InCK Marks

Helping Leaders Advance Child Health Care Transformation

TAKEAWAY MESSAGES FROM INCKMARKS NATIONAL RESOURCE PARTNER BRAINSTORMING SESSIONS ON CHILD HEALTH CARE TRANSFORMATION

November 3 InCK Marks Working Paper, 2020

The Integrated Care for Kids-InCK Marks Initiative convened four brainstorming sessions involving over thirty national resource network partners and recognized child health experts in October, 2020, to explore the specific topic of "Young Child Health Care Transformation and the Next Administration." The discussion used the InCK Marks' National Advisory Team's initial set of recommendations (involving approximating $20 billion annually in new federal investments) as a basis for the discussion. The discussions largely supported the recommendations, but proposed some additions to them, particularly in the areas of health equity and responding to children with special health care needs.

At the same time, the brainstorming sessions emphasized the need for deeper and more concerted attention to the underlying premises around which those recommendations were based. The following is drawn from the discussion and insights provided, around five key thematic areas raised in these discussions. This is an effort to represent the collective insights and conclusions from the sessions.

1. Child health transformation is critical if we are to address issues of inequity and dismantle racism (and other "isms") and secure the future our children deserve.

Children are learning how they are treated and how they should treat others. Experiencing racism is an adverse childhood experience; bigotry is unhealthy. The child health care system must be vigilant in its attention to the impacts of racism and other "isms" that marginalize children and their families – and reinforce the importance of inclusion, respect for diversity, and tolerance within its practice.

At the frontline level, practitioners must be actively seeking to reduce bias in the care process, responding to children and their families in inclusive and respectful ways in the context of their race, ethnicity, culture, and language. This involves a commitment to learning through partnering with families and the communities in which they live. This also requires a focus upon team-based care that ensures connections and effective engagement, in many instances and in the most vulnerable neighborhoods involving a community-based, relational care workforce that provides an ongoing bridge to the community and bridges the distance between "the culture of the profession" and "the culture of the community." Finally, this includes encouraging a family-led agenda and seeking and listening to parents around their hopes for their children (as in the Well-Visit Planner and Cycle of Engagement).

Societal efforts also are needed to increase the diversity of the health care profession. Any individual can become more culturally competent, responsive, and reciprocal; but an organization can only do so to the extent it itself becomes more representative of the diversity and make-up of the population it serves.

Children and their families experience growth when they are afforded the opportunity to take on new roles, often in reciprocal relationships with peers and participation as equals with others in planning and governing roles over those serving them. Child health practices can and should create avenues for participation and leadership of families and youth within their institutional settings. This includes organic opportunities, through peer-support, mutual assistance, and patient-support groups, for families to connect with one another and enable reciprocity and leadership to occur.

Child health practitioners are respected voices within their communities and can be "door openers" for those they serve. There is a role for child health practitioners to be strong and effective advocates not only for advancing child health care transformation, but also for strengthening other public health and social services and community resources.

Poverty, place, and race and their impacts on children's life course trajectories are interrelated, but they are not the same. In particular, diversity should be a source of strength in society – but it cannot be so where there is racism, marginalization, and the "othering" of people who are seen as different. A specific anti-bias approach as integral to all aspects of child health care transformation is essential to ensuring it fulfills its goals. This must begin in pediatric primary care practice.

2. Child health transformation includes but is more than child health care transformation.

As the Robert Wood Johnson Foundation has emphasized, building a culture of health requires health transformation that includes clinical health care, public health, and social services. Ensuring the healthy development of children requires stable and economically secure households, positive social ties and connections within the community, the provision of concrete services in times of need, quality learning environments (schools, preschools, child care, and community programs and activities) from birth to adulthood, environmentally and socially safe neighborhoods and communities, and affordable, available, primary, preventive, promotional, and relational health care as well as responses to all medical issues and complexities. Moreover, these different systems need to be as seamless as possible and aligned and integrated in their responses. There should be "no wrong door" for children and their families to secure what they need for their children to succeed.

Further, there needs to be attention to parental health and its known and direct impact upon nurturing and child health. The guidance at the federal level and movement within states to cover maternal depression screening under a child's Medicaid coverage is a step forward in this direction, but additional attention must be provided to preconception health and to the variety of health conditions that parents may require be addressed in order for them to respond to and nurture their children in the manner that they would like to be able to do. This involves fathers as well as mothers and a multi-generational approach that reflects all family members who are important in the child's life.

At the same time, to be a good partner with other systems and to fulfill its own role, child health care itself requires transformation. While the child health care system cannot be a substitute for good schools, safe and supportive communities, quality early care and education services, and economic security and opportunity, child health care must transform to play its own essential role in advancing child health.

The attention provided here to health care's own role and transformation is an essential and integral component to achieve society's goals for child health and equity. The child health care system can and should be an advocate for other system changes and an identifier of needs that go beyond health's own role in advancing child health. At the same time, the primary role for the child health care system is to transform its own practices ("physician, transform thyself").

In the context of young children, such health care transformation is particularly important since it is the single service most used (and the near universal point of access) in the first three years. More than 90 percent of children birth to three see a pediatric primary care provider in a year, mainly for well-child visits that can be a vehicle for strengths-based, supportive, family-centered care.

3. Child health care transformation is not just the promotion of a new program or program elements but is about the development of a robust workforce and responsive child health institutions and systems committed to the principles of relational health and high performing medical homes.

Many exemplary programs can and should be replicated, adapted, and built upon – but it is the fidelity to the undergirding attributes of those programs (family-centered, strength-based, partnering, and inclusive and committed to equity) that is essential.

Transformation is not simply about adding one new program element but about practice and institutional and systems changes that adhere to the overall definitions of child health and health equity, the guidelines set forth for primary, well-child care, and the principles embodied in team-based medical homes.

This "culture of practice transformation" has both a priori value and deep evidence and science to back it up. In moving from efficacy to effectiveness in diffusion of program and practice innovations, focusing on this culture of transformation is essential. Further, continuous quality improvement will be essential in the ongoing and iterative changes practices need to make in engaging and partnering with the children, families, and communities they serve.

Where a practice begins transformation is not as important as the fact that a practice starts. This applies to the most sophisticated child health practices such as those in children's hospital networks to the family practitioner operating as a solo practice in a rural setting. Pathways and support need to be offered for all practices to move forward.

At its most basic level, child health care transformation is about transforming from a "medical care system" based upon the child's specific medical needs to a "health care system" based also upon the child and family's strengths and needs in the context of their community and society. In many respects, this also involves a move from child health to family health. Again, this involves a two- or multi-generation approach – and should include support for the role of fathers in supporting their children.

4. **We need a "targeted universalist approach" that recognizes medical complexity, social complexity, and relational complexity as interrelated and requiring concerted and robust targeted approaches to reach universal goals.**

We have (most of) the tools and structures in place at the federal level to advance child health transformation – but we must invest much more in them to produce population-level impacts (cross the diffusion of innovation "chasm").

There is a large gap between what we know works and what we invest in and make widely available. This applies in health care where screening, measurement, and family support strategies have not been well-financed or integrated into primary care. The situation also applies in our early education and our social service systems responding to economic, social, and behavioral instabilities in families – particularly those borne by blocked opportunities for economic success.

While many children and families are on a path to success and receive sufficient support from health, education, and social institutions through our current "universalistic approach," too many do not. In fact, three in ten children currently are on trajectories that are severely compromised, and another three in ten children have far from optimal expectations for their long-term health and success. The health care system must be able to identify and respond more preventively, promotively, holistically, and comprehensively to at least this thirty percent of the child population. This requires increased responses to medical complexities, social complexities, and relational complexities and a recognition that these are interdependent. In particular and as related to medical complexity, this requires increased attention to and investments in early identification and response to developmental delays and developmental health issues, including social and emotional development. It requires much more concerted and intentional responses to presenting concerns in the child, identified early. An important and specific example is the IDEA Part C Early Intervention Program for Infants and Toddlers with Disabilities. With strains in funding, Part C has become less focused on true early intervention, let alone addressing social-emotional developmental risks and needs. Success also will mean an ecological response that recognizes that families with children with special needs require enhanced supports to enable them to fulfill their roles as parents and nurturers and partners in responding to those special needs and promoting optimal health and development.

5. **Medicaid (and CHIP) are primary levers for change.**

Since approximately half of young children are covered by Medicaid and the Children's Health Insurance Program (CHIP), any effort to improve the health and development of young children should intentionally involve Medicaid. Moreover, data reveal that well more than half of Black/African American, Native American, and Latinx/Hispanic children ages 0-18 are covered by Medicaid. Health equity cannot be achieved unless Medicaid performs at its best and promotes quality and equal treatment.

The Medicaid Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) children's benefit structure offers a way to ensure that young children receive appropriate physical, developmental, mental health, and dental services—from prevention to treatment. Every state has the opportunity to improve implementation of EPSDT. Enhanced federal financial support

for well-child visits that prioritize promotion and prevention to become high performing medical homes is one place to invest.

We know that Medicaid and CHIP coverage and program performance are extremely important to children. At both the state and federal level, however, children have not been important to Medicaid. Placing a priority upon children's healthy development as a part of Medicaid and its policies represents a long-term investment in the future and must be financed for the value they provide to society.

6. **Now is the time to act and act boldly; we need a broad chorus for investing in children and our future that includes a strong voice from the child health community around child health care transformation specifically.**

COVID-19 has both exacerbated the challenges facing child health practitioners and shown the centrality of a frontline child health care workforce in responding both to child medical needs and health-related needs. There is a pressing and increasingly recognized need to "build back better," with particular attention to supporting those on the frontlines serving children and families.

Far too many children are on very problematic trajectories and will not realize or optimize their potential – due to inequities (economic, racial, geographic, and social). The future prosperity of the nation is dependent upon doing far better by our children and families; and we know enough to act.

Child health practitioner champions, child health authorities, child health researchers and administrators, and child health advocates must lead in setting forth and implementing a public policy investment agenda that can accelerate child health care transformation. They also can contribute to the overall chorus calling for commensurate investments in other essential systems serving children and families; but child health care transformation must be a key part of those investments.

PARTICIPANTS IN BRAINSTORMING SESSIONS

National Advisory Team Members

- **Kay Johnson**, Chair, National Advisory Team, Johnson Group Consulting
- **Maxine Hayes**, Vice-Chair, National Advisory Team
- **Mayra Alvarez**, Children's Partnership
- **Melissa Bailey**, Center for Health Care Strategies
- **Scott Berns**, National Institute for Children's Health Care Quality
- **Elisabeth Burak**, Georgetown Center for Children and Families
- **Paul Dworkin**, Help Me Grow National Center
- **Jeff Hild**, Building Community Resilience, George Washington University
- **Shadi Houshyar**, Center for the Study of Social Policy
- **David Willis**, Center for the Study of Social Policy
- **Charles Bruner**, InCK Marks National Network Manager

National Resource Network Partners

- **Rahil Briggs**, Healthy Steps, ZERO TO THREE
- **Ruben Cantu**, Prevention Institute
- **Debbie Cheatham**, Zero to Three
- **Nathaniel Counts**, Mental Health America
- **Amy Fine**, Center for the Study of Social Policy
- **Hannah Gears**, Center for Health Care Strategies
- **Daniella Gratale,** Office of Child Health Policy, Nemours
- **Erin Hardy**, Datadiversitykids.org, Brandeis
- **Johanna Lister**, HealthySteps
- **Cailin O'Conner**, Center for the Study of Social Policy
- **Cynthia Osborne**, University of Texas LBJ School of Public Affairs
- **Aimee Ossman**, Children's Hospital Association
- **Rachel Roiland**, Duke-Margolis Center
- **Robert Sege**, Healthy Outcomes from Positive Experiences (HOPE), Tufts
- **Marjorie Sims**, Ascend at the Aspen Institute
- **Debbie Stein**, Partnership for America's Children
- **Alexandra Quinn**, Health Leads
- **Emily Vargas-Baron**, The RISE Institute

Other Recognized Leaders in the Field

- **Elizabeth Burke Bryant**, Rhode Island Kids Count
- **Helen Duplessis**, Health Management Associates
- **Andrew Garner**, Leadership Work Group on Early Brain Development, AAP
- **Charles Homer**
- **Milt Kotelchu**k, Harvard Medical School
- **Michael Odeh**, California Now
- **James Perrin**