Background
The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THAs) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA’s ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:
- Catalyze health agency conversations on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods
ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once.

ASTHO collected data from respondents using the electronic survey platform Qualtrics. ASTHO received responses from 41 states and three territories/freely associated states, which equates to a 75% response rate.

S/THAs were grouped according to Health and Human Services regions to produce nine reports. Region 1 includes six jurisdictions, and four agencies responded to the ACECAT (N=4).
Purpose of the 2021 ACECAT Regional Report

The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed to interpret the results. Please contact the social and behavioral health team at sbh@astho.org.

ACECAT 2019 Summary Report: Region 1

Four Respondents: Connecticut, New Hampshire, Rhode Island, Vermont

Who is Working on ACEs Prevention?

This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

FIGURE 1: Respondents describe their program role as:

- Maternal and child health: 100%
- Suicide prevention: 75%
- Behavioral health/mental health: 50%
- Family health services: 50%
- Substance misuse prevention: 50%
- Cross-cutting: 50%

FIGURE 2: Respondents are working on the following ACEs topics:

- Maternal and child health
- Suicide prevention
- Behavioral health/mental health
- Family health services
- Substance misuse prevention
- Cross-cutting

- Child abuse and neglect include physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect.
- Environmental factors include financial challenges in the household and housing instability.
- Household challenges include violence in the household, substance misuse in the household, and mental illness in the household.
- IVA
- Other protective factors include creating and supporting safe nurturing relationships with adults, providing social support, and other protective factors/mitigating factors for ACEs.
- Social determinants of health/health equity include addressing the social and environmental determinants of health at the local level and building strong, resilient, healthy communities.
What Systems Are in Place to Support ACEs Prevention?

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

Table 1.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>65%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>50%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>58%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>68%</td>
</tr>
<tr>
<td>Engaged data to promote public health goals.</td>
<td>60%</td>
</tr>
</tbody>
</table>
What Strategies Are Region 1 Agencies Working on to Support ACEs Prevention?

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

Table 2.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention</strong>: Evidence-based strategies for preventing ACEs before they occur.</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Secondary prevention</strong>: Identification and care coordination for individuals at risk.</td>
<td>48%</td>
</tr>
<tr>
<td><strong>Tertiary prevention</strong>: Reducing the health impact for vulnerable populations.</td>
<td>56%</td>
</tr>
<tr>
<td><strong>ACEs disparities</strong>: Identification of high-risk populations and high ACE score prevalence.</td>
<td>48%</td>
</tr>
<tr>
<td><strong>Workforce capacity</strong>: Education and training for medical professionals.</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Surveillance and monitoring</strong> (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>67%</td>
</tr>
</tbody>
</table>

**Call to Action**

Although the ACECAT was administered pre-pandemic in 2019, the urgency for a **systems-level** approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to maximize societal impact and efficiently achieve better outcomes.

1. **Use a shared risk and protective approach.**
   - Why? **ACECAT results** show that health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.
   - How?
     - Promote policies that address the root causes of ACEs, such as structural inequities (e.g., family financial security policies, policies addressing supports for youth experiencing unstable home environments).
     - Leverage partnerships between public health and education to mitigate COVID-related socio-emotional harms youth may be experiencing.

2. **Seek innovative partnerships.**
   - Why? **ACECAT results** show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as the ability to secure funding.
   - How? **Inventory** your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and **maximize resources**.

3. **Leverage existing funding and strengthen health equity.**
   - Why? **ACECAT results** show that health agencies can improve infrastructure to ensure populations disproportionally impacted by ACEs are prioritized.
   - How?
     - Use **evidence-based prevention strategies** that offer a positive return on investment.
     - **Leverage 1115 Medicaid waiver flexibilities** to strengthen protective factors for ACEs prevention.

**Additional Resources**

- Adverse childhood experiences, CDC
- We can prevent childhood adversity, CDC
Background

The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THAs) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA's ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:

- Catalyze health agency conversations on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods

ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once. ASTHO collected data from respondents using the electronic survey platform Qualtrics. ASTHO received responses from 41 states and three territories/freely associated states, which equates to a 75% response rate.

S/THAs were grouped according to Health and Human Services regions to produce nine reports. Region 2 includes four jurisdictions, and three agencies responded to the ACECAT (N=3).

State and Territorial Health Agency ACEs Prevention Capacity

- WHO IS WORKING ON ACEs?
- HOW ARE AGENCIES STRUCTURED?
- WHAT STRATEGIES ARE AGENCIES FOCUSED ON?
Purpose of the 2021 ACECAT Regional Report

The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed to interpret the results. Please contact the social and behavioral health team at sbh@astho.org.

ACECAT 2019 Summary Report: Region 2

Three Respondents: New Jersey, New York, Puerto Rico

Who is Working on ACEs Prevention?

This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

FIGURE 1: Respondents describe their program role as:

- Maternal and child health: 66%
- Cross-cutting: 50%
- Maternal and child health: 33%
- Other: 0%
- Maternal and child health: 10%
- Maternal and child health: 20%
- Maternal and child health: 30%
- Maternal and child health: 40%
- Maternal and child health: 50%
- Maternal and child health: 60%
- Maternal and child health: 70%
- Maternal and child health: 80%
- Maternal and child health: 100%

FIGURE 2: Respondents are working on the following ACEs topics:

- Child abuse and neglect include physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect.
- Environmental factors include financial challenges in the household and housing instability.
- Household challenges include violence in the household, substance misuse in the household, and mental illness in the household.
- Other protective factors include creating and supporting safe nurturing relationships with adults, other protective factors/mitigating factors for ACEs.
- Parental incarceration is not available.
- Parental separation/divorce is not available.
- Providing social support is not available.
- Social determinants of health/health equity include well-being, promoting respect and dignity toward all, integrating this work in other priorities, health in all policies.
FIGURE 3: Respondents are working with the following partners:

- Mental health and substance use: 67%
- Early childhood and education: 67%
- Law enforcement/criminal justice system: 67%
- Child welfare and human services: 67%
- Community-based: 33%
- Public health: 33%
- Faith-based: 33%
- Youth development: 33%
- Businesses: 33%
- Philanthropy: 33%
- Advocacy: 33%

What Systems Are in Place to Support ACEs Prevention?

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

Table 1.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>53%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>44%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>39%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>43%</td>
</tr>
<tr>
<td>Engaged Data to promote public health goals.</td>
<td>36%</td>
</tr>
</tbody>
</table>

What Strategies Are Region 2 Agencies Working on to Support ACEs Prevention?

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

Table 2.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention</strong>: Evidence-based strategies for preventing ACEs before they occur.</td>
<td>57%</td>
</tr>
<tr>
<td><strong>Secondary prevention</strong>: Identification and care coordination for individuals at risk.</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Tertiary prevention</strong>: Reducing the health impact for vulnerable populations.</td>
<td>44%</td>
</tr>
<tr>
<td><strong>ACEs disparities</strong>: Identification of high-risk populations and high ACE score prevalence.</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Workforce capacity</strong>: Education and training for medical professionals.</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Surveillance and monitoring</strong> (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>49%</td>
</tr>
</tbody>
</table>
Although the ACECAT was administered pre-pandemic in 2019, the urgency for a systems-level approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to maximize societal impact and efficiently achieve better outcomes.

1. **Use a shared risk and protective approach.**
   - **Why?** ACECAT results show that health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.
   - **How?**
     - Promote policies that address the root causes of ACEs, such as structural inequities (e.g., family financial security policies, policies addressing supports for youth experiencing unstable home environments).
     - Leverage partnerships between public health and education to mitigate COVID-related socio-emotional harms youth may be experiencing.

2. **Seek innovative partnerships.**
   - **Why?** ACECAT results show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as the ability to secure funding.
   - **How?** Inventory your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and maximize resources.

3. **Leverage existing funding and strengthen health equity.**
   - **Why?** ACECAT results show that health agencies can improve infrastructure to ensure populations disproportionally impacted by ACEs are prioritized.
   - **How?**
     - Use evidence-based prevention strategies that offer a positive return on investment.
     - Leverage 1115 Medicaid waiver flexibilities to strengthen protective factors for ACEs prevention.

### Additional Resources

- [Adverse childhood experiences, CDC](https://www.cdc.gov/trauma/childhood-trauma/adverse-childhood-experiences.html)
- [We can prevent childhood adversity, CDC](https://www.cdc.gov/trauma/childhood-trauma/childhood-trauma-prevention.html)
Background
The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THAs) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA’s ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:
- Catalyze health agency conversations on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods
ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once.

WHO IS WORKING ON ACEs?
HOW ARE AGENCIES STRUCTURED?
WHAT STRATEGIES ARE AGENCIES FOCUSED ON?
Purpose of the 2021 ACECAT Regional Report

The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed to interpret the results. Please contact the social and behavioral health team at sbh@asto.org.

ACECAT 2019 Summary Report: Region 3

Four Respondents: Maryland, Pennsylvania, Virginia, Washington, D.C.

Who is Working on ACEs Prevention?

This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

FIGURE 1: Respondents describe their program role as:

- Maternal and child health: 75%
- Cross-cutting: 25%
- Suicide prevention: 25%
- Family health services: 25%
- Substance misuse prevention: 25%

FIGURE 2: Respondents are working on the following ACEs topics:*

- Other protective factors/mitigating factors for ACEs: 100%
- Substance misuse in the household: 75%
- Creating and supporting safe nurturing relationships with adults and providing social support: 75%
- Providing social support: 75%
- Physical, sexual, and emotional abuse: 50%
- Household challenges: 50%
- Emotional neglect and physical neglect: 25%
- Parental incarceration: 25%

*Household challenges include violence in the household and mental illness in the household.
What Systems Are in Place to Support ACEs Prevention?

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

Table 1.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>49%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>72%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>61%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>39%</td>
</tr>
<tr>
<td>Engaged Data to promote public health goals.</td>
<td>44%</td>
</tr>
</tbody>
</table>

What Strategies Are Region 3 Agencies Working on to Support ACEs Prevention?

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

Table 2.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention:</strong> Evidence-based strategies for preventing ACEs before they occur.</td>
<td>39%</td>
</tr>
<tr>
<td><strong>Secondary prevention:</strong> Identification and care coordination for individuals at risk.</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Tertiary prevention:</strong> Reducing the health impact for vulnerable populations.</td>
<td>48%</td>
</tr>
<tr>
<td><strong>ACEs disparities:</strong> Identification of high-risk populations and high ACE score prevalence.</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Workforce capacity:</strong> Education and training for medical professionals.</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Surveillance and monitoring</strong> (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>42%</td>
</tr>
</tbody>
</table>
Although the ACECAT was administered pre-pandemic in 2019, the urgency for a *systems-level* approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to *maximize societal impact* and efficiently *achieve better outcomes*.

1. **Use a shared risk and protective approach.**
   - **Why?** ACECAT results show health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.
   - **How?**
     - Promote policies that address the root causes of ACEs, such as structural inequities (e.g., [*family financial security* policies, policies addressing supports for youth experiencing *unstable home environments*]).
     - Leverage partnerships between *public health and education* to mitigate COVID-related socio-emotional harms youth may be experiencing.

2. **Seek innovative partnerships.**
   - **Why?** ACECAT results show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as the ability to secure funding.
   - **How?** *Inventory* your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and *maximize resources*.

3. **Leverage existing funding and strengthen health equity.**
   - **Why?** ACECAT results show that health agencies can improve infrastructure to ensure populations disproportionately impacted by ACEs are prioritized.
   - **How?**
     - Use *evidence-based prevention strategies* that offer a positive return on investment.
     - *Leverage 1115 Medicaid waiver flexibilities* to strengthen protective factors for ACEs prevention.

### Additional Resources

- *Adverse childhood experiences, CDC*
- *We can prevent childhood adversity, CDC*
Background
The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THAs) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA’s ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:

- Catalyze health agency conversations on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods
ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once.

ASTHO collected data from respondents using the electronic survey platform, Qualtrics. ASTHO received responses from 41 states and three territories/freely associated states, which equates to a 75% response rate.

S/THAs were grouped according to Health and Human Services regions to produce nine reports. Region 4 includes eight jurisdictions, and all agencies responded to the ACECAT (N=8).
Purpose of the 2021 ACECAT Regional Report

The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed to interpret the results. Please contact the social and behavioral health team at sbh@astho.org.

ACECAT 2019 Summary Report: Region 4

Respondents: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

Who is Working on ACEs Prevention?

This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

FIGURE 1: Respondents describe their program role as:

FIGURE 2: Respondents are working on the following ACEs topics:*

*Environmental factors include financial challenges in the household and housing instability.
What Systems Are in Place to Support ACEs Prevention?

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

Table 1.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>66%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>65%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>51%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>45%</td>
</tr>
<tr>
<td>Engaged data to promote public health goals.</td>
<td>40%</td>
</tr>
</tbody>
</table>

What Strategies Are Region 4 Agencies Working on to Support ACEs Prevention?

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

Table 2.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention: Evidence-based strategies for preventing ACEs before they occur.</td>
<td>54%</td>
</tr>
<tr>
<td>Secondary prevention: Identification and care coordination for individuals at risk.</td>
<td>31%</td>
</tr>
<tr>
<td>Tertiary prevention: Reducing the health impact for vulnerable populations.</td>
<td>39%</td>
</tr>
<tr>
<td>ACEs disparities: Identification of high-risk populations and high ACE score prevalence.</td>
<td>40%</td>
</tr>
<tr>
<td>Workforce capacity: Education and training for medical professionals.</td>
<td>44%</td>
</tr>
<tr>
<td>Surveillance and monitoring (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>30%</td>
</tr>
</tbody>
</table>
Although the ACECAT was administered pre-pandemic in 2019, the urgency for a systems-level approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to maximize societal impact and efficiently achieve better outcomes.

1. **Use a shared risk and protective approach.**
   - **Why?** ACECAT results show health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.
   - **How?**
     » Promote policies that address the root causes of ACEs, such as structural inequities (e.g., family financial security policies, policies addressing supports for youth experiencing unstable home environments).
     » Leverage partnerships between public health and education to mitigate COVID-related socio-emotional harms youth may be experiencing.

2. **Seek innovative partnerships.**
   - **Why?** ACECAT results show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as the ability to secure funding.
   - **How?** Inventory your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and maximize resources.

3. **Leverage existing funding and strengthen health equity.**
   - **Why?** ACECAT results show that health agencies can improve infrastructure to ensure populations disproportionally impacted by ACEs are prioritized.
   - **How?**
     » Use evidence-based prevention strategies that offer a positive return on investment.
     » Leverage 1115 Medicaid waiver flexibilities to strengthen protective factors for ACEs prevention.

Additional Resources

*Adverse childhood experiences, CDC*
*We can prevent childhood adversity, CDC*
Background

The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THAs) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA’s ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:

- Catalyze health agency conversation on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods

ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once.

ASTHO collected data from respondents using the electronic survey platform, Qualtrics. ASTHO received responses from 41 states and three territories/freely associated states, which equates to a 75% response rate.

S/THAs were grouped according to Health and Human Services regions to produce nine reports. Region 5 includes six states, and five agencies responded to the ACECAT (N=5).
Purpose of the 2021 ACECAT Regional Report

The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed to interpret the results. Please contact the social and behavioral health team at sbh@astho.org.

ACECAT 2019 Summary Report: Region 5

Five Respondents: Illinois, Indiana, Michigan, Ohio, Wisconsin

Who is Working on ACEs Prevention?

This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

FIGURE 1: Respondents describe their program role as:

```
0%  10%  20%  30%  40%  50%  60%  70%  80%
Maternal and child health  80%
Cross-cutting  40%
Suicide prevention  20%
Behavioral health/mental health  20%
Family health services  20%
Substance misuse prevention  20%
```

FIGURE 2: Respondents are working on the following ACEs topics:*

```
0%  20%  40%  60%  80%  100%
Parental separation/divorce  100%
Other protective factors/mitigating factors for ACEs  100%
Emotional abuse, emotional and physical neglect  80%
Creating and supporting safe nurturing relationships with adults  100%
Providing social support  100%
Physical and sexual abuse  100%
Violence in the household  100%
Household challenges  100%
Environmental factors  100%
Parental Incarceration  100%
```

*Environmental factors include financial challenges in the household and housing instability.
FIGURE 3: Respondents are working with the following partners:

- Law enforcement
- Early childhood
- Philanthropy
- Business
- Juvenile justice/criminal justice
- Child welfare and human services
- Education
- Mental health and substance use
- Advocacy
- Family support networks
- Youth development
- Community-based

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law enforcement</td>
<td>60%</td>
</tr>
<tr>
<td>Early childhood</td>
<td>60%</td>
</tr>
<tr>
<td>Philanthropy</td>
<td>60%</td>
</tr>
<tr>
<td>Business</td>
<td>40%</td>
</tr>
<tr>
<td>Juvenile justice/criminal justice</td>
<td>60%</td>
</tr>
<tr>
<td>Child welfare and human services</td>
<td>60%</td>
</tr>
<tr>
<td>Education</td>
<td>60%</td>
</tr>
<tr>
<td>Mental health and substance use</td>
<td>60%</td>
</tr>
<tr>
<td>Advocacy</td>
<td>60%</td>
</tr>
<tr>
<td>Family support networks</td>
<td>60%</td>
</tr>
<tr>
<td>Youth development</td>
<td>60%</td>
</tr>
<tr>
<td>Community-based</td>
<td>60%</td>
</tr>
</tbody>
</table>

What Systems Are in Place to Support ACEs Prevention?

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>55%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>53%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>56%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>49%</td>
</tr>
<tr>
<td>Engaged Data to promote public health goals (N=4).</td>
<td>44%</td>
</tr>
</tbody>
</table>

What Strategies Are Region 5 Agencies Working on to Support ACEs Prevention?

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention</strong>: Evidence-based strategies for preventing ACEs before they occur.</td>
<td>39%</td>
</tr>
<tr>
<td><strong>Secondary prevention</strong>: Identification and care coordination for individuals at risk.</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Tertiary prevention</strong>: Reducing the health impact for vulnerable populations.</td>
<td>40%</td>
</tr>
<tr>
<td><strong>ACEs disparities</strong>: Identification of high-risk populations and high ACE score prevalence.</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Workforce capacity</strong>: Education and training for medical professionals.</td>
<td>43%</td>
</tr>
<tr>
<td><strong>Surveillance and monitoring</strong> (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>55%</td>
</tr>
</tbody>
</table>
Although the ACECAT was administered pre-pandemic in 2019, the urgency for a *systems-level* approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to *maximize societal impact* and efficiently *achieve better outcomes*.

1. **Use a shared risk and protective approach.**
   - **Why?** *ACECAT results* show health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.
   - **How?**
     - Promote policies that address the root causes of ACEs, such as structural inequities (e.g., *family financial security* policies, policies addressing supports for youth experiencing *unstable home environments*).
     - Leverage partnerships between *public health and education* to mitigate COVID-related socio-emotional harms youth may be experiencing.

2. **Seek innovative partnerships.**
   - **Why?** *ACECAT results* show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as the ability to secure funding.
   - **How?** *Inventory* your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and *maximize resources*.

3. **Leverage existing funding and strengthen health equity.**
   - **Why?** *ACECAT results* show that health agencies can improve infrastructure to ensure populations disproportionately impacted by ACEs are prioritized.
   - **How?**
     - Use *evidence-based prevention strategies* that offer a positive return on investment.
     - *Leverage 1115 Medicaid waiver flexibilities* to strengthen protective factors for ACEs prevention.

---

**Additional Resources**

*Adverse childhood experiences, CDC*

*We can prevent childhood adversity, CDC*
Background
The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THA) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA's ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:
- Catalyze health agency conversations on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods
ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once.

ASTHO collected data from respondents using the electronic survey platform Qualtrics. ASTHO received responses from 41 states and three territories/freely associated states, which equates to a 75% response rate.

S/THAs were grouped according to Health and Human Services regions to produce nine reports. Region 6 includes five jurisdictions, and all agencies responded to the ACECAT (N=5).
Purpose of the 2021 ACECAT Regional Report

The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed to interpret the results. Please contact the social and behavioral health team at sbh@astho.org.

ACECAT 2019 Summary Report: Region 6

Five Respondents: Arkansas, Louisiana, New Mexico, Oklahoma, Texas

Who is Working on ACEs Prevention?

This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

FIGURE 1: Respondents describe their program role as:

![Program Roles](image)

FIGURE 2: Respondents are working on the following ACEs topics:

- Other protective factors/mitigating factors for ACEs: 100%
- Physical and sexual abuse: 80%
- Emotional and physical neglect: 80%
- Creating and supporting safe, nurturing relationships with adults: 80%
- Providing social support: 80%
- Financial challenges in the household: 60%
- Violence and substance misuse in the household: 60%
- Emotional abuse: 60%
- Housing instability: 40%
- Mental illness in the household: 40%
- Parental incarceration: 40%
- Parental separation/divorce: 20%
- Community capacity building: 20%
What Systems Are in Place to Support ACEs Prevention?

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

Table 1.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>59%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>50%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>52%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>31%</td>
</tr>
<tr>
<td>Engaged Data to promote public health goals (N=4).</td>
<td>32%</td>
</tr>
</tbody>
</table>

What Strategies Are Region 6 Agencies Working on to Support ACEs Prevention?

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

Table 2.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention:</strong> Evidence-based strategies for preventing ACEs before they occur.</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Secondary prevention:</strong> Identification and care coordination for individuals at risk.</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Tertiary prevention:</strong> Reducing the health impact for vulnerable populations.</td>
<td>31%</td>
</tr>
<tr>
<td><strong>ACEs disparities:</strong> Identification of high-risk populations and high ACE score prevalence.</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Workforce capacity:</strong> Education and training for medical professionals.</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Surveillance and monitoring</strong> (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>52%</td>
</tr>
</tbody>
</table>
Although the ACECAT was administered pre-pandemic in 2019, the urgency for a **systems-level** approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to **maximize societal impact** and efficiently **achieve better outcomes**.

**Use a shared risk and protective approach**
- **Why?** [ACECAT results](#) show health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.
- **How?**
  - Promote policies that address the root causes of ACEs, such as structural inequities (e.g., [family financial security](#) policies, policies addressing supports for youth experiencing [unstable home environments](#)).
  - Leverage partnerships between [public health and education](#) to mitigate COVID-related socio-emotional harms youth may be experiencing.

**Seek innovative partnerships**
- **Why?** [ACECAT results](#) show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as ability to secure funding.
- **How?** [Inventory](#) your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and **maximize resources**.

**Leverage existing funding and strengthen health equity**
- **Why?** [ACECAT results](#) show that health agencies can improve infrastructure to ensure populations disproportionally impacted by ACEs are prioritized.
- **How?**
  - Use [evidence-based prevention strategies](#) that offer a positive return on investment.
  - [Leverage 1115 Medicaid waiver flexibilities](#) to strengthen protective factors for ACEs prevention.

---

**Additional Resources**
- [Adverse childhood experiences, CDC](#)
- [We can prevent childhood adversity, CDC](#)
Background

The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THA) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA's ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:

- Catalyze health agency conversations on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods

ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once.

ASTHO collected data from respondents using the electronic survey platform Qualtrics. ASTHO received responses from 41 states and three territories/freely associated states, which equates to a 75% response rate.

S/THAs were grouped according to Health and Human Services regions to produce nine reports. Regions 7 and 8 include 10 states, and five agencies responded to the ACECAT (N=5).
Purpose of the 2021 ACECAT Regional Report

The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed in interpreting the results. Please contact the social and behavioral health team at sbh@astho.org.

ACECAT 2019 Summary Report: Regions 7 and 8

Five Respondents: Colorado, Montana, North Dakota, Utah, Iowa

Who is Working on ACEs Prevention?

This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

FIGURE 1: Respondents describe their program role as:

- Maternal and child health: 40%
- Injury and violence prevention: 60%

FIGURE 2: Respondents are working on the following ACEs topics:

- Child abuse and neglect: 100%
- Household challenges: 100%
- Financial challenges in the household: 100%
- Creating and supporting safe nurturing relationships with adults: 100%
- Housing instability: 80%
- Parental incarceration: 80%
- Parental separation/divorce: 80%
- Other protective factors: 80%

- Child abuse and neglect include physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect.
- Household challenges include violence in the household, substance misuse in the household, and mental illness in the household.
- Further description for financial challenges in the household is not available.
- Further description for creating and supporting safe nurturing relationships with adults in the household is not available.
- Further description for housing instability in the household is not available.
- Further description for parental incarceration in the household is not available.
- Further description for parental separation/divorce in the household is not available.
- Other protective factors include providing social support and other protective factors/mitigating factors for ACEs.
FIGURE 3: Respondents are working with the following partners:

- Mental health and substance use: 100%
- Early childhood care and education: 100%
- Child welfare and human services: 100%
- Parenting organizations: 80%
- Juvenile justice/criminal justice: 80%
- Community-based: 80%
- Advocacy: 60%
- Philanthropy: 60%
- Law enforcement/public safety: 60%
- Other: 40%

*Other partners include business, the Indian Affairs Commission, and the Department of Transportation.

What Systems Are in Place to Support ACEs Prevention?

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

Table 1.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>72%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>73%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>56%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>43%</td>
</tr>
<tr>
<td>Engaged Data to promote public health goals.</td>
<td>64%</td>
</tr>
</tbody>
</table>

What Strategies Are Regions 7 and 8 Working on to Support ACEs Prevention?

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

Table 2.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention: Evidence-based strategies for preventing ACEs before they occur.</td>
<td>64%</td>
</tr>
<tr>
<td>Secondary prevention: Identification and care coordination for individuals at risk.</td>
<td>35%</td>
</tr>
<tr>
<td>Tertiary prevention: Reducing the health impact for vulnerable populations.</td>
<td>37%</td>
</tr>
<tr>
<td>ACEs disparities: Identification of high-risk populations and high ACE score prevalence.</td>
<td>41%</td>
</tr>
<tr>
<td>Workforce capacity: Education and training for medical professionals.</td>
<td>43%</td>
</tr>
<tr>
<td>Surveillance and monitoring (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>73%</td>
</tr>
</tbody>
</table>
Although the ACECAT was administered pre-pandemic in 2019, the urgency for a systems-level approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to maximize societal impact and efficiently achieve better outcomes.

1. **Use a shared risk and protective approach**
   - **Why?** ACECAT results show health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.
   - **How?**
     - Promote policies that address the root causes of ACEs, such as structural inequities (e.g., family financial security policies, policies addressing supports for youth experiencing unstable home environments).
     - Leverage partnerships between public health and education to mitigate COVID-related socio-emotional harms youth may be experiencing.

2. **Seek innovative partnerships**
   - **Why?** ACECAT results show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as the ability to secure funding.
   - **How?** Inventory your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and maximize resources.

3. **Leverage existing funding and strengthen health equity**
   - **Why?** ACECAT results show that health agencies can improve infrastructure to ensure populations disproportionately impacted by ACEs are prioritized.
   - **How?**
     - Use evidence-based prevention strategies that offer a positive return on investment.
     - Leverage 1115 Medicaid wavier flexibilities to strengthen protective factors for ACEs prevention.

### Additional Resources
- Adverse childhood experiences, CDC
- We can prevent childhood adversity, CDC
Background

The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THA) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA’s ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:

- Catalyze health agency conversations on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods

ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once.

ASTHO collected data from respondents using the electronic survey platform Qualtrics. ASTHO received responses from 41 states and three territories/freely associated states, which equates to a 75% response rate.

S/THAs were grouped according to Health and Human Services regions to produce nine reports. Region 9 includes 10 jurisdictions, and five agencies responded to the ACECAT (N=5).

State and Territorial Health Agency ACEs Prevention Capacity

WHO IS WORKING ON ACEs?

HOW ARE AGENCIES STRUCTURED?

WHAT STRATEGIES ARE AGENCIES FOCUSED ON?
Purpose of the 2021 ACECAT Regional Report
The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed to interpret the results. Please contact the social and behavioral health team at sbh@astho.org.

ACECAT 2019 Summary Report: Region 9

*Five Respondents: Arizona, California, Federated States of Micronesia, Hawaii, Northern Mariana Islands*

Who is Working on ACEs Prevention?
This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

**FIGURE 1:** Respondents describe their program role as:

- Maternal and child health: 20%
- Behavioral health/mental health: 20%
- Family health services: 20%
- Cross-cutting: 20%

**FIGURE 2:** Respondents are working on the following ACEs topics:

- Physical and sexual abuse: 100%
- Emotional neglect: 100%
- Violence in the household: 100%
- Substance misuse in the household: 80%
- Emotional abuse: 80%
- Physical neglect: 80%
- Other protective factors*: 80%
- Mental illness in the household: 60%
- Creating and supporting safe and nurturing relationships with adults: 60%
- Environmental factors**: 40%
- Parental incarceration: 20%
- Parental separation/divorce: 20%

*Other protective factors include providing social support and other protective factors/mitigating factors for ACEs.

**Environmental factors include financial challenges in the household and housing instability.
**What Systems Are in Place to Support ACEs Prevention?**

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

**Table 1.**

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>68%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>67%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>56%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>54%</td>
</tr>
<tr>
<td>Engaged Data to promote public health goals.</td>
<td>65%</td>
</tr>
</tbody>
</table>

**What Strategies Are Region 9 Agencies Working on to Support ACEs Prevention?**

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

**Table 2.**

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention:</strong> Evidence-based strategies for preventing ACEs before they occur.</td>
<td>51%</td>
</tr>
<tr>
<td><strong>Secondary prevention:</strong> Identification and care coordination for individuals at risk.</td>
<td>38%</td>
</tr>
<tr>
<td><strong>Tertiary prevention:</strong> Reducing the health impact for vulnerable populations.</td>
<td>29%</td>
</tr>
<tr>
<td><strong>ACEs disparities:</strong> Identification of high-risk populations and high ACE score prevalence.</td>
<td>49%</td>
</tr>
<tr>
<td><strong>Workforce capacity:</strong> Education and training for medical professionals.</td>
<td>52%</td>
</tr>
<tr>
<td><strong>Surveillance and monitoring</strong> (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>63%</td>
</tr>
</tbody>
</table>
Although the ACECAT was administered pre-pandemic in 2019, the urgency for a systems-level approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to maximize societal impact and efficiently achieve better outcomes.

**Use a shared risk and protective approach**

- **Why?** ACECAT results show health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.
- **How?**
  - Promote policies that address the root causes of ACEs, such as structural inequities (e.g., family financial security policies, policies addressing supports for youth experiencing unstable home environments).
  - Leverage partnerships between public health and education to mitigate COVID-related socio-emotional harms youth may be experiencing.

**Seek innovative partnerships**

- **Why?** ACECAT results show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as the ability to secure funding.
- **How?** Inventory your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and maximize resources.

**Leverage existing funding and strengthen health equity**

- **Why?** ACECAT results show that health agencies can improve infrastructure to ensure populations disproportionately impacted by ACEs are prioritized.
- **How?**
  - Use evidence-based prevention strategies that offer a positive return on investment.
  - Leverage 1115 Medicaid waiver flexibilities to strengthen protective factors for ACEs prevention.

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**Additional Resources**

- [Adverse childhood experiences, CDC](https://www.cdc.gov/ace/)
- [We can prevent childhood adversity, CDC](https://www.cdc.gov/ace/)
Background
The adverse childhood experiences (ACEs) capacity assessment tool (ACECAT) is an electronic survey created by ASTHO in collaboration with CDC. The ACECAT helps state and territorial health agencies (S/THA) create an internal inventory of their infrastructure and topical capacity to address the prevention and mitigation of ACEs. The tool is structured around three main components: 1) background on the S/THA’s ACEs point of contact; 2) characteristics of S/THA infrastructure to support ACEs prevention; and 3) evidence-based topical ACEs prevention strategies. ASTHO first administered the ACECAT to 59 S/THAs in 2019, and the survey is the only nationally represented data source on S/THA ACEs prevention capacity.

The goals of the ACECAT are to:
- Catalyze health agency conversations on infrastructure, topical capacity assets, and needs to advance ACEs prevention.
- Identify priorities, strengths, and opportunities to improve ACEs prevention.
- Encourage collaborative discussions and partnerships to expand ACEs prevention.

Methods
ASTHO administered the ACECAT from Nov. 19, 2019, to Jan. 2, 2020. Participants included subject matter experts (SMEs) identified by S/THA leadership and their programmatic teams. Each S/THA responded only once.

ASTHO collected data from respondents using the electronic survey platform Qualtrics. ASTHO received responses from 41 states and three territories/freely associated states for a 75% response rate.

S/THAs were grouped according to Health and Human Services regions to produce nine reports. Region 10 includes four jurisdictions, and all agencies responded to the ACECAT (N=4).
Purpose of the 2021 ACECAT Regional Report

The purpose of this report is to provide regional data to assist S/THAs in strengthening ACEs prevention in:

- Strategic planning
- Program improvement
- Funding opportunities
- Technical assistance

ASTHO staff are available to provide assistance as needed to interpret the results. Please contact the social and behavioral health team at sbh@astho.org.

ACECAT 2019 Summary Report: Region 10

Four Respondents: Alaska, Idaho, Oregon, Washington

Who is Working on ACEs Prevention?

This section highlights characteristics of the ACEs S/THA point of contact. Respondents were able to select all options that apply to each question.

FIGURE 1: Respondents describe their program role as:

- Cross-cutting: 75%
- Maternal and child health: 25%
- Suicide prevention: 25%
- Behavioral health/mental health: 25%
- Family health services: 25%
- Substance misuse prevention: 25%

FIGURE 2: Respondents are working on the following ACEs topics:

- Child abuse and neglect: 100%
- Creating and supporting safe and nurturing relationships with adults: 100%
- Providing social support: 100%
- Household challenges: 100%
- Environmental factors: 75%
- Other protective factors: 75%
- Parental incarceration: 25%
- Parental separation/divorce: 25%
- Surveillance and epidemiology related to ACEs: 25%
- Trauma-informed systems and policy work: 25%
What Systems Are in Place to Support ACEs Prevention?

For Table 1, ASTHO assessed respondents’ capacity on a four-point capacity scale and then converted to percentages ranging from no capacity, limited (33%), some (67%), and full capacity (100%). Percent capacity for each item is calculated as an average of the capacity for each tactic. This section highlights components that affect program capacity, implementation, and sustainability.

Table 1.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic partnerships that enhance coordination of efforts toward a common goal.</td>
<td>68%</td>
</tr>
<tr>
<td>Leadership at all levels that interact with and have an impact on the program.</td>
<td>67%</td>
</tr>
<tr>
<td>Funding and social capital or relationships that produce social benefits.</td>
<td>56%</td>
</tr>
<tr>
<td>Responsive planning for public health goals.</td>
<td>54%</td>
</tr>
<tr>
<td>Engaged Data to promote public health goals (N=4).</td>
<td>65%</td>
</tr>
</tbody>
</table>

What Strategies Are Region 10 Agencies Working on to Support ACEs Prevention?

Table 2 utilizes the same capacity index methodology as Table 1 to determine the percentages ranging from no to full capacity. This section highlights index scores for each level at which the ACEs prevention strategy is targeting outcomes, ACEs disparities, workforce capacity, and surveillance and monitoring.

Table 2.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention: Evidence-based strategies for preventing ACEs before they occur.</td>
<td>51%</td>
</tr>
<tr>
<td>Secondary prevention: Identification and care coordination for individuals at risk.</td>
<td>38%</td>
</tr>
<tr>
<td>Tertiary prevention: Reducing the health impact for vulnerable populations.</td>
<td>29%</td>
</tr>
<tr>
<td>ACEs disparities: Identification of high-risk populations and high ACE score prevalence.</td>
<td>49%</td>
</tr>
<tr>
<td>Workforce capacity: Education and training for medical professionals.</td>
<td>52%</td>
</tr>
<tr>
<td>Surveillance and monitoring (e.g., analyze behavioral risk factor surveillance system data).</td>
<td>63%</td>
</tr>
</tbody>
</table>
Although the ACECAT was administered pre-pandemic in 2019, the urgency for a systems-level approach to preventing ACEs remains. S/THAs can promote well-being for families that address the root causes of ACEs and combat the adverse effects of the pandemic. Based on the results, S/THAs can implement the following recommendations to maximize societal impact and efficiently achieve better outcomes.

**Use a shared risk and protective approach**

- **Why?** ACECAT results show health agencies are focusing on primary prevention of ACEs and should work towards advancing macro-level strategies, such as strengthening family financial supports.

- **How?**
  - Promote policies that address the root causes of ACEs, such as structural inequities (e.g., family financial security policies, policies addressing supports for youth experiencing unstable home environments).
  - Leverage partnerships between public health and education to mitigate COVID-related socio-emotional harms youth may be experiencing.

**Seek innovative partnerships**

- **Why?** ACECAT results show that health agencies with strong partnerships have higher capacity in other areas of prevention, such as the ability to secure funding.

- **How?** Inventory your current S/THA partnerships and strategic plans regularly to understand roles and responsibilities and maximize resources.

**Leverage existing funding and strengthen health equity**

- **Why?** ACECAT results show that health agencies can improve infrastructure to ensure populations disproportionately impacted by ACEs are prioritized.

- **How?**
  - Use evidence-based prevention strategies that offer a positive return on investment.
  - Leverage 1115 Medicaid wavier flexibilities to strengthen protective factors for ACEs prevention.

**Additional Resources**

- [Adverse childhood experiences, CDC](https://www.cdc.gov/childdevelopment/adverse-childhood-experiences.html)
- [We can prevent childhood adversity, CDC](https://www.cdc.gov/childdevelopment/preventing-adverse-childhood-experiences.html)