

**AMCHP Conference 2009**

**A Vision for Transforming our Public Health and Healthcare System  
to Better Serve America's Women, Children, and Families**

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NAN STREETER: I think that the message of change certainly rang throughout the president's campaign, and it certainly continues today. But as we all know, there are many challenges ahead of us. And change can be very good, but sometimes it brings some bad things, but not always.

So I think that the message of change is something that we have to think about as Title V directors and affiliated organizations. Is the Title V that we know today going to meet the needs of America in the future, especially with healthcare reform, and what does change mean to the work that we do, and are we ready for the changes that may be coming to Title V? Can we truly reach our vision of healthy children, healthy families, healthy communities without changing?

And as Mike had said, that repeating the same thing over and over again and expecting different results is insanity. We need to move away from those continuing what we've done before.

Joining us to think about what changes may be needed in our child health system is a distinguished panel of experts who spend their time working through the ideas and the options that are shaping the maternal and child health programs of the future. I would like to ask our panelists to join us on the stage, and would invite you to take your seats.

I believe you have seat assignments [Laughter].

Great. Thank you.

Well, moderating our conversation this afternoon is Dr. Ed Schor, vice-president of the Commonwealth Fund, where he leads the fund's child development and preventive care program. Dr. Schor is a pediatrician and has held a number of positions in pediatric practice, academic pediatrics, health services research, and public health. Immediately prior to joining the fund in 2002, Ed was the medical director for the Iowa Department of

Public Health Division of Family and Community Health, and he received the 2006 John C. McQueen award from AMCHP.

Ed, thank you so much for being with us again. It's good to see you. It's been a while.

Also joining us is Dr. Neal Halfon, who is the director of the UCLA Center For Healthier Children, Families & Communities. Dr. Halfon also directs the Child and Family Program at the UCLA School of Public Health and the federally-funded Maternal and Child Health Bureau's National Center For Infancy and Early Childhood Health Policy Research.

Dr. Halfon is a professor of pediatrics in the UCLA School of Medicine and professor of Community Health Sciences in the UCLA School of Public Health, and is the professor of policy studies in the School of Public Health and Social Research. Dr. Halfon will be presenting some of his most recent work developed in conjunction with several of the colleagues that are on the stage with him this afternoon that will, I think, present some exciting and new opportunities to move child health forward.

And, Neal, I don't know if you ever knew this, but I'm a UCLA grad, and proud of it, particularly when they play SC. So anyway, we share that.

Next I would like to introduce Dr. Charles Bruner, who serves as the executive director of the Child and Family Policy Center in Des Moines, Iowa. He holds an M.A. and a Ph.D. in Political Science from Stanford University and received his B.A. from McAllister College. He served 12 years as a state legislator in Iowa. Yay-hoo! Through the Child and Family Policy Center, Charles provides technical assistance to states, communities and foundations on child and family issues, and heads the technical assistance activities of the federally-established National Center for Health -- excuse me, for Service Integration.

And next I would like to introduce Debbie Chang, who is the senior vice-president and executive director of Nemours Health & Prevention Services based in Delaware. Ms. Chang guides the overall strategic efforts of the organization and its work in the Delaware community, representing the organization on Nemours' executive leadership team, and steers policy and advocacy activities at the national level.

Ms. Chang has 17 years of federal and state government experience in public health and enjoys a national reputation in child -- excuse me, child health policy and programs. She was previously the deputy secretary for Healthcare Financing at the Maryland Department of Health, where she oversaw Medicaid SCHP.

Next I would like to introduce Catherine Hess. Many of you more seasoned AMCHPers fondly remember Cathy as the first executive director of AMCHP, and she was in that position for 14 years and led us to a great place over many years, I think, of the evolution of AMCHP as it is today, and we thank her for that.

Cathy joined the National Association -- or, excuse me, National Academy for State Health Policy's Washington, D.C., office in May of 2005. NASHP is a nonpartisan, nonprofit organization that is dedicated to promoting excellence in state health policy and practice through policy analysis and through convening and supporting state policymakers.

As a senior program director, she develops and implements programs in the areas that include high-performance health systems, community health safety nets, and child health coverage, including SCHP and universal children's coverage programs and initiatives. She serves as the co-program director for maximizing enrollment for kids, a national program at the Robert Wood Johnson Foundation. Cathy has nearly 30 years of senior and executive level state and national health policy experience.

Cathy's work has been recognized by numerous awards, including the presentation to her of the Health and Human Services first

Dr. Vince L. Hutchins Partnership Award, which was awarded to Cathy in 2001. I remember that. That was pretty remarkable.

And last but not least is Jeff Lobas. Jeff is the chief medical officer for the Banner Children's Hospital at Banner Desert Medical Center in Mesa, Arizona. This is a new appointment for Jeff. Jeff had served in Iowa as the Children and Youth With Special Healthcare Needs director for 12 years. And, also, I need to note that Dr. Lobas is the immediate past president of AMCHP and led AMCHP through some challenging times.

So all I can say is, wow, talk about a panel of experts for sure, and I'm really looking forward to hearing what you all have to say.

And, Ed, I'm going to turn the mic over to you.

ED SCHOR: Thank you, Nan. And thank all of you. I'm really honored to facilitate this distinguished panel today.

On the trip down here this morning my colleague, Gretchen Hegalow pointed out to me I was supposed to make some opening remarks. At the moment I was reading the today's New York Times where there's a column in there looking at the history of the term "hard times," and it's at least a couple centuries old, but I think the fact that it's not a new concept is probably old news to Title V people. We seem to go through cycles where we have lots of hard times and occasionally rise up to better times, but never the great times I think that we keep hoping for.

You all know that, thinking about child health and maternal health, health in general in this country, this country ranks pretty poorly internationally. We also have huge variability among how well we're doing with various health measures and healthcare systems by state, which I personally see as a travesty. I don't know why it should matter what state you live in to determine what kind of healthcare you have available to you.

There's -- though we've noticed over a couple decades now that the health status of children has seemingly not gotten any better, the social status, according to surveys, has not gotten any better, but the morbidity that children and families are facing seems to have shifted some, particularly for children, where we've gone from decades of infectious diseases where we had a crippled children's program due to polio, where we now have a

children with chronic healthcare problems, just a special needs program, and an increasing recognition that the issues we're dealing with go into the territory of mental health, learning problems, and so on, that certainly our healthcare system is not up to the task currently of addressing effectively, and one of our missions in public health is to help them do that.

But everyone in this audience knows, since this is clearly the choir, that the state of children's health is not directly related to the state of the healthcare system. Many, many more factors affect children's outcomes and well-being and families' outcomes and well-being.

The social determinants that we all are facing and dealing with are extraordinarily powerful, and improving the health and well-being of people in this country is going to take a multisectorial approach, and that's what I think my friend Neal Halfon will be talking about today.

I just want to say, as others have, that we've heard a lot during the campaign about opportunities, about hope, about change. Certainly those of us who have been around a while have actually seen, and if you look back in history you see, that some of the

greatest innovations that we've seen in this country, particularly in terms of social policy, have come out of times like this, have come out of hard times. Innovations in Medicaid have come out of difficult times. Social Security and Medicare have come out of hard times. We're in hard times now, but I guess my advice is let's not waste this crisis, let's take advantage of it.

So it's my pleasure now to introduce my friend and colleague Neal Halfon. Neal, as many of you know, is one of the leading visionaries and thinkers about systems of care for children, a leading person thinking about child health policy in this country. You have in your materials a copy of a paper that Neal and others have worked on how we ought to transform child serving systems in this country to improve outcomes for children and for families as well.

So I'm pleased to introduce to you Neal Halfon.

NEAL HALFON: I needed the clicker.

Good evening, and it's great pleasure to be here, and I want to thank Mike and Nan and AMCHP for inviting me here today.

Part of what I'm going to be talking about also comes out of a project that I'm working on called the Blue Sky Health Initiative, which is a project about reinventing the way that America thinks about and organizes and finances health and the healthcare system. The title of the conference is "Opportunities for a New Era," and what we know is, I think, that MCH is an undervalued asset that is ripe for new investment that can yield big returns at this point.

But that's a big challenge also. It's an opportunity and a big challenge. The Obama administration is making bold attempts to transform public policy and redefine the social contract in America, and we're seeing this take place just in the last couple of weeks, and we know that tomorrow night even more and different and bolder proposals will be put forward.

This administration has identified a number of high priority areas. Health reform is clearly at the top of his list. Child healthcare coverage was a top priority, and at this point they might think that that's mission accomplished. I think we need to return to that.

Prevention is another big issue. HIT, Early Childhood, Promise Neighborhoods all provide incredible opportunities to invest in MCH and advance a transformative agenda. But realizing this potential requires a bold strategy to transform and reposition MCH in this emerging and somewhat fluid policy environment.

And we need to remember that there's a very big difference between reform and transformation. Reform, as we talk about it now, healthcare reform, is largely focused on cost, access and quality, and it's mostly about insurance reform and cost control, and it's mostly about adults at this point. In fact, Congress at this point, and I think the administration, feel like that, well, we did SCHIP and we're done with kids; let's move on to adult healthcare issues. And I think that that's something that we're going to have to challenge to continue to stay in the room and not just be sort of dismissed out: We've taken care of you, now leave us alone. We'll return to kids five, ten years down the line.

When we start thinking about health system transformation, what we're really interested in are the key drivers of poor health, chronic disease, and high cost. And many of those have to do with what happens in childhood. And this real focus is the goal on optimizing the health of the entire population, and this is going to require a major change in how our

healthcare system is organized, and it's a change in the operating system. It's not just a change of adding some more application programs, a few more things, and we're going to somehow have a much better and higher-performing healthcare system.

So what Barack Obama had laid out prior to his election was a healthcare platform that talked about expanding health insurance and requiring employers to offer and contribute a percentage to payroll coverage, provide income-related subsidies to create a national health insurance exchange, regulations on insurance, and a variety of other proposals that are all very well known to us. Tomorrow night I think we're going to be hearing more concretely about his plan and what he wants to do to move forward.

But if we're really interested in health system transformation, one of the big questions that I want to pose and I hope our panel will address is can transformation in the child health system lead the way for transformation of the overall health system in America, and why should we be thinking about healthcare system transformation. And I pose this as a question of moving child health from 2.0 to 3.0. And for some of you, this might seem somewhat cryptic. You might say, well, what was the 1.0? And I'm going to come back to that.

I want to address the following questions very quickly: Why transform the child health system rather than just reform it? What kinds of reforms are going to be necessary? What logic should guide this transformation? What changes are needed to be made, what the future system could look like, and what's it going to take to get there? What do we need to do to move in this direction?

One of the things we need to realize is that we're in the midst of a major historical change in our healthcare system, a major epochal kind of change, and this has to do with the two eras of healthcare that we've been through and the third that we're moving through. And we're going through a major paradigm shift in how we define, conceive, and approach the production of health.

And, just briefly, we went through a healthcare era of the infectious disease era from the probably 1750s to the 1950s. We went through a second era, which we're in right now, which is the chronic disease era in which we're spending 75 percent of our healthcare dollars on chronic disease in America. But we're entering a new era which is what I call health for all, and I think that this new era is going to define how we think about health.

Just briefly, the old era, the infectious disease era, focused on infectious disease, used a causal model of germ theory, very simple causal models of health, how people got sick. It's during this era that we create our modern models of medical care, the hospital, and even our modern models of public health. We created insurance during this time period, and our goal was really on focusing on reducing deaths.

As we went through a major epidemiologic shift starting about 1940 and 1950 and the life expectancy went from 47 years at the beginning of the century up to about 67 years by the mid century, what happened was that many more chronic diseases became apparent, and we started to enter the second era where there's increasing focus on chronic disease, and our model changed from just simple causal models of infection to a multiple risk factor model, and our focus turned from acute care of medical care to chronic disease management. We changed whole financing of healthcare towards a longer kind of term finance vehicle and prepaid healthcare benefits, and the goal of the health system changes just from reducing deaths to prolonging disability-free life.

We're now in a third era where we could increase the focus on achieving optimal health status for the population. It's interesting that you'll find 75 percent of people in their

seventies rate their health as excellent or very good. So we have the opportunity to have our entire population live into its eighties and in very good health.

We also understand that this is not just about multiple risk factors or simple infections, but it's about complex causal pathways that have to do with social, behavioral, and other determinants, and we also know that in order to move forward, we have to change the way that we finance healthcare. We need to invest in the health capital of the population and move towards an optimal health status.

And so what we've gone through is health system 1.0 to health system 2.0 and on the verge of moving towards a health system 3.0.

So what's driving part of this is this change in this life course development research and what we understand about human health development. In the IOM report in 2004 we outlined really a new vision for what we understood to be the health of children. In that report child health was defined as the extent to which individual children or group of children are able to or unable to develop their full -- realize their full potential, satisfy their needs, and develop the capacities that allow them to interact successfully with their biological, physical, and social environment.

What's different about this is this is no longer an absence of disease or a deficit problem, but it's an asset-based model and it's very developmentally focused. But it's based on a conception of health as a developmental process, that health develops across the life course, that health can be represented by health trajectories, that critical and sensitive periods are very important, that gene environment interactions take place during those sensitive periods.

And we can think about this, as many of you have seen before, as a health trajectory in that many of us begin our life going to a plateau and then you start to feel this sort of downward shape of that trajectory. I know that I'm starting to feel that as I try to play baseball at 57 years of age [Laughter]. And you can go into a high trajectory or a low trajectory, and part of what determines that are the nature of risk factors that push down on your trajectory or the protective factors that push up on the trajectory. And, simply, much of our healthcare policy is about optimizing trajectories and reducing the amount of disparities. What that means is maximizing for populations the number of protective factors and reducing the risk factors, so that becomes one of the overwhelming strategies.

And we see this play out for kids just looking at zero to five in terms of delayed trajectories for many children or at-risk trajectories, and those are caused by the various kinds of risk factors, and then what were more optimum or healthy trajectories will have to do with these positive factors so that the goals of our child health policy at a population level really has to do with how do we optimize trajectories for the greatest number of children.

What we need to realize is that we have large numbers of children in these delayed and at-risk trajectories, and what this means is lifelong issues that have to do with their health, what we know is that the number of children that experience adverse environments early on in life, that these compound and lead to adult health conditions like depression and heart disease. But what we also know is that this is linked to the growing numbers of adults with chronic diseases, and this is just looking, from 1987 to 2005, at the rapid rise in chronic disease in the adult population. These aren't in kids. And you see how the number of people with chronic diseases have increased in the population.

And what you see here from some work from Ken Thorpe is looking at healthcare costs and what's driving healthcare costs, and what you see is that most of -- two-thirds of healthcare cost increase over this time period has to do with the increase in the number

of chronic diseases. But I contend, and I think what all of us understand, is many of these chronic diseases begin in childhood, and what we're doing is missing the boat in terms of not only preventing chronic disease but actually dealing with the fundamental issues of our healthcare system and the healthcare costs that are weighing it down.

So when we ask now how are our children doing, as Ed pointed out, we're making progress. Mortality for children just over the last 25 or 30 years has continued to decline. Morbidity for children, as you can see here, from respiratory diseases, digestive diseases, injuries -- these are hospitalization rates -- have continued to decline, are now seemingly starting to plateau a fair amount, but we're making progress nonetheless.

What has happened, though, is that we have an increased number of children with chronic health problems, greater recognition of mental health and developmental problems, and that these are new morbidities that are affecting us. In addition, we have new conditions, new chronic conditions, that we're facing. And so you see with the obesity epidemic a real change that is happening not just in the number of children who are obese, but what this is meaning to our healthcare system. As the percent of children and youth who are overweight have tripled, what we've seen is that our problems of obesity and healthcare costs due to obesity have increased dramatically and are affecting

the entire healthcare system because of the number of people with chronic diabetes, Type 2 diabetes.

So when we look at the entire child population, we have 4 to 6 percent of children with severe disabilities, 12 to 16 percent of children with special healthcare needs, and about 30 to 40 percent of children, I would contend, that have behavioral, mental health, learning problems, or are at risk for those problems. And we have about 50 to 60 percent of children that are good enough.

[Laughter]

How many people here have kids? And when you look at your kid, do you look at them and say, "Well, they're good enough"? Right? [Laughter] But this is -- we don't -- in our country right now, even with our new MCH data systems, we have a hard time measuring -- other than the kids that have disabilities, that have disease, we don't really know how many children are thriving in our country. Is it 30 percent or 40 percent or 50 percent? And if we're going to optimize the health of the population, we need to be measuring how many children are achieving optimum health, because those are the goals that we need to be managing through.

So how well is this 2.0 system performing? I think all of us know that the demand is greater than the services available, that families have much more complex needs than are being addressed, that we have difficulty accessing services, socioeconomic gradients that are tremendous, and that we have episodic content, we have poor quality of well child care. And we know from measures that are being done -- this is from Rita Mangione-Smith's study in the New England Journal of Medicine -- you see that only 46 percent of children in the United States are receiving the ambulatory care that they're supposed to receive.

When you look more carefully at the breakdowns, what you see is that for acute care, the 1.0 care, we're at about 67 percent, for the chronic disease care we're at about 53 percent, and for preventive care we're about 40 percent. And if you look actually below there, you see for screening we're about 37 percent. This is abysmal in terms of performance for a health system. And that's partially because of the fragmented system that we have, the lack of coordination, the narrow programmatic criteria and of all the other problems that I think you all know.

So my argument is that it's an incremental versus transformation, and I think that where we're at is we have a child health system that was designed for the first era of healthcare to deal with acute care and infectious disease. In fact, our well child care is still built around an immunization model where we're doing well child care based on when we give kids immunization, and that hasn't really changed much in the last 30 or 40 years.

We upgraded our healthcare for children a bit during the chronic disease era with more regionalization, which is actually starting to go away now with managed care. We're starting to lose some of our chronic disease systems. We're ill equipped for this new era, we're under performing and facing many new challenges.

So we need to think about what's the transformation that needs to take place. And I put this rather -- somewhat complicated transformation framework. We need to think about what our current system is, how do we transform it, and what the change strategy should be. So what's the logic of our current system versus the new system?

Well, our current system is still based on an absence of disease logic and definition. We're still focused on health maintenance and individual biomedical care and on diagnosis and treatment that's episodic. What we need to shift towards is really this new

definition of children's health and optimizing population health, focus on individuals, families, and communities, and a real true biopsychosocial model that emphasizes disease prevention and health promotion over the lifespan. That's an operating system change. It's a completely different logic model that we need to adopt and move forward. We need to think about how we begin to organize our care in different ways.

So I show this in one way to provide a blueprint for thinking about this. This is just thinking about kids in the first five years of life. And I'll go through this very quickly.

What you see here is a set of services. There's a lower health trajectory, a higher health trajectory, there's a pediatric medical home, nurse home visitation, family resource center, reach-out repeats, medical home, family resource center, school readiness, peds medical home -- you get the picture.

What you're seeing there is that for that higher trajectory, you possibly need a more developed set of services. If we connect these services up, we're horizontally integrating our system, we're crossing sectors to make things work across health, family, support, and education. And if we longitudinally connect these over time, we're doing the kind of longitudinal integration. Right now all we think about mostly is vertical integration;

primary, secondary, and tertiary care. And to get to the kind of healthcare system we need, we need much more horizontal integration and longitudinal integration.

And what I argue here, from a design standpoint moving forward, what we're doing is building a scaffolding around that health trajectory for children. And what I often use as an analogy is by building the scaffolding, we're doing the same thing that we do in this building. When this building was built, it was built with certain building codes so that it could withstand certain kinds of earthquakes and shocks. It's more where I live in California than, I think, here that we build for earthquakes. But what we do is we build buildings so that when a 7.0 earthquake comes through, we have built it with building codes that we know that will withstand that.

We have many, many children in the United States living in communities where earthquakes are going through their community on a daily basis, and what's happening to them is they're being knocked into those lower trajectories even though we know how to build systems that would keep them at a higher trajectory. And that's a great moral failing of our country, but it's a great failing of our service system and our social contract given that we know what it takes to optimize the development of children and build the scaffolding that we need.

We need to reorganize our pediatric offices and redesign them so that they can provide the kinds of services. They need to be more integrated. The 1.0 healthcare system only had the pediatric office connected to the hospital. A 2.0 or 3.0 system has to be connected to a whole variety of different services if we're going to provide the kind of developmental care that we need.

We need to redesign our visits. Our 18-month visit for pediatric 2.0 is about chronic disease and disability. We're screening for 4 to 6 percent of children who have disabilities using screening tools that were designed for a very small number of children. And we're really only about a pediatric office being connected to a regional center. But in fact if we want a 3.0 healthcare system and we're about optimizing the development of children, we're talking about 30 to 40 percent of children that are going into some optimal trajectories, and those 30 to 40 percent of children need different screening tools and different pathways and a different kind of pediatric office that's really reengineered to do very different things.

What it means is our healthcare system, as currently operating, is connected in a way -- this is the 2.0 system. It's not working because we know only a small percentage of

children are getting into the IDA system anyway. And in a state like Vermont it's like 8 percent, North Carolina, 6 percent, and in my great state of California it's about 1 and a half percent. But this system's not working, and it's not going to working for 30 to 40 percent of kids. So how do we redesign this?

Well, one way, and this is just to provoke you to think about what a 3.0 system starts to look like, is we start doing screening and surveillance in child care and familiar resource centers. We create midlevel assessment centers that connect into other kinds of services and a coordination center that can link this all up. This is actually going on in the state of Connecticut with something called Help Me Grow, it's going on to some extent in the state of Rhode Island, there's parts of California doing this, parts of North Carolina. But it's a redesign, a reengineering of the system where we've created a new type of pathway where we're linking surveillance, screening, assessment, and evaluation in a way that's been re-engineered to deal with the changing epidemiology to restructure our system.

If we're going to thinking about a funding -- reorganizing our system, we have to change the funding. Right now we have healthcare that's uncoordinated with sector-specific services that just spread out all over the place. So you have healthcare, child care, social, emotional health, all this funding come down to counties and then spreading out. What

we want to be able to do is to have some kind of child health trust, some kind of integrating mechanism at the state level to allow you to bring stuff together so you can create in the communities these kinds of coordinated delivery systems. If you're going to have Harlem Children's Zones, Promise Neighborhoods throughout the United States, we have to figure out how we solve the kind of coordination and integration problems that are going to allow us to get to the point that we can integrate systems that way.

And what we're seeing with the MICHEP program that's being done across the United States in several states is a collaborative process to figure out how to begin to move in this direction. So we're making progress in this regard, but we have to be much more bold. AMCHP has to amp it up a bit. We have to really take it to another level.

Lastly, let me just show the last of this example. We have to change our performance monitor. We know that need to be able to measure health trajectories of children, not just measure health cross-sectionally, but we should be able to measure trajectories, and we should be able to measure this in every single neighborhood in the United States because the technology exists and they're doing it in other countries. We should be able to take birth certificate data and link it to pediatric early stage -- early assessment data using ages and stages, to preschool assessments and the school readiness

assessments like the early development inventory that's being used throughout Canada and Australia at present so that we can measure health trajectories at a neighborhood level so that we can actually have the kind of information that communities need to plan systems and to move policy. It's remarkable, in the countries that are beginning to do this, how it's changing the way the policymakers think about young children and what they're actually doing in their communities.

We also need to take advantage of HIT and the, you know, \$19 million that's going to be put in as the first down payment of this. Most of the HIT work that's going on is all about 1.0 medical care. It's about diagnosis and treatment and basic public health protection. It's about prescribing, charting, and linking outpatient and inpatient records. There's some 2.0 chronic disease management with decision support and a disease management and prevention registries, but what we're I think -- and this is all important. Clearly for kids with special healthcare needs it's important, clearly for our pediatric primary care practices the 1.0 and 2.0 stuff is important.

But if we're moving forward, and especially for the children's health system, we're interested in promoting optimal health. We need to have population health systems that link these health trajectories with the other kind of clinical data that we're doing. And this

is all within our reach. I know that the state of Rhode Island has much of the infrastructure in place to be able to start doing this kind of thing. The state of Massachusetts has much of this in place as well.

So at this point moving forward, innovation is not an option for us. Innovation is what we have to do if we're going to move forward. It's not about just doing the same as we've been doing. And if we're going to go from the 2.0 to the 3.0 healthcare system, it's not going to be just an incremental straight line. We like to think about going from here to there and it's just drip, drip, drip and we do every incremental reform and we'll get there.

And we know that's not the case because we have huge barriers in terms of doing data sharing across different kinds of programs. We're not going to be able to integrate all these programs if we can't share data. We can't just throw a paper airplanes at fast-moving trains and hope that they get in the window and that -- you know, that's a little bit about how our data system works at present.

And in order to change these things, we have to, you know, come up with some kind of innovative technology like a child health and development virtual private network that allows us to engineer around the barriers that have been there for years, but we haven't

quite figured the collaborative way to overcome that. And if we move ahead, we're going to find that we run into all kinds of problems with categorical funding, so we have to figure out how we engineer around that, whether it's using master contracts or some kind of healthcare trust.

There's all kinds of ways that we could be doing this, but we have to really be thinking about it. And it probably doesn't have to be state by state by state by state. This is what we need to be working on all together. We need an overall strategy for moving this forward.

And one way of doing that is by creating collaborative innovation networks, collaborative ways of taking on these problems and beginning to think about how do we pull this together so we can start identifying the problems and identifying the solutions and working together on this. In doing this, we can create a new value chain to accelerate transformation in the MCH world, because if we're going to convince the world and policymakers that MCH is an undervalued and underinvested area, we're going to have to show that there's a positive value chain that can be achieved by greater investment and by doing the kind of innovation that can happen. We're going to have to overcome these barriers that have been in our way, and we're going to have to have other partners that

are going to help us with this, and we'll have to figure out how we can demonstrate that we can optimize return on investment.

So in conclusion, our child healthcare system needs to move from version 2.0 to 3.0. This is going to require a major change in the operating system and the logic of what we're doing. This will also require a new and more integrated policy framework that is capable of supporting new and more integrated delivery platforms, newly aligned cross-sector service delivery pathways, more coordinated and integrated and long-term funding, data collection, and planning. This is going to only be accomplished through a collaborative innovation process. It's going to require a collective invention. It means all of us working together and bringing others into this process to be able to overcome these barriers, and it's going to be about spreading and customizing and scaling these innovations across the country.

If you look across the country, you'll see that in, you know, Utah they have a great program on care coordination, in Rhode Island they have a great thing on data collection, in Massachusetts they've figured out something else. And a lot of the innovations exist. They're all there. No one's just pulled them together in one place. Even in the same state, you'll have something in

Des Moines and something in Maine and something in somewhere else. You can't pull it all together in one place.

That should be our goal is to figure out how we do that through a collaborative process. This is going to require rebalancing and realigning and reengineering and redefining existing services, new partnerships across sector bridges, and framing the problems and solutions as systems and not just service problems.

This transformation of the system is going to be nonlinear. It's going to require policy jolts as well as incremental changes. We're getting a policy jolt now with what the president is putting forward. We have to take advantage of it. It's not going to happen on its own. It requires these innovations both within and across sectors, and making and responding to opportunities. The opportunities are there, but you make opportunities happen, and we have to be able to respond and not just respond individually but as a collective whole.

We published this paper in the Big Ideas Journal that came out that laid out a set of policy suggestions to move forward. And if Barack Obama is going to have a strong children's agenda, we need to not -- we've decided that we need to provide affordable comprehensive coverage for all children. That means covering the entire child. Not just

from the neck down, but the entire child. That means it requires covering all children and making sure that we're covering all the services that children need.

We need to upgrade and enhance primary health services for all children and go towards a medical home 3.0 and all of the connectivity and coordination and consultation that needs to take place. We need to integrate primary health and population prevention services to ensure optimal health development. We need to improve integration and coordination of federal, state and local health code grants for children, and this is a really big challenge, so that we're, you know, moving together all the different funding streams that exist at the federal level, but making sure that happens at the state and local level. And we need to target resources towards place-based initiatives designed to systematically address the health needs of all children in those locales.

There's a program in England called Sure Start where they're building -- they've already built 3500 Sure Start centers in poor communities in England, and they're serving as the hubs for community reorganization around early childhood in publication in Lancet a couple weeks ago showing how that Sure Start program was starting to shift the curve for children in those communities.

But we really the need to be thinking broadly not about 20 Promise Neighborhoods. I need 200 Promise Neighborhoods in Los Angeles alone. I think we need 2000 Promise Neighborhoods in the United States, and we need to be thinking about things on that scale.

We need to focus on innovation and expansion of HIT and HIE for improving childhood services. We need to implement a 21st century early childhood measurement, mapping, monitoring and improvement system. We need to establish a national child health outcomes and improvement and accountability framework similar to many other countries have done. And we need to develop financing innovations that will better support investments in children's health, coordination of child health services, and to focus on population-based approaches, these kinds of things that I was talking about, the innovations and masters contracts and healthcare trusts and the like.

Jeanne Lambrew, who's heading up or is in the Whitehouse Office of Health Reform, has been talking about health trusts and prevention trusts and wellness trusts. Well, we should be thinking about how do we advance that for children and to have children's trusts throughout the U.S.

And then, lastly, we need to increase the visibility and importance and position of child health issues. And this means that we need an assistant secretary for children's health that is -- creates the kind of providence within the department of HHS for children's issues. We need a Whitehouse office on children's health, and we need a transgovernmental kind of commission that can actually bring the kind of providence that we need for these kinds of issues.

It's going to be important for us to be able to move this kind of broad agenda forward so that President Obama and Congress don't think just by taking care of SCHIP, they're done with children's issues, and that we remind them that there are these other things that need to be done and that the time to do it is now, and that there is an agenda out there that we could move forward and that we can agree upon to move forward.

So let me end here and I'll turn it over to Ed and the panel.

ED SCHOR: Thank you, Neal. Is this working now?

NEAL HALFON: Yes.

ED SCHOR: I saw everyone on the panel scribbling madly as their turn was coming, so let's just begin.

Debbie, do you want to start with some reactions to this?

I know everyone on the panel really has been thinking about these issues for a long time and trying to figure out how to make them real, which is, of course, the tough part.

DEBBIE CHANG: Yeah. Thank you. I -- can you hear me? Oh, good. Oh, good.

I'm going to talk about this issue of making it real, how does it look on the ground. And, you know, Ed first talked about the social determinants and looking at an approach that really looked at all the different sectors that care for children, and Neal talked about how we need to transform that system and to integrate horizontally and vertically with respect to how those systems of care for children work together.

We've done that type of work in Delaware. Nemours is a not-for-profit operating foundation, and about five years ago we decided to invest new dollars in population

health. And so to Neal's earlier point, we are building a system that combines both population health and integrated it with clinical care. And that that meant on the ground really working in all the places that children spend their time, child care centers and schools and primary care, in neighborhoods, and to really give people who care for children the tools they need and the policy changes and practice changes they need to help children grow up healthy.

One of our first areas is the obesity crisis. So we have a program in place that looks at, again, giving people who care for children the tools they need to make changes that then will affect healthy eating and physical activity for children which will result in behavior change, which will result in health outcome changes. So that's an example of what we're talking about for integrating population health and medical care and a good example of cross-sectoral work, because we're working in all the places that children spend their time. They're really trying to develop a system that is built around and serves the children. So that's an example of some of the work that we're doing to make it real.

ED SCHOR: Cathy, do you have some ideas? You're sitting in a foundation with some resources and in a very small state. Do you have any suggestions for how the Title V people, where they would start?

CATHY HESS: Yeah. Well, of course, we have less resources, like many folks. But we're an operating foundation, so we actually run programs. So we have a pediatric healthcare system, and we decided to integrate that with population health.

You know, I think one of the things that we have found is that we think of ourselves as a catalyst. So a small amount of money will actually catalyze a lot of action. So, for example, one of the things that we spent a small amount, probably not more than, I don't know, maybe 80,000 a year, is a coalition, because we knew we couldn't do it alone. We didn't have the manpower to do this all ourselves, so we thought the best way for us to do this was to work with community partners, give them the tools they need, and then they would make the changes for children.

And so the coalition is a way of harnessing all that energy. And we decided that we really wanted to fund the coalition with a person because, you know, if a coalition is a voluntarily coalition, it's everyone's second or third priority and it doesn't get done. And so we invested a small amount of money to then have this coalition basically help us do our work, working in all the different sectors and working together.

And the other thing we found is that by working together, they started doing other things related to child health. And so part of it I think is -- to answer your question, part of is, I think, getting the right people together to work on these issues and to try to really break the silos. There's a lot of silos in our programs that serve children. So it doesn't necessarily take money to make that happen. Part of it is what Neal said. Will. Getting to the people around the table.

Now, for those of us in Delaware -- Nemours is based in Delaware and Northern Florida, and so we're kind of viewed as child health experts and so it was easy for us to bring people together. But I'm sure in all the states that you operate in, either your own organization, the MCH bureau, plus other organizations are there to help bring people together.

ED SCHOR: Well, I personally wish we had a single-payer universal healthcare system because it would make it a lot easier to change some of these things. But we don't. We're going to build on some of the private sector aspects of our system and meld that with some public.

And so, Jeff, you've sat in both places. What do you think?

JEFFREY LOBAS: Wow. I think -- can you hear me? Okay.

As I listen to this, and I have sat in both places, and coming from Iowa, I have experienced silos in real life [laughter], but -- just kidding. But one of the things I saw in Iowa, and as you talk about collaboration, was that I often, as I went to meetings, I was the only physician there. I would stand up and go, "Where are the doctors? Where are the doctors?" "Well, they're busy in their offices." "Well, why don't we schedule the meeting at 5:00 o'clock?" "Well, we can't. We're state employees."

And I think it's really easy to leave the physicians out. And as I saw this and read the article -- and I'm really glad, Neal, that you talked about medical home because I do think -- when I went to medical school, I really went to medical school and residency learning to treat the whole child, to learn about development, to be a healer of children and families and not to be just treat that ear infection. And I think we've really made it difficult for pediatricians.

And if we take the medical home concept really seriously, I really worry about that we create these screening centers and this center and that center and we're creating all of this when in fact the primary care offices, if we do the medical home appropriately, offers a delivery system, if we supported that, that could do much of what you're asking the system to do without creating anything new but just supporting them.

And the community health centers, they're doing a great job for a population, but they frighten me because we're going to develop a two-tiered system depending on your socioeconomic status. And pediatricians and family docs, if we train them right -- and that's a huge piece because I don't know that we're training physicians the way that Ed and Neal and I were trained -- that we need to look at that. And we also need to reinvest in primary care in a very different way.

I think the other thing, now that I -- the head of the Banner Health System, I had lunch with him the other day, and the first question -- I'd never met him before, and he said, "Well, why did you take this job?" And I was talking about, "Well, I took it because I really felt it was an opportunity to make a difference."

And I got some of the statistics, and Banner Health System, which is a big system out in the West, sees over 265,000 children a year, 60,000 inpatient visits, newborns, et cetera. It's huge. They have a unified IT system that can collect enormous data. And they have connections with community. They have subspecialists hired.

One can set standards of care working with systems like that, and one can connect the communities. And I fear that we start going state agency, Department of Ed, Department of Health, you know, you guys do it, when in fact we have big private systems -- Atlanta Healthcare, Banner Health -- that could be huge vehicles.

So if we're thinking about innovation, let's talk about teaming with those existing systems and the pediatricians out there to really do what's right for children.

ED SCHOR: Thank you.

Cathy, we have the new SCHIP reauthorization, we have an administration that seems to be painting, at least with a broad brush, some reforms if not transformative ideas. But everybody says, well, it really depends on how it plays out in the states. So what's your advice to the states? How is it going to play out?

>> CATHY HESS: Well, first I just want to start by thanking Neal for that presentation and for all the work he's been doing -- and I know a number of you have been working with him -- because I think, while the panel is to help us think about how to make it real, I think it does start with vision. And I think that Neal has really laid out a wonderful vision with a lot of elements that I'm sure many people here can embrace.

And I want to say that I think, for state action as well, that we need vision and leadership from a variety of sectors. I think the governors are meeting simultaneously here in Washington as we sit here. I would suspect that these kind of ideas are not on their agenda right now. Right?

So that means part of the work of the MCH community, I think, has got to be about engaging and educating our political leadership so that they understand some of these concepts and can engage them. Many of your governors are fully behind and have provided a lot of leadership for early childhood initiatives, but I think many of you would probably agree that those early childhood initiatives have been focused on early learning more than they have been focused on early childhood health. So we've got to help governors broaden their understanding and broaden the vision of what their pursuing.

I think, also, that we have to be thinking about transformation, but I do think incremental changes can still help push the envelope and help us test ideas that can be part of that transformation. EPSDT is a critical program in Medicaid, and now that more and more children are being covered by Medicaid, whether it's through Medicaid dollars or CHIP dollars, that program becomes increasingly important.

We know that it covers a lot of services that children need. At the same time, we know the program doesn't always function well. Maybe this is the time, in a friendly political environment with visionary political leadership at the top, when we start to kind of rethink what EPSDT looks like a bit. That may be heretical. Many of my advocate friends -- I don't know what Kay Johnson thinking about that -- would be very concerned about that because I think for a long, long time we've been so worried about losing what's in EPSDT that we've been scared to look at it and to suggest that it might look a little differently. But maybe it's time to think about, instead of EPSDT, health. I can just see the logo now: The early and life course prevention and promotion for health program.

We need to rethink some of our programs. I do want to say, given SCHIP passage, reauthorization passage, there's a lot of discussion about that not being perceived as the

final word on coverage, never mind an agenda for child health. And I don't think -- I think we'll have to be careful about that, but I don't think there's many in the policy world that view it that way. I don't think that the Medicaid and SCHIP directors view it that way.

There are -- we've been tracking them at the National Academy for State Health Policy. There are about half the states where they are trying to work on universal coverage for kids, for one thing.

In my bio it was mentioned that I'm heading up the Maximizing Enrollment for Kids Program for the Robert Wood Johnson Foundation, along with Alan Weil, our executive director. That program attracted over half the states applying to it at a time that was not as bad as it is now, but last summer the economy wasn't looking so hot either. We had over the half of states' Medicaid and SCHIP agencies saying that they and their governors are looking to get as many eligible kids on the rolls as they possibly could, and they were willing to commit the dollars to put those kids on the roll.

We may not have covered every child yet, but we are getting pretty close. So I think we've got a whole lot to build on, and our challenges are to implement those programs effectively, to build on them in terms of coverage, and I think there's roles that MCH can

play in that, but to begin to educate and engage other people in this broader vision. And if not you in this room, who will do that?

I really challenge AMCHP, the MCH Bureau, all state MCH people to step up. The time is now. Wouldn't it be great on the 75th anniversary of Title V to unveil a new vision for this program into the future that would accomplish a lot of what Neal has laid out.

ED SCHOR: And, Charlie, we're actually just beginning our advocacy and policy work for this. Some doors have opened, but I'm sure you have some ideas of what ought to walk through that.

>> CHARLES BRUNER: I also appreciated Neal Halfon's presentation, and I agree with about 90 percent of the formulation. We can talk about those things.

If I put on my legislative hat and Neal provided that presentation to me, I'd say that's daunting and I'm going to walk away from it as fast as I can [Laughter]. I don't know where to begin, and I can't explain it to my mother or my grandmother or any other constituent, and I don't know whether I'll see any end product within certain election cycles, but probably a decade. But I still think that Neal's right, and I think that there are

ways of framing this, and I think that there are ways of doing this that we can move forward and we can make it real for policymakers.

And I'd like to point to three things in particular out of that presentation. First is, I think moving from that operating system of 2.0 to 3.0, when you look at primary preventive developmental health services, looks to me like Bright Futures is pretty much a 3.0 system. It looks to me like Help Me Grow, Healthy Steps, and a variety of other programs and practitioners' offices are points where we can say that's pretty darn close to 3.0.

And number two is we're also getting some better results in that way. So we know we can get them. Some people have done it. How do we construct the pathways for others to get there in primary practice? We know what a medical home should look like. How do we do a better job of creating and constructing that? And what is the federal role and what are state roles in leadership and where does the investment have to go to make that happen? And I think that there are right answers where you can say, you know, if you did something at the federal level, you could take credit for doing this and get some real results and it wouldn't be that difficult to do, and then let all you people in the room help play it out in the states, really making it happen.

The second thing is I think we know that there's something we've got to do beyond referral when we get to primary preventive practices that is really sometimes -- I mean Help Me Grow does a great job of going beyond referral to scheduling. We know that if we identify something in families with kids, or their kids, that there's something we can do about it. How do we get that actual something being done about it?

And, again, I think that there are models for doing that. I think that there are ways. I think it's tough, but I think in the real world we can describe those and create structures that create more of that coordination and more of those interlinkages.

And, third -- and I've seen, you know, people who are legislators and members of Congress and their staff, when they see that trajectory slide, they nod their heads. They know that that's real. And if you look at what's on that slide, 90 percent of it doesn't have anything to do with biological or medical care, it has to deal with a variety of risk and prevention factors, protective factors. And most of those, you know, are things that take both community-level and population-based approaches and individual-based approaches.

But strengthening those protective factors and reducing those risk factors really are a strong purview, and it's something where -- I think I've said it before I've been before this audience that my favorite federal agency is the MCH Bureau and Merle McPherson and David Happel and other people who saw this many years before and saying it really is about the whole child, it really is about improving children's healthy development, not just chronic disease management. It really is around getting kids and their families in places where they thrive not only in terms of health, but educationally and socially as well, really that how we go about saying we need to do this. And there those community elements.

We have to rid our communities of toxic environments. We know such things as obesity is greatest among children when they don't have any recreational spaces or any spaces to go. We know that there are community building activities that need to go on. I really think that there's a new opportunity for promoting what you've been doing all along, but I do think it means -- and you have at the tables that piece on helping parents raise happy, healthy, productive children, which has a federal agenda. It really is where do you want to fit into that agenda that I really think is important.

I want to say one more word around what Cathy said around SCHIP. And I'm -- you know, I'm really glad SCHIP was adopted, and it really was a health reform made under

the realities of a Bush administration and republican Congress and what we could get at that point in time. And I'm happy it was adopted because it concludes some unfinished business. It does enable states to go forward now in some ways that they couldn't before.

There were some good new elements added to SCHIP, but it was also, I think, recognized as this is unfinished business, that we had to get behind this.

I'm a member of a child advocacy organization working with other members who really worked hard on SCHIP reauthorization. What we really said -- and this is a lot of state-based organizations, I think, right in line with you -- is we need health coverage -- we don't need just health coverage, we need health coverage that meets children's needs for healthy development. And there is only a smidgen of that within SCHIP reauthorization. There's a quality provision that starts that process, but we really said as we go forward, we still have those other four and a half million kids to insure, but we really need to focus on the quality and content of healthcare and the linkages that need to go to get children what they need for their healthy development as that next step.

I think the Obama administration, I think members of Congress and I think a lot of allies who really worked for SCHIP reauthorization under the grounds, this is the best we could do at this era, recognize that that's the critical next step.

So I think what Neal has put forward is daunting, and we've got to do it all. And some of it involves non-incremental changes, but there are plenty of places where we are ready and geared to start, and it's not like there aren't paths that we can follow that are already out there. I think that Mike -- you know, I often say we've got to move from exemplary to routine in our practices. We really do have a lot of exemplary practices that we just really need to create policies and structures and leadership and support to move toward routine.

ED SCHOR: Thank you. I don't see any microphones in the audience, and we've the next group lined up. So we'll thank our panelists for all their comments and turn this back to Nan.