Advocating for Children’s Health at the State Level

Lessons Learned

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This article documents the successful creation and promotion of a bill to fund a nurse home visitation program for high-risk mothers in Arkansas. It illustrates several key factors in successful advocacy by pediatricians working in an academic setting: a realistic time commitment; a community needs assessment, data assimilation, and review of existing resources; the identification and incorporation of stakeholders; a narrow focus on the area of greatest need; the backing of political partners; and favorable opportunities to advance child health issues.

Since the beginnings of pediatrics as a distinct discipline within medicine, advocacy has been an integral part of the profession. Recently, increased advocacy has been encouraged by the American Academy of Pediatrics (AAP) through its Department of Government Liaison and Division of State Government and Chapter Affairs, its Web sites, and recent advocacy seminars and special articles.1-3

Academic departments of pediatrics have not commonly been centers of state advocacy, with few activities originating from community pediatric leaders. The following case study will provide an example of how an academic pediatric program successfully advocated for the establishment of a well studied program targeting at-risk children in the area of violence prevention and parenting (Figure 1). This was accomplished during a 1-year period with state AAP and state health official collaboration and close adherence to fundamental principles of advocacy. Suggestions for the initiation of similar projects in other communities will be proposed, and lessons learned from this experience will be discussed.

BACKGROUND

In 1997, the Department of Pediatrics of the University of Arkansas for Medical Sciences, Little Rock, established a Center for Health Promotion to advance the health of the children of Arkansas through program development, education, and community outreach. This activity was developed in response to a myriad of public health problems affecting children in Arkansas, including high teenage pregnancy rates and increased rates of injury, obesity, hypertension, school dropouts, gang violence, and overall poor health status. The center was established using state funds and supported 2 part-time faculty and a full-time coordinator. The faculty-level codirectors had worked in tobacco use prevention and injury epidemiology and had established relationships with the public health community. Under the direction of the department chair and as a natural outgrowth of long-standing work by the department in pediatric injury, the center undertook an in-depth review of child abuse and juvenile violence.

As a starting point, a community needs assessment was formally undertaken. The center set up a series of meetings with community organizations, political groups, and health professionals. These were well attended, and there was a general enthusiasm on the part of those involved to share ideas and experiences. These meetings served as opportunities for learning more about available prevention resources and to find service niches that needed to be filled. Groups invited included local and state government, educational, faith-based, advocacy, and nonprofit groups interested in children’s welfare. One of these early meetings was with members of the governor’s staff, specifically his liaisons on health and education. The purpose was to get to know the staff members and to offer the Center for Health Promotion as an information resource on child health issues. This early, agenda-less meeting laid the groundwork for later cooperation.

From the Center for Health Promotion, Department of Pediatrics, University of Arkansas for Medical Sciences, Arkansas Children’s Hospital, Little Rock.

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In all these meetings, the center explicitly promoted using evidence-based knowledge, with a strong evaluation component to any intervention undertaken. It was made clear that the center was not the beneficiary of the program but simply sought to facilitate change.

A next step was to review and update the center’s database using the literature on child abuse and juvenile justice. This was done by review of MEDLINE, Cochrane reviews, and other electronic resources, as well as personal contact and consultation with experts in the field. Among the foci of the review were models of child development explaining juvenile violence and interventions to prevent violence. In addition, the center used local public health statistics and programmatic histories on which to formulate local ideas for local intervention.

During the review process, the nurse home visitation model, developed by Olds and colleagues, was identified as a rigorously studied intervention with evidence of effectiveness in modifying important risk factors for the development of delinquency and violent behavior. Subject families demonstrated reduced child abuse and arrest rates and improved socioeconomic status in short-term and long-term follow-up. Olds visited Little Rock for public presentations shortly after the publication of the 15-year follow-up of his group’s intervention studies, increasing local momentum for these interventions. During this time, the center contacted other states that were implementing similar programs. Each state had taken a different approach and provided good experiential advice on legislative strategies.

In the midst of the study and review process, the state and the nation were devastated in March 1998 by an elementary school shooting in Jonesboro, Ark. Two boys, aged 11 and 13 years, lured their fellow elementary school students from their classrooms with a false fire alarm and then attacked the exposed children with a handgun and rifle barrage that left 4 girls and 1 teacher dead. This incident was followed by a series of high-profile incidents in the US involving school violence and child fatalities. Several hypotheses were put forth in the media and community to explain this event, and calls came forth for all types of new legislation, from juvenile sentencing to firearm restrictions. Because of prior work in the area of juvenile justice at a local level, center staff were invited to discuss juvenile violence in “op-eds” to the local media and by newspaper and television interviews.

**IMPLEMENTATION**

**Academic Focus**

The Jonesboro shooting prompted a local charitable organization connected to the Arkansas Children’s Hospital, Little Rock, to contact the center and request the rapid submission of a proposal for violence prevention projects. Because of its previous work in this field, the center was prepared for such a request and was able to respond promptly. A menu of potential projects was prepared: (1) a pilot of a nurse visitation program for high-risk mothers, using the Olds model, (2) distribution of violence screening instruments to primary care physicians in Arkansas, (3) conflict resolution curricula distribution to elementary schools in Arkansas, and (4) training of mental health professionals in the management of children with identified behavioral problems associated with violence or aggression. These 4 juvenile violence prevention projects were funded, allowing the center to develop direct experience with different interventions.

**State Focus**

Another result of the Jonesboro shooting was the creation of a Governor’s Task Force on Juvenile Violence. Because
of the center's previous contacts in the governor's office, its directors were invited to make a presentation to the task force early in its deliberations. The presentation to the task force focused on the developmental models of juvenile justice and focused on early childhood interventions to prevent later childhood violence. The Olds model of nurse home visitation was one of several interventions described. One of the members of the task force was a senior member of the State of Arkansas House of Representatives, herself a former prosecutor and social worker. She requested further meetings with the center, with the goal of writing a bill to fund such a program. She also facilitated meetings with other legislators, including the woman's legislative caucus.

Coalition Building

Having identified a legislative champion, and with a legislative session planned in 6 months, the center gathered stakeholders together for a candid discussion of a possible bill to establish a nurse home visitation program in Arkansas. The intention was to identify the level of support among stakeholders and to try to obtain early critical thinking by potential opponents. Issues debated included cost, competition with other worthy programs that affected child welfare, other potentially less expensive models of home visitation, and the appropriate size of such a program. Program size, scope, sustainability, and administration were also discussed. An attempt was made to include all interested parties in these meetings, and all comments were considered. Staff from the governor's office and members of the legislature and state agencies were in attendance at most of these meetings.

Once consensus was established, a bill, which included an advisory board to oversee the implementation of the project, was drafted and submitted to the legislature by Rep Rita Hale's office. The state AAP lobbyist was helpful in developing strategy. Identifying a sustainable funding source for the program was a clear problem throughout this process. Coincidentally, at this point, a new director of the Department of Health was appointed, who embraced the program, promised to attend the training, and with the center staff copresented the bill in legislative committee meetings. Funding for the first stage of the program (400 clients) was allocated from existing health department funds. With this support, the bill was passed out of committee, the House and the Senate unanimously approved it, and the bill became law in May 1999 (Figure 2).

Figure 2. The bill to establish a nurse home visitation program in Arkansas became law in May 1999. Pictured from left to right: Sarah Heffley, Gary Wheeler, MD, Rep Pat Bond, Rep Bobby Lee Trammell, Gov Mike Huckabee (seated), Mary Aitken, MD, Martha Hiett, Rep Rita Hale, Leigh Ann Rowlands, and Fay Boozman, MD. suing small projects initially will help to establish experience and credibility for larger projects as they arise. In this case, the formal support of the Department of Pediatrics provided the necessary time and effort required for success.

Needs Assessment

One should convene meetings that are educational, informational, fact finding, strategic, or combinations thereof. Strategic meetings include neutral introductory meetings with the political stakeholders in one's chosen advocacy area, before asking for any support or assistance. It was in these meetings that the legislative champion, the governor, and the director of the Department of Health embraced the nurse visitation program and shepherded it.

Data Assimilation

Large amounts of data are available on every community in the nation (from the Centers for Disease Control and Prevention, Atlanta, Ga; national surveys; local health departments; and other sources). These data provide the basis for the generation of logical hypotheses and, ultimately, for the persuasion of legislators and stakeholders. These data should be compiled and artfully presented. Most of our data were compiled from the literature on child abuse and juvenile justice, with an emphasis on regional data from reports of nurse home visitation program implementation in nearby Memphis, Tenn. Local data on child abuse and teen pregnancy were also highlighted.

Existing Resources

Academic pediatricians may be a key group to carry out long-standing advocacy efforts in each state. They can represent a cost-effective way to promote children’s health by having dedicated faculty and personnel available to address children’s policy issues. Use of existing resources, however, is key to the success of any large program. Local and national AAP offices are one such effective resource for advocacy activities. In our case, no member of our team had legislative experience, but the local AAP and hospital lobb-
byists were helpful in identifying potential supporters in the legislature and were capable consultants on legislative rules and strategy. Academicians in state institutions should be wary of issues in which advocacy by state employees is limited under state or federal law. In this case, our center staff members were summoned as experts to testify in committee hearings, while professional lobbyists worked directly with legislators to promote this program.

Identification of Stakeholders

Pediatrician advocates should be aware that, in any important area of advocacy, there will be many other individuals and groups with long-term investment in the area and with credible, but sometimes differing, viewpoints. It is critical in building a coalition to know all one’s allies and opponents, most of whom will share what they know, if asked. Advocates need to have an understanding of the players in the targeted area, if they are to be taken seriously by lawmakers, and need to know and respect their opponents, who will help by being the best critics. In the center’s meetings, 2 groups that preferred directing the nurse home visitation monies elsewhere chose to stay neutral because their philosophical hesitations were taken seriously and incorporated into the long-range plans.

Focus

Where possible, it is most effective to choose a single program to advance. The promotion of a program that has been well evaluated is most effective in a legislative environment. The promotion of ineffective or unproven models of intervention is risky and hinders one’s long-term credibility. Presentation of competing choices to a legislative group may also prove to be a disadvantage. In our case, months of background work were needed to establish confidence in the model proposed for legislation and to convince the coalition that this was the single best model. Division was dealt with outside of the legislative committee rooms. Another advantage was that hypotheses about its workability were tested in a local pilot program before a legislative proposal was launched.

The Authority of the White Coat

Pediatricians are viewed as authorities in the resolution of children’s issues. This provides significant political capital that must be jealously guarded and not wasted. Arkansas Children’s Hospital, the practice site of the coalition leaders, was well respected in the community and brought attention to the presentations when they were made to the legislators.

Expertise and Politics

Politics is for the politicians. One should identify a capable lawmaker to make the case, negotiate the deals, and build the political alliances. The legislature is a unique world with its own customs and rules. Unless one is a member (certainly an effective option), one should avoid being a player. Basic courtesy, including follow-up and thank-you letters, is important in establishing relationships with politicians. It is also important not to offend any politician, remaining neutral in public settings.

One may need to work for years before the political environment is right for one’s issue. However, if prepared, the right timing will allow successful advocacy. Our center was fortunate in having had prior preparation to act quickly after the Jonesboro shooting. Clearly, there was great support and pressure in our state to do something in the area of juvenile violence. Even though the center’s timetable was to approach lawmakers 2 years later, when its own demonstration projects were evaluated, the opportunity forced the early submission of a bill that was ultimately successful.

CONCLUSIONS

Advocacy is a rewarding activity that requires energy, time, and experience. The effectiveness of our center’s activities has reinforced the observations that pediatricians can be effective advocates for children and that important changes in public health can be brought about by changes in public policy. As in the past, advocacy is a legacy of our specialty that needs continuation as we chart our course in this new millennium.

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Arkansas State House Representative Rita Hale, the legislative champion described in this article, had a stroke shortly before the legislative session of 1999. Partially recovered, she took the floor to introduce and speak on behalf of HB 1613, the Prenatal and Early Childhood Nurse Home Visitation Bill. She suffered a fatal stroke after the legislative session closed. The Rita Rowell Hale Prenatal and Early Childhood Nurse Home Visitation Program began operations in the fall of 1999.

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REFERENCES


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