FIMR

Making Healthy Communities Happen

A PUBLICATION OF THE NATIONAL FETAL AND INFANT MORTALITY REVIEW PROGRAM

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NATIONAL NFIMR FETAL–INFANT MORTALITY REVIEW PROGRAM

Happy 75th Birthday Title V!

Title V of the Social Security Act was signed into law by Franklin Delano Roosevelt in 1935. Seventy five years later, the law remains the longest lasting public health legislation in US history and the only federal program focused solely on improving the health of mothers, infants and children!

Before the law was passed in early 1935, a surprising new philosophy about maternal, infant and child health was suggested in the Report of the Committee on Economic Security to President Franklin D. Roosevelt, which emphasized that:"…the core of any social plan must be the child."

"…the core of any social plan must be the child."

This Report contained the various parts of the plan which would become the Social Security Act but importantly explained a direct focus on the welfare of the child as the epicenter of Social Security Act:

- "Old age pensions are in a real sense measures in behalf of children. They shift the retroactive burdens to shoulders which can bear them with less human cost, and young parents thus released can put at the disposal of the new member of society those family resources he must be permitted to enjoy if he is to become a strong person, unburdensome to the State.
- "Most important of all, public job assurance which can hold the family together over long or repetitive periods of private unemployment is a measure for children in that it assures them a childhood rather than the premature strains of the would-be child breadwinner."

When Congress enacted the new Title V legislation in 1935 and deliberately placed it in the Social Security Act, not in health law, it is was done to create a sweeping social support net for pregnant women and infants, children and children with special needs. The passage of Title V of the Social Security Act also reaffirmed the partnership between the federal government and state efforts to expand the

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FIMR Faces is an editorial addition to *FIMR: Making Healthy Communities Happen.* To submit you articles on the challenges and joys of working with FIMR, please send your 500-word document to:
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I was appointed associate administrator for maternal and child health in the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) on August 17, 1999. HRSA works to fill in the health care gaps for people who live outside the economic and medical mainstream. The agency uses its $7 billion annual budget (FY 2010) to expand access to quality health care for all Americans through an array of grants to state and local governments, health care providers and health professions training programs.

Through Title V, the Bureau promotes and improves the health of mothers, children, and families, particularly those who are poor or lack access to care. It administers the Maternal and Child Health Services Block Grants to the States, the Healthy Start Initiative, and the National Fetal and Infant Mortality Review Program among others. I also am the executive secretary to the Secretary's Committee on Infant Mortality.

The Fetal and Infant Mortality Review Program (FIMR) methodology is a good fit to the philosophy and programs of the Bureau and Title V as it works to improve the safety net of local services and resources for all families, but especially those that are the most vulnerable. FIMR findings also inform state Title V deeds assessment and program development. I am very proud of the successful public-private collaboration between the American College of Obstetricians and Gynecologists and the Bureau in the NFIMR Resource Center program.

75 for Title V

The Title V 75th Anniversary Meeting will take place on October 20, 2010, in Washington D.C. In support of this important event, please join the Maternal and Child Health Bureau by taking part in "75 for Title V." This campaign asks us all to engage in 75 minutes of service in our communities. There are many ways to participate as an individual or a group. Here are a few examples: volunteer at a soup kitchen, provide blankets for pediatric clinics, read to children at the local YMCA or promote a "walkathon" and donate proceeds to the local Healthy Start.

NFIMR is a collaborative effort between the American College of Obstetricians and Gynecologists and the federal Maternal and Child Health Bureau. Supported by Project #U 08MC00136 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

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Happy 75th Birthday Title V!

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health and welfare services for mothers and children. The Title V legislation resulted in further development and expansion of state departments of maternal and child health health and public welfare. This federal state collaboration was first begun under the auspices of the federal Sheppard-Towner Act of 1920. (See pp 6)

Today, Title V continues this partnership between the Maternal and Child Health Bureau and State Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) programs, reaching across economic lines to support such core public health functions as:

- resource development
- capacity and systems building
- population-based functions such as public information and education
- knowledge development,
- outreach and program linkage,
- technical assistance to communities,
- and provider training. (See below)

Title V programs support programs provide prenatal health services to 2.6 million women who have no other access to care, primary and preventive health care to 4.2 million infants, and more than 29 million children from ages 1 through 22, and more than 1.8 million children with special health needs.

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Maternal and Child Health Pyramid of Services

Reprinted from Understanding Title V of the Social Security Act, US Department of Health and Human Services, Maternal and Child Health Bureau.

Available at ftp://ftp.hrsa.gov/mchb/titlevtoday/UnderstandingTitleV.pdf *(last accessed December 11, 2008)*

The conceptual framework for the services of the Title V Maternal and Child Health Block Grant is envisioned as a pyramid with four tiers of services and levels of funding that provide comprehensive services for mothers and children. The pyramid also displays the uniqueness of the MCH Block Grant, which is the only Federal program that consistently provides services at all levels of the pyramid.

DIRECT HEALTH CARE SERVICES
(gap filling)
Basic health services and health services for Children with Special Health Care Needs (CSHCN).

ENABLING SERVICES
Transportation, translations, outreach, respite care, health education, family support services, purchase of health insurance, case management coordination with Medicaid, WIC, and Education.

POPULATION-BASED SERVICES
Newborn screening, lead screening, immunization, sudden infant death syndrome counseling, oral health, injury prevention, nutrition, and outreach/public education.

INFRASTRUCTURE-BUILDING SERVICES
Needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, systems of care, and information systems.

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MCHB/Title V

The HRSA Maternal and Child Health Bureau improves the health of mothers, children and their families. Authorized under Title V of the Social Security Act, HRSA maternal and child health programs...

- Assure access to quality care, especially for those with low-incomes or limited availability of care.
- Reduce infant mortality.
- Provide and ensure access to comprehensive prenatal and postnatal care, especially for low-income and at-risk women.
- Increase the number of children receiving health assessments and follow-up diagnostic and treatment services.
- Provide and ensure access to preventive and child care services, as well as rehabilitative services for certain children.
- Implement family-centered, community-based systems of coordinated care for children with special healthcare needs.
- Provide assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid.

From: About MCHB. Accessed on line 9/20/10 http://mchb.hrsa.gov/about/default.htm

Happy 75th Birthday Title V!

The National Fetal and Infant Mortality Review Program (NFIMR) is a collaborative effort between the American College of Obstetricians and Gynecologists and the federal Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration, US Department of Health and Human Services (Grant #U93MC00136). For twenty years, MCHB and the American College of Obstetricians and Gynecologists have worked together to provide leadership and continued support for communities and states to improve service systems and resources for women, infants and families through the NFIMR Resource Center.

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Hutchins V. Maternal and Child Health Bureau: Roots. Pediatrics. Vol 94, No 5 pp 695–699

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Markel H and Goldenberg J. Successes and Missed Opportunities in Protecting Our Children's Health: Critical Junctures in the History of Children's Health Policy in the United States. Pediatrics Vol 115, No4 pp 1129–133

Report of the Committee on Economic Security to President Franklin D. Roosevelt. Assessed on line at 9/1/10 at http://www.ssa.gov/history/reports/ces/ces.html

Understanding Title V of the Social Security Act. US Department of Health and Human Services. Health Resources and Services Administration. Maternal and Child Health Bureau. http://mchb.hrsa.gov/about/understandingtitlev.pdf

WebGuild Sentinel. Women at Work. Accessed on line 8/10/10 at http://www.webguild.com/sentinel/women infants.htm

Getting to Title V—
The Stormy US History Preceding the Signing

Two seemingly disparate pieces of history influenced the progress towards the signing of the Title V of the Social Security Act in 1935—the first was the suffragette movement (c 1840–1920) which culminated in the 1920 ratification of the 19th Amendment to the US Constitution giving women the right to vote. The second, oddly enough, was the Russian Revolution (c. 1914-1916) which resulted in the development of the Soviet socialist state. These forces' influence on enactment of Title V will become clearer as the history leading up to it unfolds:

The Children's Bureau and the Suffragettes. On April 9 1912, President Howard Taft created the first US Children's Bureau to " …to investigate and report on all matters pertaining to the welfare of and child life among all classes of our people."

President Taft named a Settlement House leader Julia Lathrop from Hull House in Chicago to direct the new Children's Bureau. In fact, Julia Lathrop was the first woman to head any US federal agency. Since Lathrop was also one of the leaders of the suffragette movement, this appointment was a nod toward its agenda and recognition of the power that the women's movement might weld in upcoming elections.

With help from 15 newly hired federal staff and volunteer suffragette groups from around the country, Julia Lathrop began a two-year evaluation of the maternal and infant mortality in the US. It quickly became clear that the US maternal and infant mortality rates were higher than those of European countries. At the same time, the War Department was concerned because thousands of young men were deemed ineligible for military service during WWI due to chronic illnesses from infancy and childhood. Both of these findings called attention to the lack of infant and prenatal care. Although the War Department was bellicose and the suffragettes had a strong anti-war philosophy, both agreed something must be done.

However, the Children's Bureau faced stiff opposition in trying to address lack of infant and prenatal care from many fronts:

1. Some states felt the Bureau overstepped federal authority.
2. The manufacturing industry was concerned that the Bureau would regulate child labor laws.
3. Fiscal conservatives said that the Bureau duplicated work already happening in the Public Health Service and/or the Bureau of Education.
4. The Catholic Church feared that the agency would interfere with Catholic school education or promote birth control.

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Suffragette marching for the vote

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5. Swirling around all these detractions was the (mostly male) distrust of the suffragette movement's and its support for better services for women and children.

Sheppard Towner Act, the Suffragettes and Marxist Russia. In 1920, the 19th Amendment finally granted voting rights to women. Although women would never form a single voting block, almost all suffragettes were united in strong support of better care for women and children. Responding to pressure from this new influential voting group, as well as the findings of the Children's Bureau two-year evaluation and the concerns of the War Department, in November 1921, President Warren Harding signed the Sheppard–Towner Maternity and Infancy Protection Act. This law allowed federal funds to be "matched" to equal state funds to establish and support public health care of mothers and infants. For some states, these funds became the seed money to develop the first state departments of maternal and child health.

The Sheppard Towner Act was passed with the best of intentions, but was repeatedly criticized throughout its eight year history by many including the American Medical Society (AMA). AMA compared the Act to the socialist/communist ideology of newly formed Marxist Russia. The Act was repeatedly referred to as "imported", "socialist" and "neo–socialist." To further alarm AMA, certain suffragettes, settlement workers including Lillian Wald and others believed that some of the Marxist socialist concepts were beneficial and might be incorporated into the US system. In addition, beginning in 1919, the US entered an era of anti-Marxism that was became known as the "Red Scare" (a dubious scenario later to be recreated by Joseph McCarthy in the 1950s). About 200 US citizens who were Marxist sympathizers, including the famous Emma Goldman were rounded up, tried for treason and deported to Russia.

In 1922, AMA formally opposed the Shepard Towner Act and developed a specific resolution against it. (See p. 7)

In 1929, with more pressure from the AMA, the US Congress allowed the Shepard–Towner Act to lapse. In 1930, prominent members of the pediatric section of AMA were so outraged over the AMA's position and the loss of the Act that they ceded from the AMA and formed the independent American Academy of Pediatrics.

However, Julia Lathrop at the Children's Bureau and policy makers in the President's cabinet immediately began to plan for a stronger and broader scope of MCH federal and state partnerships on behalf of women and children. Far reaching federal legislation was drafted at the Children's Bureau. Title V of the Social Security Act was successfully enacted in 1935 with a sweeping social mandate for women and children that survives to this day! Over time, the AMA became supportive of the new legislation and the disagreement between AAP and AMA was resolved.

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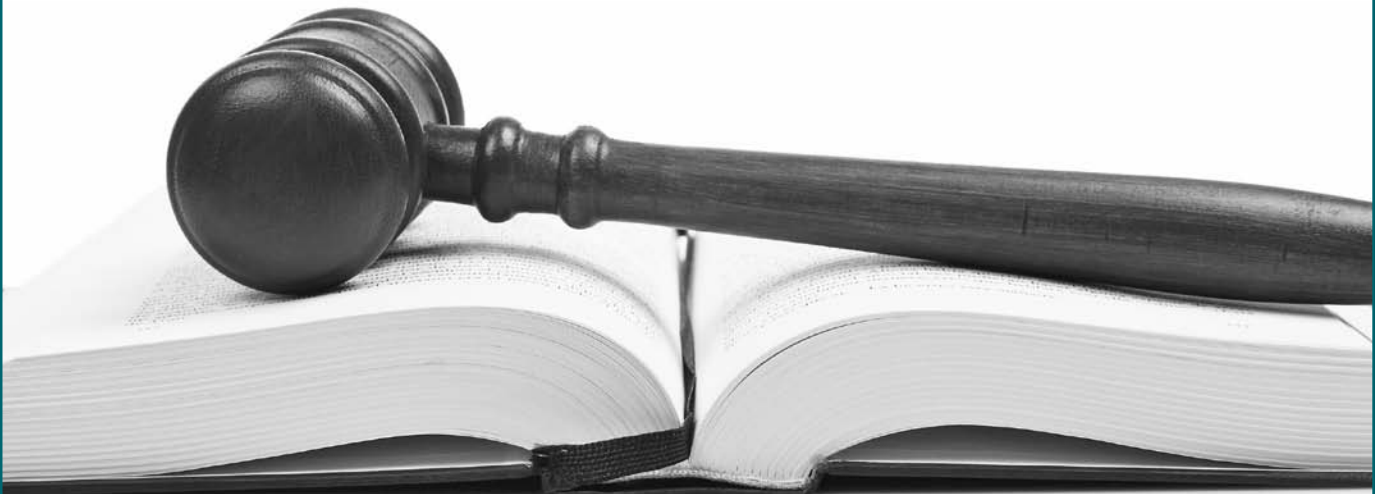
AMA Resolution

The resolution …pertaining to the Sheppard-Towner law, … is as follows:

- *Whereas, The Sheppard-Towner law is a product of political expediency and is not in the interest of the public welfare, and*
- *Whereas, The Sheppard-Towner law is an imported socialistic scheme unsuited to our form of government, and*
- *Whereas, The Sheppard-Towner law unjustly and inequitably taxes the people of some of the states for the benefit of the people of other states for purposes which are lawful charges only upon the people of the said other states,*
- *Resolved, That the American Medical Association disapprove the Sheppard-Towner law as a type of undesirable legislation which should be discouraged.*

From: Proceedings of the AMA St Louis Session (May 1922) JAMA, Vol 78, No 22, p. 1709.



Getting to Title V: One Hero Who Laid the Groundwork—Lillian Wald (March 10, 1867–September 1, 1940)

There are many who worked tireless to pave the way to the implementation of Title V. However, without the implementation of the Children's Bureau in 1912, the road to improved services for women and children through Title V in 1935 might not have been possible. Below is just the briefest of sketches of Lillian Wald, the tireless advocate, public health nurse, national policy maker and a real super-woman who changed the face of health care in the US and first proposed the need for a national Bureau:

In 1891, Wald graduated from New York Hospital School of Nursing in New York City. In 1893 Ward started to teach a class on hygiene for poor immigrant women on the Lower East Side (New York). Not long after, she began to care for sick residents of the Lower East Side as a visiting nurse. She moved into a small, bare tenement near her patients, in order to better care for them. In 1893 she also coined the term "public health nurse" to describe nurses such as herself whose work integrated nursing and community health.

In 1895, inspired by the settlement houses such as Hull House in Chicago and Toynbee Hall in England, she established the Henry Street Settlement in New York City with support from several New York City philanthropists. The Settlement House quickly expanded its range of services to meet the social, economic and health needs of the Lower East Side community. This included nursing care, the establishment of clubs, a theater at Settlement House for the community, a savings bank, a library and vocational training for young people. By 1903 Wald had organized 18 district nursing service centers that overall treated 4,500 patients in New York.

In 1899, Wald initiated a series of lectures held at Columbia University's Teachers College to educate prospective public health nurses. This led to the formation of Columbia's Department of Nursing and Public Health in 1910, and later to the establishment of the National Organization of Public Health Nurses (NOPHN). The Henry Street Settlement eventually expanded into what is the Visiting Nurse Service of New York City which is a major service agency today. Her ideas also led to the New York City's Board of Health's organizing and running the first public nursing system in the world.

Over the next few years Wald, recognizing the importance of environment to overall health, even promoted and found funding to build public playgrounds in working class areas. She later helped to found New York's Outdoor Recreation League, which focused attention on the need for public parks and playgrounds throughout the city.

From the start, she championed civil rights and set a policy of racial integration not only in all Settlement House community activities but also in her nursing service. Of note, the Settlement House hosted the first meeting of the National Association of Colored People (NAACP) on the evening of May 30th, 1909. The conference opened with an informal reception given by Wald who was described by Mary Ovington of NAACP as "one of the Association's first and oldest friends".

Because of Wald's multiple accomplishments and tireless advocacy for social justice, she was recognized as a true visionary for improvement of maternal and child health and wellbeing. When she first proposed the idea of establishing a federal Children's Bureau, Americans from all walks of life listened and tended to agreed. Over a period of time, she was able to leverage enormous support for the passage of the legislation to establish the Children's Bureau. In the campaign to get the Congress to act, Wald was one of the most powerful, persuasive and respected voices in support of the Children's Bureau–testifying before Congress, making speeches and lobbying officials.

Of note, the US Congress actually wrote into the legislation that finally established the federal Bureau the following tribute: ***" The suggestion for the establishment of a children's bureau was first made by Miss Lillian D. Wald, head of the Nurse's Settlement in New York."***

"In the name of humanity, of social well-being, of the security of the Republic's future, let us bring the child in the sphere of our national care and solicitude."

—Lillian Wald, Congressional Hearings, 1909

In 1922, The New York Times named Wald as one of the 12 greatest living American women and she later received the Lincoln Medallion for her work as an "Outstanding Citizen of New York." In 1933 she suffered a stroke, left her beloved Lower East Side and retreated to Westport, Connecticut. There she was visited by many admirers including Eleanor Roosevelt, Albert Einstein and Jane Addams. In a 1937 radio broadcast celebrating Wald's 70th birthday; Mrs. Sara Delano Roosevelt read a letter from her son, President Franklin Roosevelt, in which he praised Wald for her ***"unselfish labor to promote the happiness and well being of others."*** She died in 1940 of a cerebral hemorrhage at the age of seventy-three.

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Visiting Nurse Service of New York City. Accessed on line on 9/14/10 at http://www.vnsny.org/search/?q=lillian+wald&x=13&y=16

Women of Valor exhibit on Lillian Wald. Accessed on line on 9/14/10 at the Jewish Women's Archive http://jwa.org/historymakers/wald

Resources

The Maternal and Child Health Library at Georgetown University. Pertinent documents have been digitized from a collection of U.S. Children's Bureau publications from 1912 to 1969 in the Maternal and Child Health Library, Georgetown University. In addition, selected documents that discuss the history of the Children's Bureau are included, and links are provided to Children's Bureau documents from the period that have been digitized by other libraries. Access them at http://www.mchlibrary.info/history/childrensbureau.html

The MCH Timeline: History, Legacy and Resource. The MCH Timeline which traces the history of maternal and child health in the U.S., provides in-depth modules on topics such as MCH 101, MCH Systems of Care, Infant Mortality and MCH Performance and Accountability, and allows the reader to search for topical areas of interest. Learn more at http://mchb.hrsa.gov/timeline/

HRSA MCH Fact Sheet: A description of the Health Resource's and Service's Administration Maternal and Child Health Bureau. The Bureau administers programs that serve more than millions of women, infants and children each year. About 60 percent of U.S. women who give birth receive some services through HRSA-supported programs. To learn more, go to http://www.hrsa.gov/about/pdf/mchb.pdf

The History of Title V Fact Sheet. Over the years, the achievements of Title V-supported projects have been integrated into the ongoing care system for children and families. This Fact Sheet provides a brief history and timeline of that development. Learn more at https://perfdata.hrsa.gov/mchb/mchreports/LEARN_More/Title_V_History/title_v_history.asp

Rosenbaum S, Proser M, Schneider and Sonosky C. Using the Title V Maternal and Child Health Services Block Grant to Support Child Development Services. The Commonwealth Fund, January 2002.

This report explains how services provided through the Title V Maternal and Child Health Services Block Grant can be used to foster optimal child development intervention services in the early years of life. The authors suggest that the flexibility of the Title V Maternal and Child Health Services Block Grant program allows it to be an originating and supportive source of funding for child development programs, including direct care for mothers and children and interventions for an entire family. The authors conclude that Title V can work alone or with other sources of funding, specifically Medicaid and CHIP. By paying for services that Medicaid cannot, Title V allows for the creation of more comprehensive and "wraparound" child development services. Assessed online at 8/20/10 at http://www.commonwealthfund.org/usr_doc/rosenbaum_titlev_481.pdf

Kent H and Streeter N. Title V strategies to ensure a continuum of women's health services. Womens Health Issues. 2008 Nov-Dec;18 (6 Suppl):S67-73.

The authors conclude that maternal and child health professionals who work in Title V-funded agencies and programs are well positioned to address the continuum of women's health needs across the lifespan. Title V directors and their staff work on issues such as health status before, during, after, and between pregnancies; healthy lifestyle practices, such as physical activity; and prevention of chronic disease, such as obesity, diabetes, and heart disease.

Telfair J, Bronheim SM, Harrison S. Implementation of culturally and linguistically competent policies by state Title V Children with Special Health Care Needs (CSHCN) programs. Matern Child Health J. 2009 Sep;13(5):677-86.

This descriptive study was intended to identify actual actions, steps and processes of Children with Special Health Care Needs (CSHCN) programs to develop, implement, sustain and assess culturally

and linguistically competent policies, structures and practices. An online 52-item mixed format survey of Maternal and Child Health (MCH) CSHCN directors was conducted. Findings indicated that almost all respondents are implementing some actions to provide culturally and linguistically competent services including adapting service practices, addressing workforce diversity, providing language access, engaging communities and including requirements in contracts. These individual actions were less often supported by processes such as self-assessment and creating an ongoing structure to systematically address cultural and linguistic competence. Programs are challenged to implement cultural and linguistic competence by state agency organization and budget restrictions. CONCLUSIONS: The results of the study indicate a continued need for support within state MCH CSHCN programs in order to maintain or enhance the systematic incorporation of culturally and linguistically competent efforts.

Johnson, KA, Little GA. State health agencies and quality improvement in perinatal care Pediatrics. 1999 Jan;103 (1 Suppl E):233-47.

The origin of the federal-state partnership in Maternal and Child Health (MCH) can be traced from the Children's Bureau grants of 1912, through the Sheppard-Towner Act, to the creation of Title V and other programs of today that mandate planning, accountability, and systems development. In the past decade with the transformation of the health care system and the emergence of managed care, the authors say that there has been a resurgence of interest in public, professional, and governmental interest in quality measurement and accountability. Regional perinatal systems have been implemented in all states with varying levels of involvement by state health agencies and the public sector. This historical framework discusses two primary themes: the decades of evolution in the federal-state partnership, and the emergence in the last three decades of perinatal regional system policy, and suggests that the structure of the federal-state partnership has encouraged state variation. A survey of state MCH programs was undertaken to clarify their operational and perceived role in promoting quality improvement in perinatal care. The authors found that State efforts in quality improvement, a process to make things better, have four arenas of activity: policy development and implementation, definition and measurement of quality, data collection and analysis, and communication to affect change. Few state health agencies (through their MCH programs and perinatal staff) are taking action in all four arenas. This analysis concludes that there are improvements MCH programs could implement without significant expansion in their authority or resources and points out that there is an opportunity for states to be more proactive as they have the legal authority and responsibility for assuring MCH outcomes.

Markel H and Goldenberg J. Successes and Missed Opportunities in Protecting Our Children's Health: Critical Junctures in the History of Children's Health Policy in the United States. Pediatrics Vol 115, No4 pp 1129–1133

The authors revisit several turning points in the history of child health policy for the purpose of understanding why many current health needs of children may have not been addressed. They demonstrate how the rupture of ties between child medical and child welfare leaders, as well as the fault lines between various health care professionals, led to difficulties in establishing programs for children in the early 20th century. The authors note how wartime mobilizations helped to make the needs of the nation's youth apparent to political leaders and observe that programs begun in response to these discoveries often were ended in peacetime. Finally, they discuss how politics shaped the situation wherein maternal and child health programs, including Medicaid, are need based, may be underfunded, and administered by the states, whereas benefit programs for the elderly, including Medicare and Social Security, are general entitlements administered at the federal level.

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