Transforming Young Child Primary Health Care Practice to Achieve Health Equity

Collaborative Innovation Network’s Kitchen Cabinet Policy Statement

August, 2016
BUILD & the Child and Family Policy Center launched the Learning Collaborative on Health Equity and Young Children (LCHEYC) in 2015.

Funding from the Robert Wood Johnson Foundation under “Building a Culture of Health”
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
Today’s Webinar

• Summarize the current science of healthy early childhood development

• Summarize the Collaborative Innovative Network (CoIN)’s Kitchen Cabinet Policy Statement

August 2016
The Science of Healthy Early Childhood Development…

- 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 What That Science Spells.

**P**rotective Factors

**A**dverse Childhood Experiences

**R**esiliency

**E**pigenetics

**N**eurobiology

**T**oxic Stress

**S**ocial Determinants of Health
Different Disciplines Point to the Same Set of Needs

<table>
<thead>
<tr>
<th>Social determinants (WHO)</th>
<th>Protective factors (CSSP)</th>
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<td>The social gradient</td>
<td>Concrete services and supports in times of need</td>
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<td>Early Life</td>
<td>Knowledge of healthy child development</td>
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<td>Stress</td>
<td>Resiliency</td>
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<td>Social exclusion</td>
<td>Positive and supportive activities with children</td>
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<td>Social support</td>
<td>Social ties</td>
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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.”
Getting the Best Answers to the Question: Drawing Upon Expertise

Exploring the role that the young child primary health practice play can and should the in addressing social determinants of health.
LCHEYC’s Kitchen Cabinet and CoIN

**Kitchen Cabinet:** Leaders linking practice and Policy. KC supports the work of the exemplary programs/models participating in the LCHEYC’s CoIN and share findings and implications with field.

**CoIN:** Implementers of exemplary programs/models. CoIN continues to innovate and develop models for diffusion, scaling, and moving exemplary programs/models to a standard of care.

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LCHEYC Kitchen Cabinet Members

- *Maxine Hayes, M.D.
- *Ed Schor, M.D.
- Kay Johnson, MEd and MPH
- Angela Suaia, M.D.
- Paul Dworkin, M.D.
- * Judy Shaw, RN, MPH, and Ed.D
- Amy Fine, MPH
- Charlie Bruner, Ph.D

* Kitchen Cabinet members who attended the CoIN Launch
Role of the Kitchen Cabinet

- Present the evidence and make the case for the role of the young child primary health practitioner/practice in responding to social determinants of health.
- Support the work of the CoIN in furthering innovation, diffusion, and policy reforms and investments.
- Advocate for local, state and federal policies that support the sustainability and expansion of exemplary programs into standards of care.
The Kitchen Cabinet’s Policy Statement: Making the Case

Kitchen Cabinet Presenter

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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. The practitioner knows her child is on Medicaid, she lives in the poorest neighborhood in town, and likely is feeling some discrimination against her and her child because of her dress, skin color, accent, or language. While there isn’t a child medical condition which requires attention today, the practitioner fears that, if the family is not supported, the child is in jeopardy of experiencing significant indicators of development delay or social and emotional problems in the future.

What can the child health practice do to address what are clearly more than and different from medical needs?
Framework of the Kitchen Cabinet
Policy Statement

• Highlights an emerging vision/approach/field in young child primary health care and exemplary programs embracing this approach and the results they achieve

• Describes the common functions and attributes of exemplary programs – and what leads to their results

• Describes next steps in moving from exemplary programs to a transformed standard of care

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Highlights of the Kitchen Cabinet Policy Statement

1. The Readiness of the Young Child Primary Health Care Field for Transformation
2. Exemplary Practices Showing the Way
3. Core Components and Attributes of Exemplary Practice
4. Policies to Move from Exemplary Practice to Standard of Care

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1. Readiness for Practice Transformation

• Original concept of patient-centered/family-centered medical home came from pediatrics.
• Standards for well-child care, as presented in Bright Futures, reflect broad attention to children’s developmental health.
• Medicaid’s EPSDT provisions recognize children’s health needs as broader than adults.
• AAP stresses the importance of responding to poverty and social determinants of health, as does forthcoming edition of Bright Futures.
• Models are advancing in the field that show evidence of impact on such determinants.
2a. Exemplary Programs Exist to Build Upon

Programs in the Learning Collaborative CoIN: Selected for Leadership and Success

- Child First
- Early Childhood Mental Health
- Health Network by Cincinnati Children’s
- Healthy Development Services San Diego
- Healthy Steps for Young Children
- Help Me Grow
- Medical Legal Partnership
- Project DULCE
- Safe Environment for Every Kid (SEEK)
2b. Exemplary Programs Show Evidence of Impact

• Programs have research showing efficacy in engaging and strengthening families and achieving initial impacts on healthy child development.

• Primary care health practitioners have a unique opportunity to identify and initiate responses that do engage and strengthen families.

• Primary care child health practitioners have a role, but not the only role, to play in improving child health, one that requires recognizing and responding to current demands upon them.
3a. Core Program Components and Attributes

• While each program has distinctive elements, they all share core components and attributes that represent a new field/vision practice.

• The core components include an initial role for the primary practitioner/office in identifying families coupled with additional time and resources for a care coordinator/advocate and community service maven/networker to strengthen families through a protective factors approach.

• Attention to quality, a team approach, and engagement of families to enhance their agency are core attributes to success.
Three core components
- Health Practitioner as the first contact, Care Coordinator, and Community Networker
- These three components are needed functions, they may be configured differently and not always be separated into three discrete positions

**Health Practice/First Contact**
- Developmental/environmen tal surveillance and screening
- Anticipatory guidance
- Referral for “medical necessity”
- Referral for care coordination

**Care Coordinator/Family Advocate**
- Engagement and whole child/family approach to identify needs and opportunities
- Connection of families to services and supports to address social as well as clinical determinants of health (scheduling and follow-up)

**Community Services Maven/Networker**
- Community networking and identification of services and supports
- Continued connections with community services and supports to enhance capacity and alignment

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3c. Attributes of Exemplary Program

Families at the Center of the Work
- All those who connect with families value them, seek to build upon their strengths and agency, and use their feedback to provide better services
- There is continuity and consistency in approach that is evident to the families served

Teamwork and Valuing of Everyone’s Roles and Expertise
- All individuals (practitioner, coordinator/navigator, other personnel) involved with the child and family work together and respect each others’ roles and learn from one another
- Primary care child health practitioners provides a “warm handoff” as other partners assume the more concerted relational role with families to facilitate their growth
3d. Ideal Roles/Attributes 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/Family Advocate
- 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 and supports (referral/scheduling/follow-up/practitioner notification)

Community Service Maven/Networker (Community Utility)
- Community networking and building across “medically necessary” and other community services
- Community building and work with and support of diverse community leadership in a facilitative role

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4a. Policies to Move from Exemplary Practice to Standard of Care

Biggest challenge/need is to move from exemplary practice in a few locations to broad-based adoption and recognition as the standard of care.

This requires both qualitatively and quantitatively different investments in young child primary health care.

Actions can be taken in multiple areas.
4b. Policies to Move from Exemplary Practice to Standard of Care

1. 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 actions and investments at the federal level, particularly within CMMI (SIMs, FOA for Young Children)
   - Engage in continuous learning and improvement in expanding the field (CoIN)

2. Cover components under Medicaid and Other Insurance
   - Work within states to include environmental as well as developmental screens
   - Use service and administrative claiming to cover the three elements
   - Include family stability and nurturing as core measures and outcomes

3. Define the triple aim for young children in life course terms and make accountable care accountable to healthy child development
   - Build requirements for exemplary primary-preventive practice and follow-ups to occur within contracts for ACOs and MCOs
   - Direct portion of “shared savings” to actions with longer-term impacts
A Hopeful and Necessary Conclusion

That three month visit started a chain of connections and supports. Her now 36-month daughter came in looking forward to the checkup, knowing she would 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 group with other parents and wants help from the practitioner in getting more dentists who will serve children in their community.

These are the stories that each of the exemplary practices can tell!
Responses from the CoIN: Practitioner Imperatives

Carrie Chapman, Director, Public Benefits Practice Group Medical Legal Partnership and CoIN Member

Howard Dubowitz, Professor of Pediatrics and Director of the Center for Families at the University of Maryland School of Medicine in Baltimore, SEEK Director and CoIN Member
Medical Legal Partnership

- MLPs was initiated in 1993 and now operate in 292 health settings in 36 states.
- MLPs embed legal professionals into the health care team to identify and respond to the social and legal issues that jeopardize patient and family health and stability and contribute to stress.
- MLPs provide individual advocacy for patients and families as well as engage with the larger community to resolve systemic issues and support policy changes aimed at improving community health.
- MLPs have demonstrated its effectiveness in stabilizing families of young children so they can provide a nurturing home, removing environmental risks from the home itself, and supporting young children’s engagement in evidence-based programs to improve their health and development.
Safe Environment for Every Child (SEEK)

- SEEK was developed in 2003 to promote children’s health, development and safety and prevent child abuse and neglect by enhancing pediatric primary care to identify and address prevalent psychosocial problems such as parental depression.
- SEEK includes training of health practitioners, routine screening of families during children’s checkups, collaboration with a social worker or behavioral health professional, parent handouts and follow-up.
- Two randomized, controlled studies - one in an urban clinic and one in suburban private practices - produced very promising results. The first showed substantial reductions in reported child abuse and neglect; the second significantly less use of harsh disciplinary practices and psychological abuse. In both, SEEK practitioners had greater comfort, perceived competence and improved behavior regarding their primary care roles.
- An economic analysis of the cost of SEEK compared with medical costs associated with child abuse revealed substantial cost savings.
The Safe Environment for Every Kid (SEEK) Model - Goals

• To help address prevalent psychosocial problems
• To support parents and parenting
• To strengthen families
• To promote children’s health, development, safety
• To prevent child abuse and neglect
Core Components of the SEEK Model

- SEEK trained medical professionals
- SEEK Parent Questionnaire
- **Brief** assessment of identified problems
- Motivational interviewing principles
- **Initially** help address problems
- Medical/behavioral health - ideal
- Knowledge of community resources
- SEEK Parent Handouts
“How can I do this in 5 minutes?”
Brief Intervention

Reflect
Empathize
Assess
Plan
Reflect

Reflect on what parent disclosed on SEEK PQ

“I see you’ve been feeling down”
Empathize

“It must be hard on you and on your kids when you’re feeling down”
Assess

- Whether true positive screen
- Nature of problem
- Parent’s interest in help
Plan

• Motivational Interviewing
• Tailored to parent’s interest
• Referral for mental health evaluation
• Follow up: with own doctor, you
How SEEK Works

• SEEK Parent Questionnaire for selected check ups
• Parent completes the PQ before visit
• Medical professional has info at start of check up
• Access to mental health professional
• Briefly assess problem(s)
• Initially help address problems
• SEEK Parent Handout
• Referral to community resource
• Follow-up
Cost Analysis

• SEEK: cost $122 per case prevented

• Compare to $14,520 ($1,993 – $21,400) for medical & mental health for one physically abused or psychologically maltreated child

• SEEK is cost saving

In Sum

- Pediatric primary care offers a good opportunity to address major psychosocial issues facing many children & families

- SEEK offers a practical model to improve pediatric primary care

- Evidence that SEEK can reduce child abuse & neglect and harsh parenting, and help promote children’s health, development and safety

- SEEK is consistent with Kitchen Cabinet model and policy statement.
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
- Kitchen Cabinet Paper and Consensus Document
- Paper on Medicaid Financing
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