Health Equity and Young Children

1. The Faces We Face: The Challenge and Opportunity
2. Why It’s Important: Young Children, Diversity, and Equity
3. What We Know: The P.A.R.E.N.T.S. Science
4. Starting at the Start: 1st Five in Iowa
5. Moving Forward: Implications to Health Reform and Systems Building
6. The Faces We Face: A Hopeful and Necessary Resolution
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?
Young children (0-5) most diverse age segment of society (50% Hispanic or of color, compared with 20% of seniors) [51% Hispanic or of color, New York]

Young children most likely to live in poverty (25% of young children live in poverty, compared with 9% of seniors) [24% in poverty, New York]

Huge health and other disparities exist by race and ethnicity – by income, by multiple measures of child well-being, and by place
Our most diverse youngest are (by far) the most economically disadvantaged ...

Source: United States Census, Public Use Microdata Sample 2012
… and have the poorest overall measures of child well-being.

... and live in the neighborhoods with the greatest needs.

### Poor Neighborhoods Rich in Young Children
- Highest risk tracts: 9.2% of pop. children 0-4
- Lowest risk tracts: 6.1% of pop. children 0-4

### Poor Neighborhoods Home to Most Diverse Children
- Highest risk tracts: 82.4% of color
- Lowest risk tracts: 16.8% of color

Poor Neighborhoods have higher rates of:
- single parent families (53.1% to 20.5%),
- poor families with children (41.4% to 7.2%),
- adults without high school degree (48.0% to 13.5%),
- HoH wage income (69.1% to 80.6%),
- rental status (70.6% to 29.0%).
3. Science Shows the First Years of Life Most Critical…

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

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... and Science Spells Out Where to Focus.

- Protective Factors
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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.

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.

It’s about relationships and authenticity.
Where youngest children (0-2) are served by public services and systems

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

20-40% vulnerable to adversity and compromised well-being due to absence of protective factors, isolation and exclusion.
The role of the health practitioner as “first responder.”

The link between clinical care, family strengthening, and community building.

The opportunity for a systemic approach.
Three Components of 1st Five ...

1. **Health Practitioner Screening & Surveillance**
   - "Do you have questions about how your child is learning, behaving, or developing?"
   - Developmental screening tools

2. **Community Resource Connections**
   - Identifying and updating resources in community
   - Developing networks across providers and community resources
   - Building community capacity for response

3. **CC/HV Follow-up Actions**
   - Engaging family
   - Securing professional services
   - Securing community supports
   - Providing practitioner with feedback

Representation of coordination aspects to medical and transmedical services

- **Part C**
- **Child Mental Health Clinician**
- **Immunologist**
- **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**
... And Roles at Each Level

- **Child Health Practitioner**
  - Developmental 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 can meet those needs
  - 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
The Iowa Health Experience/Cast of Dozens

- 2003-2006 Iowa ABCD Initiative (developmental screening and surveillance/Medicaid changes)
- 2006 state funding for demonstration HELP ME GROW/1st FIVE Initiative
- 2010 Membership in HMG national network
- 2012 Further coverage of features of 1st Five under Medicaid (administrative claiming)
- 2013 Expansion of State Funding for 1st Five/Links to Child Health Specialty Clinics
- 2014 Discussion of child health metrics and focus on children within state SIM grants
- 2015 Consideration of children in Medicaid MCO/ACO transition
• Of the over 9,000 needs identified among nearly 7,600 families, 46 percent were for child health or developmental concerns (including speech and hearing).
• Another 37 percent of referrals were related to family stress and day-to-day resource needs.
• The final 17 percent ranged from caregiver depression and social and behavioral worries to language barriers and parent education needs.
Of 19,223 connections:
- 29 percent were for resource needs
- 20 percent for family-support services
- 18 percent for health-related needs
- 14 percent for early-intervention services
- The remaining 20 percent were for oral- and mental-health care and other family needs
1st Five Outcomes

- 90 percent of families reported they benefited from participation
- 80 percent of families reported the home (safety, health, and learning) environment was enhanced
- Practitioners reported that 1st Five was helpful for the vast majority of families they referred
- There were some reported “home runs”
- E.g. 1st Five had an impact upon the safety, consistency, and nurturing in the home health and learning environment.
Some Reflections and Opportunities on State Policy

• Initial funding as a state demonstration, transitioned to incorporation of developmental screening and care coordination as Medicaid billable services and practitioner training and community health liaison as Medicaid administrative claiming – Medicaid and EPSDT can and should be a major source for funding

• Incorporation of social determinants of health into SIMs grant as metrics and emphasis upon redirecting some shared savings to children’s healthy development

• Current discussion of contractual directives to MCOs/ACOs under Medicaid to provide incentives for 1st Five-type child health initiatives
Community connections as well as formal public services – 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.*

Both clinical health and public health as necessary contributors.
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

• Village Building and School Readiness: Closing Opportunity Gaps in a Diverse Society

• Healthy Child Storybook
CFPC and BUILD want to be partners in this work and bring a learning community approach to our work. For more information:

www.cfpciowa.org
www.buildinitiative.org