Children's Health in All Policies

A Workbook

KHI/10-08 | December 2010

Kansas Health Institute

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

KHI/10-08 | December 2010

TABLE OF CONTENTS

ABOUT THE REPORT

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DISCLAIMER

The contents of this report reflect the views of the authors, who are responsible for the facts and the accuracy of the data presented herein. The contents do not necessarily reflect the views of the CHAP Advisory Panel members.

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PREFACE

Ensuring the health, safety and well-being of Kansas children is important for the future of Kansas. One in four of the 2.8 million Kansans is a child under age 18. Findings from the 2007 National Survey of Children's Health (NSCH) indicate that most of these children are in very good health. Most Kansas children experience healthy physical, social, intellectual and emotional development; however, there are also serious childhood health concerns that Kansas families and communities face. Policymakers at the state and local levels are challenged to identify policy solutions to address these issues.

Leading childhood health concerns include obesity-related problems, serious injuries, child abuse, uncontrolled asthma, poor oral health, drunk driving and teen smoking. Poverty and the economic challenges that families and communities face also significantly impact the health of children. Given the complexity of the relationships between social and economic conditions and poor health, there are no one-size-fits-all programs or policy solutions to these problems. The risks for poor health are many.

In a previous Kansas Health Institute (KHI) report, *Understanding the Health of Kansas Children*,[1] we describe how the influences of the home, school, medical, physical and social environments affect children's health and safety. Our focus in this workbook is on the policy influences on children's health.

Policymakers wanting to tackle tough issues such as childhood obesity and oral health can benefit from being able to identify and evaluate best-practice policy strategies to increase physical activity and improve nutrition (e.g., mandatory active physical education, school vending machine policies), and increase access to preventive dental care (e.g., policies to address the shortage of dental health professionals in rural Kansas). Many policy strategies involve sectors other than health. For example, underage drinking policies, graduated driver's licensing, farm-to-school lunch programs and early childhood home visiting funding involve policymaking across agriculture, business, education, health and transportation sectors.

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Local and state policymaking processes require weighing and balancing public values. Views differ widely on policy approaches to preventing childhood injury and disease, promoting healthy growth and development and assuring access to treatment and services. Prevention and health promotion strategies can be controversial. Without the participation and support of parents, educators, law enforcement officials and others, these strategies fail.

Public participation and communication among policymakers across sectors are critical to identifying and implementing effective policies. Good policymaking requires public support, consideration of a range of reasonable policy alternatives and attention to unintended consequences. We recommend a Health in All Policies approach. In simple terms, this approach encourages policymakers to tackle difficult challenges using a variety of policy solutions. For example, school vending machine policies, safe street laws, menu labeling regulations and physical education standards represent policy options to address childhood obesity.

In 2009, KHI launched Children's Health in All Policies (CHAP) as a strategy for identifying effective policy solutions. Over a six month period, an advisory panel prioritized issues that affect the health of Kansas children and evaluated promising policy approaches. The panel consisted of 21 members, including state legislators and representatives from governmental and nongovernmental organizations. The panel explored how the Health in All Policies concept, endorsed by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), can be used to work within and across sectors to promote children's health.

KHI developed a five-step process for implementing a Children's Health in All Policies strategy. This workbook illustrates how this process can be used to identify good policy solutions for improving children's health and well-being.

PURPOSE OF THE WORKBOOK

The CHAP workbook is an uncomplicated, short, down-to-earth reference for identifying promising policy solutions to improve the health

of Kansas children. It is not a comprehensive comparison of best policies for improving health. Rather, the workbook is a tool for framing effective policy solutions to the leading health problems of Kansas children. The workbook illustrates a practical approach to policymaking using the strategy of CHAP. It is intended for Kansas legislators, county and city commissioners, school boards, health departments and other policymakers who want to improve the health of Kansas children.

OVERVIEW OF CONTENTS

The chapters in this workbook address six of the most pressing children's health issues, as prioritized by the CHAP Advisory Panel. The issues are obesity, oral health, special health care needs, adolescent risk behaviors, access to quality child care services, and poverty, which is one of the key determinants of health. Each chapter uses the five-step approach described on page vi.

Each chapter also ends with a note explaining the impact of the 2010 Affordable Care Act (ACA), the new health reform legislation. The ACA is designed to transform the United States' health system in the 21st century. The ACA is oriented toward health rather than sickness. This change in orientation will require significant investments in health prevention and promotion. Throughout the ACA, prevention is emphasized with the goal of promoting prevention at every level of society and involving multiple sectors (e.g., agriculture, business, education, transportation). Elevating prevention as a national priority provides unprecedented opportunities for promoting health through all policies.

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FIVE-STEP APPROACH

Each chapter demonstrates the five-step approach for implementing the Children's Health in All Policies strategy:

(1) Identify why the children's health issue is important and describe the causes — including important, and changeable, risk factors associated with a health issue such as childhood obesity (e.g., little physical activity, consumption of foods high in sugars and fats).

(2) Describe the magnitude of the children's health issue in Kansas (e.g., 16.2 percent of Kansas children are obese).

(3) Identify policy efforts and opportunities to improve children's health and well-being relative to the particular health issue.

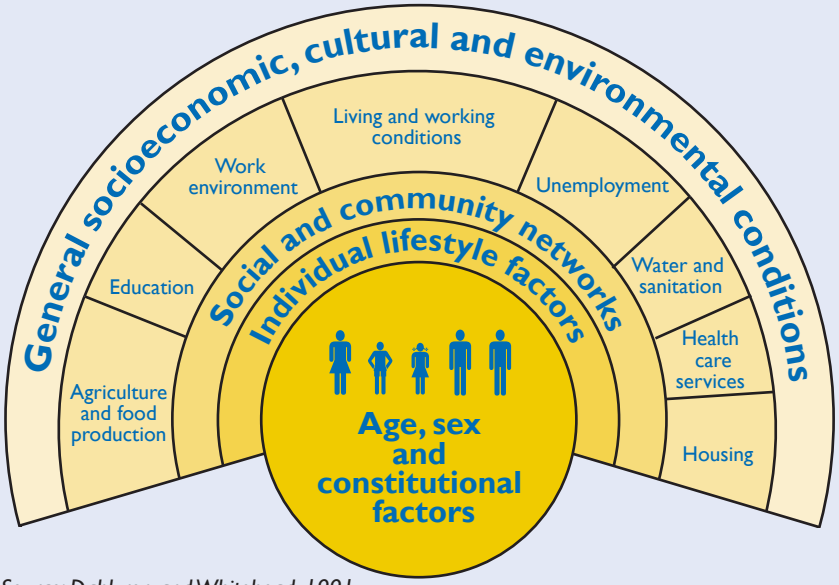
(4) Identify promising evidence-informed policy solutions to address the children's health issue at local and state levels to improve the home, school and community environments (e.g., "complete streets" policy, mandatory active physical education).

(5) Describe the potential impact of the policy solutions.

ECOLOGICAL FRAMEWORK

Individual, family, neighborhood, school and community factors, along with the physical environment, influence children's health. The Centers for Disease Control and Prevention recommends using what is called an ecological framework to understand and promote health. An ecological framework is one that organizes the many factors that influence health into concentric levels — individual, family, community and social influences. The best strategies for improving children's health occur at multiple levels — from the individual child to the family, school and neighborhood.

The Main Determinants of Health



Source: Dahlgren and Whitehead, 1991

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TABLE 1. DESCRIPTIONS OF SECTORS IDENTIFIED IN THE WORKBOOK

Sector	Description	Examples	Referenced in Chapters
Agriculture	Comprised of a range of entities involved in the production, administration and processing of meat and produce from raw input to consumer foodstuffs.	Includes farms, community gardens and the Kansas Department of Agriculture (KDA).	Children and Oral Health Children and Obesity
Business	Includes regulatory agencies as well as entities that either sell products and services for profit or manage the exchange of money for goods.	Industries in this sector include employment and temporary staffing services, banking and credit services, grocery stores, small businesses, the Kansas Department of Commerce (KDC) and the Kansas Department of Labor (KDL).	Children and Oral Health Children and Obesity Children and Youth with Special Health Care Needs Children and Poverty Adolescent Risk Behaviors Access to Quality Child Care Services
Education	Includes the formal and informal delivery or administration of all types of education and training to all levels of learners.	Includes schools, school districts, school systems, child care services, after-school programs, the Kansas Board of Regents and the Kansas State Department of Education (KSDE).	Children and Oral Health Children and Obesity Children and Youth with Special Health Care Needs Children and Poverty Adolescent Risk Behaviors Access to Quality Child Care Services
Health	Includes public health and health care organizations and agencies that provide population-based preventive services, clinical preventive services and medical care.	Includes organizations and agencies, such as local health departments, local and regional tribal health boards, hospitals, clinics, individual or group medical practices and the Kansas Department of Health and Environment (KDHE).	Children and Oral Health Children and Obesity Children and Youth with Special Health Care Needs Children and Poverty Adolescent Risk Behaviors Access to Quality Child Care Services
Insurance (Health)	Includes governmental and non-governmental agencies and organizations that provide coverage for medical, dental, vision and other health services. Also includes agencies that are responsible for regulating all types of insurance sold in the state.	Includes private for-profit entities and public insurance programs (e.g., Medicaid, CHIP), as well as the Kansas Insurance Department (KID).	Children and Obesity Children and Poverty Children and Youth with Special Health Care Needs

Sector	Description	Examples	Referenced in Chapters
Legislative	State and local levels of government responsible for creating and passing laws.	Includes the Kansas Legislature, county commissions and mayors' offices.	Children and Oral Health Children and Obesity Children and Youth with Special Health Care Needs Children and Poverty Adolescent Risk Behaviors Access to Quality Child Care Services
Media	The sector encompasses the creation, modification, transfer and distribution of media content for the purpose of mass consumption.	Includes such industries as filmed entertainment, television networks (broadcast and cable), television distribution (station, cable and satellite), radio and out-of-home advertising, internet advertising and access spending, as well as magazine and newspaper publishing.	Adolescent Risk Behaviors
Social Service	Includes entities that provide services for the well-being of people, especially disadvantaged and vulnerable persons.	Includes entities that provide food assistance, child care, special education and other support services, and the Kansas Department of Social and Rehabilitation Services (SRS).	Children and Poverty Children and Youth with Special Health Care Needs Adolescent Risk Behaviors
Transportation	Includes entities that provide a safe transportation system that ensures the mobility of people and goods, enhances economic prosperity and preserves the quality of the environment and communities. Also responsible for building and maintaining roads and bridges.	Includes local governments, state highway agencies and the Kansas Department of Transportation (KDOT).	Children and Oral Health Children and Obesity Children and Poverty
Urban Design and Community Planning	Consists of individuals and organizations that develop long- and short-term plans for the use of land and the growth and revitalization of urban, suburban and rural communities and the regions or states in which they are located.	Includes city planners, urban planning and architecture firms, engineers and departments of parks and recreation.	Access to Quality Child Care Services

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INTRODUCTION: POLICY INFLUENCES ON CHILDREN'S HEALTH

WHAT IS CHILDREN'S HEALTH?

In response to a congressional request, the National Research Council (NRC) and the Institute of Medicine (IOM) established the Committee on Evaluation of Children's Health. In 2004, this committee produced the landmark report, *Children's Health, The Nation's Wealth.*

The committee defined children's health as:[2]

> "The extent to which individual children are able or enabled to (a) develop and realize their potential, (b) satisfy their needs and (c) develop the capacities that allow them to interact successfully with their biological, physical and social environments."

The committee emphasized the importance of recognizing that there are multiple factors — behavior, family, school and neighborhood — that influence a child's development, health and safety.

Table 2 on page four is a profile of the health of Kansas children. Health measures include health status, family, school and neighborhood indicators. Statistically, for each health measure, Kansas children and their families fare as well or better than the national average:

- A higher percent of Kansas children (86.9 percent) participate in outside-of-school activities as compared with the nation (80.7 percent).
- More Kansas children have mothers with excellent or very good health (61.3 percent) as compared to the nation (56.9 percent).
- Fewer Kansas children ever repeat a grade (4.9 percent) as compared to the nation (10.6 percent).

As indicated in Table 2, most Kansas children have very good or excellent health. However, some children do not receive needed medical attention, preventive dental services, developmental screenings or mental health care. Many children under age 5 watch more than an hour of TV or movies during a weekday, live in dilapidated houses or have no access to adequate day care or safe neighborhoods and parks.

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KANSAS' STAKE IN CHILDREN'S HEALTH, SAFETY AND WELL-BEING

It is in the national interest, and in the interest of the state of Kansas, to have healthy children. Healthy children are ready and able to learn, and are more likely to become healthy adults and productive citizens and contribute to the workforce. Promoting the health, safety and well-being of all Kansas children involves more than health and social services. Public safety measures, education, quality child care, good nutrition and safe homes are just a few of the requirements. Public policies establish the laws and regulations that ensure these requirements are met.

POLICY INFLUENCES ON CHILDREN'S HEALTH

The health of Kansas children is affected by laws and governmental actions that determine the availability of health services, immunization requirements, traffic safety standards and building codes. There are also less obvious policies that can affect children's health. For example, welfare policy decisions play a role in a family's economic status and education policies play a role in the availability and quality of schools in a given community. Many improvements in children's health over the past several decades have been influenced by policies other than health.[3]

CHILDREN'S HEALTH IN ALL POLICIES

Health in All Policies is an emerging theme in Europe, Australia and the United States as a way to protect and promote the health and the well-being of citizens through policymaking in multiple sectors of society. In the United States and Kansas, societal sectors value the health and well-being of children. This shared commitment makes it possible to work together in setting policy priorities and developing a Children's Health in All Policies approach.

Improving children's health is not only based on increasing preventive and health care services, but also on improving healthy living conditions and ways of life. The health sector is essential to preventing and treating traumatic injuries and major childhood diseases, such as asthma. However, the incidence of risks for injuries and diseases can also be reduced by policy

measures in other sectors. Kansas policymakers have plentiful opportunities to improve children's health and safety at the local and state levels in multiple sectors such as transportation (e.g., encouraging "active transport" by providing safe routes for walking and biking to schools) or education (e.g., mandatory active physical education).

The goal of CHAP is to engage stakeholders, including Kansas legislators and representatives from government and nongovernment organizations, in exploring opportunities to create an integrated child health policy response across multiple sectors.

CHAP is an enormously challenging strategy. Janet Collins, director of the National Center for Chronic Disease Prevention and Health Promotion at the CDC, has defined this strategy as one in "which policies in social sectors such as transportation, housing, employment and agriculture ideally would contribute to [children's] health and health equity."[4]

Using the tools and examples in this workbook, you will be able to identify effective and systematic action for the improvement of our children's health. An essential part of informing policymaking is examining the evidence base for programs and policies. This workbook also includes an appendix of evidence-informed policy approaches.

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TABLE 2. KANSAS CHILDREN'S HEALTH PROFILE: 2007 National Survey of Children's Health[5]

Health Status			
Indicator	**Explanation**	**Kansas**	**Nationwide**
Child Health Status	Percent of children in excellent or very good health	85.3%	84.4%
Oral Health Status	Percent of children with excellent or very good oral health	71.3%	70.7%
Injury	Percent of children age 0–5 with injuries requiring medical attention in the past year	10.2%	10.4%
Breastfeeding	Percent of children age 0–5 who were ever breastfed	76.8%	75.5%
Risk of Developmental or Behavioral Problems	Percent of children age 4 months to 5 years determined to be at moderate or high risk based on parents' specific concerns	27.4%	26.4%
Positive Social Skills	Percent of children age 6–17 who exhibit two or more positive social skills	94.2%	93.6%
Missed School Days	Percent of children age 6–17 who missed 11 or more days of school in the past year	7.0%	5.8%
Health Care			
Indicator	**Explanation**	**Kansas**	**Nationwide**
Current Health Insurance	Percent of children currently insured	89.8%	90.9%
Insurance Coverage Consistency	Percent of children lacking consistent insurance coverage in the past year	14.6%	15.1%
Preventive Health Care	Percent of children with a preventive medical visit in the past year	90.4%	88.5%
Preventive Dental Care	Percent of children with a preventive dental visit in the past year	78.7%	78.4%
Developmental Screening	Percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems	24.7%	19.5%
Mental Health Care	Percent of children age 2–17 with problems requiring counseling who received mental health care	72.3%	60.0%
Medical Home	Percent of children who received care within a medical home	61.3%	57.5%
School and Activities			
Indicator	**Explanation**	**Kansas**	**Nationwide**
School Engagement	Percent of children age 6–17 who are adequately engaged in school	81.4%	80.5%
Repeating a Grade	Percent of children age 6–17 who have repeated at least one grade	4.9%	10.6%
Activities Outside of School	Percent of children age 6–17 who participate in activities outside of school	86.9%	80.7%
Screen Time	Percent of children age 1–5 who watched more than one hour of TV or video during a weekday	55.0%	54.4%

Continued on the next page.

Child's Family			
Indicator	**Explanation**	**Kansas**	**Nationwide**
Reading to Young Children	Percent of children age 0–5 whose families read to them everyday	48.6%	47.8%
Singing and Telling Stories to Young Children	Percent of children age 0–5 whose families sing or tell stories to them everyday	53.7%	59.1%
Religious Services	Percent of children who attend religious services at least weekly	56.9%	53.7%
Mother's Health	Of children who live with their mothers, the percentage whose mothers are in excellent or very good physical and emotional health	61.3%	56.9%
Father's Health	Of children who live with their fathers, the percentage whose fathers are in excellent or very good physical and emotional health	63.7%	62.7%
Smoking in the Household	Percent of children who live in households where someone smokes	26.4%	26.2%
Child Care	Percent of children age 0–5 whose parents made emergency child care arrangements last month and/or a job change for child care reasons last year	34.5%	30.7%
Child and Family's Neighborhood			
Indicator	**Explanation**	**Kansas**	**Nationwide**
Neighborhood Amenities	Percent of children who live in neighborhoods with a park, sidewalks, a library and a community center	48.8%	48.2%
Neighborhood Conditions	Percent of children who live in neighborhoods with poorly kept or dilapidated housing	18.3%	14.6%
Supportive Neighborhoods	Percent of children living in neighborhoods that are supportive	86.7%	83.2%
Safety of Child in Neighborhood	Percent of children living in neighborhoods that are usually or always safe	90.2%	86.1%

Notes: Based on statistical comparisons (lack of overlap of 95% confidence intervals), Kansans report better health than national respondents on these indicators: child participation in outside-of-school activities, mothers with excellent or very good health, and repeating a grade. Kansans did not report poorer health on any of the health indicators as compared to national respondents.

Estimated number of children: 596,113

Source: Child and Adolescent Health Measurement Initiative: Data Resource Center for Child and Adolescent Health. (2007). National Survey of Children's Health. Retrieved from www.nschdata.org.

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CHILDREN AND ORAL HEALTH

Children who suffer from oral health problems often experience discomfort and pain. In addition to affecting physical well-being, dental caries (commonly called tooth decay) may also impact behavioral and social functioning, including speech development, concentration and learning, school attendance and self-esteem.[6]

Dental caries is the most common chronic disease for children in the United States. The condition is five times more common than asthma and seven times more common than hay fever in children.[7] According to the Centers for Disease Control and Prevention (CDC), more than one-quarter of children have tooth decay in baby teeth before entering kindergarten.[8] This condition is even more prevalent for children in lower-income families. The rate of untreated cavities in children from families with incomes below the Federal Poverty Level (FPL) is double that of their peers. This disparity is a reflection of multiple, complex matters that go beyond health insurance coverage for, and access to, oral health services.

Oral health is also affected by broad social and economic factors. Thus, improvements in oral health, particularly for children, cannot be achieved solely by the health sector. These improvements require a multifaceted approach, involving other sectors such as agriculture, business, education and transportation. These approaches also require policymakers at the local, state and federal levels to address the broader determinants of health such as the social environment, the physical environment and health behaviors.

Dental Caries as a Chronic Disease

Dental caries and periodontal diseases are considered "chronic" because the underlying causes involve long-term processes that can result in irreversible tissue destruction and which can reoccur over the course of the lifetime.[9]

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WHAT IS THE MAGNITUDE OF THIS PROBLEM IN KANSAS?

According to the *Smiles Across Kansas: 2007* report, the percentage of third-grade students in Kansas who had untreated dental decay declined from 25.1 percent in 2004 to 21.0 percent in 2007.[10] This change indicates that Kansas met the Healthy People 2010 objective that calls to reduce the proportion of children and adolescents who have untreated dental decay to 21 percent. However, the state has yet to meet other Healthy People 2010 objectives related to oral health. With just 36.0 percent[11] of third-grade students receiving dental sealants, Kansas falls below the Healthy People 2010 objective that calls for 50 percent of 8- and 14-year-old children to have sealants placed on one or more permanent molar teeth.[12]

In addition, a number of studies show that poor oral health remains a concern, especially for specific groups of Kansas children. Substantial disparities in the prevalence and severity of oral health problems exist among low-income children, children without insurance and minority children in Kansas. The 2007 National Survey of Children's Health (NSCH) found that Kansas children in households below 100 percent of FPL were more than five times as likely to have their teeth in fair or poor condition, compared to children living above 400 percent of FPL.[13] According to the same survey, Kansas minority children experienced poorer oral health than their peers. The parents of approximately 18.9 percent of non-Hispanic black children reported their children's teeth were in fair or poor condition, compared to 4.1 percent of non-Hispanic white children.[14] Moreover, Kansas children without insurance had more tooth decay and toothaches than their peers. Nearly 30 percent of children without insurance had decayed teeth or cavities, compared to 14.3 percent of children with private insurance and 20.6 percent of children with public insurance such as Medicaid or the Children's Health Insurance Program (CHIP).[15] About 21.8 percent of children without insurance experienced toothaches compared to 8.8 percent of children with private insurance and 10.1 percent of children with public insurance.[16]

Other examples of oral health access disparities can be seen by the number of Dental Health Professional Shortage Areas (DHPSAs) in the

state. As of September 2010, 96 of the state's 105 counties were designated as DHPSAs.[17] Many of these counties were also designated as special population DHPSAs, meaning that the problem was not just in the number of dentists, but in the number of dentists per area willing to accept patients enrolled in state health care plans such as Medicaid.

ADDRESSING CHILDREN'S ORAL HEALTH IN KANSAS: RECENT EFFORTS AND REMAINING CHALLENGES

In recent years, Kansas has made some progress in addressing oral health issues in the state. Oral Health America's 2009 *Kansas Oral Health Grading Project* awarded the state an overall grade of B.[18] The report acknowledged the state's successful efforts in building an oral health infrastructure that provides a strong foundation for further improvements. The state's oral health plan, developed under the guidance of the Kansas Department of Health and Environment (KDHE) Bureau of Oral Health and Oral Health Kansas, includes several strategies that aim to improve children's oral health: education; prevention, such as school screening programs and community water fluoridation; oral health surveillance and data collection; and oral health programs for children and youth with special health care needs.[19]

To strengthen the provision of preventive dental services to Kansas residents, the Kansas Legislature passed and later expanded the Extended Care Permit (ECP) law for registered dental hygienists. The ECP enables dental hygienists to provide preventive dental care in a variety of settings. These preventive services include teeth cleaning, the application of fluoride varnishes and other services. These services can be provided without direct supervision of a dentist but must be sponsored by a Kansas-licensed dentist.[20]

In addition to these efforts, Kansas has taken several important steps over the years in the area of oral health prevention. In 1915 the Kansas Legislature passed a law that requires providing annual dental screenings to students.[21] However this law is not a funded mandate and therefore it has been difficult to ensure uniform implementation across all schools in

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Kansas. Another step taken by the state provided Medicaid reimbursement to physicians for application of fluoride varnish.

There are still improvements to be made in areas of oral health care access and preventive services.

One of the most significant barriers to dental care for children eligible for Medicaid and CHIP is the lack of dentists willing to see Medicaid patients. Currently, the state faces a shortage of dentists, especially those in rural areas and who accept Medicaid and CHIP patients. In Kansas, only around 32 percent of dentists accept Medicaid patients.[22] Furthermore, access to oral health care is limited, largely because of an insufficient number of dentists. The report found that there was one dentist per 2,476 individuals, and only 3 percent of Kansas dentists, or a total of 32, were pediatric dentists.[23]

To effectively address oral health issues — especially the reduction of oral health disparities within low-income, racial and ethnic groups — it is essential to understand and address a complex interplay of factors that influence oral health outcomes. Solutions to these problems will require collaboration among sectors. Policies could address children's socioeconomic circumstances, physical environment, health-influencing behaviors and medical care. One example of a cross-sectoral approach is the recent mandate from the Kansas State Board of Education (KSBE) to eliminate sugary drinks and snacks with little nutritional value from school vending machines. This approach requires participation from two sectors, business and education, and could potentially result in improved children's health behavior and contribute to positive oral health outcomes.

PROMISING POLICIES: STATE AND LOCAL INITIATIVES TO ADDRESS CHILDREN'S ORAL HEALTH

Several policies have proven to be effective in improving children's oral health (Figure 3, page 12). Among these possible solutions are policies that support prevention programs for children at high risk for oral diseases and policies that support evidence-based programs known to reduce tooth decay, such as school-based sealant programs and community water fluoridation.

About 62 percent of the Kansas population is served by a fluoridated public water source. Wichita is among the largest communities in the United States without public water fluoridation. As noted in the 2009 *Kansas Oral Health Grading Project*, Kansas has no statewide law that mandates community water fluoridation.[24]

Figure 2 shows policies that can be implemented at both the state and local levels and involve a number of sectors, including agriculture, business, legislative and transportation. For example, those in the education sector, such as teachers and school nurses, can play a key role in supporting oral health promotion activities and contributing to the oral health workforce.

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Figure 2: **State and Local Initiatives/Policies to Address Kansas Children's Oral Health**

State Initiatives	State or Local Initiatives	Local Initiatives
• Dental education infrastructure	• Community water fluoridation	• Oral health education in schools
• Medicaid reimbursement rates	• Loan repayment programs for dentists	• School-based dental sealant programs
• Extended Care Permit (ECP)	• Healthy options in school vending machines	• School-based screening programs
• Pricing of foods based on nutritional value	• Innovative workforce models	
• Integrating oral health into primary health care		

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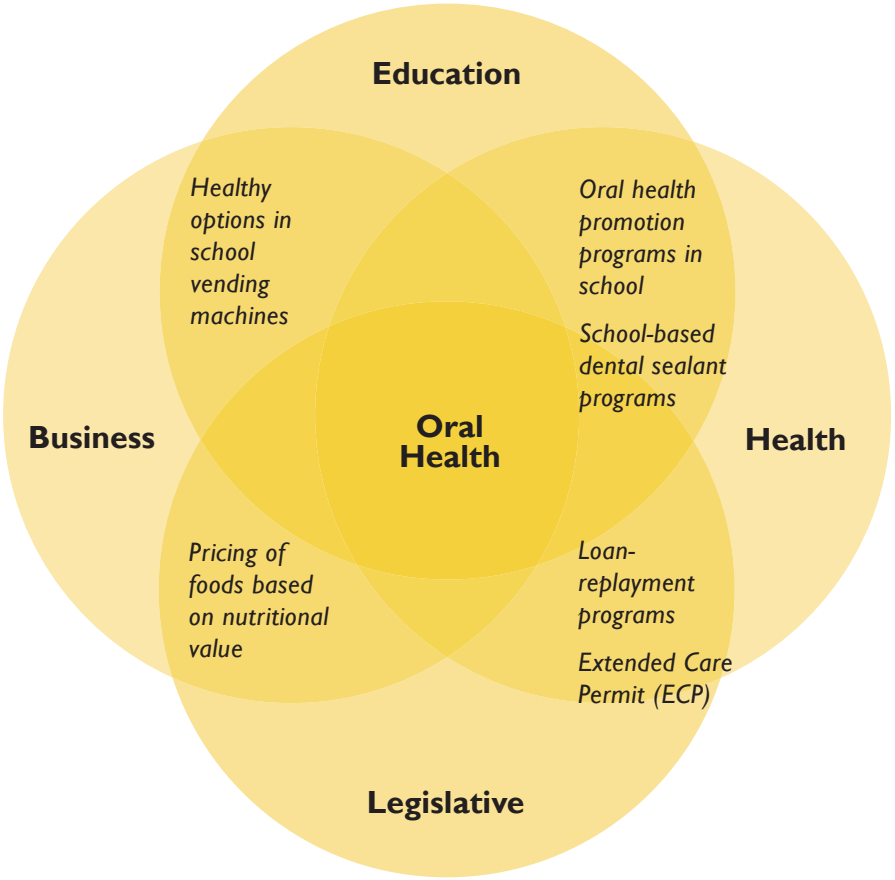
POLICY IMPLICATIONS

Historically, solutions to improve oral health have focused mainly on biological and environmental factors. Addressing environmental factors, such as inadequate community water fluoridation, can decrease the prevalence of dental caries. Likewise, biological factors that contribute to dental caries development have been traditionally addressed through early diagnosis and treatment. Although this traditional approach has proven to be effective to some extent, there still is a large number of children with dental problems.

Figure 3: **Cross-Sectoral Policies to Address Kansas Children's Oral Health**



According to the 2007 NSCH, more than 6 percent of Kansas children had teeth in fair or poor condition.[25] Furthermore, children of lower socioeconomic status were disproportionately affected by dental caries. Thus, reducing disparities in oral health will require directing promising policies to focus on populations at risk for oral diseases. These populations include those with lower socioeconomic status and racial and ethnic minority populations. In order to optimize the effectiveness and impact of existing oral health policies and programs, it is important to also address determinants of health that can impact their success.

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POTENTIAL IMPACT OF HEALTH REFORM[26]

The new federal health reform legislation contains a number of oral health provisions that pertain to dental benefits and coverage, dental workforce, oral health surveillance, dental prevention and oral health literacy. For example, it includes a mandatory oral health benefit for children up to age 21 as part of any essential benefits package offered through health insurance exchanges. The legislation also recognizes dental hygienists as primary oral health providers. Additionally, the legislation provides for 15 demonstration grants for communities and organizations to train or employ alternative dental health care providers to evaluate emerging workforce models that improve access to oral health care. Public health dental hygienists, independent dental hygienists, advanced practice dental hygienists and dental therapist models are included as models eligible for the grants.

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CHILDREN AND OBESITY

Eating nutritiously and remaining physically active can play key roles in preventing obesity. However, many other personal behaviors and environmental factors contribute to obesity. Developing policies that span multiple sectors and promote positive home, school and neighborhood environments could support children and their caregivers in making healthy choices.

Children who are obese are more likely to develop risk factors associated with heart disease and type 2 diabetes and are more likely to be overweight or obese as adults.[27] Obesity is related to more than 20 major chronic diseases and, as a result, obesity contributes to higher medical costs. Obese adults spend 50 percent more on health care costs than people of a healthy weight and obesity-related medical costs account for nearly 16.5 percent of all annual medical spending.[28] Childhood obesity alone is responsible for 14.1 billion dollars in direct health care costs.[29]

WHAT IS THE MAGNITUDE OF THIS PROBLEM IN KANSAS?

Obesity among Kansas children is a growing concern. According to data from the 2007 National Survey of Children's Health (NSCH), 14.9 percent of Kansas children age 10 to 17 were overweight and 16.2 percent were obese.[30] Obesity rates are higher among black children and children living in poverty. The rates of children who are overweight and obese in Kansas have steadily increased over the last decade.

MEASURING WEIGHT STATUS IN CHILDREN[31]

Body Mass Index (BMI), a measure of weight adjusted for height, is used to determine weight categories. BMI-for-age is determined using gender-specific growth charts that place a child in a percentile relative to weight and height. Weight categories, based on these percentiles, are as follows:

Underweight: < 5th percentile

Normal: 5th to < 85th percentile

Overweight: 85th to < 95th percentile

Obese: ≥ 95th percentile

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Although it is well known that adequate physical activity and a healthy diet are critical to preventing obesity, many Kansas children are inactive and eat poorly. In terms of exercise, the U.S. Department of Health and Human Services (HHS) recommends that children age 6 to 17 participate in moderately to vigorously intense physical activity at least 60 minutes every day.[32] In 2007, only one-quarter of Kansas children age 6 to 17 exercised 20 minutes or more per day. As for nutrition, data from the 2007 Kansas Youth Risk Behavior Survey (YRBS) indicated that 33.1 percent of high school students drank one or more sodas per day and only 20.8 percent of high school students ate five servings of fruits and vegetables per day, every day.[33]

The environment influences decisions about physical activity and nutrition. Studies have shown that people are more likely to walk and bike in neighborhoods that offer safe and effective infrastructures such as well-maintained sidewalks and bike paths.[34] In Kansas, 23.0 percent of children age 6 to 17 live in neighborhoods without sidewalks.[35] As for nutrition, access to affordable, healthy foods, through full service grocery stores, farmers' markets and other sources, influences food choices, especially among low-income and rural populations. The lack of affordable, healthy foods is linked to a lower-quality diet that is higher in fat and calories.

ADDRESSING CHILDHOOD OBESITY IN KANSAS: RECENT EFFORTS AND REMAINING CHALLENGES

Effective policies to prevent obesity are those that span multiple sectors and create comprehensive approaches to obesity prevention.

Some Kansas organizations have recently implemented policies that address transportation and school nutrition. In December 2009, the Topeka City Council passed a measure directing city staff to integrate "complete streets" concepts when designing future transportation projects. These concepts are targeted at making roadways safe and accessible for everyone, including bicyclists and pedestrians. In May 2010, the Kansas State Board of Education (KSBE) approved a requirement that all school districts meet "exemplary" wellness standards for vending machines in schools by August

2011. Exemplary vending machine wellness standards limit the number of calories and the amount of fat and sugar in vended foods and allow the sale of only healthy vended beverages, such as water and low-fat milk.

In spite of existing efforts to address obesity, the state still faces a rising trend in the rates of children who are overweight and obese. Kansas could benefit by focusing on the following areas:

- Physical environment. The state's building and urban planning policies could improve the physical environment in ways that would encourage people to engage in physical activity.
- Food pricing. Comprehensive food pricing policies could make healthier foods, like fresh fruits and vegetables, more affordable and more accessible.
- Physical activity at school. Schools with physical education programs that require a substantial number of minutes of physical activity and schools that offer recess allow children to engage in regular, daily physical activity. Children who regularly participate in physical activity are more likely to be physically fit and have better academic achievement, better attendance and fewer disciplinary problems. Studies show that more time in physical education and other school-based physical activity does not adversely affect academic performance.

PROMISING POLICIES: STATE AND LOCAL INITIATIVES TO ADDRESS OBESITY

Forty-six states around the country have operational farm-to-school programs that connect schools and local farms to serve meals and snacks made from fresh, local ingredients and to provide health, nutrition and agricultural learning opportunities. By collaborating across education and agriculture sectors, these programs increase the quantity of fresh fruits and vegetables offered in schools while supporting local and regional farmers.

Although research is limited, farm-to-school and school gardening programs have been shown to contribute positively toward students'

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knowledge, attitudes and behaviors toward healthy food and to promote healthier dietary choices and increased consumption of fruits and vegetables.[36, 37] States around Kansas, including Arkansas, Colorado, Iowa, Missouri, Nebraska and Oklahoma, have approximately 27 programs that involve 33 schools.[38] Kansas efforts to create farm-to-school programs are still in the preliminary stages.

Similar to farm-to-school programs, school gardening programs allow children to plant, harvest, prepare and taste fruits and vegetables grown at school and to participate in nutrition education lessons. Nutrition education teaches children concepts needed for life-long healthy eating, including knowledge of dietary nutrients and their sources, understanding of the Food Pyramid and use of food labeling.

Policies that create school gardens and farm-to-school programs are examples of multi-sectoral approaches that could potentially improve children's diets. Figure 4 includes examples of other state and local initiatives that can address childhood obesity.

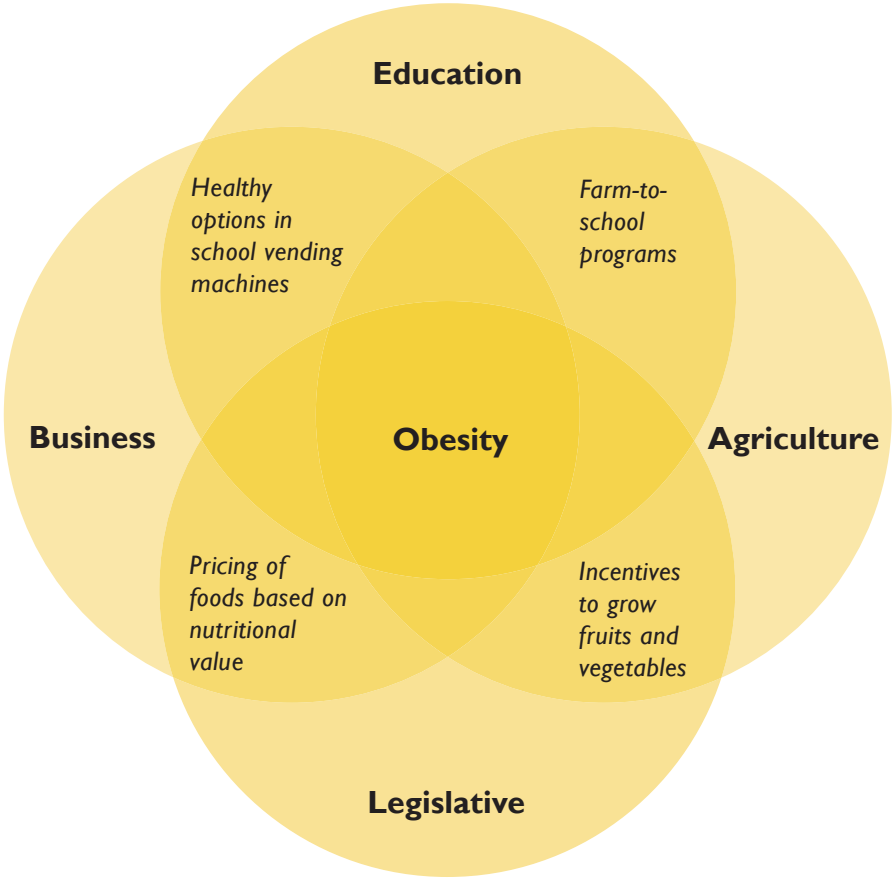
Figure 4: **State and Local Initiatives/Policies to Address Obesity in Kansas Children**

State Initiatives	State or Local Initiatives	Local Initiatives
• Agricultural subsidies to grow fruits and vegetables	• Nutritional standards for foods sold in schools	• Farm-to-school programs
• Physical education requirements for school children	• "Complete Streets" initiatives	• Access to full service grocery stores in rural and/or underserved areas
• Pricing of foods based on nutritional value	• School gardening programs	
	• Safe Routes to School programs	

POLICY IMPLICATIONS

Individuals, families, schools and communities, as well as the agriculture, business, education and legislative sectors (Figure 5), can help reduce barriers to healthy lifestyles and make healthy choices easier. Policies that help create supportive physical environments could lower the prevalence of childhood obesity. Providing neighborhoods with "complete streets," for example, allows more children to walk and bike through their communities. Food pricing adjustments help to make nutritious foods affordable and labeling options assist families in making educated decisions about healthy food consumption.

Figure 5: **Cross-Sectoral Policies to Address Obesity in Kansas Children**



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School-oriented policies may further help children lead healthier lives. Exemplary vending machine policies may reinforce good eating habits by limiting the caloric intake of children and reducing the amount of fat and sugar they consume. Additionally, farm-to-school and school gardening programs help to provide children with healthy food throughout the day and may help them think positively about nutritious diets in the future.

Addressing childhood obesity through multi-sectoral policy approaches may not only reduce chronic diseases, but also decrease health care expenditures. This type of systematic collaboration among sectors to improve the environments in which children live may benefit children individually and also benefit families, schools, neighborhoods and communities.

POTENTIAL IMPACT OF HEALTH REFORM[39]

The new federal health reform legislation includes a provision requiring chain restaurants with 20 or more outlets to disclose the calorie content of items on their menus, including drive-through menu boards. The act also requires vending machine companies that own or operate 20 or more vending machines to disclose the calorie content of their items. By March 2011, the Food and Drug Administration (FDA) must issue specific regulations for these provisions. Research in menu labeling is limited and the evidence on the impact of menu labeling is mixed. Some research has shown that, when calorie content information is posted, consumers purchase items with fewer calories and other research has shown no change in purchasing behavior.

Health reform legislation provides funding for community childhood obesity prevention projects. The legislation appropriated $25 million to a demonstration project to reduce childhood obesity in fiscal years 2010–2014. Also, competitive grants will be awarded to local and state governments and community-based organizations for programs that promote individual and community health and prevent the incidence of chronic disease. Grant activities can focus on a number of themes including: creating healthier school environments; creating an infrastructure to support active living; and developing programs targeting various age groups, including children, to increase physical activity and access to nutritious foods. Twenty percent of the grants must be awarded to rural and frontier areas.

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CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

From the time a child is diagnosed with a special need, and continuing throughout childhood developmental milestones, it is important that a family receives information, support and resources that make it possible to provide essential assistance to the child.

Caring for children and youth with special health care needs can be a complex task when families must navigate fragmented health, social service and education systems in order to ensure a supportive environment for their children's development. Since decisions made across these systems can influence a child's environment and the family's ability to care for the child's needs, developing policy options using a multi-sectoral approach can be beneficial.

WHAT IS THE MAGNITUDE OF THIS PROBLEM IN KANSAS?

According to the 2007 National Survey of Children's Health (NSCH), an estimated 144,683 Kansas children, or 20.7 percent, have special health care needs, as compared to 19.2 percent nationwide.[40] Although 69.3 percent of these children were reported to be in excellent or very good health,[41] they were likely to utilize more health care services than their peers.[42] Studies show they have medical costs from three to six times those of children without special health care needs.[43] About 22 percent of families of children and youth with special health care needs nationwide report spending more than $2,000 per year in out-of-pocket expenses for those children.[44]

Children with Special Health Care Needs

Children with Special Health Care Needs are those who have, or are at increased risk for, a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.[45]

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Comprehensive care for children and youth with special health care needs often includes medical and non-medical expenses, such as child care and educational support services. The cost of this care often creates major financial hardships for families. Nearly one in four American parents of children and youth with special health care needs reported that family members had been forced to quit a job or reduce working hours in order to care for the child.[46]

Children and youth with special health care needs often experience one or more chronic conditions that can affect their ability to function and participate in activities important for development. According to the 2007 NSCH, more than one-third of Kansas children age 6 to 17 with special health care needs had conditions that affected their daily activities and social participation.[47] In addition, children with special health needs are at increased risk for depression, due in part to the characteristics of their conditions. According to the same survey, 11.4 percent of Kansas children age 6 to 17 with special health care needs were depressed and 15.5 percent had problems with anxiety.[48] As children with special health care needs become adolescents, they can face additional issues related to health, services and supports, social isolation and education and work experiences. Some of these challenges may result in poor educational and employment outcomes.[49]

ADDRESSING CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS IN KANSAS: RECENT EFFORTS AND REMAINING CHALLENGES

A number of policies and programs from various sectors support Kansas children and youth with special health care needs and their families. These state and federal programs cover many areas such as health care, education, mental health and financial assistance. The programs include:

- Medicaid;
- Title V Maternal and Child Health Programs, including newborn screenings and services for eligible children and youth with special health care needs;

- Special education services, including early childhood programs;
- Supplemental Security Income Childhood Disability Program for disabled children living in low-income families; and
- Transition services for youth with special health care needs, such as Systems in Sync.

There are three state-level, nonprofit organizations providing information to assist families with locating resource services: Families Together; 2-1-1 Kansas Online; and the Make a Difference Information Network. Families Together, a statewide organization that serves families of children and youth with special needs, is part of a national network that works toward family-centered care for all children and youth with special health care needs and/or disabilities.[50] Primary funding for Families Together is provided by the federal Health Resources and Services Administration (HRSA) through the Maternal and Child Health Bureau.

The United Way of the Plains operates 2-1-1 Kansas Online, a toll-free phone service and website that connects Kansans needing help with nonprofit and governmental services.[51]

The Make a Difference Information Network is a collaborative effort among the Kansas Department of Health and Environment (KDHE), the Kansas State Board of Education (KSBE), the Kansas Department of Social and Rehabilitation Services (SRS) and Oral Health Kansas to connect Kansans and service providers with resources for individuals with disabilities.[52]

In addition to these efforts, in 2010 the Kansas Legislature approved a bill to reform insurance coverage for autism. The new law will require the state employee health insurance plan to provide coverage for evidence-based, medically necessary autism therapies — such as applied behavior analysis — to children. The Health Care Commission, which oversees the design of the state employee health plan, will deliver a report on the impact of the expanded coverage to the Legislature by March 1, 2011.

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Although a great deal of progress has been made in supporting families of children and youth with special health care needs, it is still important to address the availability and accessibility of services. For instance, of the estimated 144,683 Kansas children and youth with special health care needs, KDHE's Title V Services for Children and Youth with Special Health Care Needs program served only 7,124 children who met the income and health condition eligibility requirements during fiscal year (FY) 2007 and only 4,716 during FY 2009.[53] Families not eligible for this program must find and access services through other means.

Currently, families may find it difficult to access services because programs aimed at providing assistance to children with special needs span multiple sectors. For instance, the administrative responsibility for services such as medical care, special education, child care assistance and other wrap-around services rests within several departments and programs. Further collaboration among these entities, with one lead agency serving as the comprehensive centralized referral system, could provide greater support for families of children and youth with special health care needs, as suggested in the findings of the Washington state assessment that studied the integration of services between state agencies and between state and local authorities.[54]

PROMISING POLICIES: STATE AND LOCAL INITIATIVES TO ADDRESS CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Children and youth with special health care needs and their families face increased needs for support in a number of areas such as early intervention services, family-centered care coordination and access to care. Several policies implemented at both the state and local levels have proven to be effective at addressing the needs of children and youth with special health care needs (Figure 6). These policies involve a number of sectors, including business, education, health and legislative and focus on several areas identified and recommended by HRSA's Maternal and Child Health Bureau[55] including:

Medical Home: The "medical home" is a health care delivery model that utilizes a team of providers to provide coordinated, comprehensive and accessible health care.[56] In 2007, about half of Kansas' children and youth with special health care needs had access to health care that met the definition of a medical home.[57] Through the use of medical homes, children and youth with special health care needs are more likely to receive family-centered coordination of services and less likely to have unmet medical needs. The legislative sector and the health sector could collaborate to play a key role in supporting a medical home approach. The new health reform bill will strengthen the role of medical homes caring for children with chronic diseases and special needs.[58]

Comprehensive Centralized Referral System: A comprehensive centralized referral system for information that is open to all families seeking assistance will help families locate and navigate through the complex system of services. A report by the Commonwealth Fund

Figure 6: **State and Local Initiatives/Policies to Address Children and Youth with Special Health Care Needs**

State Initiatives	State or Local Initiatives	Local Initiatives
• Medical home	• Integration of services at state and local levels	• Home visiting programs
• Comprehensive centralized referral system	• Financial incentives (e.g. tax credits, subsidies)	• Child care
• Coordination of state services	• Supported employment	• Community care coordination
• Transition services for youth with special health care needs		

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highlights programs in five states — Colorado, Connecticut, Iowa, North Carolina and Rhode Island — that are promising models of organized systems of referral and care coordination for children identified with developmental disabilities and their families.[59] These strategies include: partnerships between private and public providers; use of public health systems for home visiting for health and educational interventions; parent consultants in primary care practices; payment policy changes and centralized support services; collaboration between private health care providers and community agencies providing early intervention services; and a centralized referral and case management system that promotes integration of services.

Supported Employment: Opportunities for competitive employment can promote independence and economic self-sufficiency for youth with special health care needs and/or disabilities. For instance, the National Collaborative on Workforce and Disability/Youth provides various resources including supported employment. This term refers to competitive employment in an integrated work setting in which individuals with the most significant disabilities are provided ongoing support services through an external source, such as job coaches or specialized training, transportation, assistive technology or individually tailored support.[60]

Financial Supports: Providing supports to families of children and youth with special health care needs might come in the form of financial assistance, such as subsidies or state tax credits, or requirements for adequate family leave policies in the workplace. Three states (California, New Jersey and Washington) have implemented provisions for paid family leave to care for children and youth with special health care needs.[61]

POLICY IMPLICATIONS

Comprehensive, family-centered care for children and youth with special health care needs involves more than just taking care of medical needs. The child's chronic conditions also can affect the child's ability to function

and participate in activities important to his or her development, as well as transitioning to a productive and fulfilling adult life. Families are under stress and financial burdens related to caring for their children. Effective policy strategies to address the problems faced by children and youth with special health care needs and their families require cooperation among multiple sectors (Figure 7).

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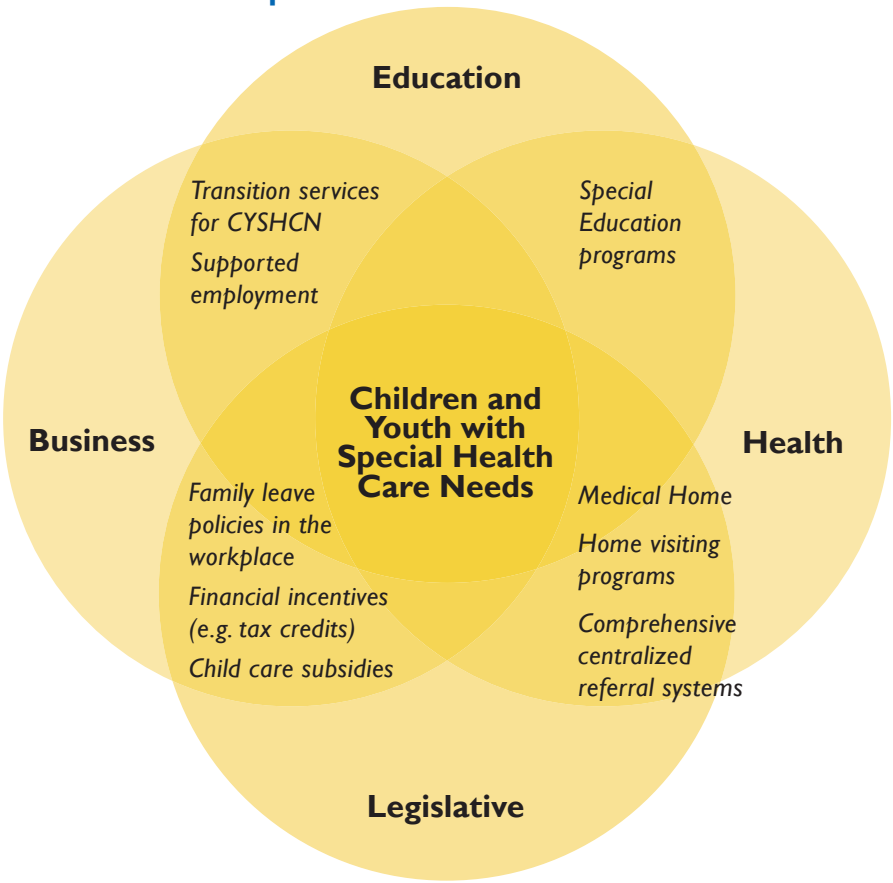
Figure 7: **Cross-Sectoral Policies to Support Children and Youth with Special Health Care Needs**



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POTENTIAL IMPACT OF HEALTH REFORM

The new federal health reform legislation contains a number of provisions that could potentially improve access and quality of care for children and youth with special health care needs. The legislation will prohibit lifetime caps on insurance coverage, prevent insurers from refusing coverage due to pre-existing conditions and extend care to dependents until age 26. In addition, the legislation will expand the use of medical homes and pediatric primary care. Furthermore, it will allow Medicaid programs to make payments to medical homes that focus on treating children with chronic conditions. Additionally, the legislation will extend autism insurance reform to some families, but not all insurance plans will be required to cover behavioral health treatment.

CHILDREN AND POVERTY

Poverty is prevalent in the United States and disproportionately affects children. The child poverty rate in Kansas increased to 17.2 percent in 2009, up 3.2 percentage points from the year before.[62] For children living in poverty, multiple risk factors converge, increasing children's risk for chronic health problems and other poor outcomes. Access to education, job opportunities, savings and credit, affordable housing and social supports can help children and families combat poverty and, in turn, help improve their health status.

WHAT IS THE MAGNITUDE OF THIS PROBLEM IN KANSAS?

Kansas children from low-income households were less healthy than children from high-income households, according to a 2008 report from the Robert Wood Johnson Foundation (RWJF).[63] The RWJF report, which used parental assessments of children's health[64] from the 2003 National Survey of Children's Health (NSCH), found that Kansas children in households below 100 percent of the Federal Poverty Level (FPL) were more than four times as likely to be in less-than-optimal health, compared to children living above 400 percent of FPL (Figure 8, page 32).

Studies have proven that higher education levels are often connected with higher income levels. The RWJF report also links education level and health status, indicating that Kansas children in households without a high school graduate were approximately four times more likely to experience less-than-optimal health than children living with an adult who had completed some college. Forty-two percent of Kansas children who lived in households without a high school graduate were in less-than-optimal health.

When compared to Iowa, Missouri, Nebraska and Oklahoma, the lowest-income children in Kansas had the worst health status. In Kansas, 35.3 percent of children below 100 percent of FPL were reported to be in less-than-optimal health. That percentage in Nebraska was 29.0 percent; in Oklahoma it was 25.7 percent; in Iowa it was 25.1 percent; and in Missouri it was 21.2 percent.[65]

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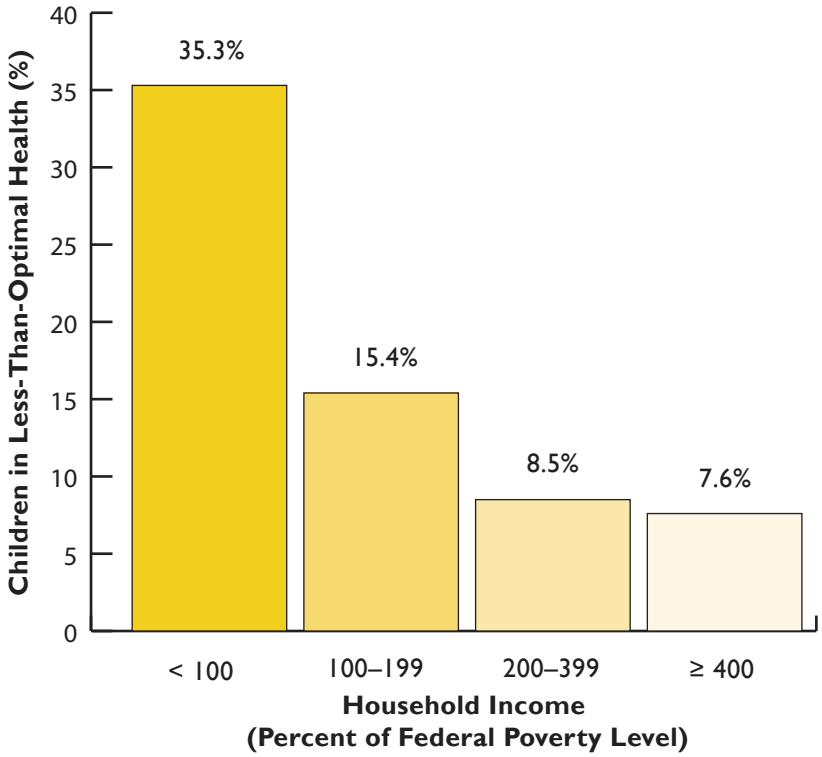
ADDRESSING POVERTY AMONG KANSAS CHILDREN: RECENT EFFORTS AND REMAINING CHALLENGES

Many policies and programs that address poverty and its health effects are supported by federal, state and local governments, as well as non-governmental organizations. In Kansas, state agencies and local nonprofit organizations provide services to low-income families. Some of these services are supported by federal funding, some are supported by state funding and others are supported by private funding. Kansas, like most states, administers a number of federal programs aimed at providing low-

Figure 8: **Percent of Kansas Children in Less-Than-Optimal Health by Household Income in 2003**



Source: Robert Wood Johnson Foundation Commission to Build a Healthier America; 2003 National Survey of Children's Health.

income families with assistance for needs such as food, housing, health insurance or child care.[66]

Kansas provides additional state-specific services to low-income families. These services include:

Income and Asset Building: In 2010, lawmakers increased the Kansas Earned Income Tax Credit (EITC) level to 18 percent for tax years 2010 through 2012, making the EITC one of the highest in the nation. Kansas also has two state-supported Individual Development Account (IDA) programs; a state 529 College Savings Plan, with matching deposits for lower-income families; food sales tax rebate for families; and a state home ownership program aimed at asset building for low-income families.[67]

Early Childhood: Federally supported Head Start and Early Head Start[68] programs exist in Kansas, along with the state-funded Four-Year-Old At-Risk and Pre-K pilot programs.[69] Kansas' Early Childhood Block Grant earmarks funds specifically for early childhood programs at state and local levels, and the Kansas Early Childhood Comprehensive Systems Plan provides a model for organizing and supporting early childhood services in Kansas.[70]

The Kansas Legislature has taken actions in recent years to address poverty. In January 2010, the state's minimum wage increased from $2.65 per hour to the federal minimum wage of $7.25 per hour, and the state's CHIP eligibility was expanded up to 250 percent of the FY 2008 FPL, based on legislation passed in 2009. However, budget cuts in the 2010 legislative session impacted many agencies providing services to low-income families.

Despite these efforts in Kansas, programs and services are often limited and fragmented for families that could benefit from a comprehensive, coordinated approach to service delivery. National data from the Community Population Survey (CPS) show a connection between higher education and higher earnings,[71] as does some research,[72, 73] but few policies or initiatives exist in Kansas to support education for low-income

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parents and teens. The state's Temporary Assistance to Families (TAF) program, which is designed to encourage self-sufficiency, does not provide incentives or assistance for adults seeking post-secondary education, as other states' programs do. Additionally, most state assistance programs in Kansas provide a disincentive for low-income families to accumulate savings because families do not qualify if they have savings or assets. Head Start and Early Head Start programs are limited to families at or below 130 percent of FPL, and often have waiting lists that limit the accessibility of these programs. Statewide access to intensive preschool programs for low-income children, which have shown positive outcomes on child health and future earnings, is limited.[74]

PROMISING POLICIES: STATE AND LOCAL INITIATIVES TO ADDRESS CHILDHOOD POVERTY

Twelve states have established initiatives aimed at reducing and preventing childhood poverty. Connecticut, for example, has used the multi-sectoral approach by creating a task force that brings together researchers, social services providers, state officials and representatives from a variety of sectors to make policy recommendations with the goal of reducing childhood poverty. The task force reports annually on the progress the state has made toward this goal. Since many factors influence childhood poverty, other states are also adopting policy initiatives that involve multiple sectors.

The following interventions are examples of best practices in reducing childhood poverty:

Education:

- Parent Education and Job Training: States can partner with local businesses, nonprofit agencies and community colleges to increase technical skills and/or education, and subsequently wages, among low-income workers. For example, Kentucky's Ready-To-Work program helps TAF recipients pursue post-secondary degrees at community and technical colleges. The program's participants had higher wages and longer lengths of employment than the control group.[75]

- Early Childhood Education: States can invest in research-based early childhood programs such as intensive preschool programs for low-income young children. A RAND Corporation review of literature on early childhood programs[76] showed that children who attended a part-time preschool that included weekly home visits earned 60 percent more when they reached age 27 than those in the control group. Children participating in nurse home visiting programs experienced 33 percent fewer emergency room visits through age 4, and their mothers were on welfare 33 percent less of the time. RAND found that both programs were cost-effective over time.

Business: States can assist families in building savings and assets through continuing to support and expand state earned income tax credits and connecting families to banking opportunities, providing incentives for savings accounts and supporting financial literacy programs.[77] These types of programs have shown to help families build savings in several states.[78, 79] Lawmakers can also improve the consumer environment in poor neighborhoods through enacting anti-predatory lending legislation and offering incentives to private industry to expand grocery stores, retail stores and bank options for consumers.[80]

Government: States can improve access and reduce barriers for low-income families to enroll in public benefit programs such as Medicaid/CHIP, TAF, food assistance, child care and other programs by streamlining enrollment and simplifying eligibility policies. For example, states could take advantage of new "express lane eligibility" rules for CHIP, combine enrollment with other programs and reduce documentation requirements, which is one of the most effective ways to increase enrollment.[81]

Many of these policy options are effective long-term approaches to addressing childhood poverty, and are more likely to be successful when individuals' immediate needs — such as food assistance and housing

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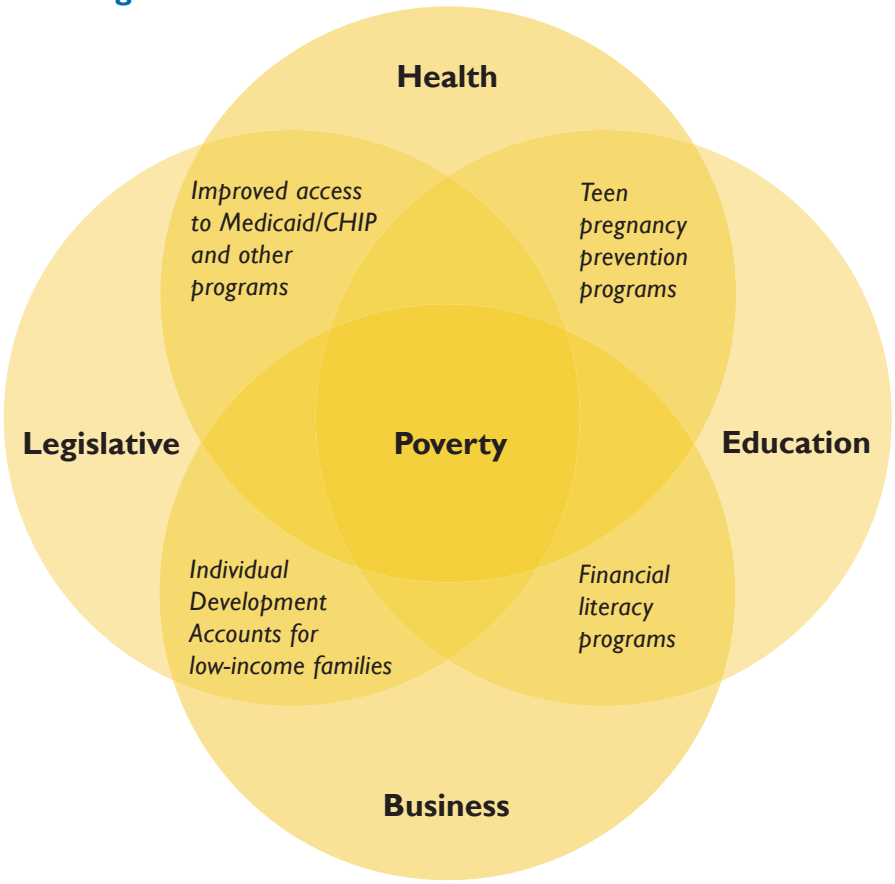
assistance — are also addressed. To combat childhood poverty both in the short- and long-term, a collaboration among sectors is needed when developing policy options. See Figure 9 for examples of cross-sectoral policies to address poverty among Kansas children.

POLICY IMPLICATIONS

Addressing childhood poverty and its health effects requires multiple interventions that provide children and families with opportunities, services and improved environments. In terms of education and job skills training for parents, research shows that programs leading to sustained financial gains have the potential to improve young children's well-being, whereas programs that fail to increase employment and income over the long term are more likely to have neutral or negative implications for children.[82] Research also indicates that education and job training programs are important in helping families and children in poverty, but the interventions are more likely to be successful with the support of various policy sectors.[83] For example, states such as Kentucky and Maine have been successful in designing education and work training programs that include case management, career counseling and access to campus and community-based services, which fall into the education sector. These programs have also connected participants with food assistance, child care and transportation, which are social service sector programs and transportation sector programs. Many evidence-based early childhood programs use a similar approach of targeting more than one sector. The evidence-based early childhood programs that have been shown to have effects on children's future earnings often involve the education sector and the social service sector.

Figure 9: **Cross-Sectoral Policies to Address Poverty Among Kansas Children**



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POTENTIAL IMPACT OF HEALTH REFORM

Federal health reform legislation expands Medicaid in 2014 to cover nondisabled adults without dependent children up to 133 percent of FPL. Currently some low-income pregnant women, children, disabled adults and parents with dependent children qualify for Medicaid, and the expansion allows adults without dependent children to also be included in the program. The Kansas Health Policy Authority (KHPA) estimates that 131,000 additional Kansans will receive Medicaid or CHIP as a result of health reform. Additionally, for individuals and families with incomes between 133 to 400 percent of FPL, health reform would make refundable and advanceable premium credits and cost-sharing subsidies available to assist in purchasing insurance through exchanges.

Because Medicaid and CHIP currently cover children up to 250 percent of the 2008 FPL, the most significant increase in Medicaid coverage in Kansas will be most likely for adults. A 2003 study by Dubay and Kenney showed that an expansion in coverage for parents in public insurance is linked to an increase in the number of children covered under Medicaid.[84] It is estimated that the number of children with either public or private insurance will also increase due to health reform. Research indicates that having health insurance is strongly associated with access to primary care for children.[85]

The health reform legislation provides some support for higher education for low-income adults, through its funding of the Pell grant program and of the "Historically Black Colleges and Universities and Other Minority Serving Institutions" program. Additionally provisions of the bill also reduce the income-based repayment percentage from 15 percent to 10 percent of income. As discussed in the previous sections, policies that help with costs of tuition, particularly in combination with policies from other sectors, may help to make higher education more accessible for low-income parents.

The health reform legislation also includes grants to states for early childhood home visiting programs targeted at low-income families and establishes new programs to support school-based health centers. There is strong evidence-based support for home visiting programs, and research shows the positive effects these programs have over time for both children and parents in terms of health outcomes and wage earnings.[86] Research shows that school-based health centers reduce barriers to accessing health care for teens, especially those who are low-income, medically underserved and/or in high-risk situations. However, research on long-term effectiveness of school-based centers on improving health over time is limited.[87, 88]

ADOLESCENT RISK BEHAVIORS

For adolescents, there exist two primary types of influences upon decision making: risk factors and protective factors. The Centers for Disease Control and Prevention (CDC)[89] calls these "antecedent factors" — pre-existing environmental circumstances in one's family, school, peer group and community that can either limit the development of healthy behaviors or help to prevent young people from making choices that put them at risk. Examples of risk factors for adolescent risk behaviors include a history of family mental illness, poverty, social isolation and exposure to youth-oriented advertising. These factors, as well as dozens of others, have been shown to hinder healthy decision making among young people.

On the other hand, protective factors such as family cohesion, healthy school policies and positive community support systems encourage resilience and positive behaviors among adolescents. Considering the influence of antecedent factors, interventions that intend to reduce risk behaviors among adolescents should not only focus on reducing environmental risks, but also on strengthening the protective factors that help youth lead healthy lives. Developing policy approaches that span multiple sectors would promote strategies that address both influences.

WHAT IS THE MAGNITUDE OF THIS PROBLEM IN KANSAS?

Data from the 2009 Youth Risk Behavior Survey (YRBS)[90] indicated that, in two instances, participation in alcohol-related risk behaviors was higher among Kansas high school students (grades 9–12) than their counterparts nationwide. First, 12.9 percent of high school students reported having driven a vehicle while under the influence of alcohol within the previous month. Second, one in four high school students reported recent binge drinking, defined as consuming five or more alcoholic drinks in a row within a couple of hours during the previous 30 days. According to a report by the American Medical Association (AMA), adolescent drinkers are more likely to "perform poorly in school, fall behind and experience social problems, depression, suicidal thoughts and violence."[91]

In terms of drug-related behaviors, according to data from the 2010 Kansas Communities That Care survey, almost 13.8 percent of Kansas

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eighth grade students reported using inhalants to get high.[92] The use of inhalants is a concerning risk behavior because even one try can cause sudden death, and prolonged exposure may result in permanent damage to the central nervous system and other organ systems.[93]

Pertaining to sex-related behaviors, data from the 2009 YRBS indicated that 34.2 percent of Kansas high school students were sexually active during the previous three months, 19.9 percent reported being under the influence of alcohol or drugs the last time they had sex and 39.9 percent reported not using a condom the last time they had sex. It should be noted that 5,371 Kansas females between age 10 and 19 reported a pregnancy in 2008.[94]

ADOLESCENT RISK BEHAVIORS IN KANSAS: CURRENT EFFORTS AND REMAINING CHALLENGES

There are areas in which Kansas is doing well to prevent risk behaviors for adolescents, and other areas that leave room for improvement. Kansas provides health education teachers and school nurses with funding for continuing education on topics such as preventing alcohol and other drug use and preventing HIV and other sexually transmitted diseases. However, the state does not require schools to teach these prevention topics to students.[95]

When it comes to alcohol-related risk behaviors, Kansas has adopted best practice approaches such as zero-tolerance policies targeted at intoxicated driving.[96] In 2010, the Kansas Legislature increased penalties for inebriated drivers. Drivers under the legal drinking age in Kansas who are caught with a blood alcohol content (BAC) of 0.02 or greater are subject to a one-year license suspension.[97] In 2010, the state also increased penalties for inebriated drivers by requiring them to use ignition interlock devices if convicted of a second or subsequent driving under the influence (DUI) offense. An ignition interlock device may be ordered on a first offense for a driver who is under the legal drinking age if the driver's BAC is 0.15 or greater.[98] These practices have been proven in other states to reduce DUI re-arrest rates and motor vehicle crashes.[99]

Comparing the 2007[100] and 2009 YRBS, data indicated that some adolescent risk behaviors have improved while others have worsened. On one hand, the percentage of high school students who reported riding with an intoxicated driver declined from 30.7 percent in 2007 to 25.8 percent in 2009. Also, the percentage of high school students reporting drinking alcohol in the previous month decreased from 42.4 percent in 2007 to 38.7 percent in 2009. On the other hand, the number of high school students who ever had sex rose to 46.6 percent in 2009 — a 1.6 percent increase from 2007. Additionally, Kansas experienced a decline in the rate of condom use among high school students. In 2007, 65.8 percent of high school students used condoms during sex; in 2009, the percentage had fallen to 60.1.

PROMISING POLICIES: STATE AND LOCAL INITIATIVES TO ADDRESS ADOLESCENT RISK BEHAVIORS

There are a number of sectors — including education, health, legislative and social service — in which evidence-based policy interventions can have an impact on adolescent risk behaviors (Figure 11, page 43).

Alcohol-, drug- and sex-related risk behaviors can be addressed at the local, family and community levels. School health education initiatives — especially those efforts focused on prevention — can help reduce risk behaviors among adolescents and positively influence their performance in school.[101] Studies have proven that after-school programs provided by private social service organizations may likewise improve academic performance while also decreasing drug-, alcohol- and sex-related risk behaviors, especially for racial minorities.[102]

States can also address adolescent risk behaviors; in fact, research has shown legislative and health interventions to be particularly effective. In terms of legislative actions, restrictions on advertisements and increases in excise taxes on alcohol and tobacco products can deter underage consumption, raise graduation rates and reduce motor vehicle fatalities among adolescents.[103, 104] Research also shows that community health care initiatives, such as nurse visiting programs for mothers of newborns, can reduce the sex-related risk behaviors of children.[105]

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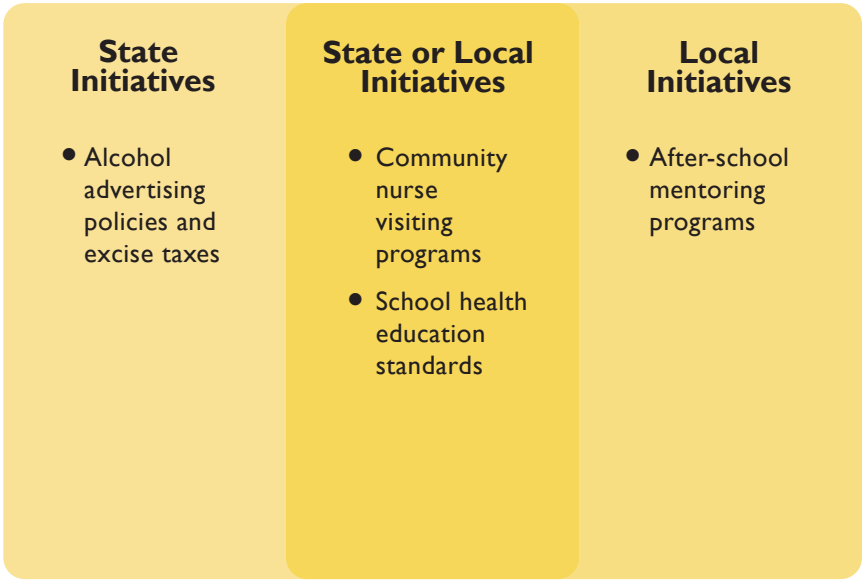
Figure 10: **State and Local Initiatives/Policies to Address Adolescent Risk Behaviors**



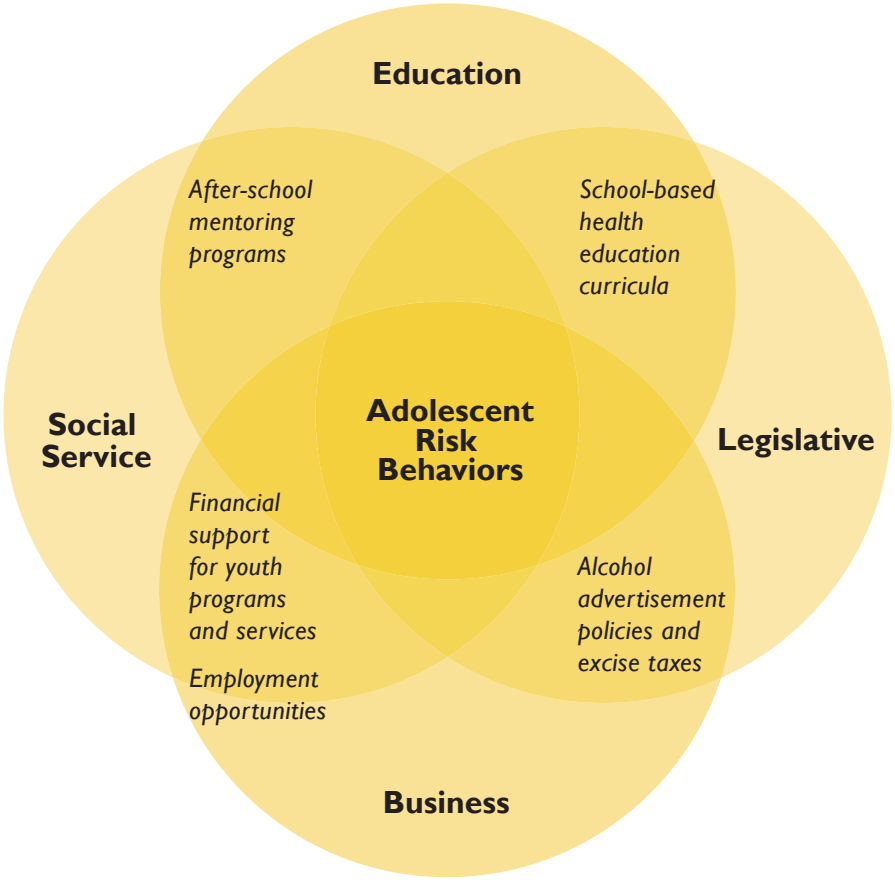
POLICY IMPLICATIONS

State and local policies (Figure 10) that reduce risk factors while increasing environmental protective factors for adolescents can effectively decrease their engagement in risk behaviors. Addressing adolescent risk behaviors through policy approaches that span multiple sectors can affect not only the psychological and physiological well-being of individual teenagers, but also the larger communities in which they reside.

For instance, taxation strategies aimed at reducing underage alcohol consumption can decrease motor vehicle fatalities and increase state revenues. Additionally, nurse visiting programs that assist new mothers can result in better health outcomes for adults and reduced risk behaviors among their children, even in the long term. Furthermore, after-school mentoring programs that encourage bonding between adolescents and adults[106] or extracurricular sports that foster a sense of self-efficacy and teamwork among teens[107] can result in healthier teenagers, better-educated

workforces, stable family environments and equitable communities. These outcomes enhance protective factors for adolescents — providing influences that can decrease a teen's likelihood of engaging in risk behaviors. Although strategies to decrease adolescent risk behaviors can be complex, the positive impacts of creative solutions can be widespread and diverse.

Figure 11: **Cross-Sectoral Policies to Address Adolescent Risk Behaviors**



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POTENTIAL IMPACT OF HEALTH REFORM

The new federal health reform legislation allocates funds to states and private organizations for "personal responsibility education," evidence-based programs designed to delay adolescent sexual activity, increase condom and contraceptive use among sexually active youth and reduce teenage pregnancy. In addition, the legislation provides grants to establish school health clinics that focus on creating year-around access points for adolescents to receive physical and mental health services, including substance use disorder assessments, crisis interventions and a variety of treatment options. Federal funding will also be available for workforce development programs to recruit professionals who provide preventive and clinical services to adolescents. The legislation will also establish a Pregnancy Assistance Fund to improve the availability and accessibility of resources and support services for pregnant or parenting teens.

These elements of the Affordable Care Act specifically target risk behaviors among adolescents. It is important to note, however, that the act contains numerous sections that fundamentally alter the ways in which adolescents are served by the health care system. Although these pieces are not mentioned here, they may nonetheless prove crucial to improving the health of adolescents in the future.

ACCESS TO QUALITY CHILD CARE SERVICES

As parents struggle to balance the demands of work and family life, access to child care services outside of the home often becomes a necessity. Child care increases the likelihood that parents are able to join the workforce or pursue education and training that enable them to support their families. But simply having a place to take their child is not their only consideration. A quality child care program is one that offers a stimulating learning environment, an appropriately trained staff, policies that encourage parental involvement and one that meets national standards that lead to accreditation.[108] Studies have shown that access to quality child care has a direct impact on healthy child development, influencing intellectual and emotional growth that extends later into the child's life.[109] By using the multi-sectoral approach and bringing together nontraditional partners to address the issues of access to and quality of child care services, the state can explore possibilities for creative solutions to these issues.

WHAT IS THE MAGNITUDE OF THIS PROBLEM IN KANSAS?

Finding quality, reliable, non-family-based child care can be a significant challenge for many parents. There are fewer child care openings than the number of children who need them. According to the U.S. Census Bureau's 2007 American Community Survey, there were 234,927 children under the age of 6 in Kansas.[110] More than half of those children lived in situations (i.e. one or two working parents) that made it likely that they would need child care.[111] However, in 2008 there was a total of only 135,874 child care spaces available in Kansas for all children under age 18. In addition to a shortage of available child care spaces, quality becomes a concern, given that of the around 5,700 facilities in Kansas that offered child care, only 3,000 were licensed by the state. Although Kansas now requires that all places offering child care be licensed, access to care that includes early childhood development programs is limited due to the insufficient workforce of trained providers with advanced education in child development principles.

For many families, cost is a barrier to accessing child care services. The average monthly child care costs for a single infant younger than age 3 often exceeds a family's other monthly living expenses. The cost of child

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care for one infant in Kansas averages 12 percent of the median income for a two-parent family and 35 percent of the median income of a single parent family.[112] The proportion of a family's income devoted to child care expenses increases with multiple infants and children.[113]

Quality is an issue as well. Kansas does not currently have a standardized method for assessing the quality of a child care facility. Beyond ensuring that regulations are followed, there are no standard indicators or ratings of whether a facility has a history of violations that could affect a parent's decision to enroll their child in that facility. The lack of easily obtainable information on regulatory compliance can hinder a parent's ability to make an informed decision when choosing a child care facility.[114]

ADDRESSING ACCESS TO QUALITY CHILD CARE IN KANSAS: RECENT EFFORTS AND REMAINING CHALLENGES

In May 2010, the Kansas Legislature passed a bill containing regulatory modifications that would require that all day care homes in the state be licensed and inspected on a regular basis. The new regulations also require the Kansas Department of Health and Environment (KDHE), the state agency in charge of day care facility oversight, to develop guidelines for child supervision and a plan to enforce these guidelines. In addition, the bill directs KDHE to develop a website that would provide public access to provider and facility inspection results.[115] These regulatory changes are steps toward ensuring the safety of children in a nonfamily care setting and additionally provide parents with information so that they may make informed decisions when choosing a child care facility.

Kansas has state and federal programs, such as the Child Care and Development Block Grant, to assist low-income families in paying for child care. The state also provides funding for early childhood development initiatives such as Early Head Start, Smart Start and Parents as Teachers through the Children's Initiative Fund. These programs use evidence-based early childhood development principles shown to be successful in preparing young children for school by having a positive impact on cognitive skills such as pre-reading and pre-math skills. When state funds are tight, however, these types of programs are often among the first to be considered

for elimination or reduction in scope and funding.[116] Improved quality of and access to affordable day care options for children have been shown to impact children's long-term success, therefore policymakers and funders should consider the benefits of these programs when making budgetary decisions.

PROMISING POLICIES: STATE AND LOCAL INITIATIVES TO ADDRESS ACCESS TO QUALITY CHILD CARE SERVICES

Multiple sectors can be involved in addressing the issues of access to and quality of child care services in the state (Figure 13, page 49). Common approaches include:

- Legislative sector solutions, such as regulatory changes that include close monitoring of facility and caregiver performance and the public sharing of compliance results;
- Business sector solutions, such as family-friendly policies supporting flex time, on-site child care or child care subsidies;
- Education sector solutions, such as creating opportunities and incentives for child caregiver training and additional credit for child care development coursework and certification.

Some of these promising approaches, such as encouraging local businesses to adopt family-friendly policies, are more likely to be implemented successfully at the local level, while other approaches, like regulatory changes that create increased accountability within the child care industry, are more appropriate for implementation at the state level (Figure 12, page 48). While there are many sectors that can play a role in addressing the challenges of child care access and quality, partnerships and collaborations between and among sectors can increase the probability for successful and sustainable solutions.

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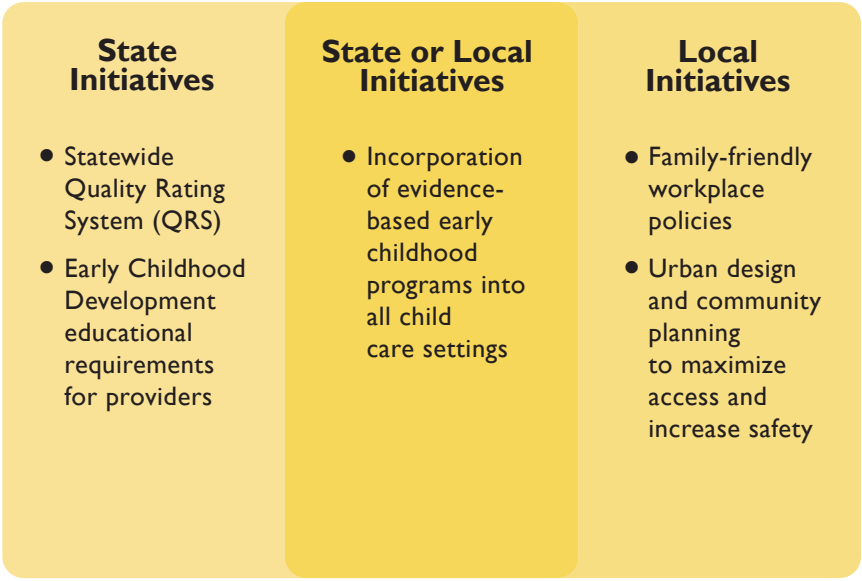
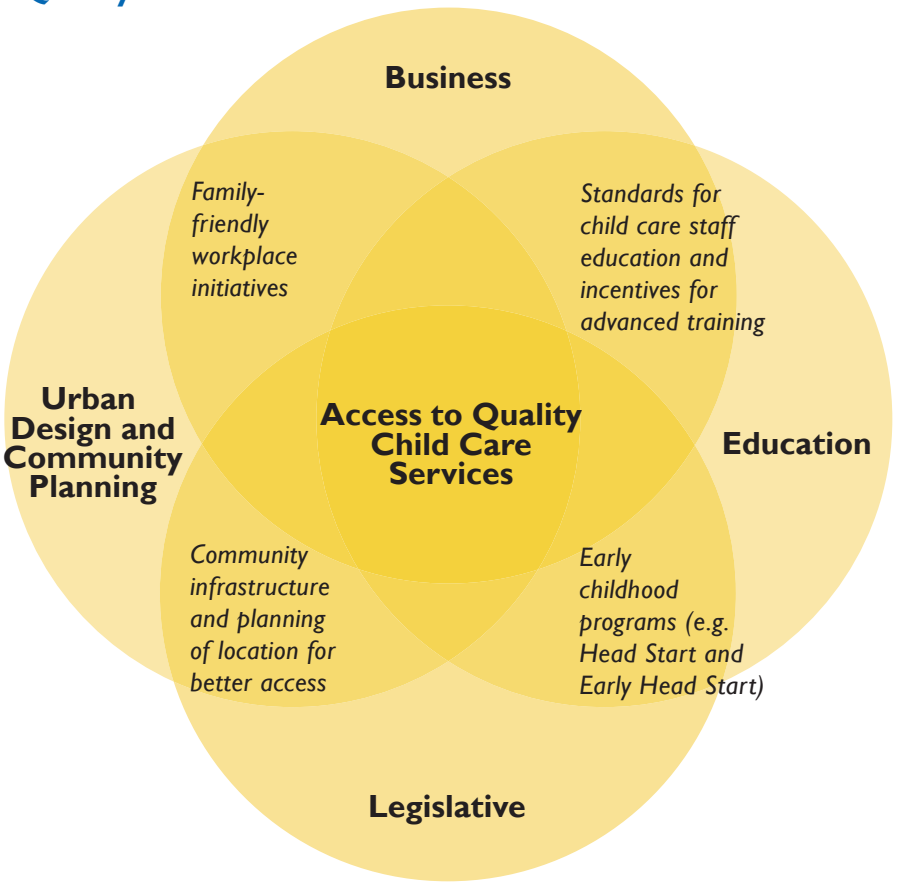
Figure 12: **State and Local Initiatives/Policies to Address Access to Quality Child Care Services in Kansas**



POLICY IMPLICATIONS

Ensuring access to quality child care is a multifaceted issue. It is unlikely that any one sector of society can address all of the complexities involved in providing affordable, accessible, quality child care in Kansas. Exploring policies that involve a variety of sectors can foster the opportunity for innovative and creative solutions to improve child care quality across the state. For example, education sector policies could promote the incorporation of evidence-based early childhood education principles into child care environments. This practice would serve to build a healthier environment for child development and longer-term social and academic success for the children. Business sector policies could provide parents the flexibility and support necessary to provide their children with reliable, quality care. These policies can help to strengthen employee loyalty and reduce employee absenteeism related to child care issues.

Figure 13: **Cross-Sectoral Policies to Address Access to Quality Child Care Services in Kansas**



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POTENTIAL IMPACT OF HEALTH REFORM

Child care workers may be among the biggest beneficiaries of health reform, according to Carmen Nazario, assistant secretary for children and families at the U.S. Department of Health and Human Services (HHS). These workers reflect a sizeable portion of low-income workers who generally do not have health insurance. According to the Center for Child Care Workforce, "Only a small percentage of early care and education teachers and providers receive fully paid health care benefits from their employers…"[117] In 2001, a Pennsylvania research group published a brief that stated "Few child care workers receive benefits such as health care. For example, in Pennsylvania, 60 percent of all workers receive health insurance benefits through their employers but only 25 percent of child care workers receive comparable benefits. Moreover, even when child care workers have access to an employer's health care plan, few can afford the premiums. Along with limited health insurance, workers in the field seldom receive other job-related benefits such as paid sick days, vacation time or retirement plans."[118] Health reform will make health insurance accessible to such workers.

There are several potential implications of improved access to affordable health insurance. Choosing to become a child care provider may become a more viable option for people who previously could not afford to choose a career that did not provide health insurance. This, in turn, could increase the available workforce and provide better access to child care for families who previously had difficulty finding child care that was convenient and reliable.

PROMISING POLICY OPTIONS

Each chapter of the workbook explores a priority health issue relevant to the health of Kansas children. The following appendix outlines policy options identified in the earlier chapters and provides additional information that policymakers and other stakeholders may find helpful when evaluating evidence-informed policy options.

PROMISING POLICY OPTIONS

CHILDREN AND ORAL HEALTH

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
School-Based Dental Sealant Program(s)	• Provides sealants to vulnerable populations less likely to receive private dental care, such as children eligible for free or reduced-cost lunch programs. • Includes the following types of programs: school-based programs, school-linked programs, hybrid programs. • Includes the following services: oral health education, dental screenings, referral for dental treatment, fluoride mouthrinsing and sealant applications. • Operates September–June (during the school year), uses portable dental equipment, requires parental consent for the dentists to examine and prescribe sealants, and utilizes dental hygienists working with dental assistants to place sealants. • Exists in 35 states and four territories.	• Education • Health • Legislative

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
Community Water Fluoridation	• Involves adjusting the naturally occurring fluoride levels in drinking water to 0.7–1.2 parts per million, the optimal fluoride level recommended by the U.S. Public Health Service for the prevention of tooth decay. • Provides a safe, cost-effective way to prevent tooth decay. • Cost of fluoridation depends on the size of the community. The annual cost of fluoridation is approximately $0.50 per person in communities of ≥ 20,000 to approximately $3.00 per person in communities ≤ 5,000. • In 2008, 72.4 percent of the U.S. population on public water systems had access to fluoridated water. • Eleven states and two territories have laws that mandate statewide water fluoridation.	• Education • Health • Legislative

Examples of Programs and Practices	Potential Outcomes
School-based dental sealant programs include: • Ohio Department of Health School-Based Dental Sealant Program • Illinois Dental Sealant Grant Program • Arizona Dental Sealant Program	• Decrease in cavities by 60 percent on the surfaces of top and bottom molars and pre-molars among children 6 to 17 years old. • Increase in the overall prevalence of dental sealants among children. • Sealants are most cost-effective when provided to children who are at highest risk for tooth decay (cost savings of $66–$73 per tooth surface prevented from needing repair among young Medicaid-enrolled children). • Reduces the racial and income disparity in sealant prevalence among elementary school students.

Examples of Programs and Practices	Potential Outcomes
Community water fluoridation policies include: • Texas Fluoridation Program • Indiana's Community Water Fluoridation Program • Oklahoma Water Fluoridation Program	• Accounts for a reduction in the amount of tooth decay in children by 40–60 percent. • Decrease in tooth decay in communities with varying decay rates and among children of varying socioeconomic status. • One dollar invested in fluoridation saves $38 in avoided dental treatment costs.

PROMISING POLICY OPTIONS

CHILDREN AND OBESITY		
Policy Option	**What Does This Policy Do?**	**What Sectors May It Involve?**
Complete Streets	• Redesigns streets and sidewalks and improves the perceived environment in order to increase physical activity. • Streets accommodate all users, including pedestrians, bicyclists and transit passengers of all ages and abilities, as well as trucks, buses and automobiles. • Applies to new construction, reconstruction and/or repaving projects. • Twenty-three states and 81 cities have a "complete streets" policy.	• Business • Health • Legislative • Transportation

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
School Physical Activity	• Increases opportunities for physical activity in the school environment. • Includes adding new PE classes, lengthening existing PE classes or increasing time spent on moderate to vigorous physical activity (MVPA) during PE class. • Recommended physical education program structure includes: instruction periods totaling 150 minutes per week (elementary) and 225 minutes per week (middle and high school); sequential curriculum of progressively more advanced skills and movement; qualified physical education teachers providing a developmentally appropriate program; teacher/student ratio in physical education no greater than 1:25 (elementary) and 1:30 (middle/high) for optimal instruction (similar to other classroom settings); full inclusion of all students, including those who are not athletically gifted, and appropriate activities for children with disabilities; physical activity should never be used as punishment.	• Education • Health • Legislative

Examples of Programs and Practices	Potential Outcomes
Statewide built environment policies include: • 2009 Colorado Department of Transportation Bicycle and Pedestrian Policy • 2009 North Carolina Department of Transportation Complete Streets Policy • 2004 Virginia Department of Transportation Policy for Integrating Bicycle and Pedestrian Accommodations	• Increase in safety of street crossings; improve aesthetics; addition of traffic calming measures; improve street lighting and sidewalk continuity. • Change in physical activity with a median increase of 35 percent (range: 16 to 62 percent). • Increase in meeting the Surgeon General's recommendations for minimum daily exercise (nearly one-third of transit users meet the Surgeon General's recommendations for minimum daily exercise through their daily travels).

Examples of Programs and Practices	Potential Outcomes
Physical education policies include: • 2007 Arkansas House Bill 1039 • 2008 Oklahoma House Bill 1186 • 2007 Florida House Bill 967	• Improvement in academic performance. • Improvement in cognitive performance and classroom behavior. • Increase in the amount of PE class time spent on moderate to vigorous physical activity (MVPA) was 50 percent (range: 6 to 125 percent). • A median increase of 8 percent in aerobic capacity and improvements in physical fitness.

PROMISING POLICY OPTIONS

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
Medical Home	• Provides family-centered care coordination in communities for health and education services. • Addresses preventative, acute and chronic care from birth through transition to adulthood. • Incentivizes quality improvement processes to reduce redundancy in testing, referral and procedures, resulting in increased efficiency and effectiveness of services that can lead to enhanced reimbursement tied to medical home services.	• Business • Health • Insurance • Legislative

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
Comprehensive Centralized Referral System	• Builds on existing infrastructure at the state level and involves partnerships with state and community agencies. • Develops formal or informal partnerships with Medicaid and care coordination organizations with funding from both private and public sectors. • Includes systematic process for tracking service gaps and other barriers to health care access so stakeholders can address them. • Provides flexibility allowing individual communities or practices to provide input, design or modify methods to best meet the needs of families. For instance, one model coordinates care primarily through telephone contact and home visits, while another model uses parents with CYSHCN as clinic care coordinators.	• Health • Insurance • Legislative

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Examples of Programs and Practices	Potential Outcomes
Models of Medical Home (MH) care coordination include: • Palmetto Pediatrics South Carolina's State Medical Home Team Project • Colorado Children's Healthcare Access Program (CCHAP) • Michigan's Children's Healthcare Access Program	• CYSHCN receiving care in a MH experience better outcomes than children receiving care in non-MH settings as providers are more knowledgeable about issues and available services for CYSHCN. • Positive results include family centeredness, effectiveness, timeliness, education in managing conditions, improved communication with providers, and improved family functioning. • Decrease in costs due to a reduction in emergency department visits, fewer hospitalizations and an increase in preventive health care visits.

Examples of Programs and Practices	Potential Outcomes
Diverse centralized referral system models include: • Iowa's First Five Initiative • Connecticut's Help Me Grow Program • North Carolina's Assuring Better Child Health and Development (ABCD) Program • Rhode Island's Pediatric Practice Enhancement Project (PPEP)	• Patient-centered care as a result of a provider resource helpline staffed by a family member of a person with special needs. • Improving parents' understanding of the health care delivery system and the available community resources helps increase the ease for parents to use services. • In North Carolina, children from birth to age 3 receiving early intervention services increased from 3 percent in 2003 to 4.3 percent in 2008. The number of developmental screenings completed at Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program visits quintupled from 2004 to 2008. • In Connecticut in 2008–2009, coordinators made over 4,000 referrals on behalf of children and families which resulted in 88 percent of service needs being addressed, an increase from 80 percent reported in the previous year. • A three-year evaluation of Rhode Island's PPEP suggests an increased use of outpatient primary and preventive care and a decreased use of more costly inpatient services.

PROMISING POLICY OPTIONS

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CONTINUED)		
Policy Option	**What Does This Policy Do?**	**What Sectors May It Involve?**
Transition and Supported Employment	• Provides youth with transition and supported employment opportunities to facilitate the development of skills that improve opportunities for success in school and society. • Provides mentoring and support that can include specially trained peer-navigators. • Provides professional development to increase knowledge, skills, and abilities to assist CYSHCN and their families in planning for adult life.	• Business • Education • Legislative • Social Service

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
Adequate Family Leave Policies in the Workplace	• Helps employees balance work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons while protecting their jobs and health benefits.	• Business • Insurance • Legislative

Examples of Programs and Practices	Potential Outcomes
Programs to assist youth with disabilities with transitioning to living and working in the most integrated settings include: • Oregon's Competitive Employment Project • Vermont JOBS (Jump on Board for Success) • New York's Most Integrated Setting Coordinating Council (MISCC) established in policy in 2002 • Minnesota Project C3: Connecting Youth to Communities and Careers • Rhode Island's Peer-Assisted Health Initiative	• Early work experiences have been recognized as a means to equip youth with disabilities with the skills, attitudes, opportunities and aspirations needed to transition successfully to meaningful careers after high school. • Promotes independence and economic self-sufficiency for youth with special health care needs.

Examples of Programs and Practices	Potential Outcomes
• Financial supports include Family and Medical Leave Act (FMLA) programs in California, New Jersey and Washington.	• Job protections and removing barriers to FMLA benefit families and CYSHCN. • Parents felt that taking leave had good effects on their child's physical and emotional health. • Program models and benefits under FMLA vary by state. For instance, California has the first government-mandated paid leave program in the United States that allows families to take leave at 55 percent of their salary.

PROMISING POLICY OPTIONS

CHILDREN AND POVERTY

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
Comprehensive Early Childhood Education and Assistance Services	• Provides comprehensive early childhood education and assistance services for 3- and 4-year-olds whose parents lack schooling and skilled jobs. • Services include: state-certified preschool teacher and assistant teacher per class; small class sizes and high adult-to-child ratios; staff trained in validated child development education model; frequent interaction and outreach to parents by staff (for example, weekly home visits). • Types of programs: school-based and community-based. Some programs also include a parent self-sufficiency component, which in several states has shown to lead to increased family income and/or parent employment status.	• Education • Legislative • Social Service

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
Education/Job Skills Training	• Provides assistance to low-income parents who decide to pursue education at a university, community or technical college. • Utilizes a partnership between the state social services department, universities and community and technical colleges. • Services include: tuition assistance; case management; aggressive advising and career counseling; and access to support services such as child care, transportation reimbursement, car repair assistance, eye and dental care and books and supplies, as well as on-campus mentors and services. • Types of programs: university-based and community or technical college-based. Some programs include a private or public sector work experience component for participants.	• Business • Education • Legislative • Social Service

Examples of Programs and Practices	Potential Outcomes
Comprehensive early childhood programs include: • Washington's Early Childhood Education and Assistance Program • Illinois' Early Childhood Prevention Initiative Program • Chicago's Parent-Child Centers • A variety of state and local programs that use the Perry Preschool Program curriculum	• An increase in economic self-sufficiency, initially for the parent and later for the child, through greater labor force participation, higher income and lower welfare usage. For example, in the Perry Preschool program, children's earnings when they reached age 27 were 60 percent higher among program participant. • Improvement in educational outcomes for the child. • Improvement in health-related indicators, such as child abuse, maternal reproductive health and maternal substance abuse. • Gains in emotional/cognitive development for the child, and improved parent-child relationships. • Reduced levels of criminal activity. *All results listed are statistically significant differences compared to control groups across nine different early childhood education and assistance programs reviewed by the RAND Corporation.*

Examples of Programs and Practices	Potential Outcomes

Statewide education and job skills training programs include:
• Maine's Parents as Scholars Program (PaS)
• Kentucky's Ready-to-Work (RTW) Initiative
• Arkansas' Career Pathways Initiative
	• An analysis of the labor market returns for postsecondary education found:
	  • Women with associate degrees earn between 19–23 percent more than other women, even after controlling for differences in who enrolls in college.
	  • Women who obtained a bachelor's degree earned 28–33 percent more than women who did not obtain a bachelor's degree.
	• Other studies have found that each year of postsecondary education increases earnings by 6–12 percent.
	• Studies that have tracked welfare recipients who completed two- or four-year degrees have found that about 90 percent of these graduates leave welfare and earn far more than other recipients.

PROMISING POLICY OPTIONS

CHILDREN AND POVERTY (CONTINUED)		
Policy Option	**What Does This Policy Do?**	**What Sectors May It Involve?**
Earned Income Tax Credit (EITC)	• Largest cash assistance program targeted at low-income families. • Provides a subsidy for low-income working families and is fully refundable — any excess beyond a family's income tax liability is paid as a tax refund. • Encourages low-income workers and offsets the burden of U.S. payroll taxes. • State plans generally mimic the federal structure on a smaller scale, with individuals receiving a state credit equal to a fixed percentage of what they are eligible to receive from the federal credit. • Some state and community agencies perform outreach and application-assistance activities to help families receive the credit. • Twenty-three states and the District of Columbia had their own EITCs in 2008.	• Legislative
Policy Option	**What Does This Policy Do?**	**What Sectors May It Involve?**
Asset Building	• Provides special savings accounts called individual development accounts (IDA) designed to help people build assets to reach life goals and to achieve long-term financial security. • Services: matching funds provided by state and/or business for IDAs; participants may also receive financial education or financial literacy classes; some programs provide "seed" money in the account. • Types of programs: targeted to parents; targeted to children for future education; some programs are connected with Earned Income Tax Credit (EITC) programs.	• Business • Education • Legislative

Examples of Programs and Practices	Potential Outcomes
Refundable state EITCs range between 10 to 30 percent in states such as Massachusetts, Michigan, New Jersey and New Mexico.	• The EITC is the largest cash assistance program targeted at low-income families. • Nationwide last year, over 24 million people received nearly $50 billion in EITC. • Participation rate in the EITC program is higher than the participation rate for either the Temporary Assistance to Needy Families program or the food stamps program. • Five million people, half of them children, are lifted out of poverty each year due to EITC. • The ratio of cost of administering the EITC program to the claims paid is less than one percent. • Without the EITC, the poverty rate among children would be nearly one-third higher, according to the Center on Budget and Policy Priorities.

Examples of Programs and Practices	Potential Outcomes
Large-scale individual development account (IDA) and financial literacy programs include: • Missouri's I Can Save (ICS) • The Community Action Project of Tulsa • Michigan's Individual Development Account (IDA) Partnership • The Mid-South IDA Initiative (Arkansas, Louisiana, Mississippi, Southeast Texas)	IDA programs resulted in: • Sixty-two percent of program participants said they saved a regular amount during IDA program participation, compared with 11 percent saving a regular amount before participation. • Four percent of program participants said they did not save during program participation, while 42 percent of program participants said they did not save at all before the program. IDA and financial literacy programs that specifically targeted asset-building for children resulted in: • Participants accumulated over $1.6 million through a combination of initial deposits, benchmark incentive deposits, participant savings and matches. • On average, each child has about $1,318 "seeded" as an investment for the future.

PROMISING POLICY OPTIONS

ADOLESCENT RISK BEHAVIORS

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
After-School Program(s)	• Offered to children between the ages of 5 and 18, operates during at least part of the school year (i.e., September to June) and occurs outside of normal school hours, which are typically 8 a.m. to 2:30 p.m., Monday through Friday. • Provides support to young people through professionally supported, carefully matched, one-on-one relationships with caring adults. • Mentors must commit to spending substantial time with their mentees.	• Business • Education • Legislative

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
Alcohol Advertising	• Bans ads on buses, trains, kiosks, billboards and supermarket carts, and in bus shelters, schools, theme parks and near residential areas and faith organizations. • Bans or limits advertising and sponsorship at community events such as festivals, parties and sporting events. • Restricts or bans TV, radio, newspaper and internet alcohol advertising. • Counters alcohol ads with public service announcements. • Restricts the size and placement of window advertisements in liquor and convenience stores. • Reduces the disproportionately high number of alcohol billboards in low-income neighborhoods. • Prohibits images and statements that portray or encourage intoxication. • Enforces existing restrictions on alcohol advertising.	• Business • Education • Legislative • Media

Examples of Programs and Practices	Potential Outcomes
Mentoring/tutoring after-school partnerships include: • Nationwide Big Brothers Big Sisters programs	• Decreases the likelihood of initiating alcohol use by 27 percent for program participants. • Reduces the likelihood of initiating drug use by 46–70 percent for racial minorities. • Increases school attendance, feelings of academic competence and course grades. • Behavioral changes are especially pronounced among females of color.

Examples of Programs and Practices	Potential Outcomes
• States with at least four of the 12 recommended "best practice" laws include New Hampshire, North Carolina, Utah and Virginia.	• Exposure to alcohol advertising during very early adolescence predicts both beer drinking and drinking intentions one year later. • Children at extremely high levels of overall advertising exposure are 50 percent more likely to drink and 36 percent more likely to intend to drink than their peers at low levels of advertising exposure. • The odds of drinking were nearly double for adolescents who reported owning a promotional item from an alcohol distributor.

PROMISING POLICY OPTIONS

ADOLESCENT RISK BEHAVIORS (CONTINUED)		
Policy Option	**What Does This Policy Do?**	**What Sectors May It Involve?**
Alcohol Excise Tax(es)	• Tax is based on the type of alcoholic beverage: spirits, wine or beer. • Every state taxes the sale of alcoholic beverages in one of two ways: either the quantity of beverage sold (most states) or the percentage of the selling price (a few states). • Average national excise taxes (February 2010): beer — $0.28 per gallon; spirits — $2.57 per gallon; wine — $0.72 per gallon. • Kansas' alcohol excise taxes (February 2010): beer — $0.18 per gallon (ranks 18th nationally); spirits — $2.50 per gallon (ranks 39th nationally); wine — $0.30 per gallon (ranks 39th nationally).	• Business • Legislative

Examples of Programs and Practices	Potential Outcomes
Substantial increases of state-level excise taxes on alcohol include: • New York's 25.0 percent tax increase on spirits and wine in 2009. • New Jersey's 58.7 percent tax increase on beer and wine in 2009.	• A 10 percent rise in the price of beer would reduce demand among adolescents by about 3 percent. • If beer prices were indexed to inflation, overall youth drinking would drop by 9 percent and heavy drinking by 20 percent. • A 10 percent price increase would reduce underage drunk-driving rates by 12.6 percent for males and by 21.1 percent for females. It would also reduce youth motor vehicle fatalities by 7–17 percent. • A 10 percent increase in price would increase graduation rates by 3 percent. • An additional $1 tax on each case of beer would increase the probability of a high school student's future college graduation by 6.3 percent.

PROMISING POLICY OPTIONS

ACCESS TO QUALITY CHILD CARE SERVICES		
Policy Option	**What Does This Policy Do?**	**What Sectors May It Involve?**
Child Care Quality Standards	• Assesses quality of child care centers by evaluating basic criteria including quality standards, accountability measures, program support such as provider training and technical assistance, financial support and parent education outreach. • Objective is to set standards by which to measure the quality of child care, especially for children receiving child care subsidies, by designating a quality rating for each program and increasing consumer awareness about which programs meet quality standards. • Twenty states have Quality Rating and Improvement System (QRIS) programs.	• Business • Education • Legislative

Policy Option	What Does This Policy Do?	What Sectors May It Involve?
Early Education Programs	• Includes the following components: advanced educational requirements for program directors and teachers; emphasis on early childhood development principles; small class size; research-based curriculum; engaged families; and focus on the whole child, including intellectual, physical and social development. • Most effective programs are child care center-based and offer an age-appropriate, socially and educationally stimulating curriculum.	• Education • Legislative

ACCESS TO QUALITY CHILD CARE SERVICES

Examples of Programs and Practices	Potential Outcomes

Statewide Quality Rating and Improvement System (QRS or QRIS) programs include:
• Reaching for the Stars program in Oklahoma
• Washington, DC's Going for the Gold Program
• Pennsylvania's Keystone STARS Quality Rating System
• Colorado's Qualistar Early Learning QRIS
	• Most research and evaluation of QRIS programs focus on program implementation and not on program impact.
	• Results from evaluations of program implementation and validation of quality measures:
	  • QRIS rating levels were designed to capture differences in quality. After implementation, differences were seen among programs that had different quality ratings assigned to them.
	• Results from evaluations of quality improvement:
	  • In participating programs, program quality improved over time; although changes were not statistically significant in all studies.

Examples of Programs and Practices	Potential Outcomes
Early childhood education programs include: • Oklahoma's Universal Pre-K Program • Illinois' Pre-Kindergarten Program • Michigan School Readiness Program • Washington's Early Childhood Education and Assistance Program	• Children have better school readiness skills. • Long term benefits including higher graduation rates, fewer school drop outs, less need for special education, and less crime. • Every dollar invested in quality early care and education saves taxpayers up to $13.00 in future costs such as public education, criminal justice and welfare costs.

PROMISING POLICY OPTIONS

ACCESS TO QUALITY CHILD CARE SERVICES (CONTINUED)		
Policy Option	**What Does This Policy Do?**	**What Sectors May It Involve?**
Workplace Support for Employees with Children	Supports working parents through various programs that include: • Flexible work schedules (modified workday start and end times); • Job sharing (part-time job shared with another employee, that is equal to the work of a single full-time employee); • Sick child leave as a valid use of employee leave time; • Condensed work weeks (e.g. four days working ten hours each day instead of five days working eight hour days); • Telecommuting all or part of the week (working from home or satellite office location); • Child care subsidies (all or part of child care cost supplemented by company, based on need and/or merit); • On-site or nearby company-sponsored child care.	• Business • Legislative • Urban Design and Community Planning

ACCESS TO QUALITY CHILD CARE SERVICES

Examples of Programs and Practices	Potential Outcomes
Family-friendly workplace policies at major corporations include: Hallmark Cards, Xerox, General Mills and First National Bank. State-level initiatives, such as Oregon's Family Friendly Policies, have been implemented in state government departments.	• Decreases in employee turnover, resulting in lower training and recruiting costs over time. • Decreases absenteeism attributed to child illness or lack of available child care. • Increases job satisfaction among workers and improves employee morale.

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