    - **Physical Safety:** All humans are safe from physical harm. The absence of harm or injury that can be experienced by any person from a physical object or practices that include physical objects. Physical objects can include a person, the room itself, furniture, medical equipment, prohibited items, toys, artwork, etc. *(https://yourexperiencesmatter.com/learning/safe-spaces/physical-safety/what-is-physical-safety/)*
    - **Psychological Safety:** The ability to be safe within oneself, to rely on one's ability to self-protect and keep oneself out of harm's way. *(Bloom, S. (2013). Creating Sanctuary: Toward the Evolution of Sane Societies. Routledge.)*
    - **Social Safety:** The sense of feeling safe with other people. We recognize that there are so many traumatized people that there will never be enough individual therapists to treat them. We must begin to create naturally occurring healing environments that provide some of the corrective experiences that are vital for recovery. *(Bloom, 2013)*
    - **Moral Safety:** The never-ending quest for understanding how organizations function in the healing process but attempting to reduce hypocrisy that is present, both explicitly and implicitly. A morally safe environment struggles with the issues of honesty and integrity. (*Bloom, 2013*)
    - Moral safety reflects an environment that actively defines and redefines a moral universe of integrity, responsibility, honesty, tolerance, compassion, peace, nonviolence, justice, and an abiding concern for human rights. Being morally safe means having a system of values that are consistent, that guide behavior, and that are founded on a deep respect for each other and all living things. In a morally

safe environment, there is no "other," no enemy that is fair game for aggression and violence. No scape goat on which it is acceptable to project one's own denied feelings or the denied feeling of an entire group. *(https://sandrabloom.com/wp-content/uploads/2017-BLOOM-THE-SANCTUARY-MODEL-THROUGH-THE-LENS-OF-MORAL-SAFETY.pdf)*

- **Trustworthiness and Transparency**
    - Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust among clients and family members, among staff, and others involved in the organization or culture.
- **Inclusion of the Voice of Lived Experience, including Peer Support and Mutual Self-Help**
    - **Inclusion of the voice of lived experience** begins with the understanding of the phrase "Nothing About Us Without Us" which recognizes the importance of working with others not for others. We recognize that organizational cultures and community cultures thrive when those who are impacted by the organization and community are active, engaged, and equal partners with those who are working within the organization and community. This work is maintained and advanced when this principle is central to all organizational decision making and quality assurance practices.
    - **Peer support and mutual self-help** are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. These are integral to the organizational and service delivery approach and are understood as a key vehicle to build trust, establishing safety, and empowerment.
- **Collaboration and Mutuality**
    - There is true partnering and level of power differences between staff and clients and among organizational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a TIROE approach.
- **Empowerment, Voice, and Choice**
    - Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in resilience, in the primacy of person-centered service delivery, and in the ability of individuals, families, organizations and communities to heal and recover from trauma. The organization understands that the experience of trauma may be ubiquitous to the lives of those who run the organization, provide services, and/or who come to the organization for assistance and support. As such, operations, workforce development, and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice, limited in choice, and have been often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine service plans centered on healing and recovery. Clients are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than

gatekeepers of help, resource, and care. Staff are empowered to work towards trauma informed service engagement through adequate training, responsive management, and supportive organizational frameworks. To promote empowerment, voice, and choice throughout the organization, leaders recognize the importance of developing a parallel agency process that fosters feelings of safety among both staff and the clients they serve.

- **Cultural, Historical, and Gender Issues**
    - A TIROE organization or community actively moves past stereotypes and biases that are based on race, ethnicity, sexual orientation, age, disability, religion, gender-identity, geography, etc. It offers gender responsive services and leverages the healing power of traditional cultural connections. The organization or community does this by incorporating policies, protocols, and processes that are responsive to the needs of underserved individuals by recognizing and addressing historical and intergenerational trauma. Finally, the organization or community examines and rectifies institutional practices that have disproportionately harmed individuals from underserved groups.
- **Anti-Racism**
    - Active commitment to identifying and eliminating racism within all state institutions
    - Addressing implicit racial bias in state service delivery
    - Understanding the institutional and structural issues that uphold systematic racism
    - Changing racist systems, organizational structures, policies and practices and attitudes at the individual, structural, and institutional levels
    - Power is redistributed and shared throughout the system
- **Anti-Bias**
    - Increased awareness of one's personal biases, both implicit and explicit, and the inherent nature of human biases, as well as their impact on interactions with others and organizational policies and practices that institutionalize bias. Actions are taken to mitigate the impact of biases on individuals, organizations, and systems. Individuals, organizations, and systems respect and value differences in people while challenging stereotyping and discrimination to support an inclusive and safe environment for everyone.
- **Social Justice**
    - Promoting the life and dignity of all human persons
    - Addressing inequities in state service delivery
    - Advancing policies that support equitable access to goods, resources, and services
    - Full participation through empowerment, voice, and choice
    - Equal protection under the law.

In addition to these principles, Maryland's TIC Commission recognizes that we must also address and affect the **Positive and Adverse Childhood Experiences (PACEs)** impacting our citizens. We define ACEs to include the original 10 items from the groundbreaking ACEs Study as well as other ACEs that include: Discrimination, Poverty, Racism, Other Violence, Intergenerational Cultural Trauma, Separation, Adjustments or Other Major Life Changes,

Bereavement and Survivorship, and Adult Responsibilities as a Child. *(HTTPS://numberstory.org)* We reserve the right to add ACEs as science advances in this area.

The original 10 ACEs are: Child Physical Abuse; Child Sexual Abuse; Child Emotional Abuse; Physical Neglect; Emotional Neglect; Mentally ill, depressed or suicidal person in the home; family member struggling with drug or alcohol addiction; Witnessing domestic violence against the mother; Loss of a parent to death or abandonment, including abandonment by divorce; Incarceration or any family member. *(https://www.cdc.gov/violenceprevention/aces/about.html)*

In addition to these Principles, the Commission adopts the following:

10 Implementation Domains as defined in SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (July 2014).

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

With the following definitions of the principles:

1. **Governance and Leadership**: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within each organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

2. **Policy**: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be hard-wired into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

3. **Physical Environment of the Organization**: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals and families being served must experience the setting as safe, inviting and not a risk to their physical or psychological safety. The physical setting

also supports the collaborative aspect of the trauma informed approach through the openness, transparency, and shared spaces.

4. **Engagement and Involvement of People in Recovery, Trauma Survivors, People Receiving Services, and Family Members Receiving Services**: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach and differentiates it from the usual approaches to services and care.

5. **Cross Sector Collaborations**: Collaboration across sectors built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could undermine the progress of the individual.

6. **Screening, Assessment, Treatment Services:** Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed and resilience-based approach. Trauma screening and assessment, and prevention are an essential part of the work. Trauma-specific interventions and resilience-based approaches are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

7. **Training and Workforce Development**: On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals and families with complex trauma.

8. **Progress Monitoring and Quality Assurance**: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

9. **Financing**: Financing structures are designed to support a trauma-informed approach which includes resources for staff training on trauma and resilience, key principles of a trauma-informed approach and resilience; development of appropriate and safe facilities; establishment of peer-support, provision of evidence-supported trauma screening,

assessment, treatment, prevention, and recovery supports; and development of trauma-informed cross-agency collaborations.

10. **Evaluation**: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma, resilience and appropriate trauma-oriented and resilience-oriented research instruments.

With the adoption of this framework, guiding principles and implementation domains, the Commission charges the **Definitions and Core Value Workgroup** with further defining terms such as Trauma, Resilience, Cultural Humility, and bringing those definitions back to the commission for adoption.