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

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INTRODUCTIONS

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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
Overview

• When families are pushed into poverty and social exclusion, the results are often devastating for children.
  – Difficult to provide adequate care for their children
  – Many deprived of: healthy diet, access to quality health care or learning opportunities.
  – In danger of facing violence and maltreatment.
  – Risk being separated from their families

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 individuals & networks have a major effect on opportunities.

Detrimental to healthy child development and learning

Fifty State Chart Book, CFPC
Race for Results, Annie E. Casey
The Learning Collaborative has three primary goals:

1. Raise understanding and awareness
2. Advance knowledge
3. Develop and support leaders

The Learning Collaborative facilitates learning to:

- Integrate the assets of the health and early learning systems
- Promote equitable outcomes for young children
- Produce policy and practice change
The Learning Collaborative strategies for achieving these goals include:

• Information exchange with peers
  – cross-state webinars
  – learning tables
  – online discussions &
  – in-person meetings

• Targeted state/community support
  – move a data point

• Create and support a group of health champions and innovators in a CoIN.
Today's Focus

Child Health Practitioner Role contributing to Health Equity
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 Imperative: Equity in Diversity

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

Martin Luther King

We cannot allow a child’s zip code or color of skin determine the child’s health.

Maxine Hayes
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 medical condition which requires attention today, the practitioner fears that, in two years, 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?
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
- 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

- **0-5 Years**
  - <100%: 25.2%
  - 100-199%: 23.1%
  - 200-299%: 16.3%
  - 300-399%: 11.6%
  - 400+%: 23.9%

- **6-17 Years**
  - <100%: 21.0%
  - 100-199%: 22.0%
  - 200-299%: 17.0%
  - 300-399%: 12.8%
  - 400+%: 27.2%

- **18-64 Years**
  - <100%: 14.8%
  - 100-199%: 17.2%
  - 200-299%: 16.1%
  - 300-399%: 13.5%
  - 400+%: 38.4%

- **65+ Years**
  - <100%: 9.4%
  - 100-199%: 22.0%
  - 200-299%: 19.1%
  - 300-399%: 14.3%
  - 400+%: 35.1%

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
Place Matters: Poorest Neighborhoods Face Multiple Challenges to Achieving Health Equity

Poorest tracts compared to least poor tracts

- Single parent families (60.1% to 24.6%)
- Adults without high school degree (28.8% to 7.3%)
- Adults with college degree (12.7% to 41.1%)
- Households with wage income (66.4% to 78.3%)
- Owner-occupied housing (41.1% to 75.2%)

(Poorest tracts – 50%+ child poverty; least poor tracts – less than 10%)
Poorest Neighborhoods: Wealthy in Young Children

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

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

<table>
<thead>
<tr>
<th>Poverty Rate (%)</th>
<th>White non-Hispanic</th>
<th>African-American</th>
<th>Other</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 50</td>
<td>18.7</td>
<td>34.5</td>
<td>7.6</td>
<td>39.2</td>
</tr>
<tr>
<td>40 to 50</td>
<td>28.4</td>
<td>22</td>
<td>8.3</td>
<td>41.3</td>
</tr>
<tr>
<td>30 to 40</td>
<td>38.3</td>
<td>17.6</td>
<td>8.8</td>
<td>35.3</td>
</tr>
<tr>
<td>20 to 30</td>
<td>50.1</td>
<td>12.9</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>10 to 20</td>
<td>58.8</td>
<td>9.6</td>
<td>10.4</td>
<td>21.2</td>
</tr>
<tr>
<td>0 to 10</td>
<td>66.5</td>
<td>6.2</td>
<td>12.9</td>
<td>14.4</td>
</tr>
</tbody>
</table>

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.

Implication:
Strategies need to address issues of inclusion and combat discrimination and marginalization, as well as being culturally and linguistically responsive.
Composite scores of child well-being across twelve different indicators:

## What We Know About Child Well-Being: Disparities Start Early

<table>
<thead>
<tr>
<th>Indicator</th>
<th>White</th>
<th>African American</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Below poverty (0-5)</strong></td>
<td>161</td>
<td>427</td>
<td>361</td>
</tr>
<tr>
<td><strong>Infant Mortality</strong></td>
<td>5.3</td>
<td>12.2</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Low birthweight</strong></td>
<td>70</td>
<td>132</td>
<td>70</td>
</tr>
<tr>
<td><strong>Uninsured (0-17)</strong></td>
<td>39</td>
<td>49</td>
<td>97</td>
</tr>
<tr>
<td><strong>Foster care</strong></td>
<td>5.5</td>
<td>10.7</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Part C participation</strong></td>
<td>28</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td><strong>Maternal health poor or fair (0-17)</strong></td>
<td>57</td>
<td>114</td>
<td>100</td>
</tr>
<tr>
<td><strong>Unsafe neighborhood (0-17)</strong></td>
<td>68</td>
<td>230</td>
<td>228</td>
</tr>
</tbody>
</table>

*Early intervention services for infants and toddlers with disabilities (birth-3) have been a part of IDEA since 1986. This section of the law is commonly known as Part C of IDEA.*

- **Young children (0-5) most diverse age segment of society** (50% Hispanic or of color, compared with 20% of seniors)
- **Young children most likely to live in poverty** (25% of young children live in poverty, compared with 9% of seniors)
Question 1:
Where is your state or community in terms of having data/information about young children, their diversity, and their needs?

a) Have good information for now  
b) Have some, want more  
c) Starting to plan to get some  
d) Not on our radar right now
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.

Outcome One for young child health is a safe, stable, and nurturing home (and community) environment.
Question 2:
Where is your state/community in terms of a focus upon policies and investments to ensure safety, stability, and nurturing in the home environment?

a) Top of our list and work  
b) Emerged as a focus  
c) On the horizon for discussion  
d) Hasn’t come up  
e) We can’t go there
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

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
Three Essential Components of Evidence-Based Practice

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

1. Health Practitioner as First Responder

2. Follow-Up Care Coordination/Navigation

3. Effective Engagement with Helpful Supports

- Part C
- Child Mental Health Clinician
- Concrete Services and Legal Support
- Home Visiting
- Head Start
- Domestic Violence Shelter
- Peer Support Group for Grandparents
- Church Family Night Program
- Parent of Children with ADHD Group
- Hispanic Resource Center
- Parents Anonymous
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 expanding 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 HRSÅ)

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

Health Equity and Young Children, February 25, 2016
Question 3:
Where is your state/community in terms of promoting practice and policy changes in primary child health practitioner roles?

a) Have critical base to go to scale  
b) Working on policies to build base  
c) Having discussions across fields  
d) Beginning to consider  
e) What??
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”

*It takes a multi-disciplinary team-village to raise a child.*

Place, inclusion, and cultural and linguistic reciprocity matter.
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.
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
Question 4:
What would you MOST like next from the Learning Collaborative?

a) Making the case
b) Gathering data and research
c) Building the health practitioner field
d) Developing policy
e) Good for now
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