Learning Center on HEALTH EQUITY & Young Children

a partnership between the BUILD Initiative & the Child and Family Policy Center

Health, Equity, and Young Children: The Child Health Practitioner's Role

Charles Bruner, First Five Alameda County Presentation

June 29, 2016

Introductions

- BUILD & the Child and Family Policy Center launched the Learning Collaborative on Health Equity and Young Children
- Funding from the Robert Wood Johnson Foundation

Perspective on Poverty

When families are pushed into poverty, the results can be devastating for young children.

- Meeting immediate basic needs – adequate health care, food and nutrition, safe housing, transportation and clothing – is compromised
- Families cannot make investments in activities for their kids that more affluent families care
- Families are under additional stress, which can carry over to their relationships with their children
- Children themselves can be stigmatized and have additional barriers to participating, at least on a par, in activities and opportunities for more affluent children

Perspective on Race

Cultural, racial, ethnic, and linguistic diversity should be a source of strength in society, but:

- Children of color and their families are more likely than white children and their families to experience social and structural **discrimination**, **exclusion**, **marginalization** and **poverty**.

- Race influences the social networks available to children and their families, and networks have a major impact on economic and social opportunities.

- Children are learning who they are and how they are treated in the larger world, and exclusion or discrimination and biases they or their families experience are damaging to their well-being (and children who learn prejudice are damaged, as well)

Perspective on Race and Poverty

In the United States, race and poverty are highly intertwined, but they are not the same.

We need approaches which respond to socio-economic disparities and poverty (relative and absolute), but these are not a substitute for addressing issues of discrimination and exclusion, nor of recognizing and valuing diversity.

We need individual service strategies focusing upon opportunity and responsibility, and we need community-building strategies focusing upon equity and social justice.

Focus of this Presentation

Young Child Health Practitioner Role Contributing to Health Equity

Health and Health Equity Defined

Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential.

– World Health Organization

Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices.

– Healthy People 2020

The Faces We Face: The Opportunity and the Challenge

A mother brings her three month-old in for a check-up. It's clear the mom is stressed, discouraged, and not picking up on the child's cues for attention. While there isn't a child medical condition which requires attention today, the practitioner fears that, in two years, if the family is not supported, there will be significant indicators of development delay and likely social and emotional problems.

What can the child health practitioner do to address what are clearly more than and different from medical needs?

Health, Equity, and Young Children

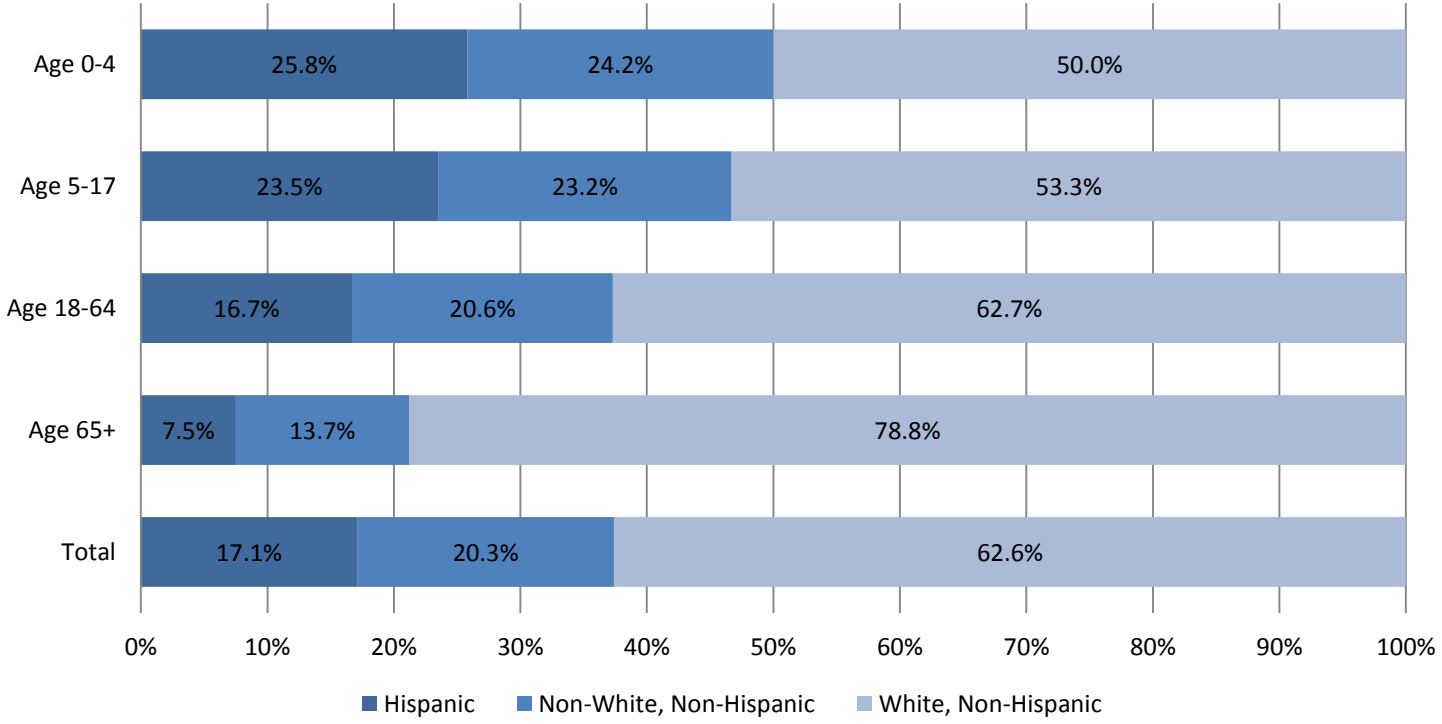
1. *Why It's Important: Young Children, Diversity, and Equity*
2. *What We Know: The Research Base*
3. *Starting at the Start: The Health Practitioner's Role*
4. *Building Upon Success: The Evidence Base*

1. Why It's Important: Young Children, Equity, and Health

- Youngest children (0-5) most diverse age segment of society
- Youngest children age group most likely to live in poverty
- Youngest children of color most likely to live in poverty
- Poor neighborhoods rich in young children
- Children of color concentrated in poor neighborhoods
- Poor neighborhoods have fewer child and family-friendly opportunities (social capital)
- Large health and other disparities exist by race and ethnicity – by income, by multiple measures of child well-being, and by place

Young Children Most Diverse Age Group in Society

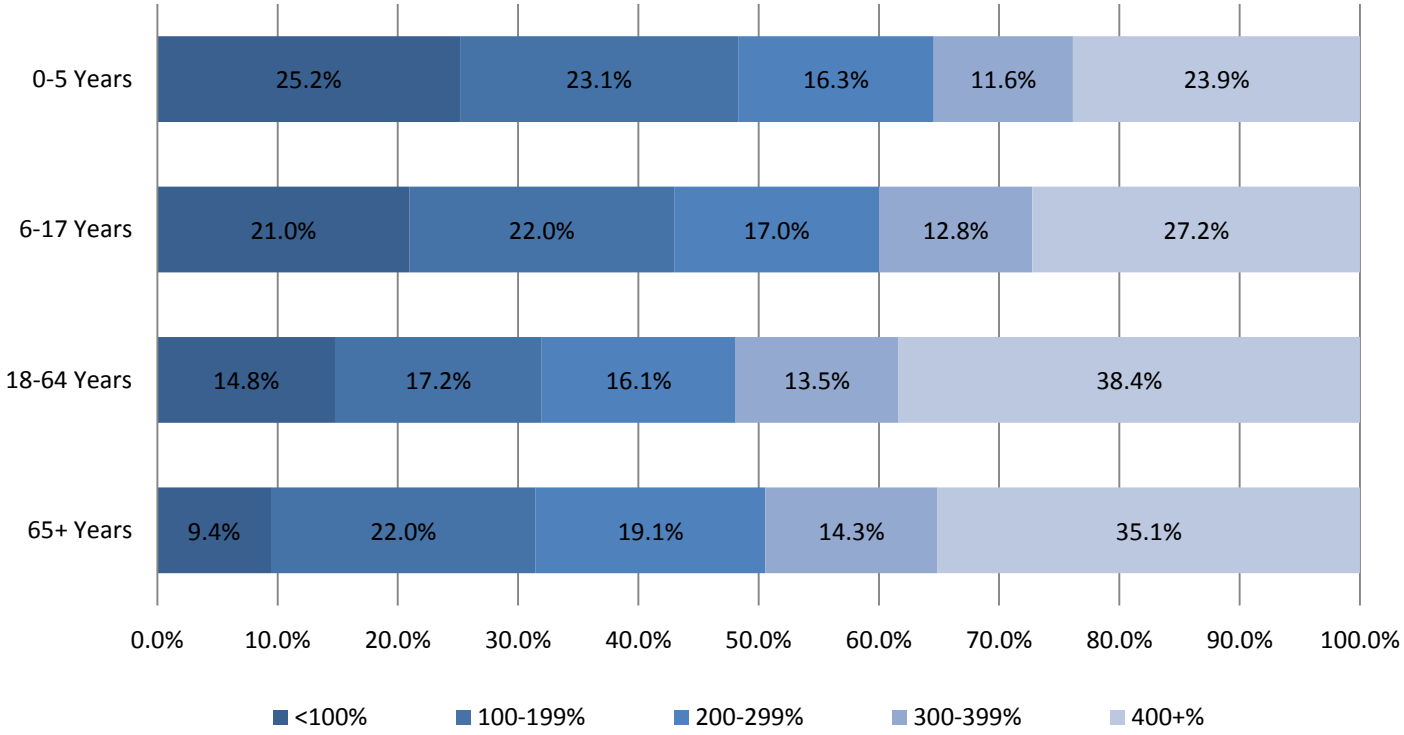
Distribution of the U.S. population by race/ethnicity and age 2013



Source: United States Census Bureau, Population Division 2013

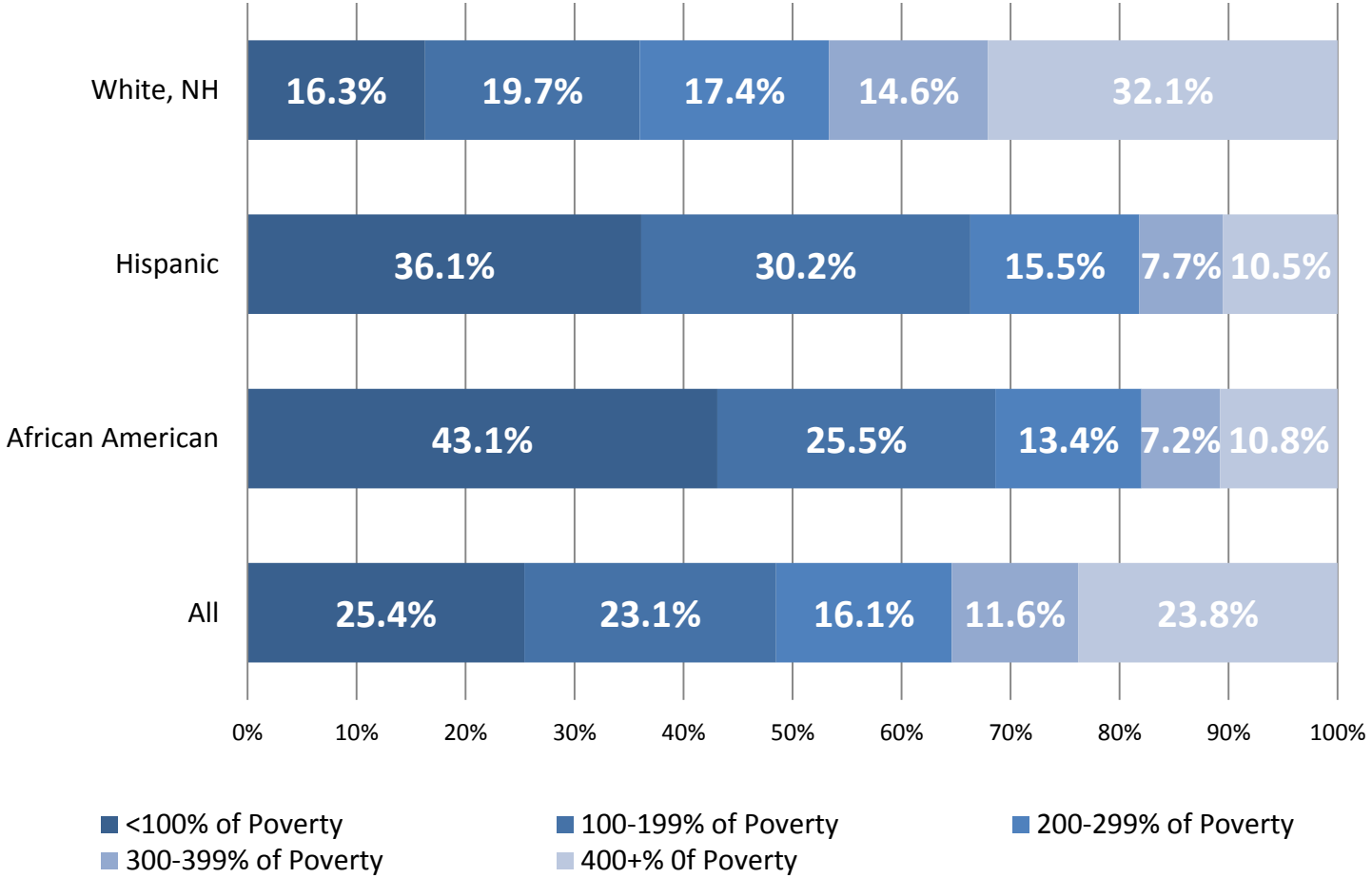
Young Children Age Group Most Likely to Live in Poverty

Distribution of the U.S. population by household income and age
2013



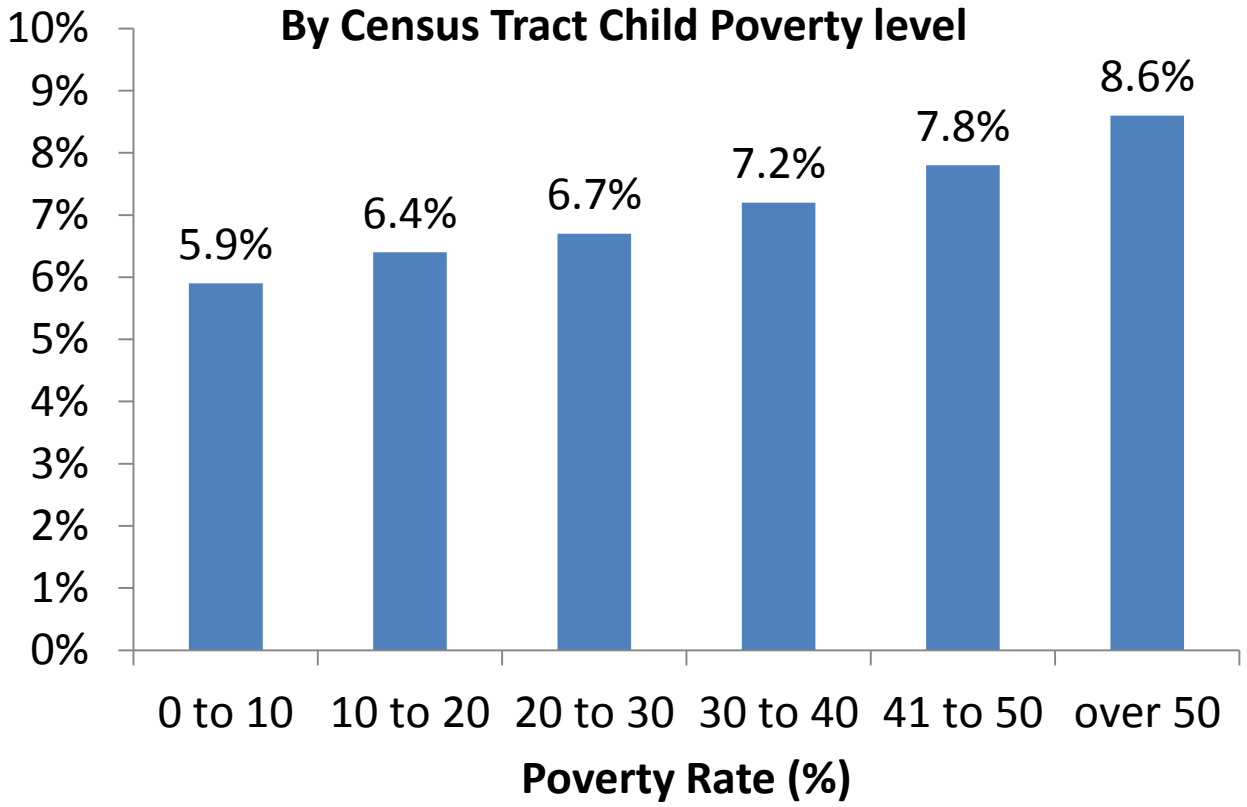
Source: U.S. Census Bureau, Public Use Microdata Sample, 2011-2013

Most Diverse Youngest, by far the Most Economically Disadvantaged



Source: United States Census, Public Use Microdata Sample 2012

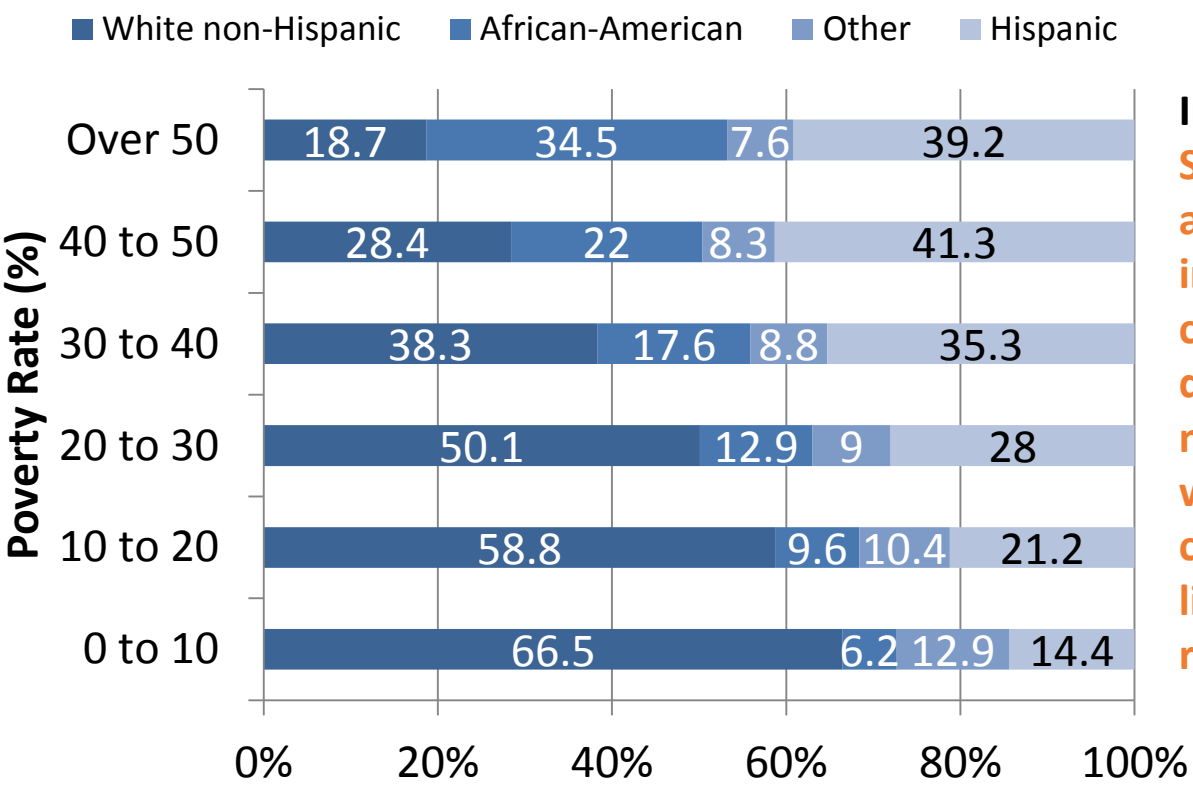
Poorest Neighborhoods: Wealthy in Young Children



Implication: **Poorest neighborhoods need half again as many child and family-friendly gathering points, activities, and supports.**

Source: United States Census Bureau, Population Division 2013

Poorest Neighborhoods: Highly Segregated



Implication:
Strategies need to address issues of inclusion and combat discrimination and marginalization, as well as being culturally and linguistically responsive.

Note: While 8.4 percent of White, non-Hispanic children live in census tracts where the poverty rate is above 40 percent, 38.2 percent of African Americans, 31.9 percent of Native Americans, and 28.9 percent of Hispanics do.

Poor Neighborhoods: Less Economic, Educational, and Physical Capital

Poorest tracts (50%+ child poverty) compared to least poor tracts (10%- child poverty):		
	Poorest	Least Poor
Single parent families	60.1%	24.6%
Disconnected Youth (16 yrs. – 19 yrs.)	16.4%	5.4%
Adults without high school degree	28.8%	7.3%
Adults with college degree	12.7%	41.1%
Households with wage income	66.4%	78.3%
Households with savings/wealth	8.2%	30.1%
Owner-occupied housing	41.1%	75.2%
Preschool participation 3-5 year-olds	37.3%	49.4%
Young children of color	81.3%	33.5%

Implication: Whether or not a family is experiencing poverty, living in these poorest neighborhoods means there are likely to be fewer protective factors and more risk factors with which their children must contend as they shape their dreams and future expectations.

Digging Deeper: Two Polk County Neighborhoods

Viva East Bank

South Johnston

Recreational Capital

	Viva EB	S. Johnston
Baseball, soccer, basket-ball, tennis fields/courts	5	16
Miles of bike paths	1	35
Cub, brownie, girl scout troops --- participants	3 41	25 352
Private music/ swimming/ martial arts locations	0	9
Home swimming pools	0	68

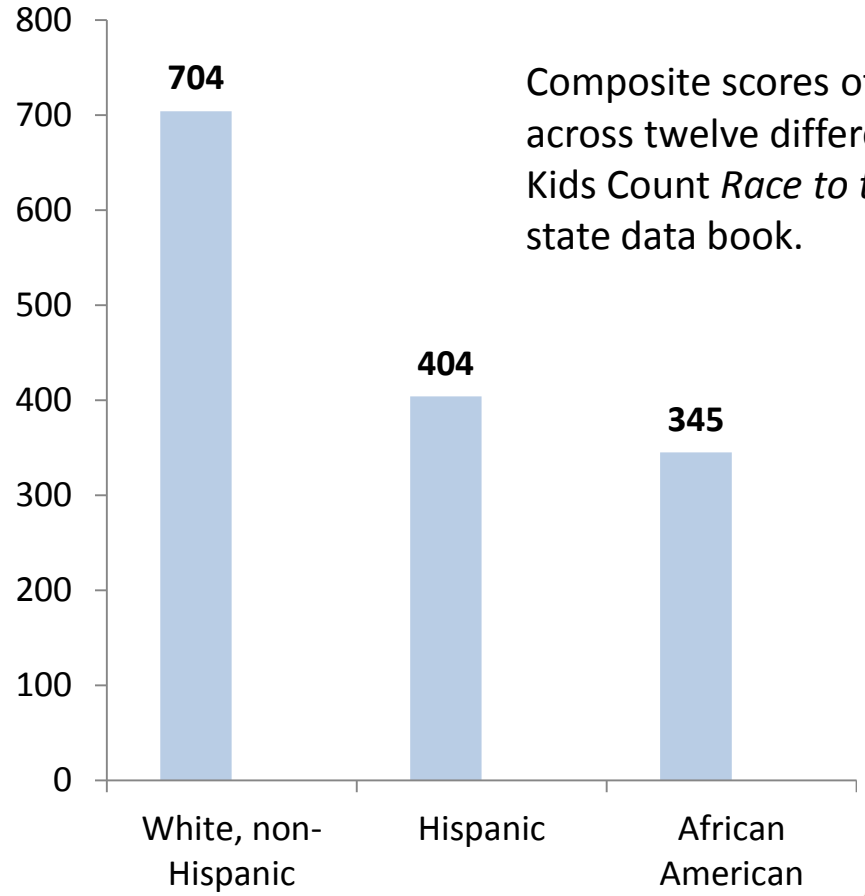
Commercial Capital

	Viva EB	S. Johnston
Banks	1	7
Payday lending/ check cashing	3	1
Nearby grocery stores	1	5
Non-grocery stores that accept SNAP	42	12
Pet clinics and hospitals	0	4
Laundromats	8	2

Literary Capital

	Viva EB	S. Johnston
Public Schools	5	7
Computers in school labs	40	100+
Corporate partners for schools	5	22
Library	Small	Large
Home-reported preschool participation of 4 year-olds	35%	60%
Bookstores	0	3

Child Health and Other Disparities Profound by Race



Composite scores of child well-being across twelve different indicators: Kids Count *Race to the Top 2014* 50 state data book.

Innate Human Capital: Resident Hopes for Children and Community

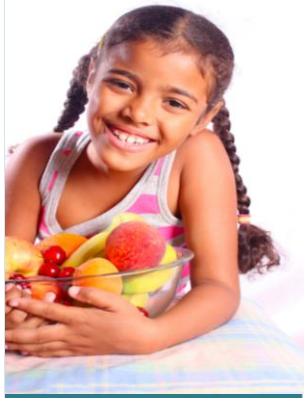
Detailed household surveys and focused front-steps interviewing/kitchen table conversations in Viva East Bank:

1. Kids rank high on what adults want for their community – activities and opportunities for children and youth tops list (above jobs, community safety)

2. Schools and churches seen as loci for additional services and supports

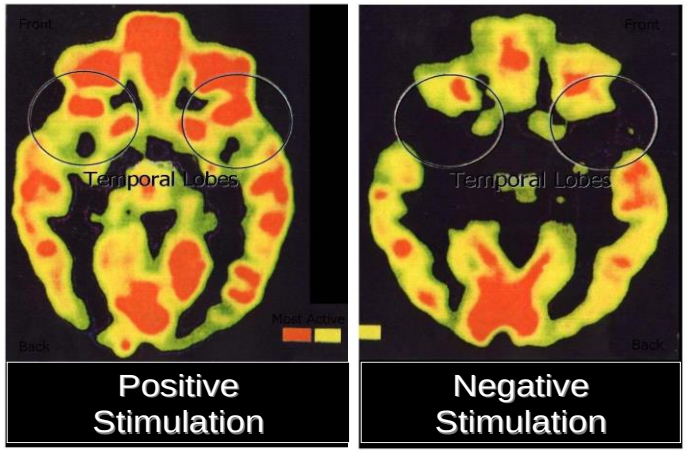
3. Residents want to contribute to their community – volunteer interest especially high around working with children

2. Science Shows the First Years of Life Most Critical…



- Protective Factors (Strengthening Families)
- Adverse Childhood Experiences (Center for Disease Control and Prevention)
- Resiliency (American Academy of Pediatrics)
- Epigenetics (Genetics)
- Neurobiology (Brain Research)
- Toxic Stress (Center on the
- Developing Child)
- Social Determinants of Health

(World Health Organization)



Harry T. Chugani, MD, PET Center Director, Chief of Pediatric Neurology and Developmental Pediatrics, Children's Hospital of Michigan

…and Science Spells out Where to Focus

Protective Factors

Adverse Childhood Experiences

Resiliency

Epigenetics

Neurobiology

Toxic Stress

Social Determinants of Health

P.S. Different Scientific Disciplines Point to the Same Set of Needs

The Social Gradient. Life expectancy is shorter and most diseases are more common further down the social ladder. [**Concrete services and supports in times of need**]

Early Life. A good start in life means supporting mothers and young children; the health impact of early development and education lasts a lifetime. [**Knowledge of healthy child development**]

Stress. Stressful circumstances, making people feel worried, anxious and unable to cope, are damaging to health. [**Resiliency**]

Social Exclusion. By causing hardship and resentment, poverty, social exclusion and discrimination cost lives. [**Positive and supportive activities with children**]

Social Support. Friendship, good social relations and strong supportive networks improve health at home, at work and in the community. [**Social ties**]

Social Determinants – WHO **Protective Factors** – CSSP

Conclusions from P.A.R.E.N.T.S. Science and other Research on the Role of Families

- Parents are their child's first teacher, nurse, safety officer, and guide to the world.
- The safety, consistency, and nurturing in the home health and learning environment is critical and foundational to ensuring positive health trajectories (CDC).
- Inclusion and cultural responsiveness in the earliest years are key to combating bias, discrimination, and devaluation that produce stress and diminish resiliency for children of color (and promote adverse impacts on those who learn to be prejudiced).

Outcome One for young child health is a safe, stable, and nurturing home (and community) environment.

3. Starting at the Start: Health Practitioners and Youngest Children (0-3)

91.0% have a well-child visit

55.2% receive health coverage under Medicaid/CHIP (avg. 2.2 well-child visits per year)

15% in some form of regulated child care

4.5% in families that receive public assistance (TANF)

4.2% receive a subsidy for child care (CCDBG)

2.7% receive early intervention services (Part C)

1.5% receive Early Head Start/MIECHV (home visiting)

0.7% in foster placement

Child health practitioners are the point of first contact with young children and their families and can play a critical, "first responder role."

Young Children and their Families: Current Needs and Actions

Current Range of Young Child Needs

HIGH

LOW

Tier One: 2-4% Child-Specific Great Medical Complexity

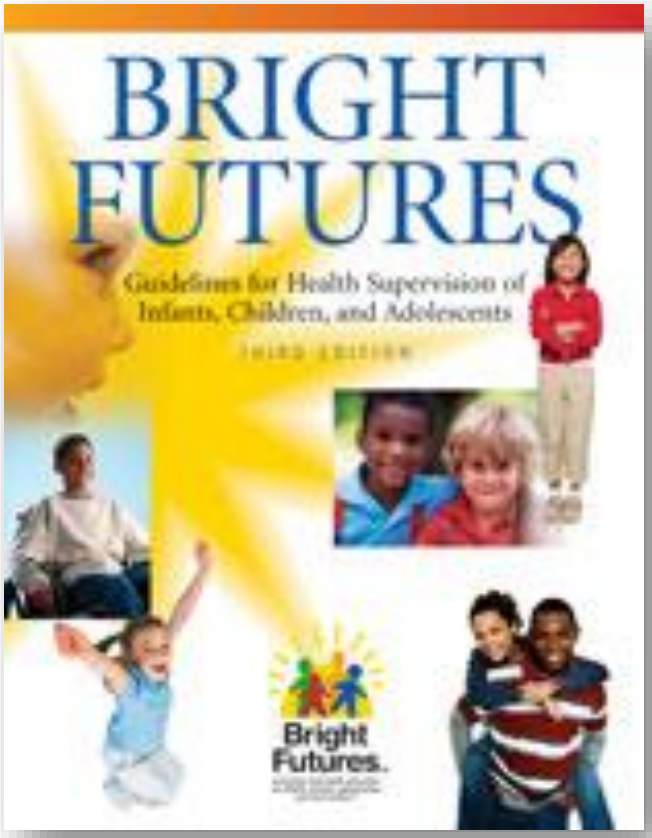
Tier Two: 10-14% Significant Diagnosable Health/MH/DD Needs

Tier Three: 30-40% Child/Family Compromised Behavioral, Developmental, Learning Concerns

Tier Four: 60-70% Remaining Children Without Special Needs or Concerns/For Now

Adapted from slide developed Dr. Neal Halfon, UCLA Center for Healthier Children, Families, and Communities

4. Building on Success: The Evidence Base in Practice



Help Me Grow National Center

HEALTHY STEPS℠

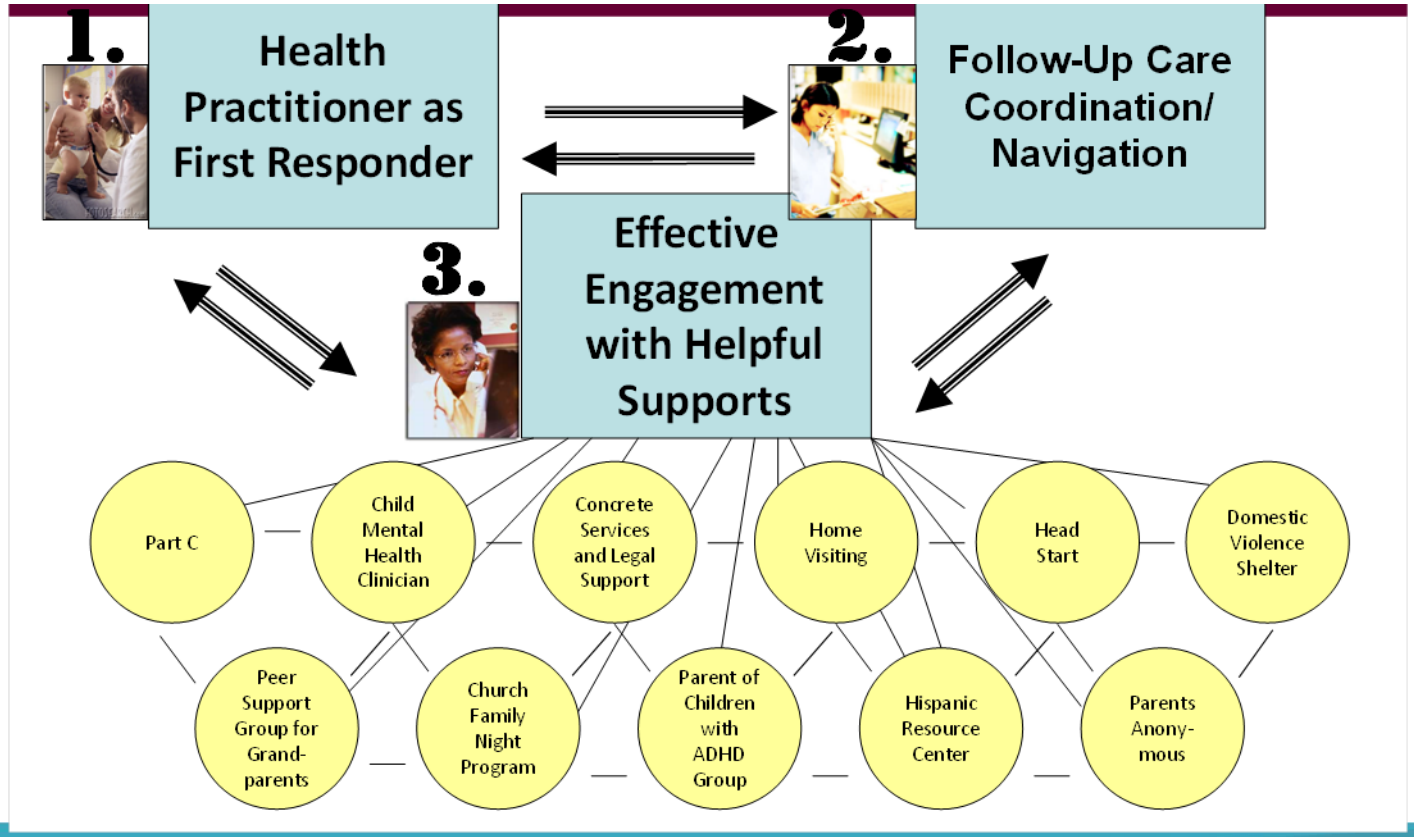
developmental understanding & legal collaboration for everyone
dulce

child first

MYCHILD

Three Essential Components of Evidence-Based Practice

The Child Health Practitioner as Part of a Health Neighborhood and Community



Roles at Each Component Level

Child Health Practitioner/First Responder

- Culturally and linguistically responsive practice
- Developmental and environmental surveillance and screening
- Anticipatory guidance
- Referral for “medically necessary” services
- Referral to care coordination

Care Coordinator/Networker

- Motivational interviewing and whole child/family approach to identify further needs/opportunities
- Identification of available services and supports which meet those needs in the context of family race, culture, and language
- Connection of children and families to services (referral/scheduling/follow-up/practitioner notification)

Community Service Maven (Community utility)

- Community networker and builder across “medically necessary” and other community services
- Community building and work with and support of diverse community leadership in facilitative role

Spreading and Financing Practices: Policy Roles

Build a critical mass of innovators and early adopters and expand the field

- Identify and support health practitioners seeking to innovate within their practices and recognize their work
- Encourage action to support at federal level, particularly within CMMI (SIMs, FOA for Young Children)
- Expand from "developmental screening" to "environmental screening" (including within HRSA)

Cover approaches under Medicaid and Other Insurance

- Define "medical necessity" to include environmental (not just child-specific) diagnoses
- Use service and administrative claiming to cover three elements
- Establish a welcome to Medicaid child visit with requirements for comprehensive screening and follow-up
- Include family stability and nurturing as core measure and outcome

Define the triple aim for young children and make accountable care accountable to healthy child development

- Build requirements for exemplary primary-preventive practice and follow-ups to occur
- Direct portion of "shared savings" to actions with longer-term impacts

Extending Beyond Clinical Care: Building Villages

Community connections as well as formal public services essential – time, place, and opportunity to connect with others and provide a supportive community – e.g. “village building”

Role of FCHCs, hospitals, and other health providers as part of that supportive community and locus for activities

Place, inclusion, and cultural and linguistic reciprocity matter.

A Hopeful and Necessary Conclusion (Home Run)

That three month visit started a chain of connections and supports. When her now 36-month daughter came in for a checkup, she was looking forward to the visit, knowing she will receive a new book and excited to tell the nurse she will be going to Head Start next month. The mother has with her an ASQ form, completed at her family day-care home, and a set of questions for the practitioner about her daughter, who's already starting to read. The mother is in a mutual assistance group with other parents and wants help from the practitioner in getting more dentists who will serve children in their community.

Measuring Success and Recognizing Home Runs are Rare

Effective practices should have a few encounters where they contribute to someone hitting a home run (which are substantively significant even if they aren't statistically significant).

As important is contributing to more singles and walks and even going up to the plate and taking a swing (which are important but often are discounted as not producing a score in themselves).

Evaluation and measurement is needed to assess impact, but must be based upon what is realistic and not expected everyone (or even a large portion) to hit home runs.

Summarizing: Takeaway Thoughts for Discussion

Primary child health practitioners have a role, but not the only role, to play in improving child health.

They should be held accountable to that role, but not others' roles.

There are particular opportunities for primary health practitioners to play this role in poor neighborhoods.

Additional Resources

- Top 10 Things We Know about Young Children and Health Equity… and Three Things We Need to Do with What We Know
- Fifty State Chart Book: Dimensions of Diversity and the Young Child Population
- Where Place Matters Most (and Village Building and School Readiness: Closing Opportunity Gaps in a Diverse Society)
- Healthy Child Storybook of Exemplary Programs and Practices

Sharing What We Learned

CFPC and BUILD want to partner with others and bring a learning community approach to further development and diffusion. CFPC and BUILD have teamed to create a **Learning Collaborative on Health Equity and Young Children**.

For more information:

www.buildinitiative.org

www.cfpciowa.org

Learning Center on HEALTH EQUITY & Young Children

a partnership between the BUILD Initiative & the Child and Family Policy Center