Understanding ACEs and Resiliency for Better Health Care

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OBJECTIVES

• Understand the linkages between ACEs and poor health in adulthood.
• Articulate the importance of assessing ACEs scores in conjunction with Resiliency scores.
• Describe a primary care approach to incorporating Adverse Childhood Experience knowledge into Practice.
WHAT IS TOXIC STRESS?
Adverse Childhood Experiences

“We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.”

The effects of ACEs

• ACE scores range from 0 (none) to 10 (all). One in five study participants reported 3 or more ACEs.

• Compared to persons with an ACE score of 0, those with an ACE score of 4 or more were:
  – twice as likely to be smokers
  – 12 times more likely to have attempted suicide
  – 7 times more likely to be alcoholic
  – and 10 times more likely to have injected street drugs.
Obesity
Heart disease and early death from MI
Alcoholism and alcohol abuse
Chronic obstructive pulmonary disease
Depression
Fetal death
Health-related quality of life
Illicit drug use
Liver disease
Risk for intimate partner violence
Multiple sexual partners
Sexually transmitted diseases
Smoking
Suicide attempts
Early and unintended pregnancies
Early initiation of smoking
Early initiation of sexual activity
Adolescent pregnancy
Premature Mortality with ACEs

- People with 6 or more ACEs died nearly 20 years earlier on average than those without ACEs.
- Average Years of Life Lost (YLL) was three times greater among people with six or more ACEs than those without.
- Increase in risk was only partly explained by documented ACE-related health and social problems.

“Adverse Childhood Experiences have created a chronic public health disaster.”

— Robert Anda
Adverse Childhood Experiences → ??? → Adult Health Risks
Toxic stress & the biological impact

- Maladapted neural connections in the brain
- Over-stimulated stress response
- Ongoing issues managing stress response and decision-making
- Particularly vulnerable early in life (<2 years)

How ACEs impact health

- Adverse Childhood Experiences
- Social, Emotional, & Cognitive Impairment
- Adoption of Health-risk Behaviors
- Disease, Disability and social problems
- Early Death
- Death
Multiple Influences on Outcomes

Risk factors: increase likelihood of poor outcome

Protective factors: increase resilience
Key protective factors

- Connection with a caring adult
- Parental warmth and monitoring
- Safe, cohesive neighborhood
- Parent without trauma symptoms
Factors in Resilience: The 7 C’s

- Connection
- Confidence
- Competence
- Character
- Coping
- Control
- Contribution

From Ken Ginsburg, MD
THE ROLE OF PRIMARY CARE:
THE MEDICAL HOME RESPONSE
Recognizing that families play a vital role in ensuring health and well-being of the patient. Acknowledging that emotional, social and developmental support are integral components of health care.

Simultaneously addressing medical, behavioral, and social issues. Treating the whole individual and ALL of his or her needs.
MCHB Definition of CYSHN

- Children with special health care needs are those who have or are at-risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.
Considering CEV as CYSHN

- Medical home model originally developed for CYSHN
- CEV meet the definition of CYSHN as they...
  - Are at risk for poor health outcomes
  - Should be connected to additional services compared to other children
  - Deserve tracking and follow up
- “CEV need developmental promotion times ten.”
Applying Medical Home Principles to Children Exposed to Violence

• Identify the population through screening or surveillance, and track them

• Assess the family and patient strengths / assets, and needs for specific services

• Make referrals

• Provide self-management tools (developmental promotion)

• Follow up on referrals / close communication loops
Four Starting Questions:

• Why am I looking?
• What am I looking for?
• How do I find it?
• What do I do once I’ve found it?
What Do I Do Once I’ve Found It?

• Ethical question: why screen if you don’t know what you’re going to do with the information?
Addressing Every Provider’s Greatest Fear...

• Listening is therapeutic.
  – “When something becomes speakable, it becomes tolerable”.
  – Drawing the connection between the emotional brain and the thinking brain is the first step toward healing and integration.

• Principles of Motivational Interviewing 101.
  – Abandon the “righting reflex”.
  – Solutions to patients’ problems often can be found within the patients themselves.

• Put your own oxygen mask on first.

• Key message: “you aren’t alone, it’s not your fault, and I will help.”
Steps in Trauma Informed Care

• Individual: can I take care of myself while addressing the trauma of others?
• Interpersonal: can I listen effectively to the trauma history my patients and families?
• Organizational: is my clinic a safe place to reveal trauma and address it?
• Environmental: are there community resources that I can use to help patients and families who have experienced trauma?
Why am I Looking?

• Is there a particular need in my community or patient population that needs to be addressed?

• Is there a specific interest amongst my providers to address a particular practice gap?
  – Is there a clinical problem that I’m trying to get a handle on?

• Is there an outcome that I’m trying to improve?
What am I Looking For?

• Different approaches depending on practice readiness and goals of screening / surveillance.
  – Am I looking for a specific trauma or toxic stress / ACEs in general?

• Who am I screening?
  – Universal?
  – Targeted for specific problems: somatic complaints, mental health concerns, school failure?
  – Patients or families / parents?
### Types of Childhood Violence Exposure

<table>
<thead>
<tr>
<th>Endemic</th>
<th>Episodic</th>
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</thead>
<tbody>
<tr>
<td>• Abuse – physical, emotional, sexual</td>
<td></td>
</tr>
<tr>
<td>• Domestic Violence</td>
<td>• School violence</td>
</tr>
<tr>
<td>• Bullying</td>
<td>• Natural disasters</td>
</tr>
<tr>
<td>• Dating Violence</td>
<td>• Terrorism</td>
</tr>
<tr>
<td>• Community violence / gang activity</td>
<td>• War / Genocide</td>
</tr>
<tr>
<td>• Sexual exploitation / trafficking</td>
<td></td>
</tr>
</tbody>
</table>
How do I find it?
Deciding on an Office Workflow

• At which visits will I begin to ask screening questions?
• How will I ask the questions? Pre-visit questionnaire versus direct interview?
  – If a questionnaire, who will distribute, explain to patients, and get it to the provider? How do I ensure patient privacy as they answer the questions?
  – If direct interview, what decision supports will help me remember the questions?
• How do I document the results?
• How will I maintain respect, privacy and trust?
How Do I Find it? Surveillance Tips

• Specific surveillance questions for individual exposures can be found at the AAP Resilience Project Website.

• Universal surveillance question:

  “Since the last time I saw your child, has anything really scary or upsetting happened to your child or anyone in your family?”

  (Cohen, Kelleher, & Mannarino, 2008),
Specific Screening Tools

• Safe Environment for Every Kid (SEEK)
  – [https://brightfutures.aap.org/Bright%20Futures%20Documents/PSQ_screen.pdf](https://brightfutures.aap.org/Bright%20Futures%20Documents/PSQ_screen.pdf)
  – Given at 2, 9 and 15 month, and 2, 3, 4, and 5 year visits.

• Survey of Wellbeing in Young Children (SWYC)
  – [https://sites.google.com/site/swycscreen/home](https://sites.google.com/site/swycscreen/home)
  – Includes screening items for development, mental / behavioral health, and family risk factors.

• ACE questionnaires
  – Center for Youth Wellness: [http://www.centerforyouthwellness.org](http://www.centerforyouthwellness.org)
  – The Children’s Clinic
What do I do Once I’ve Found It?

KEEP CALM AND CARRY ON
What do I do Once I’ve Found It?

• Assessment of child and family safety
• Assets, resources and resiliencies in the family
• Follow up tools for assessing mental health in patients
  – PSC, Emotional Distress Screening, PTSD Reaction Index
• Connecting with appropriate resources
What do I do once I’ve found it?
Making Community Connections

• Local Child abuse hotline
  – Can be a resource for community agencies
  – Does your community do “differential assessment”? 
• Hospital or health plan social workers
• Family to Family Network (www.familytofamilynetwork.org)
• Public Health Department – Futures without Violence, Defending Childhood
• Mental Health Organizations
• 211Info / Help Me Grow
Other Practice Resources

• AAP Resources:
  – Connected Kids
  – Feelings Need Checkups Too
  – Bright Futures – [www.brightfutures.org](http://www.brightfutures.org)
  – Bright Futures in Practice: Mental Health
  – [www.aap.org/theresilienceproject](http://www.aap.org/theresilienceproject)
  – [www.medicalhomeinfo.org](http://www.medicalhomeinfo.org) – tips for identifying your community resources

• [www.healthychildren.org](http://www.healthychildren.org) – website for parents, includes parenting resources and tips

• [www.cdc.gov](http://www.cdc.gov) – positive parenting tip sheets
OK...so you aren’t a Pediatrician...

• First thing to know: the effects of ACEs can be mitigated no matter the age of the patient.
• Mindfulness / Meditation / Yoga, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), Interpersonal Psychotherapy (IPP) are evidence-based for helping reverse these effects.
• What screening do you need to do in a practice caring for adults?
  – IPV, mental health, substance abuse, food / housing insecurity.
  – Consider trauma history in mental health assessment and treatment.
  – Know community agencies that can offer support and services.
  – Refer to MH providers that can offer appropriate therapies.
PRACTICE EXAMPLE: THE CHILDREN’S CLINIC EXPERIENCE
Case Study: The Children’s Clinic

• 28 providers in two practice sites
• Strong interest in early childhood development / developmental promotion
• Since 2008 have implemented multiple standardized universal screening protocols
  – Developmental delay
  – Autism
  – Maternal Depression
  – Adolescent Depression
  – Adolescent Substance Abuse
• Adolescent questionnaire has always included questions about dating violence; many providers ask about bullying in their history for school aged children.
The Theory...

• Certain moments in the life of an infant or toddler will be stressful
  – Tantrums, colic, toilet training, hitting / biting, sleep problems are examples

• What happens to a parent who has experienced trauma? Will their response be:
  – Fight?
  – Flight?
  – Freeze?
  – Something else?

• How can we better prepare at-risk parents for these inevitable moments?
And thinking further...

- If a parent experienced trauma, do they have appropriate skills/ideas for:
  - Taking care of themselves?
  - Identifying when they need help?
  - Modeling appropriate conflict resolution?
  - Discipline that is developmentally appropriate?
  - Playing with their child?
Our Logic Model

Standard Anticipatory Guidance

“Enhanced” Anticipatory Guidance
What we did...

• At the four month visit, parents are given the ACE screener, along with a questionnaire about resilience and a list of potential resources.
  – Cover letter explaining the rationale for the screening tool, and what we plan to do with the information
• Created a confidential field in the EMR that does not print into notes, but perpetuates into visits to document results while minimizing risk to families.
• Eight providers piloted screening. Spread screening to rest of site, then to our second site – now 27/28 providers screening.
Hypothesis #1

• Screening for parental Adverse Childhood Experiences is feasible.
  – In other words: our providers will do it, and our patients will accept it.

• This includes a thoughtful consideration of “burden”.
## Overall Results

<table>
<thead>
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<th>Number of ACEs</th>
<th>Percent</th>
<th>Average Resiliency</th>
<th>Resiliency Range</th>
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<td>17-60</td>
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<tr>
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<td>7.8</td>
<td>56.1</td>
<td>27-60</td>
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<tr>
<td>3</td>
<td>5.9</td>
<td>55.3</td>
<td>26-60</td>
</tr>
<tr>
<td>4 or more</td>
<td>8.1</td>
<td>45.4</td>
<td>18-60</td>
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↑ Oregon BRFSS: 17%
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<tr>
<th>Number of ACEs</th>
<th>Total (n=1450)</th>
<th>Private Insurance (n=842)</th>
<th>Public Insurance (n=487)</th>
<th>Mothers (n=980)</th>
<th>Fathers (n=368)</th>
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<tbody>
<tr>
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<td>56.2</td>
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</tr>
<tr>
<td>4 or more</td>
<td>8.1</td>
<td><strong>5.9</strong></td>
<td><strong>12.3</strong></td>
<td><strong>9</strong></td>
<td><strong>5.7</strong></td>
</tr>
</tbody>
</table>
Surveying Providers

- Survey sent to TCC providers asking about their experiences.
- 14 questions rated on a Likert scale, remainder were more qualitative.
- Sent out similar questions to a group about to start screening to check perspectives before starting ACE screening.
Overview of results

- Providers generally **DISAGREE** that parents were unwilling to discuss ACEs.
- Providers generally **AGREE** that ACE screening provided important information for providing care.
- Providers generally **DISAGREE** that time was a barrier.
- Provider **COMFORT** with discussing ACEs was mixed.
Before starting to screen, what is / was your greatest fear?

- time
- opening a can of worms...opening Pandora's box
- not feeling confident
- I won't be able to help
- not knowing
- Triggering a full emotional / mental collapse
- what to say
- no resources
Was it as scary as you thought?

NO
How has screening for ACEs changed your practice?

- better insight
- improved communication
- I know the parents better
- there is no subject that is “off the table”
- more empathy
- better understanding of the forces shaping parental responses
- my office is a safe place to talk about things
- cultivates a trusting relationship
What referrals have you needed to do?

• Most say none.
• Parenting classes, parenting support groups, reading materials.
• Rarely counseling for parents (referred back to their PCP).
What Else Did We Find?

• “I would never go back to the way we did things before.”
• Average initial conversation lasts 3-5 minutes.
• Most effective “trigger question”: How do you think these experiences affect your parenting today?
ACTUAL CONVERSATIONS...AND WHAT WE LEARNED
What didn’t really happen...
The Yelling Infant

• 4 month old infant in for a well visit. Primary concern is colic. Infant spends 3-4 hours crying every evening.

• Two parent household, 7 year old sister at home.
  – Mom works full time, dad is in training to be a firefighter.
  – Generally mom leaves work, immediately drives through traffic to get home to relieve the nanny.

• He feeds fine, growth is great, not spitting up. Remainder of physical exam and review of systems doesn’t add anything to the story.
Fight, flight or freeze?

- ACE score for mom: 5
- Parents went through an acrimonious divorce. Verbal abuse, domestic violence, substance abuse were common in her household.
- Her reaction to a “yelling” infant? The infant’s reaction to her reaction?
Tapping into Resilience

• Mom used to do yoga before the new baby.
• How can mom return to this mindfulness activity?
  – If no time for yoga class, can she carve out 15 minutes out of her day to breathe, relax, recharge?
• Two months later...much more relaxed! Colic wasn’t entirely gone, but stress was less, crying was less, and perceptions were improved.
Punchlines

• Parents often need “permission” for self-care.
• Parents may not be entirely aware of how their own experiences affect how they handle parenting, stressful situations, or work-life balance.

“...Place the oxygen mask on yourself first before helping small children or others who may need your assistance.”
The Sleepless Household

- Second time mom...fills out the ACE tool for the first time.
- Screening reveals that mom was abandoned by her own mother at age 2... her father experienced depression.
- Trigger question: How do you think this affects your parenting?
- “Do you remember how you told me to let my first son cry for a few minutes when he wouldn’t sleep? I couldn’t do it because I felt like I was abandoning him.”
Tailoring Advice and Anticipatory Guidance

- Conversation turned to other methods of sleep training...
  - What is mom comfortable with in terms of training?
  - How can dad be involved to serve as an anchor with a different perspective?
- Once mom said the words about her fears out loud, she immediately felt differently about sleep training.
Punchlines

• Drawing the connection between the thinking brain and feeling brain is the first step toward helping people integrate their experiences and start to heal.

• When our advice isn’t heeded or doesn’t seem to work…it may not be for the reasons we think...
The Quietly Failing Teen

- 12 year old male in for a well visit...first time with this office.
- Mom concerned that his grades are slipping: he used to be a B student, now C-D student.
- In a new school this year, patient cries when talking about how he has made no friends.
- Not disruptive in the classroom.
- Past history of anxiety.
- No thoughts of self-harm.
How would you respond if...

• Both parents are actively involved in the teen’s life?
• Home life is “typical”?
• He lives in an affluent neighborhood?

• Learning evaluation, sleep history, further mental health screens (depression, anxiety, attention deficit), physical causes of fatigue?
What if...

• Father is in jail?
• Both parents have a history of substance abuse?
• Parents are divorced?
• Mother has a history of anxiety and depression and “can’t get on the right medications”?
• Used to live with his grandmother, but now that mom “has her act together” he has moved across town and not only is in a new school but also is no longer allowed to talk with his grandmother?

• **ACE score: at least 4...**
Factors in Resiliency: The 7 C’s

- Connection
- Confidence
- Competence
- Character
- Coping
- Control
- Contribution
Addressing Some of the 7 C’s

• **Connection**: Big Brother, school counselor, other mentoring programs.

• Asking about his strengths, interests and passions assesses **Competence** and **Confidence**:
  – Really likes skateboarding...Boys & Girls Club has competitions...

• **Coping**: exercise, meditation, Youth Contact for counseling.
Punchlines

• Screening for ACEs in ANY context in our practice has made us aware of ACEs in ALL contexts.

• This fundamental culture shift towards Trauma-Informed Care changes how we view patients and their problems.

• Instead of just asking “what’s wrong with this patient?”, think “what happened to this patient?”
The Mom Who Cried

- Hispanic mother, three children: 16 years, 5 years and 4 months.
- When discussing the ACE screening tool, mom reveals that her father was an alcoholic, she witnessed domestic violence to the point that she feared for her mother’s life, and that father was physically and verbally abusive to her and to her sister.
- Mom’s sister is married to the same kind of man.
- The 16 year old daughter has dropped out of school, is already been pregnant and moved back to Mexico to live with extended family.
Mom’s Primary Concern...

“I don’t want to make the same mistakes again. I want better for my children than what I had.”
Punchlines

• Listening is therapeutic.

• Most parents come to the conversation about ACEs with incredible strengths, despite past adversity.

• We deal with parents’ emotions all the time...and we don’t necessarily have to have answers.

• My key message: you’re not alone, it’s not your fault, and I will help you.
“One does not need to be a therapist to be therapeutic.”

J. Ford, C. Wilson
Hypothesis #2

- Screening for parental ACEs will make a difference.
Next Steps for Practices

- Assess your practice’s readiness to address ACEs
- Train your staff and providers in Trauma Informed Care – may stimulate interest
- Explore potential screening tools, community resources
  - See if there’s a match between what your patients need, what you can screen for, and available community resources
- Pilot a small test of change – maybe with one or two providers, maybe just the next five patients
  - Share what you learn with your colleagues!
Summary

- CEV can and should be integrated into medical home model of practice
- When considering screening for CEV, remember to start small but think big
- From Bright Futures:
  - Prevention works
  - Families matter
  - Health is everyone’s business