Santa Cruz Women's Health Center

East Cliff Family Health Center

Santa Cruz Community Health Centers

SANTA CRUZ COMMUNITY HEALTH CENTERS

BUILDING A PEDIATRIC CENTER OF EXCELLENCE

DATE

May 2018

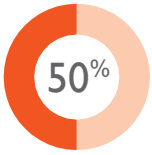
IMPACT OF
CHILDHOOD ADVERSITY

For more than 40 years, Santa Cruz Community Health Centers has borne witness to the complex needs of thousands of adults whose life tragedies were rooted in childhood. Medical, social, educational, and government institutions do their utmost to turn lives around and yet for many it is too late. The greater the adversity in childhood, the greater the risk for poor social, emotional, educational, and health outcomes later in life. To break generational cycles of poverty and poor health, the answer is to start early, with intention, toward an integrated system of care.

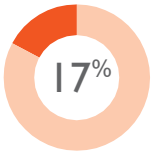
Neuroscience teaches us that "human development is shaped by a dynamic and continuous interaction between biology and experience."[1] All children are born "wired for feelings and ready to learn,"[2] however many children grow up in environments that hinder their natural potential.

Long-term studies[3] have shown that adverse childhood experiences such as chronic stress, poverty, homelessness, parental mental health and substance use, exposure to violence, and lack of access to abundant, healthy food and safe spaces for exercise have enormous, long-term impacts. These experiences can undermine healthy brain development during the critical period between birth and age three. They can also lead to increased incidence of heart, liver, and lung diseases in later life.[4] Overall, such consequences follow the child through life, limiting his or her capacity to regulate behavior, form healthy relationships, succeed in school, and thrive as an adult.[5]

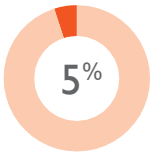
SNAPSHOT OF ADVERSITY IN SANTA CRUZ COUNTY



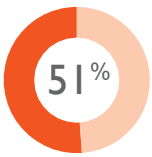
OF SANTA CRUZ COUNTY FAMILIES CAN'T AFFORD BASIC LIVING EXPENSES[6]



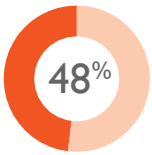
OF SANTA CRUZ COUNTY CHILDREN LIVE IN POVERTY[7] (A FAMILY OF 4 EARNING NO MORE THAN $28,290 PER YEAR)



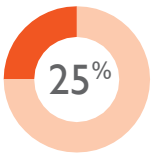
OF CHILDREN UNDER 6 LIVE IN DEEP POVERTY[8] (A FAMILY OF 4 EARNING NO MORE THAN $12,169 PER YEAR)



OF LIVE OAK SCHOOL DISTRICT STUDENTS HAVE NOT MET THIRD-GRADE READING PROFICIENCY (A PREDICTOR OF FUTURE ACADEMIC SUCCESS)[9]



OF 5TH GRADERS ARE NOT IN THE HEALTHY FITNESS ZONE[10]



OF LIVE OAK ELEMENTARY SCHOOL STUDENTS ARE HOMELESS[11]

WHY SANTA CRUZ COMMUNITY HEALTH CENTERS

Fortunately, we are resilient as human beings. Protective factors can combat the consequences of adversity:

- Parents and caregivers who are themselves healthy in mind, body, and spirit
- Responsive, informed parenting practices that nurture confidence and school readiness
- Educators who have responsive community partners to support students at risk
- Health and social services agencies that are organized and integrated

Together with parents, families, schools, and community agencies, Santa Cruz Community Health Centers is working to strengthen these factors. A key role for us is to provide appropriate clinical and social interventions that can shield and help heal children from trauma or other circumstantial adversity.

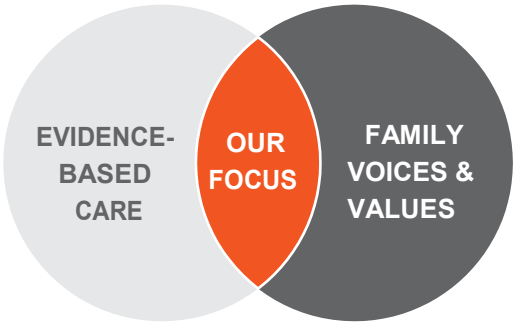
We are there from the beginning – at birth – to help cultivate positive social determinants as part of a community-wide system of care.

BUILD STRONG CHILDREN

"It is easier to build strong children than to repair broken [people]"

—Frederick Douglass

LIFE-COURSE APPROACH



SCCHC currently serves over 4,000 children. Ninety-percent of their families live at poverty level. As a Health Care for the Homeless site we serve over 800 homeless people, including 182 homeless children.

Our approach, over four decades, has been to merge the best of what science and human compassion dictate, with the voices and values of our patients.

We envision ourselves as a trusted orchestrator of protective factors for at-risk children. As pediatricians, nurses, social workers, and case managers, we develop bonds with parents and caregivers who share with us their deepest fears and challenges.

With compassion, clinical expertise, and professional linkages to other systems of care we are uniquely positioned to assess and coordinate across the domains in a child's life: where she lives, learns, and plays.

Our vision is an integrated system of care rooted in the pediatric medical home and branching out to the external systems of family, school, and community throughout the course of the child's life.

PEDIATRIC HEALTH HOME

The Pediatric Health Home[12] model is designed to respond to the needs expressed by families while incorporating the evidence base for healthy development, success in school, and a promising adulthood.

Fundamental to the model is the interdisciplinary Pediatric Care Team that follows the child as she grows. The core team includes parents and caregivers, pediatrician, nurse, social worker, case manager, and support staff. Engagement with children and their families occurs at every stage such that the family is holistically empowered at every step.

The Pediatric Health Home consists of comprehensive family practice and pediatrics that includes annual well care, timely immunizations, developmental assessments, and oral and vision care as early as age one to ensure needs are proactively identified and addressed. Additionally, the following services and modalities are integrated into the Health Home:

- **Comprehensive Prenatal Care** to ensure healthy births through the Centering Pregnancy model (a group, peer empowerment model) that aligns with the Pediatric Care Team's holistic approach to integrated, risk-assessed, and coordinated care.
- **Integrated behavioral health** to address social and emotional needs and provide evidence-based interventions for children and their parents, with special attention to parental mental health, depression, substance, use, and family violence.

PEDIATRIC HEALTH HOME

- **Developmental, emotional and behavioral screening** to ensure effective, age-based screening for physical, cognitive, emotional, and behavioral needs. Access to services like developmental-behavioral pediatrics, occupational therapy, and other specialties are provided.
- **Social screening** identifies environmental risks such as poverty, homelessness, food insecurity, and other factors to inform interventions with external community partners.
- **Care coordination** via a specialized Pediatric Care Coordinator who helps families successfully navigate the clinic's services as well as external resources, featuring a "warm hand-off" approach that ensures follow-through.
- **Health education** for nutrition, lifestyle, and wellness for healthy growth and development via a health educator and through Shared Medical Appointments, an evidence-based peer support group model (e.g. a healthy eating and active living group for youth and a post-partum or parenting group for caregivers).
- **Positive Parenting** is promoted through the evidence-based Triple P program, along with guidance and resources to support successful parenting.
- Guidance on **school readiness** offers parents early-learning strategies using the Reach Out & Read program and "Talk, Read, Sing," and other curricula.
- **Complex Care** featuring the specialties described above along with intensive case management services and working partnerships with Lucile Packard Children's Hospital providers for children with complex medical needs.

LIVE OAK CRADLE TO CAREER

Since 2013, SCCHC has provided leadership to the Live Oak Cradle to Career initiative (C2C). This is a collaborative approach to improving the health and educational outcomes of Live Oak students. The partnership includes district Supervisor John Leopold, Community Foundation, County Health & Human Services, Encompass, First 5, Live Oak Community Resources, and the Live Oak School District.

The initiative has prioritized family engagement through the development of a **Parent Leadership Committee** which co-designs and co-leads C2C. Programs responsive to parents interests have included Triple P parenting workshops, nutrition education, English language classes, Zumba, and advocacy and leadership trainings. A long-term set of outcomes and indicators has been established and the School District continues to take on a larger ownership role of the initiative.

In addition to support of the above, and as fiscal sponsor to C2C, SCCHC has also been leading the development of a **Community Care Team** that unites clinic staff (medical, behavioral health) and our affiliated Stanford development-behavioral specialist, with school staff (teacher, counselor, psychologist) to consult on children with high risk needs. Through a combined case conference, including voice recordings of parents expressing their concerns for their children, this cross-sector team can piece together the behavior and experiences of the child to build a shared Care Plan. That Care Plan includes information heretofore inaccessible to the pediatrician via a basic medical encounter. Similarly, the advice of expert clinicians has been unattainable by school personnel. Early case conferences have focused on parental wellness and the treatment and educational placement of a child with autism.

VISION FOR THE FUTURE: A PEDIATRIC CENTER OF EXCELLENCE

We are laying a solid foundation for the Pediatric Home implementing some of the building blocks described above. But there are many additional steps to be taken to achieve our vision of a true Pediatric Center of Excellence. Considerable investment is needed to design and build the systems, structures, and innovations required to prevent and address childhood adversity. This includes:

- **Technical assistance** to refine our interrelated Pediatric Health Home, Complex Care and Cradle to Career strategies including consultation on models for prenatal and pediatric primary care.
- **People** such as additional program management staff to oversee design, process improvement, and integration of the components; plus additional care coordinators, intensive case management, and health educators. Training and data analysts are needed to ensure fidelity to evidence-based models and effective evaluation.
- **Technology** such as new data platforms for care planning and coordination within the health center as well as across sectors, allowing data to be securely shared by several partners when a child's care plan involves outside education or social service providers.
- **Place,** a new primary care facility at 1500 Capitola Road in Live Oak that will provide a larger space to implement our pediatric vision, in partnership with Dientes Community Dental Care and Mid-Peninsula Housing, an affordable housing developer.

CHILDREN'S HEALTH, OUR COMMUNITY'S WEALTH[13]

All families, regardless of social and economic circumstances, need specific resources to raise healthy children who can grow to be healthy, thriving adults. Ensuring that children in disadvantaged families have equitable access to such assets is essential not just for children, but for our entire community. Investing in our Pediatric Center of Excellence will help to:

1. **Prevent the achievement gap by narrowing differences in cognitive and social skills development that persist and widen throughout life without intervention.[14]**
2. **Improve health outcomes and reduce long-term risk for serious cardiovascular disease, stroke, and diabetes associated with adverse childhood experiences.[15]**
3. **Boost future prosperity for children in low-income families, putting their earnings on par with more advantaged peers.[16]**
4. **Boost community prosperity due to better health, increased education and economic productivity outcomes.[17]**

SANTA CRUZ
COMMUNITY HEALTH CENTERS

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[1] National Research Council, Institute of Medicine, "From Neurons to Neighborhoods," National Academy Press, 2000.

[2] Ibid

[3] CDC-Kaiser Adverse Childhood Experience (ACE) Study, 1995-97, www.cdc.gov/violenceprevention/acestudy/about.html

[4] Ibid

[5] Center on the Developing Child at Harvard University, "From Best Practices to Breakthrough Impacts: A Science Based Approach to Building More Promising Futures for Young Children and Families," 016. www.developingchild.harvard.edu

[6] Children Now 2016-2017 County Scorecard, www.childrennow.org

[7] Ibid

[8] Ibid

[9] California Assessment of Student Performance and Progress, Smarter Balanced Assessment Test Results for Live Oak District, www.caaspp.cde.ca.gov

[10] CA Physical Fitness Report, 2016-17, CA Dept of Education Data Quest: www.dq.cde.ca.gov

[11] Live Oak School District data via California Longitudinal Pupil Achievement Data System (CALPAD)

[12] Adapted, in part, from the Healthy Steps model, Zero-to-Three, www.healthysteps.org

[13] Adapted from, "Children's Health, the Nation's Wealth," National Research Council and the Institute of Medicine 2004, the National Academy of Sciences

[14] Op Cit 1

[15] Op Cit 3

[16] John Heckman, economist, "The Heckman Equation", www.heckmanequation.org

[17] Ibid