InCK Marks

Dismantling Racism: 10 Compelling Reasons for Investing in a Relational/Community Health Workforce for Young Children and Their Families

Discussion Brief

InCK Marks Child Health Care Transformation Series

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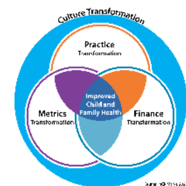

Foreword

The mission of the Integrated Care for Kids—InCK Marks initiative is to "support leaders in advancing child health care transformation." InCK Marks had its beginnings in 2015, in a Health Equity and Young Children (HE&YC) Initiative, also funded by the Robert Wood Johnson Foundation. The HE&YC Initiative also developed a discussion brief, "10 Things Policy Makers Need to Know About Health Equity and Young Children." At the time, although there were champion innovators, the field was only beginning to see the larger role that child health services could play in responding to social determinants of health.

Working with a group of those child health programs and practice change champions and innovators as a learning collaborative, HE&YC began to spell out the components of child health care transformation further developed by InCK Marks.

What we learned from the participant champions, many of whom brought frontline staff to our meetings, was that they all viewed frontline staff in their practices who provide additional help to families as fundamental to their effectiveness In most instances, these frontline staff were from the communities being served and shared the racial, cultural, and linguistic backgrounds of those in the community.

Sometimes called care coordinators and sometimes called something else, these frontline staff served as much more than connectors of children and families to community services. They fostered trusting relationships with the families served, partnered with them in defining goals and objectives, supported them in establishing nurturing home environments, and advocated with them for both their own needs and for the needs of their communities. Further, they served as key bridges or connections to the professionals within the practices in which they served and often were recognized by the professionals as advisors and mentors to them in their journeys of becoming more culturally responsive and anti-racist.

InCK Marks has further described the key roles such frontline staff play and the supports they need to be effective in its 2021 working paper, *Building a Relational Health Workforce for Young Children: A Framework for Improving Child Well-Being,* with commentaries from many of its National Advisory Team members. While that paper describes these frontline staff in terms of a "relational care workforce," the term "community health worker" also could be applied.

Today, there is much increased emphasis upon the need to eliminate health inequities and dismantle racism, and to expand the health workforce to include within these efforts community health workers, who share the backgrounds and have the trust of people living in poor, medically underserved, disinvested, and marginalized neighborhoods. At the same time, this emphasis has not necessarily focused upon the need and opportunity to dismantle racism and deploy community health workers with the needs, hopes, and potentials of young children and their families in mind. While it is important to expand a relational health/community health workforce for all residents, young and old and in families or not, it is particularly important to do so for young children and their families and critical for dismantling racism and its impacts for the next generation.

This Discussion Brief, developed by Charles Bruner, Maxine Hayes, Shadi Houshyar, Kay Johnson, and Leslie Walker-Harding, is designed to promote discussion and action to include children, and young children in particular, in efforts to build a community health/relational health workforce and to use that

workforce to advance racial equity. Moreover, the skills and empathy inherent in this workforce and its emphasis upon inclusion and realizing the aspirations of the children and families it serves also counters all other “isms” in society that jeopardize optimal growth and development. The appendices provide further information on the importance of deploying such workers within communities that have historically been marginalized by public policies and institutional practices, and on the locus of new federal funding opportunities for a community and public health workforce to focus upon young children and their families.

Dismantling Racism: 10 Compelling Reasons for Investing in a Community/Relational Health Workforce for Young Children and Their Families

Of all forms of inequality, injustice in health care is the most shocking and the most inhumane. Martin Luther King (1966)

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What we know is this: racism is a serious public health threat that directly affects the well-being of millions of Americans. … Over generations, structural inequities have resulted in stark racial and ethnic health disparities that are severe, far-reaching, and unacceptable. As the nation's leading public health agency, CDC has a critical role to play to address the impact of racism on public health. – Rochelle P. Walensky, CDC Director (2021)

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2021 provides those in the child health field with a year of opportunity – contributing to advancing child health, reducing health disparities, and dismantling racism that is at the heart of many of our society's most pressing problems. The COVID-19 pandemic has brought into sharper focus the deep-rooted inequities in our society and a call not only to respond to the urgent needs of children and their families, but also to build stronger, better, more responsive systems that will persist beyond this global pandemic. While there is increased public and policy attention to addressing racism, increased emphasis upon transforming health care from a medical to a whole health system, and new commitments to investing in a new health workforce to do so, this emphasis will only truly achieve its objectives if it directs specific attention and a good share of its investments to children and families and where they live.

Now is the time to reimagine health care and be bold. We must create a health care system that is guided by anti-racist policies and practices. This includes a health system that provides universal health care and addresses the full-range of families' health and health care-related needs by ensuring access to timely preventive care. This includes drawing upon and valuing community health workers and others with lived experience and expertise in supporting families as they navigate services. This includes actively combatting racism and other structural and social determinants of health, particularly by partnering with families through strengths-based, relational care that respects families' knowledge and expertise.

This discussion brief presents compelling reasons for doing so. We want these reasons to be the source of public discussion, policy action, and community implementation. We want children to be a priority as we grapple with creating a more just and racism-free society. We want child health care systems to be at the forefront in doing so.

Below are our ten compelling reasons for investing in a community/relational health workforce for children and their families, followed by questions we believe deserve additional concerted attention.

We look forward to both dialogue and concerted action to answer these questions as we move forward to improve child health.

- Charles Bruner, Maxine Hayes, Shadi Houshyar, Kay Johnson, Myra Jones-Taylor, and Leslie Walker-Harding

WHY YOUNG CHILDREN?

1. Starting early matters. At birth, children are developing their brains, identities, and lifelong health trajectories. Brain research has highlighted the critical importance of the first years of life for lifelong health and development. The Centers for Disease Control and Prevention and Healthy People 2030 have emphasized that safety, stability, and nurturing in the home and community environment set the critical foundation for healthy development. Families with young children who are faced with systemic and institutional racism, and other “isms,” are systemically disadvantaged, marginalized, and harmed by our systems, institutions, policies, and practices. These families are most likely to face barriers in accessing services, supports, and opportunities, and in providing safe, stable, and nurturing home environments. Further, young children are beginning to understand who they are, the color of their skin, and how that shapes how others treat and respond to them. Racism and discrimination can have both direct and strong indirect impacts upon their growth and development.

2. Children are our diverse future. While less than one-fifth of those over age 70 are people of color, one-half of children born today are children of color. Therefore, if the goal is to dismantle racism, a very significant part of the strategy must be focused on promoting racial equity at the start of life and as children grow and learn about themselves and form their own views of others. The literature on childhood experiences and social determinants of health all point to the damage that early adversity—including racism, exclusion, and marginalization— can have on long-term and often lifelong development. Alternatively, the literature on protective factors, resiliency, and social support and inclusion all point to keys to supporting healthy development in an environment that consistently nurtures, includes, and supports young children and their families.

WHY PRIMARY HEALTH CARE?

3. Primary health care is the near universal point of contract for engaging young children and their families. In terms of health insurance coverage, the United States has made very significant strides to provide coverage for children through public programs (Medicaid and CHIP). While still not universal and work must continue to make it universal, almost all children have either health coverage or have secured and receive primary health care through community health centers. Medicaid and CHIP now cover half of all young children in the country, and nearly two-thirds of Black, Hispanic, and Native American infants and toddlers. Moreover, when children are very young (birth to three), the primary health care system is the one near universal point of contact and can serve as a locus for two-generation strategies that support healthy development. It also is the time when the most well-child visits are recommended, with guidelines for those visits (*Bright Futures*) emphasizing whole child responses that engage both child and family.

5. We know enough to act. Exemplary programs and practices show success in elevating child health trajectories and reducing disparities. Fortunately, many child health practitioners across the country have expanded their focus beyond the medical needs of children they serve to focus on social, economic, and developmental factors as well. Usually through philanthropic or institutional support, programs and health system practice changes are being used to respond and engage more holistically and ecologically with children and their families. There is an emerging new field of primary pediatric practice for young children that has proved effective in optimizing child health. Many of these practices exist in poor and medically-underserved communities that have disproportionate numbers of children of color.

WHY FOCUS UPON RELATIONAL/COMMUNITY HEALTH WORKERS?

5. A multi-disciplinary research base shows the importance of well-resourced and supported relational/community health workers for improving child health. Although often not focused specifically (or at all) on children, there also has been increasing emphasis upon the role of community health workers in maintaining and advancing health. Often, this community health workforce is viewed as being substantially recruited and selected from the poorest and most disinvested neighborhoods and communities – e.g., a community-based health workforce. There is a diffuse but ultimately consistent and compelling literature (across family support, community organizing and community building, and reforms in child welfare, juvenile justice, mental health, responses to persons with disabilities, and now health care) that has identified the qualities and attributes that make this workforce effective in its role.

6. Relational/community health workers are key to success in responding to disparities and inequities by race and socio-economic status and supporting practices in being culturally and linguistically responsive and anti-racist. Although they go by different names, exemplary programs and practices incorporate some form of community health worker, or relational care coordinator (case manager) who is an integral part of the medical home team and serves as a bridge between the practice and the community and as a foundational point of trust and engagement with families and their children. The challenge now is to spread, scale, and sustain such efforts across many more medical homes and to incorporate their financing into public (and private) health coverage.

WHY FOCUS UPON PLACE?

7. Low-income neighborhoods are rich in young children and where children learn, play, and grow. When children are very young, they spend much of their time in the immediate vicinity of their home and neighborhood. Yet disinvested neighborhoods generally have far fewer safe and nurturing places, parks, school grounds, and activities that more affluent neighborhoods do. They have less safe housing and more environmental hazards and public safety concerns. Responding to correct inequities and disparities in child health requires community-building (public and population health) strategies as well as individual service changes. This makes the role of the community-based health worker/relational health worker a critical one not only in providing individual services and supports – but also serving as a point of light and nexus for mutual assistance, community advocacy, and community building.

8. Dismantling racism requires changing conditions within these neighborhoods, with a racial equity lens that relational/community health workers provide. A focus upon the most disinvested and underserved neighborhoods also must be directed to improving living conditions for people of color –

with these neighborhoods not only marginalized but usually very segregated both in terms of race and ethnicity and lacking the availability of resources and opportunities that more affluent communities have. Large shares of the population have racial, linguistic, cultural, and documentation statuses that differ from the larger communities in which they live – which can subject them to discrimination and stress and keep them from achieving their goals. Child health care systems can play an important role in providing racially and culturally responsive and reciprocal actions to counter discrimination and racism, including using their voices in advocacy within the larger community.

WHY NOW?

9. Federal investments for building back better from the COVID-19 pandemic can be used for this purpose. The Biden Administration is calling for major new investments in an expanded community health workforce, starting with funding in the American Rescue Plan Act of 2021 and calling for annual investments of at least $6.5 billion for at least 100,000 additional community health workers. Multiple Members of Congress have introduced legislation or signed onto a statement supporting the development of a community-based community health workforce, emphasizing recruiting and hiring members from within the communities to be served. While there is a major focus on building this workforce, however, its particular and special role in serving the child population has not been emphasized and requires articulation.

10. Medicaid is key to financing primary health care for children. There is momentum for for using Medicaid to move exemplary child health practice to the standard of care. Medicaid and its Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit requires that states provide comprehensive primary care and follow-up services for children. It provides an opportunity for responding from a relational perspective and supporting community health workers in doing so. At the same time, reimbursement rates for child health care and state efforts to contain Medicaid costs have meant that the vision for EPSDT has been far from realized. While children represent about half of all individuals covered by Medicaid, they contribute to only twenty percent of the costs – and the benefits to improving their development generally accrue over the long-term, not in immediate Medicaid cost savings. Although they have the potential to do so, most state Medicaid programs do little toward financing holistic, team-based child health care in high performing medical homes.

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DISUSSION QUESTIONS

1. **How can we ensure that young children are included as a concerted focus in developing a community health workforce?**

2. **How can we develop Medicaid financing opportunities that support states in advancing primary care practices and high performing medical homes, including relational/community health workers?**

3. **How can we provide data and metrics that point to neighborhoods of high need but also recognize and identify the opportunities for investing in them, including as relational/community health workers?**

4. **How can we provide training, peer support and networking, mentoring and supervision, and professional advancement for relational/community health workers so these become sustainable occupations and careers?**

5. **How do we provide the training and support needed to ensure workers have the knowledge and skills about advancing young children's healthy development (physical, cognitive, social/relational, and emotional/behavioral), with a culturally-responsive, equity-driven and anti-racist approach?**

6. **How can we ensure relational/community health workers have the support they need within their organizations to advance changes both to practitioners and office personnel and in correcting institutional or structural biases?**

7. **While young children and their families represent a particular population requiring attention from the primary health care system, the value of relational/community health workers is also critical to advancing child and adolescent health and their developmental stages and experiences. How can we also develop a relational/community health workforce sensitive to and responding effectively to older children, adolescents, and their families?**

8. **How can we continually celebrate successes and use challenges as learning opportunities in reciprocal ways that recognize the value of lived experience and community knowledge as well as professional and clinical knowledge?**

APPENDIX ONE: Place Matters

One of the important emphases in developing a relational/community health workforce is in ensuring that those with lived experience, deep knowledge of the community, and sharing the culture and language of community members are part of the helping and service community, including primary health care. This is particularly critical in poor, underserved, socially vulnerable neighborhoods and communities. Using census tract-level data available from the Center for Disease Control and Prevention website for the state of Texas shows such neighborhoods are both rich in children, where children of color disproportionately reside, and have dramatically different characteristics in terms of wealth, a built environment, educational capital, and coverage for health services.

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The Centers for Disease Control and Prevention has established a social vulnerability index (SVI) to identify census tracts deserving of much increased attention from public health. The Health Force and Resilience Force Act to establish such a community workforce (introduced in the House by Representative Panetta and in the Senate by Senators Gillibrand and Bennet) references the CDC SVI as one way to locate such a community-based health workforce.

The SVI includes fifteen data points from the American Community Survey/ACS (and provides a sixteenth related to health insurance coverage) in categorizing all census tracts in the country – calling for special attention to the top decile of tracts on its scale. While the SVI lacks some data points which could be gathered from the ACS and could provide additional insights into "child vulnerability," it can be used both to identify those high vulnerability tracts and to show something about their characteristics – economic, social, housing, and educational – and the need to focus upon children in a response to them.

The following table shows, for the state of Texas and its census tracts, the differences across tracts by their degrees of social vulnerability (SV) on the SVI. For simplicity, the Table shows the data for the top decile and bottom decile of tracts, and the middle quintile (5th and 6th deciles combined). The data shows not only that tracts differ on a composite SV score, but the many ways in which they differ. They clearly differ profoundly in terms of personal economic status (median personal income, poverty, unemployment). They also differ in terms of identified health status and coverage (disability status and uninsurance) and in terms of housing conditions (overcrowding, multi-housing units, mobile homes) and transportation access (automobile ownership). They differ in family structure as one indicator of social characteristics (single parenting – here related to the percent of all households and not just families with children, or the percentages would be much higher). In many ways, they are most dramatic in their differences in terms of educational status (adults without high school education). Even from these relatively few indicators, it is clear that living in a census tract with the highest levels of SV is very different – and creates many more barriers to raising children – than living in one with an average level of SV, let alone a much lower one.

In addition, it also is clear that there are sharp racial divisions in where people live and where those most likely to be immigrants (limited English proficiency) live. Of the nearly 2.5 million people in Texas living in the highest social vulnerability tracts, over nine in ten are people of color (other census tract analyses indicate that the percentage for children of color would be even greater). Almost one in five is in a limited English household.

These have major implications for establishing a community-based health workforce that can immediately establish trust with, understand the circumstances of, and even communicate with those in these neighborhoods. Much of any community health workforce, to be able to perform its roles in outreach, engagement, and support, must reflect the race, language, and ethnicity of the community being served and understand the circumstances in which people in the neighborhood live their lives.

In addition, the data show that those tracts with high SVIs also are rich in children (again, other census tract analyses show this is particularly pronounced among the population of very young children (0-4)). Responding to the needs of communities with high rates of social vulnerability requires additional and focused attention to the needs of children and the parents who are raising them. A significant share of any community health workforce directed to such high SV neighborhoods must be skilled in relating and responding to the specific needs, hopes, and aspirations of children and their families.

Doing so can help bridge the distance between children and families in these neighborhoods and the public and professional services they use, including health care and including sensitive issues of race, class, and power. It can be a powerful source for dismantling racism and its impacts at the outset of life.

TEXAS CENSUS TRACTS GROUPED BY SOCIAL VULNERABILITY INDEX (SVI)

Source: 2014-2018 American Community Survey Data, CDC Tables

	Highest Vulnerability	**Average Vulnerability**	**Lowest Vulnerability**
	SV 90-100%	**SV 40-60%**	**SV 0-10%**
Population	2,466,305	5,580,277	2,811,881
Percent Poverty	36.4%	15.0%	4.1%
Percent Unemployed	9.4%	5.5%	3.2%
Median Personal Income	$ 13,890	$ 26,232	$ 60,883
Percent over 25 No High School Diploma	39.4%	16.5%	3.1%
Percent over 65	11.8%	13.7%	13.5%
Percent under 18	30.9%	24.1%	23.1%
Percent over 5 with Disability	16.1%	13.3%	7.3%
Percent Single Parent	17.8%	11.4%	4.4%
Percent Minority (SVI term – e.g. not “white, non-hispanic”)	90.9%	52.8%	29.5%
Percent over age 5 Limited English	19.4%	5.5%	1.3%
Percent Multi-Unit Housing	16.0%	12.7%	11.0%
Percent Mobile Homes	7.9%	10.5%	0.1%
Percent Overcrowded Homes	11.7%	4.4%	0.8%
Percent Households No Auto	14.2%	5.0%	1.6%
Percent Group Quarters	2.5%	3.1%	0.7%
Social Vulnerability Score	**0.950**	**0.500**	**0.050**

Percent Uninsured	29.4%	17.7%	5.5%[1]

[1] One of the authors has done substantial other work with the American Community Survey in examining census tracts by their "child raising vulnerability," using some of the same measures used by the CDC but incorporating other, more child-specific ones. His work includes data not only on overall poverty, racial composition, and uninsurance, but on child poverty, child racial composition by different racial and ethnic groups, and child uninsurance. He also has recommended including the percent of the adult population with a college degree, the percent of households with internet access, the percent of home ownership, the percent of households where housing costs exceed thirty percent of income, the percent of families with children who are single parents, and the percent of grandparents raising grandchildren. See: *Village Building and School Readiness* and "ACE, Race, Place, and Poverty: Building Hope in Communities," in *Academic Pediatrics*. While there has been much good work to describe neighborhood conditions and impacts upon well-being, the particular impact on children and the prevalence of children in those neighborhoods often is not given attention. Constructing the table above required pulling down the entire data set from the CDC website for Texas (over 6000 individual tracts, with 150 different data items for each tract) and then sorting and segmenting the data into deciles, summing the columns, and producing averages. While the SVI has been used in some initiatives to identify neighborhoods of focus, the more extended data upon which the SVI is developed generally has not presented in CDC reports or by others who have used the CDC index. Making it much simpler for communities, and the people who live in them, to develop tables like the above is a goal of that author. The uninsurance rate is at the bottom of this table, as this is an additional variable added to the CVI downloadable data and not part of the CVI index.

APPENDIX TWO: Federal Actions, Proposed Legislation, Resolutions, and Sign-On Statements Related to Building a Community Health Workforce

Both during the campaign and in his administration's initial actions, President Joe Biden has called for major new federal investments in children and families and in developing a community health workforce. Leaders in Congress have included funding in their relief and rescue plans for COVID-19 and proposed statutory legislation or otherwise provided statements on the need to develop a community health workforce.

White House Proposals and Actions

During the campaign, Presidential candidate Joe Biden called for funding of community health workers as a part (circa $6.5 billion for 100,000 workers annually) of a **21st Century Caregivers and Education Plan** that would provide $775 billion over 10 years to expand direct care, community health, and child care frontline staff in their work.

President Biden has continued to press for this level of investment, making it a core element in his infrastructure plans, as well as including initial investments within the American Rescue Plan Act of 2021.

Congressional Actions

CARES Act of 2020 – Provided the Centers for Disease Control and Prevention (CDC) with funding that CDC has used to issue a $300 million, three-year grant program application request (Notice of Funding Opportunity – NOFO) to support community health workers in high need areas and for priority populations, with a community coalition at the county level overseeing contracting with community organizations and ensuring integration with other health services.

American Rescue Plan Act of 2021 – Provided the Center for Disease Control and Prevention of $7.66 billion in additional funding for responding to COVID-19 immediately but also to address the needs of vulnerable populations longer-term, with specific reference to the option to use these funds to support community health workers. In proposing such funding to Congress, President Biden indicated that a major share be used to employ community health workers.

Bills in Congress

Public Health Infrastructure Saves Lives Act (Murray in Senate) – authorizes formula grants to local health department to expand the public health workforce, starting with $750 million in FY2022 increasing to $4.5 billion in FY2026 and subsequent years

Health Force, Resilience Force, and Jobs to Fight COVID-19 Act of 2021 (Panetta in House and Gillibrand and Bennet in the Senate) – authorizes $40 billion each in 2021 and 2022 for a Health Force within focal, high need communities, administered through CDC with the intent of ten-year funding.

Building a Sustainable Workforce for Healthy Communities Act of 2021 (Casey) – authorizes $ 8 billion in annual funding to employ, through a competitive grant process for community-based organizations,

150,000 community health workers. Defines community health worker as “trusted member of the community who has an unusually close understanding of the community” and enumerates specific roles, skills and competencies, and responsibilities of organizations employing those workers. Emphasizes their service in underserved areas and with low-income and diverse populations. Emphasizes their multiple roles in care coordination, in providing preventive services, and in serving as a bridge and advocates for and with the populations served.

Congressional Resolutions and Sign-On Statements

Resolution to Dramatically Expand and Strengthen the Caregiving Workforce (Bowman in the House and Warren in the Senate): Including 52 “whereas’s” related the caregiving economy, inclusive of health, education, and human services, calls for “raising the pay, benefits, protections, and standards for existing care workers” and “creating millions of new care jobs over 24 the next decade, including as part of existing and new public jobs programs.”

Sign-on Letter to Congressional Leaders (Khanna in the House and Warren in the Senate with 139 colleagues) – calls upon Congress to create “250,000 permanent, high-paying public health jobs to rebuild our depleted public health workforce,” with recognition that “workers can be recruited from and serve their home communities, and they should be trained in alignment with best practices.”

Note: All these actions call for major, and often transformational, investments in an expanded frontline health workforce. Many emphasize community health workers with lived experience and connections to the communities as a focus, and many emphasize the need for focus investment in high need communities. At the same time, there is very little reference to this workforce regarding its particular role, skills, and emphasis in serving children and families. Most of these documents are available on the health activities webpage of www.2020visionsforchildren.com/child-health-activities.