Assessment of Parental ACEs in Pediatrics

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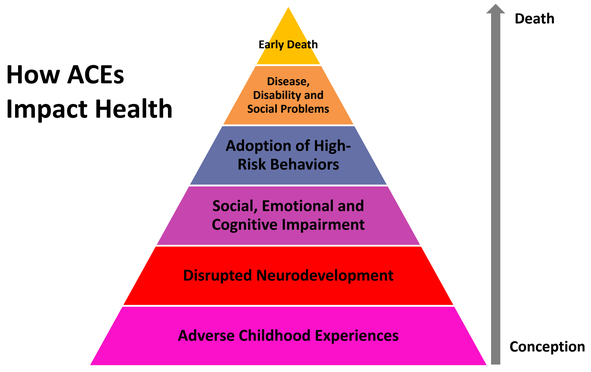
BACKGROUND

- Adverse Childhood Experiences (ACEs) are associated with myriad lifelong health and mental health conditions.
- Adults with an ACE score of ≥4 die nearly 20 years earlier than those without.
- Primary care pediatricians are faced with preventing transmission from one generation to the next and to ultimately improve lifelong outcomes for children.



PROJECT DESCRIPTION

1. During the four-month well visit, parents are asked to complete an assessment tool that includes:
   - Parental ACE score
   - Parental resilience score
   - Interest in potential resources
2. If the parental ACE score is ≥4, parents are offered additional anticipatory guidance on self-care, promoting development, appropriate discipline and modeling conflict resolution, spread out over the next 2 years.
3. Initial clinic goal: to explore the feasibility of assessing for parental ACEs in primary care.

WHAT ARE ACES?

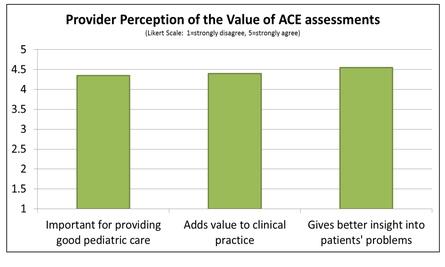
Abuse: Physical, emotional, sexual
Neglect: Physical, emotional
Household dysfunction: Divorce/separation/loss of parent, domestic violence, parental substance abuse, parental mental health disorders, incarcerated parent

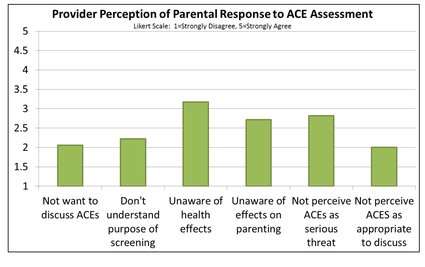
Other toxic stressors: Racism/prejudice, community violence, natural disasters, severe bullying, immigration, war/genocide

RESULTS TO DATE

- Rate of ACE scores of 4 or higher was lower than BRFSS estimates (8.1% vs. 17%)
- Disparities were noted between privately insured and publicly insured parents (5.9% vs. 12.3%)
- Surveyed providers generally agreed that knowledge of ACEs was important for providing good pediatric care and "would not go back to the way we did things before."

Number of ACEs	Total (n=1450)	Private Insurance (n=842)	Public Insurance (n=487)	Mothers (n=980)	Fathers (n=368)
0	52.6	56.2	47.0	51	57.8
1	25.6	25.1	25.7	25.3	25.3
2	7.8	8.3	7.2	8.6	6.3
3	5.9	4.5	7.8	6.1	4.9
4 or more	8.1	5.9	12.3	9.0	5.7





QUESTIONS

1. Why are detection rates lower than expected population rates?
2. How can this project be spread to other settings, and what are the important considerations for practices initiating ACE assessments?
3. Given that the first theoretical step in long-term poor health outcomes is "disrupted neurodevelopment," how do we protect the developmental outcomes of children whose parents experienced adversity?

OBJECTIVES

1. Determine best assessment tools for parental ACEs and resilience.
2. Develop support materials for primary care providers in using ACE and resilience assessments for project spread.
3. Measure developmental screening rates, referral rates to Early Intervention and rates of completion of services for children whose parents experienced high ACE scores or low resilience scores.
4. Create clinical workflows for families where (a) ACE scores are high or resilience scores are low and (b) developmental screening tools are failed, to provide additional referrals to home visitation to ensure developmental services are received.

REFERENCES

1. Felitti, et al. *Am J Prev Med* 1998;14:245–258.
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3. Garner A, et. al. *Pediatrics* Vol. 129 No. 1 January 1, 2012 pp.e224-e231.

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