InCK Marks

Building a Relational Health Workforce for Young Children: A Framework for Improving Child Well-Being

Working Paper Seven

InCK Marks Child Health Care Transformation Series

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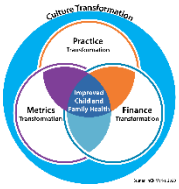

Foreword

This is the seventh in a series of working papers by the InCK Marks Initiative on key issues and levers to transform child health care practice. These papers are designed to describe the state-of-the-field in child health care transformation and emerging issues and opportunities to further advance that transformation.

This working paper focuses upon young children and the relationships that form the basis for their health, safety, and growth. Dr. David Willis, Senior Fellow at the Center for the Study of Social Policy (CSSP) and member of the InCK Marks' National Advisory Team (NAM), has directed much greater attention to relational health as a core component of overall physical, psychological, and cognitive health. Using the term "early relational health," Dr. Willis has advanced thinking and pediatric practice in working to strengthen children's relational health through supporting strong bonding, nurturing, and attachment in the earliest years. The Center for the Study of Social Policy has long advanced such an approach, through family support and strengthening families and enhancing protective factors for children and youth.

While the importance of such nurturing has long been recognized as the foundation for healthy development, the focus upon relational health has opened new attention to the child health community's role in strengthening that nurturing and in building protective and supportive factors for children in the child's home life. Dr. Christine Bethell, Director of the Child and Adolescent Measurement initiative at Johns Hopkins University and also a member of NAM, has furthered work in measuring relational health in children and examining children's well-being in the context of medical, social, and relational risk factors or complexities.

This working paper draws from the experience of its author, Dr. Charles Bruner, Manager of InCK Marks and its National Resource Network, on developing more preventive, promotive, asset-based, family-driven, ecological, and services for vulnerable children and their families – in health care, child welfare, early learning, disability services, youth development, school-based services, poverty reduction, and general family support. Across forty years of work in the field of health and human services, Bruner has examined reforms and exemplary practices across these multiple child-serving systems and concluded that there is a common thread of relational practice across them, one that involves people on the frontline themselves establishing relationships with those they serve in order to support them in realizing their, their children's, and their community's hopes. This paper seeks to describe this workforce and the rigor with which policy makers and practitioners need to approach developing, valuing, and sustaining it.

COVID-19 has heightened attention to the centrality of those providing frontline services and provides an impetus for actions to ensure that a relational health workforce is robust and valued and sustained – immediately in response to the pandemic but longer-term in response to other needs and concerns. While children have not borne the major brunt of COVID-19 in medical terms, the long-term effects of the disruptions to their lives, the stresses on themselves and their families, and the adversities they have experienced require response, particularly through relational health services. Closing health disparities, including those now afflicting the adult population, and therefore achieving health equity requires investments to enhance relational health at the start of life.

The working paper itself only touches upon many core concepts and opportunities for advancing a relational health workforce for young children as an element of child health care transformation. The commentaries that accompany the working paper are from members of the National Advisory Team and represent additional perspectives on the relational health workforce and different key issues that deserve attention and exploration.

Acknowledgements and Disclaimer

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Building a Relational Health Workforce for Young Children: A Framework for Healthy Child Development

Community health workers, family advocates, promotores, accompagneurs, family development specialists, family service workers, home visitors, care coordinators, outreach specialists, family coaches, health realization workers, networkers, navigators, village builders, mutual assistance network facilitators, family and community organizers

Introduction: The Need to Build a Relational Health Workforce for Young Children

As enumerated above, relational health workers come with many names and defy neat categorization. They often are funded when an enlightened community organization or service provider can scrape together a few additional funds to provide them a modest salary. They often live and work in poor communities – urban and rural – where they are recognized points of light to the people they serve, but seldom recognized by the larger policy leadership in the community for the critical nature of what they do. When community collaboratives are established to promote integrated approaches to improving school readiness (or reducing teen pregnancy, advancing early childhood mental health, preventing child abuse, or providing transitions to adulthood for youth in foster or other group care, etc.), they often determine that such frontline workers are a missing piece in their efforts and devote any resources they have secured to establishing them.

Critical to their effectiveness is their ability, often through persistent and creative outreach and engagement, to form their own nurturing relationships with the children and families they serve that then support the child and family's own relational health. The term "relational child health workforce" will be used to encompass this work (see box for definition of terms].[1]

They are particularly important in ensuring young children (birth or prenatal to three) get off to a good start – for several reasons.

First, this is the time in the child's development when relationships and intimate serve-and-return interactions with parents serve as a foundation for future growth and lifelong approaches to social and emotional (as well as cognitive and physical) development.[2] Across the fields of health, child development, child welfare, and family support, it repeatedly has been established that the safety,

Relational health. Relational health refers to a child's or individual's capacity for and ongoing engagement in growth-fostering, empathetic, and empowering interpersonal interactions.

Early relational health. Early relational health involves positive, nurturing and stimulating early relationships and security, particularly within the home in the first years of life, which build the foundation for a lifetime of relational health.

Relational health care. Relational health care is care within a health care setting [or associated with health care] that contributes to a child's and family's relational health. Relational health care recognizes the importance of social connections, supports and interactions in overall child and family health (ensuring engagement, trust and partnerships with families to combat all forms of discrimination and racism).

Relational health workforce. The relational health workforce represents workers whose primary responsibility is to foster relational health, through building relationships of trust and coaching and modeling empathetic and nurturing relationships with children, youth, and families and increasing positive social relationships.

stability, and nurturing in the home environment is the most critical element to healthy and life-course young child development.[3] In fact, the P.A.R.E.N.T.S. Science (Protective factors,[4] Adverse childhood experiences,[5] Resiliency,[6] Epigenetics[7], Neurobiology, Toxic stress,[8] and Social determinants of health[9]) all view relationships as core to children's growth, health, and development.

Second, this is a time when new parents, in particular, are most receptive to and eager for help in taking on their parenting roles – both biologically (their own brain development)[10] and environmentally (the new demands and possibilities parenting places on them).

Third, this is a time, particularly in American society, where taking on the caregiving role often is challenged by maintaining the breadwinning role. While a majority of parents can fulfill those dual roles with the help and support from their family, friends, relatives, and employers, too many face new stresses and isolation in doing so. These stresses and that isolation affect the safety, stability, and nurturing they provide to their infants.

Fourth, this is a time when the child spends most, if not all, of the time in the home and with the family. The one near-universal point of contact with families is the child health care practitioner, which offers an opportunity to check-in with the family. Unless that practitioner is staffed and supported to provide such care and support, which most are not, families may have no gateway to such attention and support.[11]

In his work with Partners in Health, Paul Farmer has applied the tenets of liberation theology to effective health practice: (1) a preferential option for the poor and marginalized (e.g. targeted universalism); (2) an imperative against structural violence (doing what it takes to keep families safe); and (3) accompaniment (relationship-based support). Depending upon the country and language in which they operate.[12] Partners in Health has called their community-based workforce "accompagneurs" or "accompanantes" and view them as the heart and foundation of their work.[13] All the tenets of liberation theology apply to the relational child health workforce.

The Essence of the Workforce: The Aptitudes. Attitudes, and Skills Needed for Effectiveness.

This relational health workforce, per force, must possess certain aptitudes and attitudes as well as skills to be effective.[14]

They must believe in the children and families they serve, as well as link them to resources and advocate on their behalf. They must provide mutual support and encouragement to those children and families to advocate and act for themselves and represent someone who values their doing so.

When supported and valued within the organizations in which they operate and provided the time and tools to do their relational work, they advance healthy child development, strengthen families and their resiliency, and contribute to community-building. They make their own organizations more robust and successful. They serve as catalysts and conduits for enlisting new leadership that produces greater social capital and cohesion in the communities they serve. For some families, they represent that special person who believed in them, held them to high expectations, and provided what was needed at the time it was needed to create new futures that were unseen in the larger society.[15]

They establish and build upon relationships with and among the children and families they serve. Ideally, they laugh a lot and enjoy celebrating the everyday successes that families on the move experience,

while also processing setbacks and helping families be resilient in responding to those setbacks and charting new courses. They are "humbly wise" and often their biggest breakthrough is, through their presence and accompaniment, fostering reasoned hope in families who, whatever their previous setbacks and barriers, are able to step out anew.

Really smart administrators recognize that they are worth their weight in gold, although usually compensated at a level that is at the bottom of their employee compensation structures.

When administrators, policy makers, and licensed professionals in child-serving fields bemoan the challenge to engaging families, it is because they do not have such workers in their programs or place them at such a level that they can serve as bridges to the community and establish trust with families.

Alternatively, when programs and practices have such workers, they find that their families not only are engaged but want to contribute, particularly in connecting with others with similar concerns about their children (affinity networking) and in activities that lend themselves to reciprocity and mutual assistance. They further provide a bridge to enable others in the programs and practices, often those with professional backgrounds and discrete skills, to better interact and engage with the families they serve. They often are viewed as the glue within a medical home that provides team-based care that enables partnering with the families being served.

Where they exist and are recognized and valued, people emerge from within the population served to represent what they and others have learned to make systems better in responding to all families. The challenge many in the child-serving fields face in engaging families is that they are unprepared to take that step in fostering the opportunities for families that result in their engagement.

While there may be no formal certification or advanced degree and credentialing for such workers nor a need for post-secondary school degrees (or even secondary school) to perform the work, being effective requires both aptitudes and skills. Recruitment and selection require attention to the aptitudes needed to be successful in this role; organizational structure and support requires attention to the climate and work setting and opportunities for learning and growth to use and further develop those skills.

Beyond the Buzzwords: Operationalizing the Attributes of the Workforce.

In her seminal work, *Within Our Reach: Breaking the Cycle of Disadvantage* in 1989, Lisbeth Schorr[16] described a diverse array of programs and their practitioners and leaders who worked with some of the most challenged children, youth, and families and achieved success in doing so. She looked beyond the specific programmatic elements and practice protocols to identify common characteristics or attributes with their practices.

1. Such health practice principles – family-centered (driven) services, relational care coordination, coaching and mentoring, community health navigation, trauma-informed care, two-generation strategies, asset-based services, preventive/promotive/developmental/ecological/whole-child primary care – often are included in goals and vision statements of exemplary practices and aspirations for the field of practice. In pediatrics, they are represented in the principles for a medical home[17] and in the well-child visit standards established within *Bright Futures*[18]. They have been articulated, in various ways, in systems reform efforts in child welfare, juvenile justice, special education, child mental health, early childhood education, disability services, and welfare reform/child poverty reduction[19]. Schorr described these as "attributes of effective

practice" with an operational rigor that lent itself to both determining their core and causal role in achieving success working with children that other systems had failed. These attributes, rather than the specific programmatic interventions, protocols, or location or professional affiliation of the organization, also represent the key to successful replication of results (e.g. moving from efficacious to effective). While some have been identified as "research-based" or "evidenced-based" program models (usually because they have incorporated research models that involve a strong counterfactual), it is more the quality of their staffing and commitment to such principles than the specific model itself that produced their results.[20]

These attributes also are more than a set of buzzwords; they have a very substantial research and scientific base. (The focus upon program evaluation and research and the emphasis upon measuring program efficacy in terms of discrete outcomes often fails to capture the impact such attributes have on those programmatic impacts.) Where they have been examined in their own right – as qualities of practice – there is a strong research base for their importance to achieving success. Much of the work of Karl Dunst and Carole Trivette[21] as well as of the Family Resource Coalition/Family Support America has been on operationalizing those principles into practice and ensuring fidelity to them in the field. For interventions which require relationships to be effective, assessing the fidelity to such attributes is more important than assessing fidelity to program protocols and the subject matter of interventions. They may require different measurement tools and their own "family support approach to evaluation," but these are no less rigorous nor essential than more traditional evaluations of programs and interventions.[22]

Simply put, the qualities or attributes of effective workers in advancing relational health through engaging families and their children include: (1) positivity and appreciative inquiry and motivational interviewing in engaging people to talk about themselves and bring out their hopes; (2) empathy and validation of concerns, disappointments, and fears without taking those on oneself to solve; (3) tolerance for ambiguity and missteps and continuous encouragement to take a next step forward based upon what the person is learning and ties back to their own goals; and (4) celebration and appreciation of actions taken, while holding people to taking action and the goals they set for themselves.

For interventions which require relationships to be effective, assessing the fidelity to such attributes is more important than assessing fidelity to program protocols and the subject matter of interventions.

Key Roles for Systems in Developing the Workforce.

Key to developing such a workforce starts with a recruitment and selection process that, in fact, assesses potential workers for these qualities and attributes and makes selections accordingly. While professional training in counseling, social work, and other fields is consonant in many ways with honing these attributes, such training and credentialing is no guarantee of their presence. Similarly, there are those at a community and paraprofessional level that have these qualities and attributes, can perform very effectively in this work, and for some people and communities have additional knowledge and rapport that can enable them to establish relationships and engage families at their community level. Research also has shown that some families feel most comfortable, are most responsive to, and establish trust

with people from their own community and set of experiences, while other families are most responsive to and open up with those outside their own communities and with more professional backgrounds.[23] There is both selecting workers for these attributes and building a workforce that reflects the diverse people in the community to be served.

Key to enabling this workforce to be effective is providing an organizational structure that supports them for the work they do, values their role and expertise, and enables them to grow and learn and develop. Turnover in such a workforce not only requires additional time and effort to select and train replacements; it also disrupts the relationships that have been established with families being served.

This requires an organizational structure that truly values these workers and turns to them for insights and considers them a core part of the team in achieving the organizational mission. In terms of a medical home, their expertise is needed by the health practitioner every bit as much as the expertise of the health practitioner is needed. They cannot be considered to be at the lowest organizational level and one that is easily replaceable. They require an organizational structure that recognizes continuous learning and includes reflective supervision and support. In many respects, the essence of the work with families involves continuous problem-solving, adaptation, and goal setting based upon a huge diversity and range of ever-changing challenges and opportunities. Workers, whether with extensive professional education or not, engage in continuous learning and should become more effective in this work through the wisdom they acquire over time and the insights they glean from processing their experiences with others in the field. Effective family support programs with such workforces generally have established routines for ongoing case reviews and creative problem-solving with supervisors and other peers in the field. Again, the organization itself must support and value this workforce for the essential contributions they make.

When that is the case, problems related to staff burnout, turnover, and workload stress are minimized – provided compensation and opportunities for advancement are sufficient to meet the worker's own needs in pursuing a career.

Assessing the Workforce Gap: The Need for Both More and Better Financed.

This relational health workforce is essential to child health care practices responding to social determinants of health and equipping families to be their child's first teacher, nurse, safety officer, and guide to the world. Whether or not social and economic need of a family can be addressed, where relational health workers are supported and able to help families move forward and feel empowered and valued in strengthening their bonding and attachment with their young child, the result is greater resiliency in the child and reasoned hope in the parent – which makes the next step easier, more probable, and more likely to succeed.

Of course, for many families with young children, there are grandparents, aunts and uncles, spouses and friends and colleagues, who fulfill this role. Such workers do not constitute a substitute for such community. They do, however, often serve as bridges for the family in developing such a community.

The challenges to doing so, as put forward by one of the authors over a quarter century ago, requires developing public policies to enhance these frontline relationships and interactions – "to institutionalize the noninstitutional, replicate the unique, professionalize the voluntary, and mass produce warm, caring relationships."[24]

In fact, although not financed at a scale and scope to reach more than a very small share of parents, the development and expansion of block grants in the era of "devolution" in many respects provided space and some financing to establish some of this workforce.

A good share of the funding through the Community Service Block grant, which provides resources to the community action agencies developed in the 1960s to foster "maximum feasible participation" as part of the War on Poverty, now goes to support family development specialists in those agencies as part of their ongoing work.[25] The Head Start program established at the same time incorporated family service workers to conduct outreach and engage families, and the Early Head Start expansion emphasized such development specialists as core to engaging families with infants and toddlers.

When the Aid to Families with Dependent Children (AFDC) program was converted to the Temporary Assistance to Need Families (TANF) program (thereby capping what had been an entitlement to states), new flexibility enabled states to develop preventive services with some of the funding, which many did through establishing home visiting programs or other community-based programs for parents. The Social Services Block grant (SSBG) from the outset provided such flexibility to states, although most states use a large share of that funding for services to seniors and persons with disabilities and only a small part goes to outreach and engagement of families with young children.

As part of the Affordable Care Act, the Maternal, Infant, and Child Health Home Visiting (MIECHV) program was established, providing all states with some federal support to establish or expand home visiting programs. The oldest federal block grant, the Title V maternal and child health block grant, while often focusing upon children with special health care needs, has leveraged state funding as well as federal funding for outreach to families with young children and a community health workforce to support them. Much smaller Child Abuse and Prevention and Treatment Act (CAPTA) funding and select pilot programs such as Project LAUNCH have also provided for such support.[26]

Other funding to support nutrition for limited resource families – under the Women, Infant, and Children (WIC) program and the Expanded Food and Nutrition Education Program (EFNEP) program within Cooperative Extension, both housed in the U.S. Department of Agriculture – provide relationship-based support and education services to families with very young children around nutrition and health.

Within a largely categorical funding system at the federal level directed to addressing discrete presenting conditions and diagnoses of families, this more holistic and relational work, particularly when use of the funding has been made more flexible and decisions on how to use those funds directed down to the community level, has been viewed as a missing element to at least begin to address with left-over funds.

One reason that there is a call for greater alignment across systems as a means to improve results for young children is that administrators and policy makers see this multiplicity of funding streams and the emergence within many of them of relational health workers as a sign of fragmentation and duplication – not as a recognized identified of a current gap in providing effective services.

In fact, however, while these spring up within community-based organizations and their funding may be from multiple sources (and patched together at that level with challenges to those organizations meeting multiple reporting requirements from the different funding sources), the overall reach of such efforts – both in terms of the numbers of families who are served ad the degree to which the workers

the time and support to "do what it takes to succeed" with individual families is small in relation to need and opportunity.[27] At best in most states, one in twenty families with a young child have consistent and ongoing support from such a relational health worker to support their and their child's growth, while at least one in five would benefit from and, with creative and persistent outreach, engage and participate.[28]

Because they are so fragmented and diffused and often a very small part of a larger organization's work and mission, such relational care workers also often do not receive the training, support, supervision, and learning opportunities that would develop their skills and make them effective in this work. They often do not have standing and support and networking opportunities with their peers to influence their work settings or their overall position in their organizations. And, they often are the last funded and first defunded and most subject to turnover and ambiguity in what their roles are.

In short, they currently represent a small, often ill-defined and poorly-supported, part of a largely diagnosis-driven system of services to address the most severe needs of children – with limited ability to truly advance healthy development from a more preventive and promotive system and to realize their potential.

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Opportunities for Elevation and Policy Action and Investment.

The COVID-19 pandemic has elevated both public and policy maker attention to the role essential workers play in society. Many of these frontline workers are in the helping progressions serving vulnerable families and their children whose lives have been disrupted – and are providing the type of relational care coordination described here. Moreover, new attention is being given to the needs of this workforce and its contribution to the nation's health, at all times and not just during a pandemic.

While not encompassing all the workers or locations where they may reside, the President's proposals to expand and improve the compensation of a community-based workforce, initially with $6.5 billion for 100,000 such workers under the American Rescue Plan and to invest $775 billion over ten years in constructing a "21st Century Caregiving and Education Workforce" could provide the type of federal financing and leadership to begin to scale, compensate, and value such work. His call for putting a child development expert within all federally qualified health centers and providing community support for other pediatric practices to do so as well, and his call to double the size of the MIECHV program, also would contribute to the development of this workforce.[29] Perhaps most importantly, these proposals recognize that these workers are essential to the prosperity of American society and themselves are part of the fabric of our social and economic structure. Investing in them is not only good for the people they serve, but essential to the health of the economy.

Moreover, these plans themselves generally resonate with the public. At an academic level, they have received significant support and consensus across the political spectrum – particularly when they are not

seen as a substitute for family but a contribution to strengthening families and their own personal responsibility and involvement in community well-being, while providing fair and equitable opportunities for all children to succeed.[30]

Increasingly, community collaboratives to address cross-cutting concerns such as school readiness, school success (with attendance and grade-level reading as important intermediate markers), adolescent pregnancy, and transitions to adulthood for those with disabilities, simply as examples, have recognized the importance of such a workforce, but also the importance of "first responders" within and across different systems that share the values of such work and align their work and relational response accordingly. Community collaboratives often recognize that there should be "no wrong door" for families, but that there also should be "appropriate and enriched follow-through" that advances relational health.

Some of this work, and particularly the "no wrong door" and first responder role from the child health practitioner community, can and should be financed through the health care system itself. The field's own definition of a medical home and well-child visits includes anticipatory guidance and follow-up responses to provide this relational health. Operationally, it has been described for young children and financing under Medicaid as a "high performing medical home."[31]

The relational health care workforce itself also could be incorporated into medical practice settings, particularly larger systems serving young children in underserved and vulnerable communities, such as community health centers and children's teaching hospitals. It could be financed through Medicaid and covered as a specific prevention or care coordination/targeted case management service within community-based programs. Medicaid and CHIP, since they cover half of all young children and at least two-thirds of all young children who would most benefit from such services, must play a key role in this financing.[32]

At the same time, these efforts must be fostered within and across other systems serving young children and their families – Title V and WIC, MIECHV, Early Head Start, and center-based and family-home providers of child care for young children, among others. Whether a new funding source or through one or more of these existing funding sources, the federal government could dramatically scale up such actions. Under Title V or a new block grant, there could and should be requirements for collaboration across other systems serving young children and the flexibility to use funding to enhance those other funding streams for that specific purpose. Providing $10 billion in funding to advance this workforce through and across current federal funding streams but directed to a relational care workforce would enable contouring of and ownership by community-based collaboratives and programs closest to the people being served. In addition, such actions would support greater attention to building the recruitment, selection, training, staff development, and career opportunity pathways for this workforce, regardless of where it is housed.[33]

Providing $10 billion in funding to advance this workforce through and across current federal funding streams but directed to a relational care workforce would enable contouring of and ownership by community-based collaboratives and programs closest to the people being served.

The research suggests that investments in the very young, particularly around their social, emotional, and relational development, constitute

investments with the highest return to society in terms of economic prosperity.[34] They also hold the greatest promise for closing the gap in results for those currently most likely to be marginalized. And they reflect American values of family, community, personal responsibility, and opportunity for all.[35] Such investments can also help bring America more together and be key drivers for ensuring the next generation has the skills, health, and commitment to inclusion we need to prosper.

Commentary – David Willis, MD

Early Relational Health: Building Upon Science. As presented in the working paper, early relational health (ERH) is a new term that has caught the attention of child health providers and policy makers. It embraces the science of relationship-driven development, a two generational focus, an emphasis on the first 1000 days as a critical period of development, and a targeted attention to the dyadic relationship between an infant or toddler and an adult caregiver. ERH is neither a new field nor a separate professional practice but rather an expanded, intentional, and now urgent focus on the centrality of foundational relationships for future well-being. It is based upon the knowledge, research, and wisdom within infant and early childhood mental health (IECMH), neurodevelopment, and related fields, unbiased by a mental health label.

The science of child development and developmental neuroscience makes clear that the foundations for future health, development, and well-being for infants and children begin prenatally and are first established by safe, nurturing and stimulating early relational experiences provided by loving parents and the supports from additional caregivers within their broader community. In addition, cultural anthropology's studies of young family life within various cultural groups and more recently articulated indigenous parenting and community practices make clear that most contexts and historical practices for early child development occur within complex social networks of support, encouragement, shared responsibilities and complex relationships.

Our nation's social evolution has moved far beyond the tribe or clan, the extended family, and even the nuclear family, and is currently challenged to address the needs of single, often poor, near-poor, and isolated young woman and their infants, who must work and share the care of their infants and young children with others outside of their own homes - family, friends, or a childcare system of strangers. Isolation, loneliness, and insufficient time devoted to their young families and children has become the lament of many young parents, especially during the COVID-19 pandemic. The consequences of such challenges are known to bring family stress that then can compromise optimal health, child development, social-emotional development, and education readiness.

InCK Mark's bold articulation of the urgent need for a broad relational health workforce initiative especially focused on the youngest families is an essential element for our nation's "building back better" policies for our next generation. The evidence is clear of the positive impacts and stress reduction for families of locally developed, peer networks of community workers who deliver individual supports for pregnant woman and young families with infants and young children. This approach is cost-effective, preventive, culturally respectful, career building, and community revitalizing. And, in the rebuilding of our social fabric to support foundational relationships and early relational health with intention, every community has individuals whose lived experiences and natural qualities can be enlisted to become part of this relational health workforce for young families.

I believe that the COVID-19 pandemic has exposed those powerful intrinsic healing and protective forces in communities. We have witnessed vast networks of people helping people, and self-organizing communities bringing supports to their neighbors. Building from the COVID-19 crisis, the expansion of this relational health workforce with intention captures, too, a moment when our nation's communities and people seek a new authentic and anti-racist connection with each other.

If we are careful in the development of this workforce, we have an unprecedented opportunity to advance early relational health, equity, and social fabric rebuilding with a focus on relationships that counter isolation, bring empathy, provide encouragement and hope, demonstrate their own courage that confronts racism, support recovery and healing, and bring the human-to-human storytelling that is the essence of relational protection, healing, recovery, and community resiliency. As a longtime champion of this paradigm shift to a relational frame in all formal and informal activities that surround young families, InCK Marks' promotion of the relational health workforce for young families brings forth that missing and integral element of next generation community building, early childhood system building and health/public health transformation. Hope springs eternal!

Commentary – Maxine Hayes, MD

Dismantling Racism: Relational and Public Health. Having good health is an asset that is required to enjoy the essence of life itself. We often tie this asset to our productivity, our economic success and our status in a global society. COVID-19 pulled back the curtain of something sinister that public health leaders have known a very long time: Health, this precious asset, is not known to many of us. Disparities in health run deep in our country. In 1998 President Bill Clinton noted, "Nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people … no matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all."

Fast forward from 1998 to year 2020. In that year we witnessed our nation fighting three pandemics at the same time: COVID-19, racism and a failing economy. Only history will tell if we made the right choices for a brighter future, but we will not succeed addressing any of the three without addressing racism.

The link between a productive workforce and a vibrant economy is crystal clear. We must assure a healthy population from which to employ workers. How do we get there? If we accept WHO's definition of health as not merely the absence of disease or disability but a state of positive well-being (physical, mental, social. spiritual), we have much work to do and the work will largely be outside of the clinic walls and require engaging multiple disciplines and multiple sectors. Success will depend on creating environmental conditions for health that everyone can access.

I believe we get there by investing more in assuring healthy early child development. That will mean transforming our clinical practices to mean more than medical care. We need to pay close attention to social determinants and intervene at the very beginning of life.

This working paper emphasizes one critical area for such investment, in a relational health workforce. We must emphasize, however, that this workforce also can and must contribute to intentionally addressing inequities and the structural, institutional, and personal racism that does exist in our society. It must be part of our overall public health infrastructure as well as the individual health services we provide. If it does so, it can be a key and transformational lever for dismantling racism.

Governmental public health at all levels – federal, state, tribal, and local – is the locus of accountability for this work. Public health must be what we as a society do collectively to assure the conditions in

which people can be healthy. That means a level of civic engagement is required to keep policy makers informed regarding adequate resources and capacity to accomplish the job. Today, we know much more about health than we did in 1988. Opportunities exist that we are learning from COVID-19 the hard way. Social Policy is Health Policy. We must update our thinking and renew our commitment to racial justice in all our systems and we must increase our moral courage to act on what we know to be true. Health is more than medicine. Today, opportunity for health does not exist for everybody.

COVID-19 exposed the racial disparities in poor outcomes and deaths, with populations of color bearing the largest burden. There are stories behind each death that need to be told. These include histories of a pile of preventable chronic diseases and their social determinants (e.g. poverty, unremitting stress, food insecurity, violence, trauma, police brutality, incarceration, poor housing, toxic environments, and poor access to any opportunity for meeting a family's basic needs). Until COVID-19, these realities were either unknown or simply ignored. Today, the number one determinant of racial and ethnic disparities in health has been called out. It is RACISM.

James Baldwin once said, "Not everything that is faced can be changed but nothing can be changed until it is faced." It is time to face the truth, ask the hard questions and commit to ending the many racial injustices in health.

As a pediatrician and public health advocate, I always have called for addressing complex problems by attending to "root" causes first. Disparities and inequities in health and well-being begin long before adulthood (starting with preconception health). If addressed early, many chronic conditions we see in adults can be prevented. Today we have the science of early child development. We now need to act on what we know with a greater sense of urgency. Our new knowledge needs to be fully integrated into our thinking and we should be transforming our practices and forming community-based partnerships to support children and their families in all domains of ages and stages.

We should be asking this question at all points along a child's developmental trajectory: How are inequities, biases and structural racism operating at each developmental milestone of childhood? What will be the consequence of doing nothing, continuing to do what doesn't work, and failing to take action on what we know to be true? Because we know children of color and their families are subject to unequal treatment along the trajectory, we have to dismantle racism in all of its forms "from womb to tomb." We must also assure distributive justice of all available resources to support families.

Going back to the working paper and its foreword, there is an important warning to prepare today for a pandemic of mental health issues tomorrow: "While children have not borne the major brunt of COVID-19 in medical terms, the long-term effects of the disruptions to their lives, the stresses on themselves and their families, and the adversities they have experienced require responses, particularly through relational health services. Closing health disparities, including those now afflicting the adult population, and therefore achieving health equity requires investments to enhance relational health at the start of life." Moreover, this relational health care must be concerted in confronting and dismantling racism and its impacts in all of its forms.

Unless we as a society ensure health equity for children and their families at the very beginning of life, we will not eliminate disparities in population health and well-being.

Commentary – Christina Bethell, PhD, MBA, MPH

Evidence for a Whole Child, Relational Health Policy and Health Measurement System. The science of child development is largely a science about relational health. The definitions of relational health and early relational health that is the basis for this paper are founded in this science- as well as common sense. While relational health is a core component of overall health, its presence in early life predicts its development in later life and is also fundamental to children's whole physical, cognitive, social, and behavioral health and well-being. To examine opportunities to promote relational health for US children, researchers led by the Child and Adolescent Health Measurement Initiative (CAHMI) used population-based data to estimate family based relational health risks (RHR) among US children and identify actionable strategies to prevent and mitigate impacts due to these risks.[1] They also explored associations between RHR and social health risks (SHR) to understand how they are associated and if RHR operate independently in predicting children's medical and mental health problems and flourishing. If so, this would argue for a distinction in measurement between SHR and RHR so that the interaction between these types of risks and their independent impact on child health can be recognized.

In this research, a high bar was set for assessing relational health risks. Included was whether children (1) had caregivers who experience very low levels of mental or emotional health, (2) had multiple adverse childhood experiences, (3) had caregivers experiencing high stress and aggravation related to parenting or (4) had caregivers that lacked emotional support and/or were coping poorly. About 2 in 5 US children were identified with this higher level of RHR using these criteria. Large variations were found by income, race/ethnicity and type of health insurance. Rates of SHR were lower (28.2%) and 43.3% of children with SHR did not also experience RHR.

Verifying hypotheses, the new research found that RHR have an independent impact from the SHR more typically addressed today (e.g. food insecurity, economic hardship, unsafe neighborhoods, racial discrimination). Results showed that RHR have a greater impact on a child's experiencing mental, emotional or behavioral health problems (MEB) and other physical and developmental conditions than SHR on their own. Over 40% of children with RHR did not also experience a SHR. Yet, nonetheless, MEB rates were nearly 45% for these children compared to about 15% for children without RHR. It is the combination of RHR and SHR that has the greatest impact. Researchers found that nearly two-thirds of US children with higher levels of RHR and SHR also had an MEB diagnosis or problem and that 50% of children with MEB in the US also experienced the RHR assessed.[1]

This and related research urge swift progress toward establishing a whole child relational health policy, with an emphasis at the clinical and population level on conducting and coordinating systems to respond to whole child assessments that include both relational health strengths and risks, in addition to other social determinants, medical health risks and other factors essential understanding the whole child.

As difficult as the times are that we face today, we now have important population-based findings that mirror long-standing evidence sufficient to support an era of implementation and capacity building to dramatically improve healthy child development and early and lifelong child flourishing through the promotion of relational health-our greatest public health opportunity.[1-5] This, in turn, requires that we give attention to measuring relational health, relational health risks and relational health care as we move forward. The overall child health care transformation framework developed by InCK Marks emphasizes that metrics transformation is a core component for this work.[6] The work of researchers led

by the CAHMI on defining and measuring relational health risks and how they relate to social health risks and medical and mental health risks and child flourishing does just that.

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Commentary – Paul Dworkin, MD

Supporting and Sustaining Innovations in Child Health Services Transformation. Through its comprehensive, integrated approach to developmental promotion, early detection, referral and linkage of children and families to community-based programs and services, the Help Me Grow model strengthens families' protective factors, thereby enhancing their capacity to promote their children's optimal health, development, and well-being. Among such protective factors are families' promotion of their children's social-emotional development, a key feature of health care that can be facilitated by relational health workers. This working paper raises the question of how health care financing can support and sustain innovations such as a relational health workforce for young children as a component of child health services transformation.

We are all too familiar with the challenges of encouraging a focus on child health services in discussions of health care reform. The "triple aim" of health care reform – including better health outcomes, improved health service delivery, and cost savings – has prioritized a "relentless pursuit of scorable savings." As the working paper indicates, the potential for cost savings in child health services is paltry compared to that attainable by addressing the high costs of care for adults with chronic conditions such as obesity and type II diabetes.

Other factors also contribute to the lack of focus on child health services in health care reform efforts that stress cost savings. This includes the challenge of capturing the long-term return on investments

made during the childhood period (i.e., the "long pocket" problem). For example, investing in infant's healthy relational development may yield some of the greatest cost returns-on-investment but these are literally over the life course, such as through decreasing adult rates of preventable morbidities.

Capturing such returns also is a challenge because of the complexities of aligning investments with savings (i.e., the "wrong pocket" problem). For example, investments in child health services, early care and education, and family support services, such as home visiting, lead to savings in special education, behavioral health, and the juvenile justice and corrections system. Reconciling investments and returns across these sectors is challenging, at best, and not possible in most states.

Despite these challenges, a variety of strategies should be considered to support innovation and child health services transformation even in the context of the demand for cost savings. Such strategies include, but are not limited to:

- Blending of administrative and financial resources across agencies, including public-private partnerships;
- Applying meaningful, feasible pay-for-success approaches; and
- Building capacity to demonstrate the return on investment (ROI)/cost savings/cost benefit to support an "invest/reinvest strategy" in primary health care for young children.

The latter approach requires that we have the capacity to adjust the time frame to capture longer-term savings and perform the accounting to credit subsequent savings realized in other sectors on earlier investments made in child health. Key is developing sound and convincing methodologies to project both short- and long-term returns on investment, cost savings, and cost benefits for transforming child health services.

This is precisely the methodology that the Help Me Grow National Center, in partnership with Manatt Health, has developed to capture the ROI, cost savings, and cost benefits of a comprehensive, integrated approach to developmental promotion, early detection, referral and linkage. Initial application of the "ROI calculator" has yielded impressive savings in both the short- and long-term. Examples of successful short-term strategies leading to savings include diversion from unnecessary developmental assessments, addressing food security, and maternal depression detection and referral. Strategies demonstrated to yield longer-term savings include early detection and referral to Head Start, preschool programs, and early intervention; positive parenting; home visiting; and preventive child dental care.

While the rationale for child health services transformation is multi-faceted, including the moral imperative that "children are our future" and society has a primary responsibility to ensure the next generation grows up healthy, we must be able to demonstrate financial benefits to capture both the hearts and minds of policy makers. James Heckman, a Nobel economist now focusing upon such analysis, has concluded that the highest returns-on-investment from social interventions effectively involve strengthening the relational health of the youngest in our society. We need to apply his analysis to child health care. The good news is that we are rapidly developing the methodology to do so.

Sources for further information:

For information about the Help Me Grow Return On Investment Calculator developed with Manatt Health, see: https://helpmegrownational.org/resources/help-me-grow-return-on-investment-resources-updates/.

For information about the Heckman Equation (which focuses upon early care and education but also can and should be applied to developmental and relational health care, see: www.heckmanequation.org.

Commentary – Shadi Houshyar, PhD, and Juanita Gallion

Becoming an Anti-Racist Organization. In *Building a Relational Health Workforce for Young Children: A Framework for Improving Child Well-Being,* Bruner highlights the value of relational health workers (RHWs) for promoting healthy child development, strengthening families, and contributing to community-building. RHWs also can be key to advancing racial equity and transforming health and health care delivery to meet the needs of all children and families.

As an organization committed to holding racial equity as a core value, the Center for the Study of Social Policy (CSSP) has developed a series of recommendations for organizations seeking to become anti-racist. To be clear, when we talk about racial equity, we mean acknowledging unequal starting places and tackling the root causes of inequities to create a racially, economically, and socially just society where all children and families can thrive, and where race no longer predicts the course of a person's life. To advance racial equity, our work must be grounded in an anti-racist approach that includes an active process of identifying and challenging racism by changing systems, organizational structures, policies and practices, attitudes, and cultural messages to redistribute power in an equitable way.

RHWs have the potential to be part of an anti-racist approach in transforming health care, shifting power by lifting up and advocating for the needs of those marginalized by systems due to systemic and institutional racism, working to alleviate structural inequities and improve community conditions by effectively connecting and building trust with families, helping to build the capacity of a more responsive health workforce, and drawing on their own grounding in communities to support the health and wellbeing of children and families. This is particularly true when RHWs are drawn, in significant measure, from the communities being served and reflect their cultural, linguistic, and racial backgrounds and experiences.

Currently, although RHWs play an important role in health systems, they often are not equitably compensated or valued for the critical role they serve in health care delivery. For organizations employing RHWs, much can be done to solidify policies and infrastructure to support a vibrant RHW workforce, including standards for equitable compensation, adequate training, ongoing supervision, and opportunities for professional development. RHWs should be represented in decision-making and be recognized as key members in providing team-based care, particularly as they often serve as bridges between the health system and the families and communities being serviced. Any standards that seek to define high quality RHWs should avoid prioritizing education over skills, empathy and cultural connectedness, aptitude, leadership quality, and connection to community.

All organizations can benefit from an intentional focus on centering equity, inclusion, and justice in their internal organizational policies and practices. For organizations seeking to do external facing racial equity work - especially those employing RHWs - it is essential to make a parallel and explicit organizational commitment to confronting and dismantling racism and valuing equity, by creating a culture of self-reflection and organizational improvement.

For organizations that seek to value RHWs, what does that look like? How does equity show up in your work? Our recommendations - several of which are shared below - are inclusive of considerations around hiring, training and support for staff, as well as equitable compensation and standing in the organization - key issues for the relational health workforce.

Ensure that you are continually examining internal policies, practices, and procedures. You can use data to continually examine recruitment, hiring, retention, training, support, promotion, contracting, compensation, and other practices and procedures to ensure equitable employment practices. Develop performance measures and an accountability structure that staff and leadership agree upon and use. Create a structure for continuous reflection and improvement and make space for midcourse corrections.

Identify champions—both internal and external—who will support and hold your organization accountable to your commitment to racial equity. These can be board members, staff, external partners, funders, etc., and they should be involved continuously. They can help you stay accountable for living your values internally and externally – and provide critical feedback on how you show up in community.

Create the expectation that all staff are leaders and change agents for racial equity. Racial equity work is not optional when looking to achieve improvements for children, youth, and families. All staff, regardless of their position in the organization, should understand they have a critical role to play in advancing equity both within and external to the organization.

Foster an inclusive and respectful environment that values staff as whole individuals and ensures staff do not blame others, assume disinterest or poor motivations, and encourages openness, dialogue, and room for mutual understanding.

Balance the need for ongoing internal capacity building while maintaining a laser-like focus on external work to improve outcomes for children and families. This means having a dual focus and double bottom line and is crucial to staff having a high level of proficiency and pushing equity focused work forward.

Seek funding that allows for dedicated staff time to focus on racial equity. Organizational resources—both money and time, are essential to creating a culture that seeks to advance racial equity and ensure that staff are constantly working to grow and improve. Prioritize this work as much as you prioritize core programmatic or organizational work and support staff so that they can take advantage of training opportunities.

Conclusion. Now is the moment to take an anti-racist approach to transforming health and health systems to meet the needs of all children and families. Organizations seeking to become anti-racist should commit to examining and improving internal and external efforts to center racial equity in their work and bring to it the staff time, attention, accountability, and infrastructure needed to make change. Having a vibrant and diverse relational health workforce can play a major role in doing so.

You can learn more about what it takes to become an anti-racist organization and about CSSP's Journey to Center Equity, Inclusion and Justice at: https://cssp.org/resource/moving-forward-together/

Commentary – Kay Johnson

Relational Health and High Performing Medical Homes. This working paper describes the importance of relational health in child health and goes on to describe the qualities of a workforce which fosters that relational health. While not using the exact term "relational," the principles for a medical home established by four major organizations representing primary care providers [1,2] and the *Bright Futures* guidelines for preventive pediatric health care developed and endorsed by the American Academy of Pediatrics (AAP) and the federal Maternal and Child Health Bureau (MCHB-HRSA-HHS) [3] emphasize the need for primary pediatric practice to respond holistically and relationally in the context of the child's

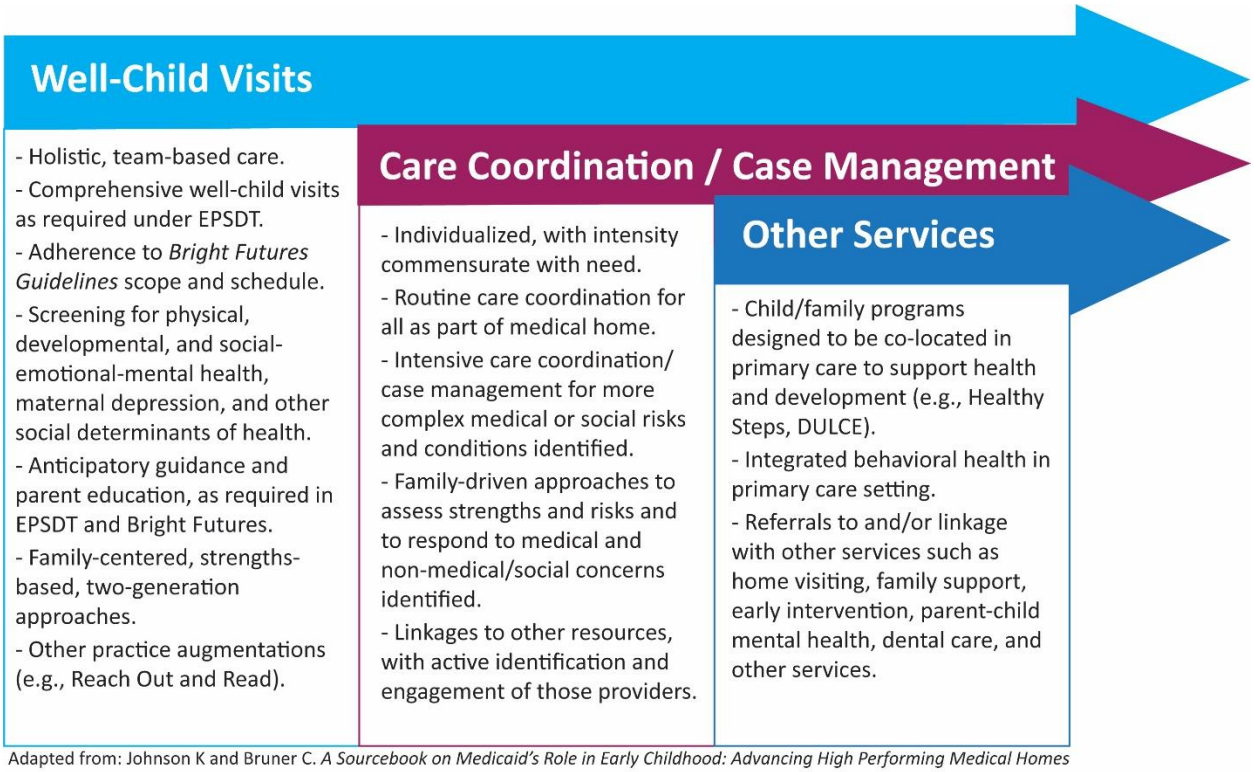
family and community. The shared principles for a medical home are to deliver primary care that is: patient and family centered, comprehensive, team-based, accessible, coordinated and committed to quality, safety, and equity. The most recent Fourth Edition of *Bright Futures* gives greater emphasis to promoting lifelong health and to responding to risk and protective factors. Both place the child's relationship with the child's parents as caregivers at the core of promoting child health.

Yet too many children, especially poor children and children of color, do not have a medical home. Too few providers have the resources to fully implement the Bright Futures guidelines. Primary and preventive child health care, even in medical homes, often is limited to addressing medical issues and not other social and economic factors that affect child health.

National survey data reveal that only about half (51 percent) of young children without special health care needs have care that meets medical home criteria, which include having family-centered care, completed referrals, and effective care coordination.[4] At the same time, however, there is a growing recognition of the opportunity for primary child health practice to be more holistic, preventive, and relational.

A 2018 report I co-authored with Charles Bruner, *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health*,[5] drew upon developments in child health practice to propose a state-of-the-art design for a "high performing medical home" for young children in Medicaid. We also didn't use the term "relational health" at that time, but many of the components of that "high performing medical home" explicitly were designed to strengthen the parent-child relationship in order to promote optimal child health and development. As shown in the figure, this focuses on transforming the pediatric primary care/medical home experience at three levels:

1. **Provide comprehensive well-child visits and preventive services based on Bright Futures and Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT)** child health benefit standards, including screening, anticipatory guidance and parent education, that extend beyond the physical/bio-medical health of the child to the social and environmental factors that affect child health and development (e.g. family stress, maternal depression, food insecurity), with a two generation emphasis on improving child health (including the parent-child relationship itself).
2. **Provide care coordination/case management at appropriate levels of intensity**, depending on child and family presenting concerns. Consistent with the concept of team-based care for a medical home, this includes supports for an effective, warm "handoff" from the health practitioner to a care coordinator to ensure follow-up that connects families with resources and supports that meet needs and build strengths, including the relationship between child and family. A part of this care coordination is to network with other services and supports in the community to facilitate effective connections and ensure completed referrals. The report emphasizes that such care coordination requires trust and relationship-development with the family.
3. **Increase use of other services and supports for healthy development**. This can include augmented services located within the primary care setting, such as early childhood development specialists, integrated behavioral health, or community health workers to support families. Primary care practices also should link to or integrate with other services such as home visiting, parent-child dyadic mental health therapies, early intervention for developmental delays and disabilities, and parenting programs.



Adapted from: Johnson K and Bruner C. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health*. Child and Family Policy Center. October, 2018.

Medicaid and CHIP provide coverage for approximately half of all births, and more than 60 percent of Black, Native American, and Hispanic infants. More than 40 percent of all children birth to three years – nearly 7 million infants and toddlers – rely on Medicaid for well-child visits and other care.[6] We cannot achieve equity for infants and young children without high performing medical homes for young children in Medicaid. Such high performing medical homes would, by design, promote strong and nurturing parent-child relationships, recognize the inherent strengths in those relationships, and respect family voice and lived experience.

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Commentary – Melissa Bailey

From Relational Health to Relational Health Policy. Charlie Bruner and this working paper, once again, make the case for the types of supports and services that will make a difference to young children and their families and ultimately for society.

We often hope there is one perfect intervention or treatment that can change the course for families, but we know one of the most impactful "prescriptions" is having the right supportive relationships – people who understand a family's circumstances, their story, and support a family in identifying what will help them be most successful. That often is the most important aspect of a "treatment plan."

It long has been held in the adult mental health and substance abuse system that peers often are the best support for an individual seeking change and improvement in his/her life. Peers assist people in finding the motivations within themselves to make change while also helping the individual identify the external supports they need to be successful. People grow from reciprocal relationships of giving as well as receiving help, which occurs within supportive peer relationships. Having someone that believes in you and that can be a sounding board and has experienced similar life circumstances often can have the greatest impact.

Applying that same relational concept to families parenting young children and investing in a workforce that is grown from the communities it serves, is a win-win. Implementing policies that support the practice of modeling, reflecting and guiding, provide the tools needed to improve the service delivery system.

This working paper highlights the importance of not only creating access to a workforce that provides the relational supports but also emphasizing their role, incorporating it as part of the strategic leadership of a care system. It further recognizes that without this opportunity to engage in relational health, all the other traditional supports and services are not nearly as impactful.

The opportunity is in front of us to establish funding and policies to incorporate this necessary aspect into the care continuum. Although not always recognized as an academic "evidence-based practice," recognition of "community-based evidence" is growing. We see that communities thrive when those who are connected and invested in the community and its members are supported as leaders in helping the community.

The paper further begins to describe the elements of policy that need to be implemented to support the grounding and holding up of relational health. Much occurs naturally and at a voluntary, community level, particularly when people have the financial resources and supportive environment to do so. But

there also is a government and public role to support relational health to strengthen families and their and their children's relationships with others. This is a universal and most human need. In the end, what do we all need to be successful? Encouragement, understanding, people believing in us and not doing for us, but supporting us in the doing. We must be ready to take on the doing, creating the infrastructure through policy and funding to take relational health care to the next level and have it become integrated and recognized as part of a family's success.

Appendix A: The DNA of Transformed Practice

In reviewing transformational efforts in early childhood across health, early care and education, and family support, *Village Building and School Readiness* described this underlying culture as a DNA of effective programs,[36] as shown in Chart Five. The two interconnecting DNA strands in the double helix relate to staff and family roles embedded in those transformational efforts. These attributes themselves share commonalities with other descriptions of exemplary family support practices and describe the relational characteristics of described in this working paper for relational health workers.

CHART FIVE

The DNA of Transformed Practice

STAFF DNA Strand	PARTICIPANT DNA Strand	DESCRIPTION of Interconnecting Strands
ASSET-BASED APPROACH	RECIPROCITY	Staff recognize and work to build upon family strengths. Participants reciprocate by using their assets to help others and the community.
FACILITATED NETWORKING	MUTUAL ASSISTANCE	Staff facilitate participant groups and support development of affinity-based networks. Networks and groups provide support to one another and community.
INDIVIDUAL TAILORING OF SERVICES	PERSONAL RESPONSIBILITY	Staff work with participants and respond to individual needs in providing services. Participants take personal responsibility for addressing family needs.
PASSIONATE SKILLED STAFF	ACTIVATED PARENT LEADERSHIP	Staff are passionate and skilled in what they do, with expertise in own areas and a collaborative mentality. Participants assume leadership roles and build skills, often leading to new roles and careers.
MUTUAL ACCOUNTABILITY FOR SUCCESS		Both staff and participants hold themselves accountable for their roles in personal and community growth and success.
PARTNERSHIP	OWNERSHIP	Staff partner with families, including planning activities and services. Participants take ownership and make commitment for sustaining the program.
CULTURAL CONGRUENCE	EMBRACE DIVERSITY	Staff reflect the culture of the community they serve and value diversity and inclusion (race, gender, disability, sexual orientation, age). Participants advocate for inclusion and model that behavior with family and community.
COMMITMENT TO EQUITY		Achieving equity and eliminating "isms" is embedded in the work.
FAMILY FOCUS	WHOLE FAMILY INVOLVEMENT	Staff maintain a family focus and an environment that is welcoming to all family members. Families strengthen their involvement with their (and others') children and with other families.
COMMUNITY EMBEDDEDNESS	FOCUS UPON COMMUNITY BUILDING	Staff are connected to the community as more than a place to work. Participants act to strengthen and build their community. Staff maintain a family focus and an environment that is welcoming to all family members. Families strengthen their involvement with their (and others') children and with other families.

Appendix B: Iterations of Principles of Effective Frontline Practice

In 1989, Lisbeth Schorr's book, *Within Our Reach: Breaking the Cycle of Disadvantage*, identified a variety of effective social programs that "beat the odds" in succeeding with vulnerable children and their families – children and families that current systems otherwise had failed. Moreover, she went beyond documenting their impacts to identifying some core, common, attributes they shared that were key to their success. While some had specific programmatic features and protocols, she provided compelling evidence that what made them effective was the positive relationships they were able to establish and the reasoned hope they were able to provide to support those families in achieving their aspirations. *Within Our Reach* heartened those in the helping world, as it provided evidence of the successes possible when those on the frontline are supported in helping people help themselves.

In 1994 in *Beyond the Buzzword: Key Principles of Effective Practice,* Jill Kinney, one of the founders of Homebuilders, and her colleagues examined a broad range of empirical research on therapeutic interventions with children and families and their conceptual and theoretical underpinnings in the science of human behavior. She identified a very similar set of principles, including pragmatic ways to assess their presence or absence in practice:

- **Building on Strengths**: Effective workers emphasize client strengths, rather than client pathology, and use client strengths and resources in problem-solving
- **A Holistic Approach**: Effective workers view their clients holistically and their treatment plans encompass a broad range of factors
- **Partnership in Decision-Making**: Effective workers join with their clients as true partners in a collaborative problem-solving effort
- **Individual Tailoring of Services**: Effective workers tailor treatment plans to meet the needs and goals of their clients
- **Goal Setting and Monitoring**: Effective workers and clients work together to create very specific, short-term, measurable goals for treatment
- **Worker Characteristics and Skills**: Effective workers display certain skills and attitudes, including the ability to engage clients in a trusting working relationship, to express appropriate empathy, and to facilitate learning of a broad range of life skills.

The Appendix to *Beyond the Buzzwords* offered iterations of these principles from systems reform and trans formation efforts across a multitude of disciplines. In addition to those set out by Schorr, these included: (1) Principles for Family Support Programs (FRC), (2) Principles for Early Childhood Programs and Services for Infants and Toddlers, (3) Principles for Child Mental Health (CASSP), (4) Principles for Health Care Services for Infants and Toddlers with Special Health Care Needs, (5) Principles for Child Welfare, (6) Principles for Child Abuse Prevention, (7) Principles for School-Community Collaborations and School-linked Services, (8) Principles for Education, (9) Principles for Disability Community, (10) Principles for Youth Development, and (11) Principles for Service Integration (NCSI).

At the same time, at the political level there was an increased emphasis upon "results accountability" and directing funding to evidenced-based or research-based programs – and with a focus upon

validation through research designed that employed randomized trials or at least quasi-experimental design – generally not involving measures of the presence or absence of such practice qualities and generally focus upon discrete and linear measures of impact. While programs adhering to these principles often can show results, the reason they do so often goes unrecognized and their major long-term gains (in resiliency, reasoned hope, and reciprocity) are not considered. Continuing this narrow approach to evaluation and identification of programs worthy of replication is not likely to advance the development of a relational health workforce.

To advance relational health care and establish a relational health workforce requires concerted attention to precisely those attributes. This, in turn, requires a different political and policy conception of what constitutes effective care and helping. It is worth presenting (and not dismissing), what then-Congressman Paul Ryan expressed in the opening of a TED Talk he did on June 24, 2015, around this very issue.

> Four miles from here [Pennsylvania Avenue, D.C.], in a part of town called Anacostia, there's a shelter called the House of Help, City of Hope. Years ago, the place was boarded up. And the neighborhood was a mess. Drugs, gangs, crime were everywhere. When the utility guy came to check the meter, he needed a police escort.
>
> But then a woman in the community took action. Her name is Shirley Holloway. And she worked with a philanthropist, a non-profit led by my friend Bob Woodson, and the District of Columbia to buy the building and turn it into the House of Help. They chased out the gangs. They cleared out the drugs. And now, the House of Help has served thousands of people struggling with addiction and homelessness. It goes to show what happens when all parts of the community work together.
>
> They do a lot of good work. Let me give you just one example. When I went there, I met a guy named James Woods. He told me, when he was younger, he fell in with the wrong crowd. Joined a gang . . . sold drugs. He was a tough guy—the enforcer. He got addicted, went homeless, and went to jail. When he got out, he knew he needed to change, but he didn't know how—till he joined the House of Help. Then he went clean, found a job, got married, and turned his life around.
>
> The question is, why? What worked? If you asked James, he'd say one thing: Shirley Holloway. To keep him out of jail, she paid his legal fees. He promised to pay her back. But she didn't cash his checks; she saved them. And when he got married, she turned over all the money she'd saved so he and his wife could have a nice wedding.
>
> Nobody had done that for him before. Nobody had put him first.
>
> So, a heart-warming story, right? Sure. But I'm not speaking to the heart. I'm speaking to the head. There's a reason Shirley Holloway got through to James Woods. She had credibility. He knew he could trust her. And when she gave him advice, and taught him new skills, and held him accountable, he listened. Credibility is the key to unlocking people's potential. Credibility is what makes the policy effective.
>
> And what I learned from James was, credibility doesn't come in bulk. It's small-scale. It's gradual. It's personal. And it is our ultimate weapon in the War on Poverty.

Endnotes

These endnotes draw heavily from the author's own forty-plus year journey in seeking to ask a question posed at a family support workshop by Ralph Smith in 1980, "How can we succeed with children current systems fail?" Many of the references are to my different efforts to respond to this question in the context of different policy and practice reform efforts – service integration, family support, child welfare reform, community schools, community-based-and-building systems reform, early childhood education, family engagement and empowerment, child health, etc. While there are many references to my own work in these referenced, in most of these (and their citations and discussions) can be found references to the work and thinking in the field at the time. Three of the more extensive efforts to capture the "state of the field," where there is a substantial effort to summarize the research underpinnings for policy action, are. The conclusion in each is that "we know enough to act" and invest much more boldly in responding, as best we can, to the question posed in 1980 by Ralph Smith.

Bruner, C (1996). *Realizing A Vision for Children, Families, and Neighborhoods: An Alternative to Other Modest Proposals*. A policy paper for the Carter Center Leadership Symposium on Community Strategies for Children and Families. National Center for Service Integration.

Bruner, C (2000). *Social Service Systems Reform in Poor Neighborhoods: What We Know and What We Need to Find Out.* Working Paper of the National Center for Service Integration. Also published by the Aspen Roundtable Institute on Comprehensive Community Initiative's *Voices from the Field II.*

Bruner, C (2009). *Philanthropy, Advocacy, Vulnerable Children, and Federal Policy: Three Essays on a New Era of Opportunity.* Working Paper. National Center for Service Integration Clearinghouse and Child and Family Policy Center.

In addition, several documents engaged leaders in the field in responding to different aspects of this work. Three most pertinent to this frontline community-based workforce are:

Bruner, C, Cahn, E, Gartner, A, Giloth, R, Herr, T, Kinney, J, Nittoli, J, Reissman, F, Trent, M, Trevino, y, and Wagner, S (1998). *Wise Counsel: Redefining the Role of Consumers, Professionals, and Community Workers in the Helping Process.* National Center for Service Integration Resource Brief 8. Child and Family Policy Center.

Bruner, C, Greenberg, M, Guy, C, Little, M, Schorr, L, and Weiss, H (2001). *Funding What Works: Exploring the Role of Research on Effective Programs and Practices in Government Decision-Making*. National Center for Service Integration and Center for Schools and Communities.

Bruner C. et. al. (2007). *Village Building and School Readiness: Closing Opportunity Gaps in a Diverse Society*. State Early Childhood Policy Technical Assistance Network. Des Moines, IA.

ENDNOTES

[1] These definitions are adapted from those developed by David Willis and the Center for the Study of Social Policy for relational health and early relational health and described in the joint Frameworks Institute and CSSP paper, based upon expert interviews and peer discourse sessions. See: Frameworks Institute and Center for the Study of Social Policy (May 2020). *Building Relationships: Framing Early Relational Health.* Authors. Retrieved at: https://cssp.org/wp-content/uploads/2020/05/FRAJ8069-Early-Relational-Health-paper-200526-WEB.pdf

[2] National Research Council and Institute of Medicine. (2000) *From Neurons to Neighborhoods: The Science of Early Childhood Development*. JP Shonkoff and DA Phillips (Eds.). Washington, DC: The National Academies Press

[3] Office of Disease Prevention and Health Promotion. (2016). *Healthy People 2020*. Washington, DC: United States Department of Health and Human Services.

[4] Horton, C. (2003). Protective Factors Literature Review: Early Care and Education Programs and the Prevention of Child Abuse and Neglect. Washington, DC: Center for the Study of Social Policy.

[5] Felitti, V.J., Anda, R.F., Nordenberg, D., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine.* 14(4):245–258, Garner AS, Shonkoff JP; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. (2012). Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. Pediatrics. 129(1):e224-31. doi: 10.1542/peds.2011-2662.

[6] Henderson, N., Benard, B., & Sharp-Light, N. (eds.) (1999). *Resiliency in Action: Practical Ideas for Overcoming Risks and Building Strengths in Youth, Families, and Communit*ies. Masten, A.S., Barnes, A.J. (2018) Resilience in children: *Developmental perspectives*. *Children*. 5, 98; doi:10.3390/children5070098.

[7] National Scientific Council on the Developing Child (2010). Early Experiences Can Alter Gene Expression and Affect Long-Term Development: Working Paper No. 10. Available at: www.developingchild.harvard.edu.

[8] Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 129(1 :e232-46. doi:10.1542/peds.2011- 2663.

[9] Wilkinson, R., Marmot, M. (2003). *Social Determinants of Health: The Solid Facts. 2nd Edition*. London: World Health Organization.

[10] Clearly, the first years of life are times of rapid brain growth and development and, in particularly, the formation of self-identity and response to different stimuli. Adolescence (into early adulthood) also is a time of continued brain development, particularly around executive function, and a time when some adolescents and young adults also are taking on parenting roles and responsibilities. At the same time, however, becoming a parent also creates additional opportunities for neural development around taking on that protecting role of another. Citation.

[11] Bruner, C, & National Advisory Team (2020). *Health Care Transformation and Young Children: The State of the Field and the Need for Action.* InCK Marks Initiative. Working Paper 1.

[12] Farmer, P. (2014). How liberation theology can inform public health. *Soujourners.* Also retrieved at: https://www.pih.org/article/dr.-paul-farmer-how-liberation-theology-can-inform-public-health.

[13] Stern, C. (2017). *Bending the Arc.* Impact Partners. A film directed by Davidson, K, and Kos, P.

[14] This section draws heavily upon the family support literature and its principles of effective practice, drawn from the experiences and reflections of over two thousand family support programs sharing their

views of what constituted the essence of their work. See: Family Resource Coalition (2001). *Guidelines for Family Support Practice: 2nd Edition.* Chicago: IL.. For a summary of this literature in the context of developing evaluation systems for such programs and practices, see: Bruner, C. (2006). Developing an outcome-evaluation framework for use by family support programs," in Dolan, P., Canavan, J., Pinkerton, J. *Family Support as Reflective Practice*. Jessica Kingsley Publishers: London, UK,

[15] Bruner, C (2011). *Thirst to Contribute: Fostering Personal Growth, Building Social Capital, and Strengthening Community Through Public Policy.* Child and Family Policy Center. Report to the Annie E. Casey Foundation.

[16] Schorr, L with Schorr, D (1988). Within our Reach: Breaking the Cycles of Disadvantage. Random House: New York, NY. Schorr, L; Both, D; Copple, C (eds). (1991) Effective Services for Young Children: Report of a Workshop. Washington, DC: National Academy Press, pp. 31-35.)

[17] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association (2007). Joint Principles of the Patient-Centered Medical Home. www.medicalhomeinfo.org/Joint%20Statement.pdf, Bruner, C (2009). Medical Homes and Young Children: State Policy Opportunities to Improve Children's Healthy Development as Part of Early-Childhood Systems Building. Build Initiative and Child and Family Policy Center.

[18] Hagan, J, Shaw, J, and Duncan, P (2017). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* American Academy of Pediatrics.

[19] Kinney, J; Strand, K; Hagerup, M, Bruner, C (1994). Beyond the Buzzwords: Key Principles in Effective Frontline Practice. National Center for Service Integration. Appendix Two of this paper provides (pp. 7-23), [provides iterations of these principles in different human service system reform efforts.

[20] Bruner, C, and Johnson K, with Hayes, M, Bailey, M, Dworkin, P, Hild, J, and Willis, D (2020). *Young Child Health Transformation: What Practice Tells Us.* Working Paper Two. InCK Marks Initiative.

based practices that build on the capacities and strengths of children, parents, families, communities, and public and private organizations. This is accomplished using different approaches and strategies that draw from a wealth of knowledge and experiences for improving efforts directed at supporting and strengthening family functioning." The website includes a wide array of articles, including many by Karl Dunst and Carol Trivette. Website address is: http://www.puckett.org/,

[22] See: Bruner, C, Greenberg, M, Guy, C, Little, M, Schorr, L, and Weiss, H (2001). *Funding What Works: Exploring the Role of Research on Effective Programs and Practices in Government Decision-Making*. National Center for Service Integration and Center for Schools and Communities. The report from a symposium offers various expert perspectives on the importance of shifting evaluation and definitions of what constitutes evidence away from discrete programmatic evaluations to broader attribute evaluations.

[23] See: Bruner, C, Cahn, E, Gartner, A, Giloth, R, Herr, T, Kinney, J, Nittoli, J, Reissman, F, Trent, M, Trevino, y, and Wagner, S (1998). *Wise Counsel: Redefining the Role of Consumers, Professionals, and Community Workers in the Helping Process.* National Center for Service Integration Resource Brief 8. Child and Family Policy Center.

[24] This challenge is presented in one of the first writings by the author on this subject and part of a collection of essays outlining the then-emerging field of family support. Bruner, From State-Level Policies to Street-Level Services. Bruner, C (1993). "From Street-Level Services to State-Level Policies," in: Kagan, L, Powell, D, Weissberg, B, & Zigler, E (eds). *America's Family Support Programs: Perspectives and Prospects.* Yale University Press.

[25] They also have developed a results-oriented manage accountability framework based upon the work of those family development specialists in support family growth and development. Some of this effort stems from the work of Gary Stokes and others at Mid-Iowa Community Action. Stokes' three part-series, "Ordinary people, Extaordinary Organizations," in *Journal of Philanthropy.*

[26] There have been a variety of both foundation and federal initiatives that can be built upon in this work. The InCK Marks paper, *Health Care Transformation for Young Children*, provides an overview of such efforts which can be built upon in advancing such a frontline community-based workforce, often in the context of broader efforts to improve child health and well-being at a population level. InCK Marks (2020). *Health Care Transformation for Young Children: A Landscape of Federal and Foundation Initiatives and Model Dissemination Efforts.* This landscape builds upon the earlier review of advances in the field in: Bruner, C (2009). *Philanthropy, Advocacy, Vulnerable Children, and Federal Policy: Three Essays on a New Era of Opportunity.* Working Paper. National Center for Service Integration Clearinghouse and Child and Family Policy Center.

[27] See Appendix E of Bruner, C and Johnson K (2019) *Federal Spending on Children Prenatal to Three: Developing a Public Response to Improving Developmental Trajectories and Preventing Inequities,* Center for the Study of Social Policy, Washington DC, pp.44-17. This Apoendix provides an estimate of the size and reach of different federal program investments. The InCK Marks paper on estimating risk and response indicates that one-quarter of families with young children can benefit and would engage in ongoing relational care coordination and coaching, but only five percent of families now receive such care. Bruner, C, Johnson, K, and Bethell C (2019) *Risk Stratification for Young Children in Medicaid: Achieving the Potential of Prevention.* InCK Marks Initiative and Child and Adolescent Health Measurement Initiative. . While the field can appear as fragmented (often because such work is and should be very local in nature) and therefore potentially duplicative (with calls for "service integration"), this analysis shows that the collective reach of more preventive programs is small in relation to the population which can benefit.

[28] For different cuts at such an estimate, and the general underinvestment in young children's development, see also: Bruner, C (forthcoming). *Scope and Scale: Developing a Risk/Opportunity Strategy for Identifying Young Children and their Families to Achieve Gains in Population Health.* InCK Marks Initiative. Working Paper 8.

[29] For more information on the Administration's proposals, see: www.2020visionforchildren.com.

[30] American Enterprise Institute and Brookings Institution Working Group on Poverty and Opportunity (December 2015). *Opportunity, Responsibility, and Security: A Consensus Plan for Reducing Poverty and Restoring the American Dream.* American Enterprise Institute and Brookings Institution,

[31] Johnson, K, and Bruner, C (2018). *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health.* Child and Family Policy Center.

[32] In addition to the work of InCK Marks, a roundtable facilitated by the National Institute for Children's Health Quality set forth common principles for Medicaid's role in advancing child health transformation. *Opportunities for Medicaid to Transform Pediatric Care for Young Children to Promote Health, Development and Health Equity* 2018). Representatives from Ascend at the Aspen Institute, BrunerChildEquity LLC, Center for Health Care Strategies, Center for the Study of Social Policy, Georgetown University Center for Children and Families, Johnson Consulting Group, Inc., National Institute for Children's Health Quality, and ZERO to THREE. That statement is available at: https://img1.wsimg.com/blobby/go/35bcb6ed-a93b-41a3-9ad9-273bceb67f08/downloads/Medicaid%20and%20Early%20Childhood%20Consensus%20Documen.pdf?ver=1615573785621. Working paper 5 describes what currently exists in state Medicaid contractual language that can be built upon to advance such health. Johnson, K and Bruner, C (2020). Johnson K, Bruner C. (January 2021). *Medicaid Managed Care: Transformation to Accelerate Use of High Performing Medical Homes for Young Children.* InCK Marks Working Paper Series. No. 5. InCK Marks Initiative.

[33] This forms the fourth recommendation in the National Advisory Team's statement to the Biden-Harris administration in a sign-on letter, with over eighty leaders in the child health transformation field. That sign-on letter and statement can be accessed at: xxx. The Community-Based Workforce Alliance has a

very similar and consonant statement regarding the need for an overall community-based workforce (for children, families, and adults). That statement can be accessed at: xxx.

[34] Heckman equation. While estimates of the potential cost-benefits of such investments largely draw from the ROI literature around child care and education programs (Perry Preschool, Abecedarian, and Chicago Parent-Child Centers), the initial impacts that promote gains that such programs that lead to those long-term ROIs are in social-emotional development and orientations to learning. See the resources on the website, the Heckman equation: https://heckmanequation.org/. For a review of the ROI and "cost of bad outcomes" literature that preceded the work of James Heckman, see: Bruner, C. (2002) *A Stitch in Time: Calculating the Costs of School Unreadiness*. Washington, DC: The Finance Project.

[35] For one reflection of what public opinion surveys show and how this relates to political opportunity, see: Bruner, C (2017). *To the Bottom of the Trump Vote in the Rural Midwest: Battleground Angst and How to Address It.* Retrieved at: https://storage.googleapis.com/wzukusers/user-22867503/documents/ee3467aca5f54360b818e8b1b0e17641/ToBottomTrumpVotepdg.pdf

[36] Bruner C. *et. al*. (2007). *Village Building and School Readiness: Closing Opportunity Gaps in a Diverse Society*. State Early Childhood Policy Technical Assistance Network. Des Moines, IA.