



Meeting Report
March 14, 2008

A REPORT FROM THE WORKSHOP

Completing the Recipe for Children's Health: New Variations on Key Ingredients

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OVERVIEW — *This paper offers a broad overview of the issues surrounding the social and environmental determinants of children's health. These issues were explored during a discussion convened by the National Health Policy Forum on June 28, 2007, among a group of individuals concerned about the influences beyond medical care on the health of children. The paper considers the policy and financing tensions that exist across programs and populations that make addressing the full range of influences challenging. It also highlights some of the community-based initiatives that have been successful in providing services to children and families, as described during the workshop. Finally, this meeting report outlines several potential strategies that emerged from the discussion, which could be pursued in order to better coordinate health and social services for children.*

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Completing the Recipe for Children's Health: New Variations on Key Ingredients

As part of its programming on child health issues, the National Health Policy Forum convened a workshop on June 28, 2007, to explore issues surrounding the social and environmental determinants of health. The meeting brought together academic and health policy leaders who are advancing thinking about social and environmental influences on children's health as well as several community leaders who are engaged in initiatives designed to address these influences. At the close of the workshop discussion, the group developed a set of short- and long-term suggestions that may help inform the debate at the federal policymaking level. This report provides background on the issues and summarizes the major areas of discussion that occurred.

It is widely understood that health insurance coverage provides no guarantee of good health. Beyond genetic makeup, one's health is determined by a range of factors, including environmental influences, such as air and water pollutants or exposure to lead-based paint; socio-economic circumstances, like as family income, geographic location, and educational opportunities; and behavioral factors, including nutritional choices and extent of physical activity. In fact, researchers estimate that 20 percent of preventable mortality in the United States can be attributed to social and environmental circumstances, 30 percent to genetic predispositions, and 40 percent to behavioral patterns; only 10 percent is attributed to shortfalls in medical care.¹

Clearly, medical care is critical to children's health, but social circumstances and environmental conditions likely play a more significant role than previously understood. As one researcher has noted, "healthy children are produced by healthy families in healthy environments."² According to a John D. and Catherine T. MacArthur Foundation study, only 70 percent of children from poor families were reported by their mothers to be in excellent or very good health, compared with 87 percent of children from higher-income families.³ Indeed, each step down the socioeconomic ladder leads to fewer opportunities for children and adolescents to engage in healthful behaviors: there are fewer recreational facilities available, fewer supermarkets that are stocked with fresh produce, more fast food restaurants, and more outlets for tobacco and alcohol. And families at lower-income levels tend to experience increased levels of stress, which can contribute to the onset of health problems into adulthood.⁴ The medical profession can only do so much when many aspects of patients' health are beyond its influence.

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A clear evidence base exists to illustrate the interaction of a wide range of social and environmental factors that affect children's health. Yet there is an ongoing debate about the best way to act on this information. All too often, the discussion (and, in large part, the underlying research) focuses on keeping a meticulous count of how many children have health insurance coverage, the source of that coverage, and how many have gained and lost coverage since the previous year.⁵ The actual impact of these programs on care and outcomes in terms of children's health is less well-defined.

Champions of the social determinants model speak passionately about the need to move away from the medical model toward a way of thinking that assesses the needs of the whole child, including physical environment and social service needs, and considers those needs over a long-term trajectory. This "life-course" approach is based on a growing body of literature that has begun to document how adult health conditions can actually originate in childhood. The research demonstrates how prenatal and early childhood risks that interfere with a child's growth and development can increase the risk of heart disease, hypertension, obesity, and diabetes. Further, early exposure to infections and environmental toxins are known to increase the likelihood of cancer and stroke.⁶ Accepting these correlations on a broad scale seems to be the first step toward shifting thinking and practice and toward making early intervention and disease prevention "business as usual" rather than an afterthought.

From a federal perspective, the implementation of the social determinants model poses many challenges. The public financing streams that flow from federal to state to community levels are not aligned in ways that effectively mitigate environmental and socioeconomic influences on health. Legislative and regulatory limitations often prevent intermingling of funds across programs. In addition, relevant federal programs are spread across departments and agencies, from Health and Human Services to Agriculture, Education, Justice, Housing and Urban Development, and the Environmental Protection Agency, with each developing its own budget and working with different congressional authorizing and appropriating committees.

Further, there has been renewed debate about the appropriate federal government role for improving child health, not only on a broad scale but also when it comes to programs like Medicaid and SCHIP (the State Children's Health Insurance Program) paying for nonmedical interventions such as lead abatement efforts, child safety seats, or parenting classes. Given the recent debate and ultimate veto of legislation reauthorizing the SCHIP program, the current federal policy environment for increased emphasis on children's overall health is uncertain, even while the philanthropic and academic communities continue to see the value of addressing these issues in a comprehensive manner. For example, the Robert Wood Johnson Foundation recently announced the launch of the Commission to Build a Healthier America, whose task will be to identify and recommend practical solutions to address social and environmental influences on health, and to find "innovative ways to make ours a healthier nation."⁷ Despite these

tensions, researchers and policymakers can continue to think strategically about short- and long-term changes that could eventually make a difference in the lives of children, if only in one community at a time.

POLICY AND FINANCING TENSIONS

Research has produced an evidence base that is beginning to receive more attention from policymakers, but there are several structural and cultural barriers to a paradigm shift toward a more comprehensive approach to children's health.

Culture

One of the most significant barriers is that the current health care system is based almost entirely on the medical model of care. The physician's task is to diagnose diseases as they are presented, discover their causes and symptoms, and design treatments that are aimed at eliminating or minimizing the symptoms of the disease, or the disease itself. The concept of prevention has been in existence for decades, but its importance has not always been at the forefront of physicians' minds. Clinical preventive services such as immunizations, mammograms, and more recently colonoscopies, have become widely accepted, but the payment system has only begun to reflect their importance. Reimbursement for child health promotion and development is even less accessible.

The Medicaid program has served as a vehicle for increasing the emphasis on prevention, particularly for children, but Medicaid has not been without its challenges. For example, the program generally does not provide coverage for nonmedical interventions, such as home visits to identify environmental conditions that might be causing or aggravating a child's asthmatic condition—interventions that might ultimately make medical care more efficient and cost-effective. This is, in part, due to Medicaid's historical roots as a vendor payment program built on a medical model that requires the program to consider whether the proposed services are medically necessary before approving reimbursement. To date, financing associated with the medical model has not taken into account the value of prevention beyond well-child visits.

The Medicaid statute includes a set of benefits known as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) that theoretically provide the full range of primary and preventive care that is recommended by the American Academy of Pediatrics. However, states have come under fire on many occasions for failing to ensure that children enrolled in Medicaid actually have access to the full complement of services covered by EPSDT. Annual state-reported data indicate that most states fall well short of the long-standing federal participation goal that 80 percent of children enrolled in Medicaid should receive timely EPSDT medical screens each year. While medical screening rates start out high for infants (82 percent of Medicaid-enrolled children under the age of 1), they tend to decline significantly with

age (26 percent of 6 to 9 year olds receive appropriate screens).⁸ Additional concerns have been raised that many children do not actually receive the treatments that are indicated by the screening process.

Structure and Financing

In discussions about the challenges to effective and comprehensive ways to ensure children's health and well-being, one of the main buzz words is "silos." This term invokes the image of farm silos, which are tall, narrow buildings with no windows that are designed to be airtight, preventing any flow of substances into or out of the silo. Organizational silos exist throughout government and have histories dating back to the early 20th century. As noted above, there are silos dividing congressional committee jurisdictions, silos within the federal agencies, and consequently, silos preventing intermingling of financing streams.

Funding for children's programs seems to be distributed without an organized plan for how all of the pieces should fit together. In part, this is due to the fact that the authorizing responsibility for the many programs that serve children is spread over a half-dozen congressional committees with competing priorities. And the appropriations process for discretionary spending programs⁹ further complicates the situation; a discretionary program cannot be implemented until funds are appropriated to it. It is not unusual for an authorizing committee to approve one funding level, only to have the appropriations committee fund the program at a lower level, or in some cases not at all.

Similarly, among federal agencies, financing streams are not aligned in ways that optimize children's health coverage and access to services. Federal programs that target the same groups of children are often designed in ways that do not make it easy for families to access all of the programs and services for which they might be eligible. Income eligibility guidelines across the programs are similar—usually based on some correlation with the federal poverty level—but the states' processes for calculating income vary greatly, and the rules can make it exceedingly difficult for families to navigate the system successfully. Inconsistency among program rules also prevents states from simplifying application processes in order to quickly identify families that might be eligible for Medicaid, Food Stamps, and child care assistance without a lengthy cross-verification effort. In addition, management and operation functions are often split across state and even local agencies. Because programs and their respective sectors are financed, organized, administered, and evaluated separately, accountability is limited and often ignores potential contributions to the broader health system. Proponents argue that there is a need for both vertical and horizontal integration of financing streams in order to improve system's ability to meet the overall needs of children.¹⁰

Jurisdictional and structural barriers further complicate the federal and state governments' ability to collect, report, and utilize data that is critical to targeting priorities, strengthening the evidence base, and measuring

The History of the Children's Bureau: Consistent Focus, Evolving Function

Although many Presidents have noted the well-being of the nation's children as a top priority, the exact organizational structure and funding levels that are appropriate for ensuring children's health continue to be under debate. For example, the Children's Bureau [currently housed in the Administration for Children and Families (ACF) within the Department of Health and Human Services (HHS)] was created in 1912 when President Taft signed a law with the stated purpose of creating a federal agency to "investigate and report upon all matters pertaining to the welfare of children and child life among all classes of our people." The 16-person Children's Bureau was initially established within the Department of Commerce, but was transferred to the Department of Labor (DOL) in 1913 due to concerns about the prevalence and health implications of child labor. Although it has always been a component of the Bureau's charter, health care was not a primary focus of the Children's Bureau until the enactment of Title V of the Social Security Act in 1935 (now known as the Maternal and Child Health Block Grant; see text box). Title V implementation activities were assigned to the

Children's Bureau in 1936. Interestingly, oversight of the Aid to Dependent Children (Title IV) program was assigned to the Social Security Board rather than the Children's Bureau.

The Children's Bureau remained in DOL until 1946, when President Truman signed an executive order transferring the Bureau to the Social Security Administration in order to "strengthen the child-care programs by bringing them in closer association with the health, welfare and educational activities with which they are inextricably bound up." The Children's Bureau was moved (and its role was expanded) five more times before arriving in its current home within ACF. And although the Children's Bureau has primary responsibility within HHS for the overall welfare of children, health care is no longer one of the Bureau's main components. The Title V program is now housed within the Health Resources and Services Administration (HRSA) in its Maternal and Child Health Bureau. The mandate of Title V remains the same as when it was originally enacted, but the ties to the social welfare arena have loosened.

Source: Social Security Administration, "The Children's Bureau"; available at www.ssa.gov/history/childb1.html.

outcomes. It seems clear that significant changes are necessary, but in order to achieve results it is important to consider what has been attempted and accomplished at the state and local level in terms of integrating financing streams and collaborating across disciplines.

The following section of this meeting report provides a summary of the discussion that took place during the National Health Policy Forum workshop on June 28, 2007. The workshop highlighted several of the community-based initiatives that have been successful at improving circumstances for children. The discussion also generated some potential short- and longer-term strategies that might be effective at improving children's overall health.

WORKSHOP SUMMARY

On June 28, 2007, the National Health Policy Forum convened a workshop discussion focused on the social and environmental determinants of children's health (see the agenda and a list of participants in the Appendices). This workshop was part of the Forum's body of work around children's health and health coverage and was made possible

with the generous support of Nemours Health and Prevention Services. Funding from the David and Lucile Packard Foundation, the W. K. Kellogg Foundation, and the Robert Wood Johnson Foundation also supports the Forum's child health programming.

Setting the Stage

The discussion opened with some "stage setting" comments from the president of the American Public Health Association, **Deborah Klein Walker, EdD**, who reminded the group that although children's health and development should be considered in the context of the larger population, children are not little versions of adults. They have specific developmental needs that are particularly vulnerable to outside influences. Yet the resource base is directed to the medical system and to dealing with health problems after they develop, rather than preventing them. For example, Dr. Walker noted a recent financial analysis of investments in early childhood programs demonstrating that every dollar invested in a child generates a \$17 dollar return.¹¹ However, though there is a great deal of research in existence and a number of strategies that have been identified, the political will to act in a comprehensive manner is lacking.¹²

Eileen Salinsky, formerly a principal research associate at the National Health Policy Forum, offered some insights into the evolving role of government in individuals' lives. She asserted that the framers of the Constitution very consciously sought to place limitations on the federal government's involvement and therefore delegated many of the public health functions to the state level. Ms. Salinsky suggested that, beyond tax policy, the federal government actually has very little broad-based influence over the social and environmental determinants of health. She noted that through tax incentives, government can provide help by encouraging businesses to establish themselves in low-income neighborhoods, but it can also contribute to the problem by, for example, placing a new highway structure directly in the middle of a community, effectively cutting its economic lifeline.

Ms. Salinsky also noted that the role of Title V of the Social Security Act (the Maternal and Child Health Block Grant; see text box, right), has not met expectations as a point of accountability for federal-state partnerships. Many have suggested that Title V could serve

Title V: The Basics

Title V is a broadly defined but limited source of federal funds that states can use to help address the social, financial, behavioral, and structural barriers to health care for women, children, and families. Federal Title V funding, together with state and local funds, supports an array of public health and community-based programs designed to serve as a safety net for uninsured and underinsured children, including children with special health care needs (CSHCN). Federal funding—\$693 million in fiscal year (FY) 2007—accounts for a small portion of the total funding for Title V activities. In FY 2005, states served 33.1 million women and children under Title V, including 1.3 million CSHCN, with a total budget of approximately \$5.2 billion. Of the children served, one-third, or 10.1 million had Medicaid or SCHIP coverage.

For more information see Christie Provost Peters, "The Basics: Title V," National Health Policy Forum, September 2007; available at www.nhpf.org/pdfs_basics/Basics_Title%20V_09-24-07.pdf

as a logical vehicle for addressing these issues and a mechanism for channeling sorely needed funding directly into communities. Further, Title V could provide a jumping-off point for the development of a more integrated framework for improving children's health.¹³

COMMUNITY LEADERSHIP

A second goal of convening the Forum's child health workshop was to offer community leaders, academics, and national policy leaders an opportunity to come together to learn from one another about strategies that have been successful in addressing social and environmental influences on health. The group heard from four community leaders who are currently involved in initiatives that serve children and families across the health and social service spectrum: **Charles Bruner**, Executive Director, Iowa Child and Family Policy Center; **Debbie Chang**, Senior Vice President and Executive Director, Nemours Health and Prevention Services; **Paul Dworkin, MD**, Physician-in-Chief, Connecticut Children's Medical Center; and **Lisa Klein**, Director of Early Childhood Initiatives, Kansas Health Institute. The activities and strategies they described are highlighted below.

Two key points emerged from the discussion around community-based initiatives for children's health. First, although important, health coverage programs like Medicaid and SCHIP are not currently equipped to ameliorate environmental influences on health. Although states have found mechanisms to get reimbursement for certain prevention activities (such as lead abatement in Rhode Island), the programs generally are not designed to offer population-based solutions like those that have been developed at the community level. Second, the presence of dynamic community leaders is critical to the success of any new initiative. These individuals must be willing and able to collaborate with leaders in other disciplines, to think outside of traditional parameters, and to share their experiences (both positive and negative) so others can learn from them.

Now We Know Our ABCDs

Charles Bruner offered several points regarding his efforts to develop and expand the Assuring Better Child Health and Development (ABCD) initiative in his community and the state of Iowa more broadly (see text box, next page). His goal was to find ways to support the pediatric practitioners' role in developing relationships with families to help ensure they receive primary and preventive care as well as referrals to appropriate services as needed. As a result of these efforts, Iowa has utilized ABCD as a mechanism for leveraging other funding sources, including Medicaid and Title V, and for providing mental health services more effectively.

The ABCD Initiative

The Assuring Better Child Health and Development (ABCD) Program was designed to assist states in improving the delivery of early child development services for low-income children and their families by strengthening primary health care services and systems that support the healthy development of young children, specifically those ages 0 to 3. The program focuses particularly on preventive care for children enrolled in Medicaid or other state-supported health programs. It is administered by the National Academy for State Health Policy (NASHP) and financed by The Commonwealth Fund.

The ABCD program began in 2000 and has helped eight states create models of service delivery and financing through this laboratory for program development and innovation. A second phase, the ABCD Consortium (ABCD I), provided grants to four states (North Carolina, Utah, Vermont, and Washington) to develop or expand service deliv-

ery and financing strategies aimed at enhancing healthy child development for low-income children and their families. This phase of the grant program concluded in 2003.

The ABCD II Initiative was launched in 2003 and ended in early 2007. It was designed to assist states in building the capacity of Medicaid programs to deliver care that supports children's healthy mental development. The initiative funded the work of five states (California, Illinois, Iowa, Minnesota, and Utah). Finally, the ABCD Screening Academy began in April 2007 and provides technical assistance to 19 states and territories around implementing policies and practices that promote the use of standardized screening tools as part of well-child care, shifting from a "best practice" to a "standard of practice." This 15-month initiative's primary focus is to increase use of a general developmental screening tool by primary care providers who act as young children's medical homes.

Source: The National Academy for State Health Policy, "Assuring Better Child Health and Development Resource Center"; available at www.abcdresources.org.

Growing Up Healthy: Kids Can't Do It Alone

Debbie Chang offered some insights from her work at Nemours Health and Prevention Services (NHPS). At its inception in January 2004, NHPS began to lay the groundwork for implementing Nemours' vision of a comprehensive and integrated approach to children's health. NHPS is dedicated to promoting children's health in Delaware, with plans to expand its efforts to the state of Florida.

Nemours is attempting to reach beyond the traditional role of children's health care using a population-oriented approach that is multi-faceted, works across sectors, and involves multiple caregivers as change agents. NHPS engages community-based partners using this integrated and place-based strategy. The initial areas of emphasis are childhood obesity prevention and emotional and behavioral health. Since 2004, NHPS has reached nearly 100,000 of Delaware's children.

NHPS concluded that a population-based approach would make the greatest sustainable impact for the greatest number of children. It is working with more than 200 partners including schools, primary care providers, child care providers, and community organizations to catalyze changes in targeted policies and practices at the organizational and systems levels,

focused on the areas where children live, learn, and play. These activities are designed to motivate children and their families to change their behaviors, practice healthy lifestyles, and attain better health outcomes. NHPS also utilizes a statewide social marketing campaign to accelerate these cultural changes. In 2007, NHPS launched a Web site (www.GrowUpHealthy.org) as part of a knowledge mobilization strategy, with the goal of being the “go to” place for practical, action-oriented information related to child health promotion. Nemours’ model was highlighted in the March/April 2007 issue of *Health Affairs*.¹⁴

In October 2007, NHPS launched its social marketing campaign “The Campaign to Make Delaware’s Kids the Healthiest in the Nation” with the goal of providing opportunities for Delaware’s kids to eat nutritious foods and beverages and engage in more physical activity. There are two components of the campaign which hopes to accelerate community efforts: “Kids Can’t Do it Alone,” which targets policymakers, key opinion leaders, and other concerned adults, and aims to create policy and practice change in the state; and “5-2-1 Almost None,” which is designed to encourage behavioral change among children (primarily ages 8 to 13) and their parents.

Immunize Kansas Kids

Lisa Klein from the Kansas Health Institute talked about the importance of “messaging” to help educate families about behavioral influences on health (healthy eating, anti-smoking, getting kids immunized etc.) For example, recent data in Kansas indicated that there had been a substantial decline in childhood immunization rates. In response, a governor-appointed task force examined the information available on the immunization system in Kansas, leading to the creation of an initiative called “Immunize Kansas Kids (IKK).” IKK is supported by a partnership among the Kansas Department of Health and Environment, the Kansas Health Institute, and dozens of stakeholder organizations in the state. The state is implementing programs, including an immunization registry, to assist parents and physicians in tracking vaccinations. Kansas has also revised its recommended immunization schedules, offered incentives to families to obtain immunizations, and provided information about immunizations to other programs that serve children and families. The partnership has produced results: the state’s vaccination rate increased to 84 percent in 2006, from a 2004 level of 77.5 percent. The IKK was designed to be data-driven, and tracking the data was instrumental in guiding the strategies that the initiative’s steering committee adopted and the communications that followed.¹⁵

Help Me Grow, and Grow

Paul Dworkin, MD, talked about his program, “Help Me Grow,” a comprehensive, statewide, coordinated system of early identification and referral for children at risk for developmental or behavioral problems. Parents,

pediatricians, and other providers are given information and training in how to recognize the early signs of developmental problems and to contact Help Me Grow when they have a concern or need help. Children who are facing difficulties are then connected to community resources and local programs. The program is operated through a collaboration of nonprofit organizations and state health and education agencies working to facilitate coordinated services. It is through this collaboration that Help Me Grow contributes to a statewide network for providing triage and referral for those concerned about children's development.

The components of the program include:

- On-site training for pediatricians and family health care providers in early detection of child developmental and behavioral concerns
- A statewide toll free telephone number (the Child Development Infoline) and Telephone Care Coordinators who triage calls, provide referrals and follow up with families;
- Partnerships with community-based service and advocacy agencies facilitated by the Help Me Grow Child Development Liaisons

Help Me Grow is an expansion of the pilot project, ChildServ, which was spearheaded by Dr. Dworkin in 1998. The project began in Hartford, Connecticut, and proved to be effective in linking children and families with needed services. The pilot program provided the foundation for building a statewide program, which launched in January 2002.¹⁶

According to an independent evaluation of the program, Help Me Grow has been successful in disseminating information and facilitating referrals for families in need of assistance. The number of information and referrals has increased steadily in each year of operation—a 23 percent increase in calls inquiring about child development programs between 2006 and 2007—and the program now serves several thousand families. Due to the increase in the number of callers and the number of service requests per family, there was also a 60 percent increase in referrals from the previous year. Eighty-six percent of families involved with Help Me Grow were successfully connected to and received at least one service in 2007.¹⁷

FUTURE PROSPECTS

As the research into the social determinants of health has broadened and gained more prominence, the focus has begun to shift from building the evidence base to identifying solutions. Many analysts have suggested that the federal government should be playing a more significant role in educating the public about social determinants of health and supporting strategies for ameliorating environmental influences.¹⁸ The challenge is to find solutions that are feasible given the multitude of competing priorities and political complexities that exist. The group noted that the nation seems to be entering a time of renewed discussion about possibilities for universal

health care coverage. Although there is continued learning about the challenge of achieving health system changes, there may be a window of opportunity for broadened thinking about children's health.

It should be noted that the strategies that follow are synthesized from the workshop discussion and are intended to inform the policymaking process rather than serve as formal recommendations from the National Health Policy Forum.

Defining Child Health

The Institute of Medicine, in its report *Children's Health, the Nation's Wealth: Assessing and Improving Child Health* (National Academies Press, 2004), proposed the following definition: "Children's health should be defined as the extent to which individual children or groups of children are able or enabled to (a) develop and realize their potential, (b) satisfy their needs, and (c) develop the capacities to allow them to interact successfully with their biological, physical, and social environments."

Reaching for the Low Hanging Fruit: Short-Term Fixes

- **Build on existing models.** As illustrated by the community-based examples described above, several strategies for effective early intervention and disease prevention have proven successful and can be replicated in other communities and/or states. Continued sharing of best practices and technical assistance among community leaders could help facilitate expansion of these strategies and eventually have an overall impact on improving health. Foundations could continue to support these models, and organizations could continue to look for ways to subsidize the programs with state and federal funds.
- **Streamline programs and eligibility rules.** There has been a great deal of discussion in the past 15 years about the need to better align program rules, income eligibility guidelines, and application processes in order to facilitate more efficient enrollment in publicly financed health and social service programs, with some success. For example, states can now assume a child is eligible for Medicaid if they have qualified for the Free and Reduced-Price School Lunch program, and School Lunch programs in many states share eligibility information with the state Medicaid agency (unless the family opts out), in order to facilitate enrollment. This type of streamlining strategy could significantly improve families' ability to navigate the social service system and could save families a great deal of time and effort.
- **Use outreach and messaging to accelerate changes.** Because an estimated 40 percent of a child's overall health is thought to be determined by behavioral factors, outreach campaigns and messaging can be an effective strategy for improving health outcomes, particularly when coupled with on-the-ground community activity. For example, several foundations have mounted anti-obesity campaigns designed to encourage healthier choices and more physical activity and to challenge communities to provide more opportunities for families to have access to higher-quality food and safe, open spaces for exercising and play. While

potentially costly, social marketing campaigns could pay for themselves in the form of better health in the long run.

States proved the importance and effectiveness of outreach and messaging when they designed and implemented SCHIP. Using new, catchy names like “PeachCare” and “HealthWave,” many states successfully changed the negative connotations that had been associated with the existing Medicaid program and were able to achieve record enrollment levels. Kansas has also had success with its “Take It Outside” campaign intended to reduce children’s exposure to secondhand smoke.

Eye on the Prize: Long-Term Strategies

Several longer-term and larger-scale strategies have also been suggested and were discussed at the Forum workshop. Prominent researchers have developed proposals for a complete redesign of the child health system, and several smaller-scale possibilities are under consideration within the child health and development community. Following are some possible long-term strategies that were put forth during the workshop discussion.

■ **Expand Title V.** Title V (also known as the Maternal and Child Health Block Grant Program; see text box) has been amended, expanded, and consolidated over the years to reflect changing national approaches to maternal and child health and welfare.¹⁹ Analysts and advocates for the programs argue that the Maternal and Child Health Block Grant Program has been underfunded and therefore underutilized in its potential for supporting overall child health. They argue that Title V funds often serve as a supplement to other funding sources rather than as the primary resource for health promotion and prevention activities. As a result, the program is often not appropriated as much money as is initially authorized, and Title V funding has been steadily decreasing in recent years. In fact, the program’s appropriations have never reached the \$1 billion level, relegating it behind even relatively small coverage programs like SCHIP, which had an annual allotment of \$5 billion in 2007.

The stated goals, structure and legislative authority of Title V could provide a vehicle for advancing population-based primary and preventive services. States currently contribute the majority of funding for Title V activities and have the flexibility to determine how services are allocated. One exception is that states must devote 30 percent of their federal Title V funds to primary and preventive care.²⁰ Congress could increase funding for Title V and require that a larger percentage be used for prevention activities. In addition, it could direct the federal government and the states to use the program to develop and augment strategies to more directly combat the many environmental influences that affect children’s health. For example, a grant program specifically targeted at developing and implementing lead abatement strategies could provide the necessary response to the alarming lead screening results that have emerged in many low-income communities.

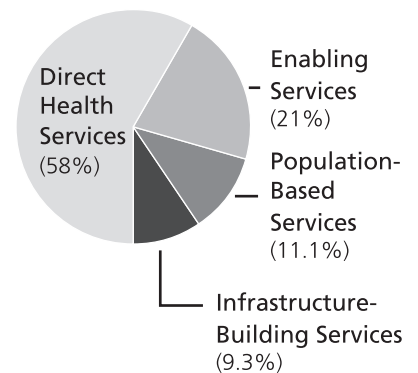
In fiscal year 2005, 58 percent of Title V expenditures went to direct health services (provider-patient care); 21 percent went toward the provision of enabling services (such as case management, transportation, translation services); and only 11 percent of expenditures went toward population-based services (such as newborn screening, lead screening, and injury prevention activities). (See figure, right.)

- **Establish social determinants demonstrations.** Congress could provide targeted funding for a series of “demonstrations” to determine the efficacy of approaches to improving overall health and limiting the negative environmental influences, much as it has tested new approaches in Medicare over the years. For example, a demonstration could fund home visits for children at risk of or diagnosed with asthma, pay for case management or mentoring services for children in the child welfare system, or cover legal fees for a community’s case against a landlord unwilling to remove lead paint from an apartment building. These demonstrations could also build on existing strategies that appear to be successful but need organizational support in order to be replicated in other communities. This type of effort would need to be considered on a long-term basis, as it is extremely difficult to measure the dollar value of prevention. An evaluation component would also be critical. If a strategy proved to be cost effective and demonstrated positive health outcomes, it could potentially be extended on a broader, perhaps national, scale.
- **Create a federal Child Health Development Agency.** Although there is already a Children’s Bureau in existence, its main focus is not on health. Several proponents have suggested that a federal Child Health Development Agency be created as a mechanism for consolidating and reorganizing existing funding streams and for implementing strategies that would optimize child health. The new agency would consolidate under one “roof” existing programs that serve children and would be a central point of interaction with comparable agencies at the state level.²¹ Alternatively, a child health agency could be placed directly under the HHS Secretary’s authority. Although the benefit to children seems clear, there would need to be a great deal of political will to undertake such a major organizational overhaul across a number of federal agencies.

CONCLUSION

A shift away from the medically based approach to promoting children’s health is a challenging undertaking at best, and some would disagree that such a shift is the right course. But as any teacher of a child who has missed school because of chronic asthma attacks or who has trouble focusing because of hunger or family instability can attest, an integrated approach to achieving child health is critical. The “right” solution has eluded policymakers thus far, but the evidence base continues to gain traction. As more attention is generated by child health experts, clinicians, thought leaders, and policymakers, a series of strategies might emerge and thinking about children as a whole could become the rule rather than the exception.

Title V Expenditures by Service Type, Fiscal Year 2005



Source: Christie Provost Peters, “The Basics: The Title V Maternal and Child Health Block Grant Program,” *National Health Policy Forum*, September 24, 2007; available at www.nhpf.org/pdfs_basics/Basics_Title%20_V_09-24-07.pdf

ENDNOTES

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6. Neal Halfon, Helen DuPlessis, and Moira Inkelas, "Transforming the U.S. Child Health System," *Health Affairs*, 26, no. 2 (March/April 2007): p. 316.
7. "Robert Wood Johnson Foundation Launches Commission to Look Beyond Medical Care System to Improve the Health of All Americans," press release, February 28, 2008; available at www.rwjf.org/newsroom/newsreleasesdetail.jsp?productid=26672&typeid=160.
8. Christie Provost Peters, "EPSDT: Medicaid's Critical but Controversial Benefits Program for Children," National Health Policy Forum, Issue Brief 819, November 20, 2006; available at www.nhpf.org/pdfs_ib/IB819_EPSDT_11-20-06.pdf.
9. Discretionary spending is spending that is subject to the appropriations process, whereby Congress sets a new funding level each fiscal year for programs covered in an appropriations bill. Health-related discretionary programs include Title V and other HRSA grant programs such as Ryan White. Mandatory spending includes entitlement programs, such as Medicaid, Social Security, and Medicare. In general, mandatory spending is on-going (that is, it does not require legislation to continue from year to year) and discretionary spending requires new funding each year through an appropriations bill. For more information, see New America Foundation, "Federal Budget Process"; available at www.newamerica.net/programs/education_policy/federal_education_budget_project/basics.
10. Halfon, DuPlessis, and Inkelas, "Transforming the U.S. Child Health System," p. 321.
11. Rob Grunewald and Arthur Rolnick, "A Proposal for Achieving High Returns on Early Childhood Development," Federal Reserve Bank of Minneapolis, May 2005; available at www.minneapolisfed.org/research/studies/earlychild/draft_eed_proposal.pdf.
12. Studies, most famously the High/Scope study of Perry Preschool, have tracked the correlation between early childhood intervention and success later in life and provided significant evidence of the 17:1 cost-benefit ratio. For more information about Perry Preschool, see www.minneapolisfed.org.
13. Klein Walker, "Public Health Strategies Promote Healthy Children, Youth and Families," p. 366.
14. For more information, see Debbie I. Chang *et al.*, "Beyond Medical Care: How Health Systems Can Address Children's Health Needs Through Health Promotion Strategies," *Health Affairs*, 26, no. 2, 2007.

Endnotes / continued ►

Endnotes / continued

15. For more information on the Kansas Health Institute, see www.khi.org; to learn more about "Immunize Kansas Kids," see www.immunizekansaskids.org.
16. For more information about Help Me Grow, see Marcia Hughes and Meredith Clay Damboise, "Help Me Grow: 2007 Annual Evaluation Report," The Children's Trust Fund, November 2007; available at www.ct.gov/ctf/lib/ctf/hmg_report_2006-2007.pdf.
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18. Nicole Lurie, "What the Federal Government Can Do about the Nonmedical Determinants of Health," *Health Affairs*, 21, no. 2, (March/April 2002): pp. 94–106).
19. Christie Provost Peters, "The Basics: The Title V Maternal and Child Health Block Grant Program," National Health Policy Forum, September 24, 2007; available at www.nhpf.org/pdfs_basics/Basics_Title%20V_09-24-07.pdf.
20. Provost Peters, "The Basics: The Title V Maternal and Child Health Block Grant Program."
21. Halfon, DuPlessis, and Inkelas, "Transforming the U.S. Child Health System."



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Friday, June 28, 2007

-
- 8:30 am Registration — Coffee available
-
- 9:00 am Welcome, Introductions, and Overview of Workshop Goals
Judith D. Moore, *Senior Fellow*, National Health Policy Forum
-
- 9:15 am Setting the Stage: Review of Existing Evidence Base and Potential Implications for Child Health
Deborah Klein Walker, EdD, *President*, American Public Health Association
Eileen Salinsky, *Principal Research Associate*, National Health Policy Forum
- What is the existing body of evidence around environmental and social determinants of health?
 - How can population-based health issues be addressed most effectively?
 - What are the key successes and challenges with new models for addressing social/environmental influences?
-
- 9:30 am Current Initiatives and Top Priorities
Charles Bruner, *Executive Director*, Iowa Child and Family Policy Center
Debbie Chang, *Executive Director*, Nemours Health and Prevention Services
Paul Dworkin, MD, *Chairman*, Department of Pediatrics, University of Connecticut School of Medicine
Lisa Klein, *Director*, Early Childhood Initiatives, Kansas Health Institute
- All Workshop Participants**
- What has been your experience with developing and executing child health improvement initiatives? What barriers to success have been the most challenging in implementing/sustaining your particular program? How can successful programs be replicated?
 - What would be your top two priorities in changing the existing system and the corresponding financing streams?
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- 10:30 am Break

AGENDA

Agenda / continued ►

Tuesday, June 28, 2007 / continued

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- 10:45 am Exploring Organizational Roles and Policy Tensions
- All Participants**
- To what extent have government agencies and public policies played a major role in addressing social and environmental determinants of health for children?
 - Where do the most significant policy barriers exist?
 - Silos across government agencies
 - A reimbursement system geared toward diseases rather than disease prevention and a medical model of care
 - Lack of coordination and prioritization among financing streams
 - No regulatory accountability outside of the health sphere (for example, environmental, agriculture, education)
 - If there were an opportunity to enact federal legislation that might better align policies and financing streams to address children's health issues more broadly, what would be the first priority?
-
- 11:45 am Break – Working Lunch
-
- 12:00 pm Working Lunch and Closing Discussion: Potential Improvements in the Current Policy Climate
- Given the competing priorities that continue to exist when it comes to federal legislation, what might be the most realistic first step toward improving the system?
 - How can government agencies, community-based entities and philanthropic organizations work together most effectively to address broad-based children's health issues?
-

AGENDA

Participants

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Iowa Child and Family
Policy Center

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