City of Madison
NOTICE OF POSSIBLE QUORUM
COMMON COUNCIL

City of Madison
Madison, WI 53703
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Child Poverty Presentation by Dr. Bernard Dreyer

Wednesday, October 9, 2013
7:00 p.m.
Room 201, City-County Building
210 Martin Luther King Jr. Boulevard

If you need an interpreter, translator, materials in alternate formats or other accommodations to access this service, activity or program, please call the phone number below at least three business days prior to the meeting.

Si necesita un intérprete, un traductor, materiales en formatos alternativos u otros arreglos para acceder a este servicio, actividad o programa, comuníquese al número de teléfono que figura a continuación tres días hábiles como mínimo antes de la reunión.

Yog hais tias koj xav tau ib tug neeg txhais lus, ib tug neeg txhais ntawv, cov ntawv ua lwm hom ntawv los sis lwm cov kev pab kom siv tau cov kev pab, cov kev ua ub no (activity) los sis qhov kev pab cuam, thov hu rau tus xov tooj hauv qab yam tsawg peb hnub ua hauj lwm ua ntej yuav tuaj sib tham.

For more information contact: Karin Thurlow-Peterson, Dane County Board Office, (608) 266-4531

The Dane County Poverty Commission will host a presentation by Dr. Bernard Dreyer of NYU School of Medicine regarding child poverty. The presentation will be at 7 p.m. on Wednesday, October 9, 2013 in Room 201 of the City County Building.

The Academic Pediatric Association and the American Academy of Pediatrics are focusing on Child Poverty as a key issue in the coming year. Dr. Dreyer will be speaking a number of times to a variety of audiences, including the legislature (via the Evidence-Based Health Policy program), child care providers, medical students, and others. This is an opportunity for members of the County Board, the City Council, and others to hear him speak.

Ken Taylor, director of the Wisconsin Council on Children and Families, has shared a couple articles as background and they are attached. Please spread the word about this opportunity!

Please note that a **possible quorum** exists of members
of the **Common Council** at this presentation

APA TASK FORCE ON CHILDHOOD POVERTY

4/30/2013

A Strategic Road-Map: Committed to Bringing the Voice of Pediatricians to the Most Important Problem Facing Children in the US Today

The Academic Pediatric Association (APA) and the American Academy of Pediatrics (AAP) have both made reducing childhood poverty in the US and alleviating the effects of poverty on child health and well-being a strategic priority.

APA Task force on Childhood Poverty

A STRATEGIC ROAD-MAP

SCOPE OF THE PROBLEM

One in five children lives below the federal poverty level (FPL) in the United States and almost one in two are poor or near poor. Children are the poorest members of our society, a society that knows how to use policies and programs to raise its citizens out of poverty. Thirty-five percent of seniors lived below the FPL in 1959, but due to programs like social security expansion and Medicare, only 9% of seniors are poor today. What the US does for seniors is clearly good; so why do we not also protect children from the life-altering effects of poverty?

The effects of poverty on children's health and well-being are well documented. Poor children have increased infant mortality, higher rates of low birth weight and subsequent health and developmental problems, increased frequency and severity of chronic diseases such as asthma, greater food insecurity with poorer nutrition and growth, poorer access to quality health care, increased unintentional injury and mortality, poorer oral health, lower immunization rates, and increased rates of obesity and its complications. There is also increasing evidence that poverty in childhood creates a significant health burden in adulthood that is independent of adult-level risk factors and is associated with low birth weight and increased exposure to toxic stress (causing structural alterations in the brain, long-term epigenetic changes, and increased inflammatory markers).

The consequences of poverty for child and adolescent well-being are perhaps even more critical than those for health. These are the consequences that may change their life trajectories, lead to unproductive adult lives, and trap them in intergenerational poverty. Children growing up in poverty have poorer educational outcomes with poor academic achievement and lower rates of high school graduation; they have less positive social and emotional development which, in turn, often leads to life "trajectory altering events" such as early unprotected sex with increased teen pregnancy, drug and alcohol abuse, and increased criminal behavior as adolescents and adults; and they are more likely to be poor adults with low productivity and low earnings.

At present, there is not a consistent and unified pediatric voice speaking out about childhood poverty, the most important problem facing children in the United States today. The Academic Pediatric Association (APA), the American Academy of Pediatrics (AAP) and the Pediatric Policy Council (PPC) all advocate for individual issues (such as Medicaid, Child Health Plus, and food supplementation) that are important programs related to childhood poverty. There is, however, no sustained focus on childhood poverty itself, which underlies many of the ills of children, and which needs to be addressed in a comprehensive manner.

GUIDING PRINCIPLES

Therefore, the APA Task Force on Childhood Poverty has as its mission to pursue an agenda to address childhood poverty. The Task Force has these guiding principles:

- Pediatricians are among the most trusted experts on children's health and safety, which makes us potentially powerful advocates for the most vulnerable children and families.

- Pediatricians, child health nurses and early childhood educators have extensive contact with children before age three, prior to preschool, and therefore, have the opportunity to work with children and their families to maximize health and development during this critical period.

- We will focus on both lifting children out of poverty and alleviating the effects of poverty on children.

- Poor children live in poor families. Any solutions to childhood poverty will focus on family poverty and the factors that strengthen the resiliency of families living in poverty.

- Childhood poverty is not without solutions. Other developed countries, including the United Kingdom, have devised long-term national efforts to dramatically decrease childhood poverty and have succeeded. Where there is a serious public intention and effort to tackle childhood poverty, substantial reductions can in fact be achieved. We will treat childhood poverty as an issue with a pathway to resolution and focus on specific policies, programs and actions.

- There are serious inequities in childhood poverty, disproportionately affecting very young children, racial/ethnic minorities, Native Americans, and children in immigrant families. Special attention will be paid to these groups of children, including addressing their cultural and linguistic needs.

- Poor and low-income families are more likely to have children with special health care needs and at the same time have less access to quality health care, and fewer resources to address the health and emotional well-being of their children. The health care delivery system will need to address the special needs of these children and families.

- Childhood poverty is a long-term problem. Despite the urgency, solutions can only be implemented over time. We cannot wait any longer and are beginning a long-term effort to address poverty in children. Any solutions that are found will also need to be sustained and protected from retrenchment.

- Key indicators of child health and well-being should be monitored systematically. Analysis of existing data sources (such as US Census data, the National Survey of Children's Health, UNICEF Reports on Child Well-Being internationally) at both the national and state levels will need to be performed and publicized. New methods of collection or collation of key data will be considered. Data regarding social determinants of health in addition to income level (e.g., discrimination, education, marital status, place of residence, crowding conditions, the built environment, adequate nutrition, access to quality health care, insurance status) needs to be consistently and systematically collected by our health care system and as part of national datasets.

- Neighborhood characteristics (such as poverty, crime, residential turnover, availability of quality child and family institutions, poor social control and interaction, negative normative expectations, and low employment and marriage rates) all have negative impacts on poor children's health and well-being. Model "place-based" programs to address these issues should be explored.

- We plan to communicate the issues of childhood poverty with effective and coherent messaging and with terminology that doesn't "trigger" partisan and non-productive responses. We will frame these issues in ways that appeal, as much as possible, across the political spectrum. We will endeavor to collaborate with business and social science professionals skilled in messaging. This is not about "welfare" but about the future of our country. This is about half the children in the US, everyone's children. Child well-being is a public good that benefits us all.

- The APA Standing Committees (Public Policy and Advocacy, Health Care Delivery, Education, and Research), Regions and Special Interest Groups will be involved in the efforts of the Task Force. AAP Councils, Committees and Initiatives, such as the Council on Community Pediatrics, the Committee on Psychosocial Aspects of Child and Family Health, the Committee on Early Childhood, the Committee on Pediatric Research, and the Early Brain and Child Development Initiative, will also be involved.

- We intend both to lead and to collaborate. We want especially to collaborate with all other pediatric organizations (including the AAP and the other members of the PPC, as well as the National Medical Association and the National Hispanic Medical Association), with university-based institutes on poverty, with our colleagues in economics and social sciences, with non-profit organizations advocating for poor children and families, and with private corporations and public agencies. The AAP has recently made "Child Health and Poverty" a strategic agenda plank and we intend to closely align the efforts of both organizations.

A STRATEGIC ROAD-MAP

The Task Force will focus on specific strategies involving public policy and advocacy, health care delivery, medical education, and research. These strategic priorities are a first step in a "war on childhood poverty".

Public Policy and Advocacy

In addition to existing, ongoing policy and advocacy activities (such as support for Medicaid and CHIP), the Task Force will focus on four strategic priorities:

1. **Raising families out of poverty**: Scientific evidence shows that income matters. We support making work pay through raising the minimum wage so that families with at least one full-time wage-earner will no longer live below the FPL, through improvements in the Child Tax Credit to make it refundable to poor families, especially those with the youngest children, and by further strengthening the Earned Income Tax Credit, which provides more targeted benefits to poor families. We also support strengthening and improving access to Temporary Assistance for Needy Families to better help parents receive benefits and find and keep jobs. Efforts will be needed at both the federal and state levels.

2. **Providing high quality early childhood programs and high quality affordable child care to poor families:** The clearest evidence for interventions that alleviate the effects of poverty on children and give them a chance at productive lives is in early childhood. We support free high quality pre-Kindergarten for all 3- and 4-year-old poor and near poor children; improving and expanding Head Start and Early Head Start, as well as other innovative models starting at birth; evidence-based home visiting programs for all poor children; and evidence-based interventions in pediatric primary care. We also support high quality affordable child care. Availability of high quality affordable child care will improve early childhood development, decrease the significant economic burden of child care on poor families (thus decreasing poverty), and allow parents to work (further decreasing poverty). One tool to make child care affordable is to modify the Child and Dependent Care Tax Credit by substantially raising reimbursements of qualifying child care expenses for poor families. Increasing the availability of high quality child care to poor families will require working with Congress, federal agencies such as the DHHS Administration for Children and Families, and state legislatures and agencies regarding local funding and implementation.

3. **Promoting a White House Conference on Children and Youth:** From 1909 to 1970, seven White House Conferences on Children and Youth, roughly every ten years, took place in Washington, D.C. There has not been a Conference since 1970. These Conferences were devoted to improving the lives of children across the nation. They were one or two-year long endeavors, involving the executive branch, Congress, voluntary agencies and state level activities. They produced many important outcomes, including a commitment to ending the institutionalization of dependent children, ending child labor, the first significant report on child health and welfare standards, the creation of the US Children's Bureau (now part of the DHHS Administration for Children and Families), the development of a national Children's Charter, funding for maternal and child health programs, improvements in education, and legitimacy given to the benefits of creative freedom and healthy personality development on children's well-being. Legislation to convene a new White House Conference on Children and Youth has been promoted in Congress, and non-profit advocacy groups have focused on getting support from the White

House. The time has come to refocus the nation on the needs of children and develop a vision for the welfare of children and youth in the 21st Century.

4. **Neighborhood Revitalization Initiatives ("place-based" initiatives):** The White House has committed the federal government to develop effective initiatives to improve neighborhoods, including: improving school quality and access to high-quality early childhood care; improving the built environment with better streetscapes, more fresh food stores and better transportation; providing more local job training; and increasing funding to address crime. We have great experience in partnering with families and communities though decades of experience in community pediatrics and community-based participatory research. We plan to work with the Department of Health and Human Services (especially MCHB and ACF), the Department of Education, and the Department of Justice to bring pediatric expertise to these initiatives.

Health Care Delivery

The Task Force will work, in collaboration with the AAP, to support pediatric practitioners in their efforts to care for children in poor and near poor families. These efforts will include:

1. Developing elements of a Patient-Centered Medical Home for Children (PCMHC) that addresses the needs of poor and near-poor families
    a. Identification of children living in poor and near poor families and determination of the specific needs of those children and families
    b. Systems that facilitate connecting families with community and government resources and benefits, including maximizing utilization of the ACA home visiting programs.
    c. Establishment of appropriate roles within the health care team for the above activities
    d. Screening and evaluation for speech and language, school function, child mental health, maternal depression, and parental adverse childhood events.
    e. Evidence-based, primary care program located strategies that disproportionately help children in poor families, e.g.:
        i. Reach Out and Read
        ii. Other parenting strategies in primary care
        iii. Obesity reduction programs
        iv. Medical-Legal Partnerships
        v. Health Leads
2. Support for the development of payment systems and structures to support pediatric practices that devote time and resources to reducing the negative impacts of poverty on populations they serve.
    a. Identification of resources for care coordination
    b. Meaningful linkages with community resources
3. Adapting health care systems to address the specific challenges faced for poor and low-income families with children with special health care needs.
    a. Coordination with services provided by child care, schools, Title V, housing, nutrition and other publicly-funded agencies
    b. Work within systems to provide new services identified in ACA (e.g., ABA-therapies for children with ASD)
4. Support for the developmental of collocation programs including two generation programs for mothers and children, and collocation of behavioral health programs with medical programs.

5. Enhancements to Bright Futures: Integrating the issues of poor families more strongly into Bright Futures with appropriate screening tools and tool-kits that help practitioners:
    a. Identify needs of poor and near-poor families
    b. Identify community and government resources for those children and families
    c. Assist families in accessing those resources
6. Developing non-partisan programs to encourage families to vote on children's issues.
7. Establishing a framework for evaluation of the impact of the expanded PCMHC upon child and family well-being.

Education

The Task Force has set up a subcommittee to develop educational products and activities regarding childhood poverty for medical students, residents, fellows, faculty, practitioners, and other child health providers. These efforts will promote:

1. Understanding the impact of poverty and other social determinants of health on well-being over the life course and across generations.
2. Development of the knowledge, skills, and attitudes necessary to implement the elements of the PCMHC.
3. Advocacy training toward poverty reduction in conjunction with the AAP Community Training and Advocacy Initiative (CPTI), and models of advocacy training from residency training programs across the US. We will work to build statewide and regional collaboratives uniting the pediatric voice across the nearly 200 pediatric training programs in the US. Collaboration with other organizations offering advocacy training may also be important, including efforts of the American Academy of Family Physicians, the American Medical Student Association, Physicians for a National Health Program, and others.

Research

The Task Force will work with the APA Research Committee and the AAP Committee on Pediatric Research to create a research agenda to develop better evidence regarding childhood poverty, especially the effectiveness and implementation of policies and programs to improve the health and well-being of poor children. While we will await the deliberations of these committees for a thoughtful and detailed agenda, areas of focus may include:

1. Continued research into early brain development and the effect of toxic stress on adaptive self-regulation, executive functioning, social-emotional and cognitive development, and resiliency. In addition, further research on the impact of epigenetics on brain functioning and its relationship to toxic stressors in poverty
2. Further research on developing the evidence base for interventions
3. Further research to determine how policies, programs and other interventions lift children out of poverty and how they alleviate the effects of poverty on children: filling in the gaps of previous research.
4. Taking evidence-based practice to scale (implementation and dissemination)
5. Community-based participatory research
6. Development of valid and reliable measures of important outcomes and determinants related to childhood poverty.
7. A life course approach to research on childhood poverty.

MAY 13, 2013, 5:03 PM

Poverty as a Childhood Disease

By PERRI KLASS, M.D.

Poverty is an exam room familiar. From Bellevue Hospital in New York to the neighborhood health center in Boston where I used to work, poverty has filtered through many of my interactions with parents and their children.

I ask about sleeping arrangements. Mother, father, older child and new baby live in one bedroom that they're renting in an apartment, worrying that if the baby cries too much, they'll be asked to leave.

I encourage an overweight 9-year-old who loves karate, and his mother says, "We had to stop; too expensive." I talk to a new mother who is going back to work too soon, leaving her baby with the cheapest sitter she can find.

Is your housing situation secure? Can you afford groceries? Do you go with the cheapest fast food? Can you get the prescription filled? Raising children in poverty means that everything is more complicated.

Me, I'm one generation out. My mother will tell you about her Depression childhood, the social worker who checked the family's pots to see whether they were secretly able to afford meat, the landlord who put the furniture out on the street. It wasn't character-building or noble, she says. It was soul-destroying, grinding and cruel.

And it's even crueller, now that social mobility has decreased and children who grow up poor are more likely to stay poor.

At the annual meeting of the Pediatric Academic Societies last week, there was a new call for pediatricians to address childhood poverty as a national problem, rather than wrestling with its consequences case by case in the exam room.

Poverty damages children's dispositions and blunts their brains. We've seen articles about the language deficit in poorer homes and the gaps in school achievement. These remind us that — more so than in my mother's generation — poverty in this country is now likely to define many children's life trajectories in the harshest terms: poor academic achievement, high dropout rates, and health problems from obesity and diabetes to heart disease, substance abuse and mental illness.

Recently, there has been a lot of focus on the idea of toxic stress, in which a young child's body and brain may be damaged by too much exposure to so-called stress hormones, like cortisol and norepinephrine. When this level of stress is experienced at an early age, and

without sufficient protection, it may actually reset the neurological and hormonal systems, permanently affecting children's brains and even, we are learning, their genes.

Toxic stress is the heavy hand of early poverty, scripting a child's life not in the Horatio Alger scenario of determination and drive, but in the patterns of disappointment and deprivation that shape a life of limitations.

At the meeting, my colleague Dr. Benard P. Dreyer, professor of pediatrics at New York University and a past president of the Academic Pediatric Association, called on pediatricians to take on poverty as a serious underlying threat to children's health. He was prompted, he told me later, by the widening disparities between rich and poor, and the gathering weight of evidence about the importance of early childhood, and the ways that deprivation and stress in the early years of life can reduce the chances of educational and life success.

"After the first three, four, five years of life, if you have neglected that child's brain development, you can't go back," he said. In the middle of the 20th century, our society made a decision to take care of the elderly, once the poorest demographic group in the United States. Now, with Medicare and Social Security, only 9 percent of older people live in poverty. Children are now our poorest group, with almost 25 percent of children under 5 living below the federal poverty level.

When Tony Blair became prime minister of Britain, amid growing socioeconomic disparities, he made it a national goal to cut child poverty in half in 10 years. It took a coalition of political support and a combination of measures that increased income, especially in families with young children (minimum wage, paid maternity and paternity leaves, tax credits), and better services — especially universal preschool programs. By 2010, reducing child poverty had become a goal across the British political spectrum, and child poverty had fallen to 10.6 percent of children below the absolute poverty line (similar to the measure used in the United States), down from 26.1 percent in 1999.

"Poor families who benefited from the reform were able to spend more money on items for children: books and toys, children's clothing and footwear, fresh fruits and vegetables," said Jane Waldfogel, a professor of social work at Columbia who has studied the British war on childhood poverty.

Dr. Dreyer said: "Income matters. You get people above the poverty level, and they actually are better parents. It's critical to get people out of poverty, but in addition our focus has to be on also giving families supports for other aspects of their lives — parenting, interventions in primary care, universal preschool."

At the Pediatric Academic Societies meeting, the most unexpected speaker — to a room full of pediatricians — was Robert H. Dugger, managing partner of Hanover Investment Group, who made the economic case for investing in young children. "History shows that productivity increases when people are able to access their rights to life, liberty and the

pursuit of happiness," Mr. Dugger told me. "There is no economic recovery strategy stronger than committing to early childhood and K-through-12 investment."

Think for a moment of poverty as a disease, thwarting growth and development, robbing children of the healthy, happy futures they might otherwise expect. In the exam room, we try to mitigate the pain and suffering that are its pernicious symptoms. But our patients' well-being depends on more, on public health measures and prevention that lift the darkness so all children can grow toward the light.

This post has been revised to reflect the following correction:

Correction: May 17, 2013

The 18 and Under column on Tuesday, about the lasting effects of living in poverty in early childhood, misstated the academic position held by Jane Waldfogel, who has studied British efforts to reduce the rate of childhood poverty. Dr. Waldfogel is a professor of social work at Columbia University, not a sociologist there.