



Helping Our Children Grow and Thrive:

Leveraging the Health Care System to Prevent and Mitigate Adverse Childhood Experiences and Advance Health Equity in Childhood

Housekeeping

- Today's presentation is being recorded
- The slides and recording will be made available
- To ask questions:
 - Type your question in the chat box
 - We will answer questions at the end of the presentation

Speakers



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HEALTH EQUITY ACTION

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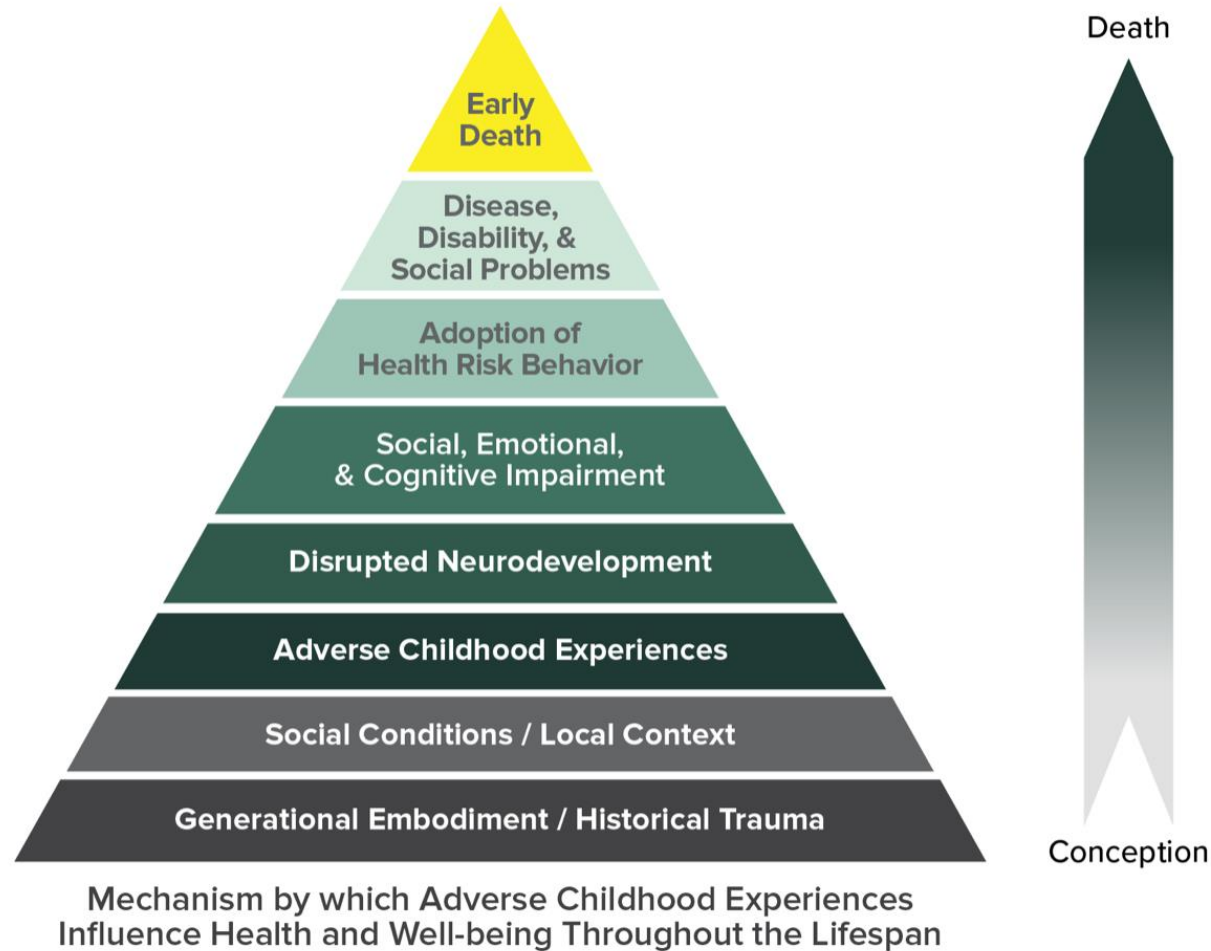
Agenda

- I. Adverse Childhood Experiences (ACEs) and prevalence rates across communities
- II. The role of historic, systemic and institutional inequities as source of and fuel for ACEs
- III. Leveraging the health care system to prevent and mitigate ACEs and improve health equity
- IV. Recommendations

Adverse Childhood Experiences (ACE) Study

Largest study of its kind, designed to understand the influence of adverse childhood experiences on behaviors underlying leading causes of disability, social problems, health-related behaviors and death

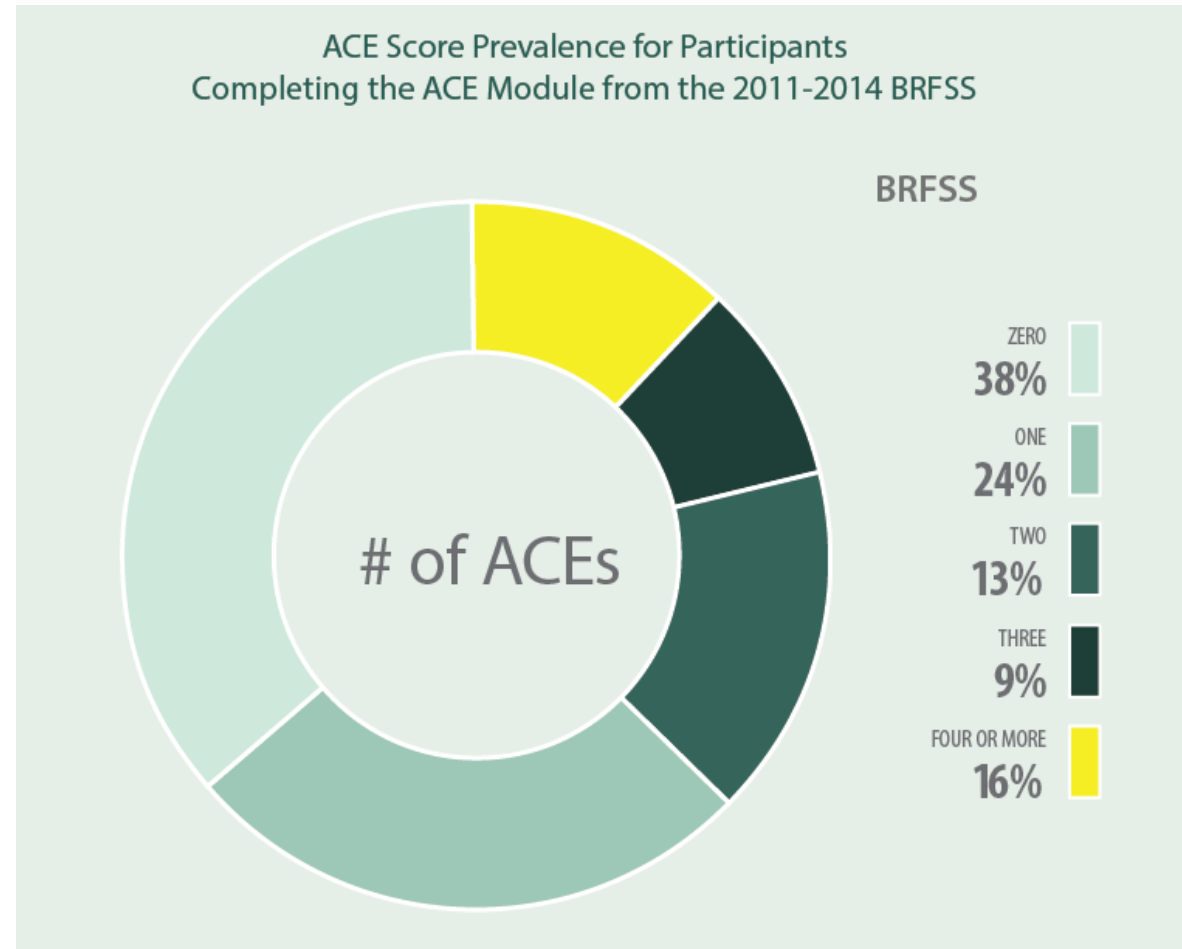
The ACE pyramid



The Extended ACEs Pyramid



How common are ACEs?



ACEs have a graded dose-response relationship w/outcomes and can have long-lasting consequences



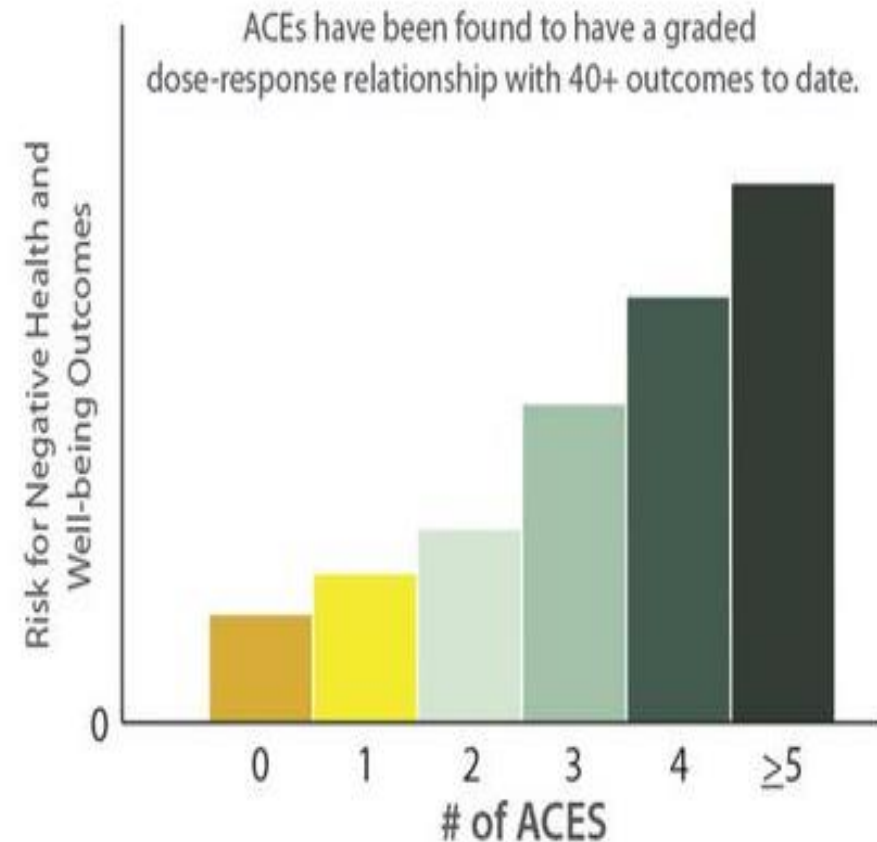
Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)



Behaviors (smoking, alcoholism, drug use)



Life Potential (graduation rates, academic achievement, lost time from work)



*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcome.

Risk factors
are not
predictive factors
because of
protective factors.

Key protective factor: Supportive relationships

- Supportive early relationships offer protection from effects of stress
- Absence of relationships can limit the brain's capacity for managing stress and its recovery
- Early relationships also protect against biological hazards to healthy brain growth -- nutritional inadequacy, physical illness, sensory impairment, dangerous exposures -- beginning prenatally

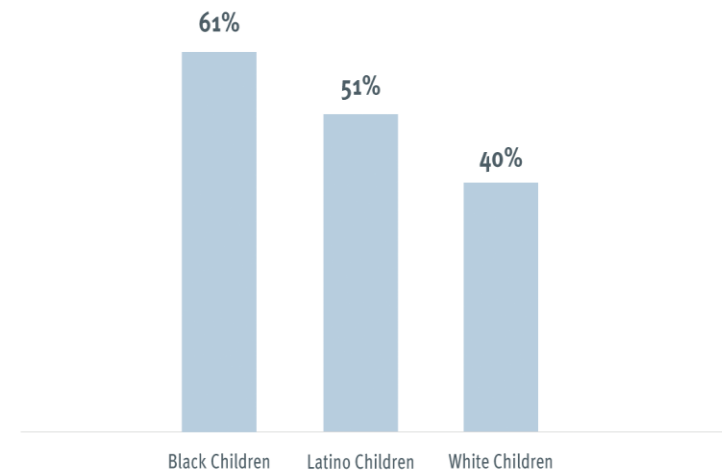
ACEs disproportionately impact low-income children, children of color, and other marginalized populations

- ACEs are far more concentrated and prevalent in communities struggling with poverty, economic hardship, community or neighborhood violence
- These experiences are often driven by deeply entrenched historic, systemic and institutional economic, racial and ethnic inequities that increase risk for poor health and limit resources available to promote or improve health
- Even at higher income levels, children of color continue to experience disproportionately high levels of ACEs compared to white children of same income levels
- Low-income children and children of color are also less likely to receive the services and supports they need to mitigate the effects of exposure to ACEs

ACEs disproportionately impact low-income children, children of color, and other marginalized populations

- 62% of children with family incomes < 200% FPL have at least 1 ACE
- One in three black children have experienced 2 to 8 ACEs compared to 1 in 5 white children
- LGB-identifying adults have higher ACE mean scores than non-LGB adults

Racial and Ethnic Disparities in the Occurrence and Experience of ACEs



Data also suggest racial and ethnic disparities in the occurrence and experience of ACEs.

Well over half (61 percent) of black children and 51 percent of Latino children experience one or more ACEs compared with 40 percent of white children.

Historic, systemic, and institutional inequities are source of and fuel for ACEs

These inequities are a result of generations of government policies favoring some communities over others and are some of the many factors at the heart of and fuel for ACEs, including:

- Historical trauma (e.g., 200+ years of slavery and Indian boarding schools)
- Systemic racism (e.g., residential segregation of communities of color from economic opportunity; mass incarceration)
- Institutional racism in health care that affects coverage, access, care delivery (e.g., biases in care treatment)

The link between racism, health inequities and ACEs

- Racism as a neighborhood-, community-, or societal-level ACE
- Racism as a stressor compromising parenting, quality of the parent-child relationship, and family functioning impacting family- and household-level ACEs
- Perceived racial discrimination, as well as the downstream effects of racism experienced by other family members, can impact a range of child health outcomes

Leveraging the health care system to prevent and mitigate ACEs: The opportunity

- Health care is well positioned to address ACEs given it is a nearly universal system
 - Majority of young children are seen regularly from birth to early years in pediatric primary care
 - FQHCs serve 25 million people annually and are present in the poorest, most disinvested neighborhoods
- Health care is becoming more attuned to health related social needs
 - Delivery and payment transformation is focused on SDOH that drive close to 80% of variation in health outcomes

Health is influenced more by what happens outside clinic walls



SOURCE: Ellie Zuehlke, Courtney McGuire, Brad Crotty, and Nathan Fleming, Practical Tools to Address Social Determinants of Health, *Institute for Health Care Improvement* (December 2018), http://app.ihc.org/FacultyDocuments/Events/Event-3135/Presentation-17910/Document-14731/Presentation_ML4_Practical_Tools_to_Address_Social_Determinants_update12.10.pdf

Recommendations for Leveraging the Health Care System to Prevent and Mitigate ACEs and Improve Health Equity

Federal and state policymakers should invest in and scale home visiting programs

- In 2014, 48% of families receiving home visiting through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program were living in extreme poverty
- Majority were young mothers; 39% were single mothers; 43% were women of color
- Nationwide, 18.3 million families have a child under 6 or a child on the way who could benefit from home visiting
- Evidence-based models reach about 3%
- Scaling home visiting will require expansion of federal funding

State Medicaid agencies should expand financial support for utilizing CHWs to coordinate care in pediatric health and other settings

- Many CHW programs report a financial return on investment ranging from \$1.50 to \$5 for every \$1
- Example: Healthy Start Program Madrina uses CHWs to deliver home visiting services and has successfully linked pregnant Latinas to perinatal health care, health education, and support services
- Pediatric interventions including HealthySteps and Project DULCE draw on this model to employ a HealthySteps specialist or related role in the health care setting to support families

State Medicaid agencies should allow pediatric health providers to bill for maternal depression screening and cover treatment under child's Medicaid benefit

- 5% to 25% of all pregnant, postpartum, and parenting women experience some type of depression
- Low-income women experience depressive symptoms at higher rates—between 40% to 60%
- Maternal depression prevalence similar across racial and ethnic groups, but black women and Latinas are less likely to receive care
- At least 25 states cover maternal depression screenings in Medicaid well-child visits

Health systems should partner with families at all levels, including policy development, program design, and implementation

- Effective inclusion of voices and priorities of communities of color and other marginalized groups is a matter of equity
- Family-centered care and shared decision making also contribute to better health outcomes, improvements in quality and patient safety
- Strategies for creating space and lifting the voices of families underrepresented groups:
 - Pursuing community-based participatory research
 - Creating opportunities for shared decision-making with parents at every level of program development and policy
 - Partnering with and investing in parent and community-based organizations to support their ideas and priorities

Health systems and organizations setting policy for pediatric practice and quality improvement should institute staff training on implicit bias

- In health care, implicit bias affects care in a number of ways with harmful consequences for underrepresented patients
- For instance, communities of color and other underserved groups are:
 - Less likely to be prescribed pain medication
 - More likely to be viewed as medically noncompliant
 - More likely to be viewed as medication-seeking or having some other motive to seek medication other than receiving needed care
 - Implicit bias associated with disparities in pain management in pediatric care

Health systems should use Institutional Analysis to identify and mitigate the health harms of institutional racism

- Institutional Analysis (IA) is often used in child welfare, juvenile justice, and other public intervention agencies to confront structural contributors to poor outcomes for children and families
 - Standardized institutional methods like administration requirements, job descriptions, employee training
 - Pinpoints inherent organizational policies and practices – underlying structural barriers contributing to inequities
- IA could be used to surface and mitigate structural barriers in health care
- Hospital community benefit and community health needs assessment

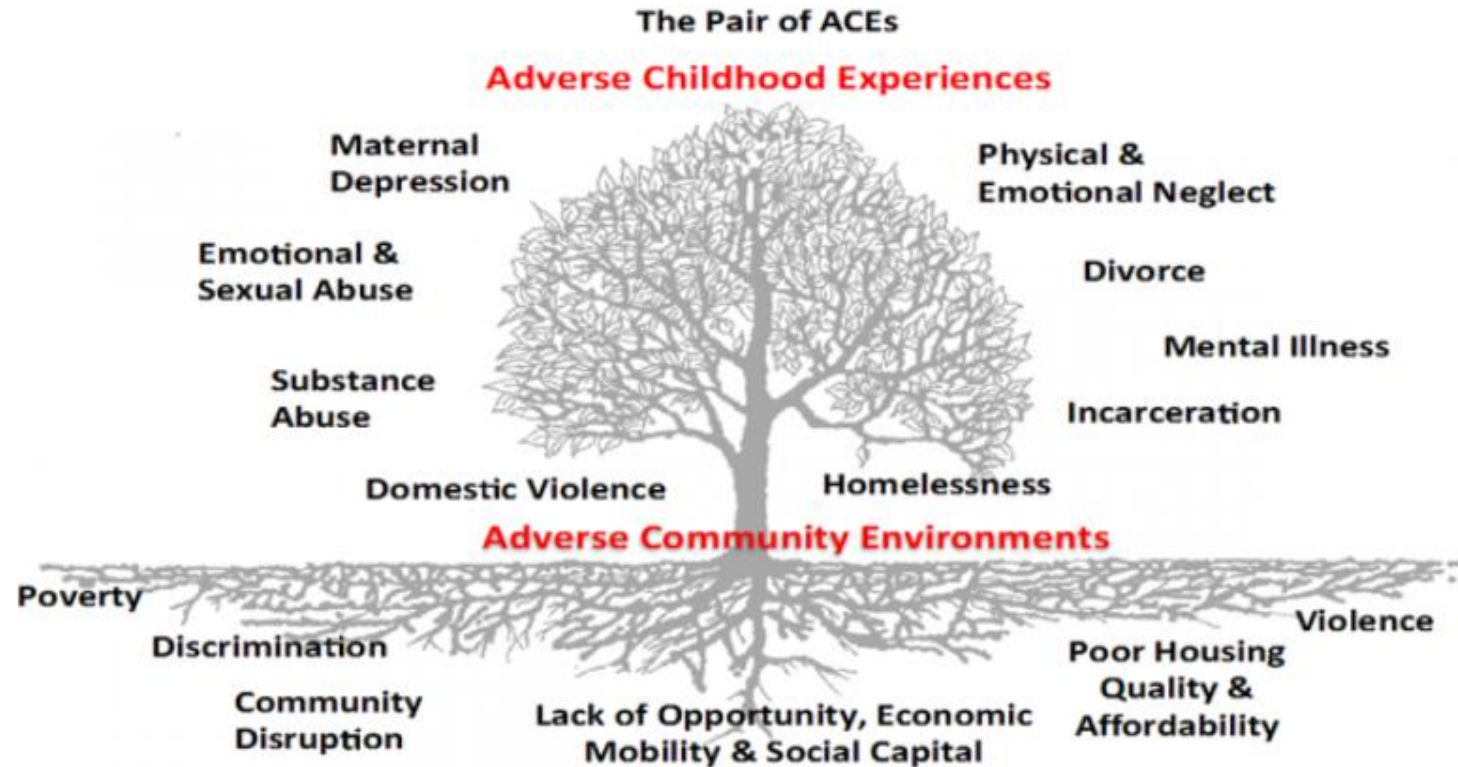
Primary care providers should promote population health by better connecting and integrating health care and social supports

- Social, economic, and environmental factors influence child health
- Opportunities exist to promote population health by better connecting and integrating health care and social supports to collectively address broader drivers of health outcomes
- Several models use these strategies in pediatric settings:
 - E.g., Safe Environment for Every Kid, Project DULCE, Help Me Grow
- These models screen for risk factors, concrete supports (e.g., nutrition assistance, housing needs, utility assistance), child development and parent functioning (e.g., maternal depression, interpersonal violence), connecting families to services, supports and opportunities

Primary care providers should target interventions to young children ages birth to 3 and their caregivers

- Early childhood is a time of rapid brain development, physical growth, and learning, sets the foundation for later health, academic success, and social-emotional and behavioral development
- Interventions involving parents during the first few years of a child's life can dramatically improve parental sensitivity, discipline strategies, and encourage supportive, warm parenting
- Need for multigenerational approaches that combine caregiver and child health care
 - Centering Parenting, Child First, HealthySteps, Project DULCE

Primary care providers and researchers should expand definition and screening for ACEs



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. *Academic Pediatrics*. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011



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Additional resources

- Center for the Study of Social Policy
 - [MANIFESTO for Race Equity & Parent Leadership in Early Childhood Systems](#)
 - [Institutional Analysis](#)

Questions?



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