Addressing Adverse Childhood Experiences and Social Determinants of Health in Pediatric Primary Care

A BRIEF OF THE LITERATURE AND KEY INFORMANT INTERVIEWS

STUDY GOAL

Develop a set of recommendations to shape a quality improvement approach to engage NH pediatric and family medicine practices in addressing adverse childhood experiences (ACEs) and social determinants of health (SDOH) among families with young children.

DEFINITIONS AND METHODS

Current Centers for Disease Control and Prevention definitions for both ACEs and SDOH were used. ACEs are defined as “all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18”. SDOH are defined as the “conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes”.

Study methods included: 1) a literature review of evidence-based tools and interventions and 2) key informant interviews to understand barriers and opportunities to addressing ACEs and SDOH in pediatric and family medicine clinics.

KEY THEMES FROM THE LITERATURE REVIEW AND KEY INFORMANT INTERVIEWS

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<tr>
<th>In-Office</th>
<th>Screening</th>
<th>Care Planning &amp; Referrals</th>
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<tr>
<td>• Approaches to addressing ACEs and SDOH through multidisciplinary care teams is supported in the literature.</td>
<td>• A number of screening tools exist for SDOH. Two ACEs tools are utilized: Parent-report of their own childhood ACEs and parent or child-report of the child’s ACEs. Cumulative ACE scores are recommended. Did not identify any NH pediatric primary care clinics screening for ACEs, but some are inquiring about SDOH.</td>
<td>• Approaches to addressing ACEs and SDOH through multidisciplinary care teams is supported in the literature.</td>
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<td>• Staff capacity to deliver team-based care varies tremendously in NH. Significant challenges: time, staffing, and the “handoffs”. Requires flexibility in visit focus, length, billing, and ancillary service availability.</td>
<td>• Tools to address resiliency and protective factors exist. A strengthening families approach is supported by the AAP. Resiliency screening appears to occur infrequently.</td>
<td>• Models such as integrated behavioral health in primary care and medical-legal partnerships have been shown to impact ACEs and SDOH. Relational and informational continuity is paramount.</td>
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<td>• Building family resiliency and discussing positive childhood experiences is equally important in mitigating trauma.</td>
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### In-Office Provider Needs & Supports

- Providers hesitate to address ACEs when they are either, 1) unaware of what resources are available to them or 2) do not have access to the proper resources patients need in addressing ACEs because of their location.
- Providers need on-going support and training around ACEs, general relational skills, and trauma-informed care.\(^\text{15}\)
- Mechanism to help clinicians and staff dealing with own trauma or secondary trauma.\(^\text{16, 17}\) Education of the community and a community based approach is key to providers having support and being able to enact lasting change.\(^\text{18}\)

### Systems Policy & System Factors

- Families and patients should be connected to trauma-informed resources that match their risk and need.\(^\text{19}\)
- Standardize communication between organizations to enhance referral processes.\(^\text{20}\)
- Use a strength-based approach when working with families; they may bring their own community connections and external resources.\(^\text{21}\)
- Access to a formal inventory of a community resources is an intervention strategy.\(^\text{22}\)

### External Resources & Referrals

- Home visiting and parent education were noted as evidence-based intervention strategies for prevention and family support.\(^\text{23, 24}\)
- Research supports broad-based community collaboration to address ACEs.\(^\text{25}\)
- Revealed systems factors that can impact what can be done in-office. These include: lack of access to resources and services, funding and reimbursement, public awareness, coordination of systems, stigma, and workforce.

### Cultural Considerations

- Expressed that all patients should have access to high quality treatment in a culturally appropriate manner. Communication of information should be both linguistically and culturally acceptable.\(^\text{26}\)
- Trauma and trauma-related symptoms intersect in many different ways with culture, race, gender, region, and language.\(^\text{27}\)
- Development of staff from culturally diverse backgrounds.
- ACEs tools are not available in a variety of languages or validated in different cultures.

### RECOMMENDATIONS

**BUILD MOMENTUM**
- Create public awareness about ACEs and SDOH and discern clinician & administrative leadership support for addressing ACEs and SDOH

**PROMOTE DISSEMINATION OF EFFECTIVE STRATEGIES**
- Behavioral health integration in primary care, use of linguistically and culturally appropriate care, identifying local resources, and build capacity statewide to provide evidence-based services to mitigate trauma

**PROVIDE KNOWLEDGE AND SKILLS NEEDED**
- Training for providers and staff on resources available, trauma-informed care, physiological pathways for ACEs, effective interventions, and more

**CREATE OPPORTUNITIES FOR MUTUAL SUPPORT AND LEARNING**
- Build a mechanism/process to support clinic staff in responding to trauma, sharing of best practices, and more