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## Keeping Score—How the States Measure Up on Health

If all states did as well as some states on leading health indicators, the nation would be a healthier place, according to a state scorecard on health system performance released in June by the Commonwealth Fund.

“The rich geographical diversity of the United States is part of its appeal. The diverse performance of the health care system across the U.S., however, is not,” the Commonwealth Fund said.

The June report ranks states on five dimensions of health system performance—access to health care, quality of care, costs of care, potentially avoidable use of hospitals, and the ability to lead healthy lives. Taken together, those categories cover 32 separate indicators of performance, ranging from infant mortality to the percentages of adults and children who have health insurance.

“Currently, where you live in the United States matters for quality and care experiences,” the report points out. “There is wide variation among states. Leading states consistently outperform lagging states. All states have substantial room to improve.”

Many of the highest-ranking states healthwise are in the upper Midwest—Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin—and in the Northeast—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Performing in the next rank down on the Commonwealth Fund’s five indicators are Colorado, Idaho, Montana, Utah, Washington, and Wyoming in the Northwest and Kansas is the Midwest, plus Maryland, Michigan, New York, Ohio, and Pennsylvania.

Ten widely separated states—Arizona, Idaho, Illinois, Indiana, New Jersey, New Mexico, North Carolina, Oregon, South Carolina, and Virginia—fall into the next quartile, with a large number of states—Alabama, Arkansas, California, Florida, Georgia, Kentucky, Louisiana, Mississippi, Nevada, Oklahoma, Tennessee, Texas, and West Virginia—ending up at the bottom of the rankings.

#### What Is Being Measured

- **Access.** The nation would insure 22 million more adults and children if all states moved to the level of coverage provided in the top-performing states. The percent of adults under age 65 who were uninsured ranges from a low of 11 percent in Minnesota to a high of 30 percent in Texas. The percent of uninsured children varies fourfold, from 5 percent in Vermont to 20 percent in Texas.
- **Quality.** Even in the best states, performance falls far short of optimal standards. Childhood immunization rates range from 94 percent in Massachusetts to less than 75 percent in the bottom five states. The percent of children with a medical home that helps coordinate care ranges from a high of 61 percent in New Hampshire to less than 40 percent in the bottom 10 states.
- **Avoidable use of hospitals and costs of care.** State rates of hospital admission for childhood asthma range from a low of 55 per 100,000 children in Vermont to more than 300 per 100,000 in South Carolina. For Medicare, if all states reached the low levels of hospital admissions found in the highest ranked states, Medicare could save billions of dollars annually.
- **Equity.** Equity gaps by income and insurance coverage exist in most states but the gaps are widest in states that perform poorly overall on quality and access indicators.

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- **Healthy Lives.** If death rates for all states improved to levels achieved by the best state (Minnesota, with 70.2 deaths per thousand), about 90,000 fewer premature deaths would occur annually. The report points out, however, that health system performance is only one of many forces that shape health status and longevity, including family history, immigration status, risk factors such as smoking and obesity, and workplace and environmental regulations.

The implications of its state scoreboard, the Commonwealth Fund said, are that “we have much to gain as a nation by aiming higher with a coherent set of national and state policies. Benchmarks set by leading states show that there are broad opportunities to improve and achieve more and better health care. All states can do better, and all should continually ask, ‘Why not the best?’”

*Information about the report, “Aiming Higher: Results from a State Scoreboard on Health System Performance,” which shows the performance of individual states on 32 indicators of health system performance, is available at [www.commonwealthfund.org](http://www.commonwealthfund.org).*

## What We Know and Do Not Know about Child Protection

School officials are required by law to report suspected cases of child abuse or neglect, but sometimes they fail to do so because of concern that child protective services will not help the children.

Trying to determine how well the U.S. child protection system actually works is the responsibility of the National Survey of Child and Adolescent Well-Being (NSCAW), an ongoing study authorized by the 1996 welfare reform law and administered by the Child and Family Services Division of the U.S. Department of Health and Human Services. The study currently looks at outcomes of abuse and neglect charges for more than 5,000 randomly selected children in investigated families in 92 randomly selected counties in the United States, plus several hundred children in foster care and a number of children living in child welfare institutions.

In a report published in July by the Brookings Institution, the authors examine what NSCAW has found so far and suggest that studies of children and families touched by the child protection system are rare. “We do not know enough about child abuse and neglect, and much of what we think we know is questionable.”

Some of the findings:

- Each year in the United States, nearly 900,000 children are physically harmed or neglected by their caretakers and approximately 1,300 of them die.
- Half a million children live in foster care—a living arrangement that includes families previously unknown to the child,

- relatives, and various forms of group and residential care.
- The nation’s child protection system includes mandatory reporting laws written and enforced in every state that require various professionals who have contact with children, such as doctors, nurses, and teachers, to report incidents of suspected abuse or neglect.
- Every state operates programs that are supposed to investigate these reports, to determine whether children have actually been abused or neglected and to decide what to do about it if abuse or neglect is confirmed.
- A third component of the protection system is “a somewhat haphazard set of services” that aims to help abusive families and their children.
- As established in federal and state statutes, the goals of the child protection system are to maximize child safety, keep children in permanent living arrangements, and promote the development of children in its care.
- In pursuing those goals, if abuse or neglect is confirmed, the welfare agency must first decide if it is safe to leave a child with its family or whether the child should be removed and placed in a foster home or with relatives. If children stay at home, the agency has to determine whether to provide services. If children are placed outside their homes, the agency must make reasonable efforts to reunify them with their families unless the situation is so dire that reunification would not be reasonable. If these efforts fail, the agency must make permanent arrangements in as timely a fashion as possible, with adoption the preferred option.
- These various and complex decisions are made by social workers who may have caseloads of 20 or more children. The courts then review the decisions.
- The child protection system is paid for by a combination of state, federal, and local resources. Federal funds flow from Title IV of the Social Security Act, which provides approximately \$7 billion a year to states that agree to abide by the rules specified in Title IV and the federal Child Abuse Prevention and Treatment Act.
- Parent training programs are believed to be effective in preventing future abuse, but most child protection agencies do not provide such services or use programs with little validation of effectiveness.

Making the case for parent training, the Brookings report points out that in most child protection cases, even when maltreatment is substantiated, children remain at home with their parents, and “a surprising share” of those families receive no services except, possibly, visits from a social worker. “Logic would suggest that parent training should be among the preferred offerings. After all, if parents are maltreating their children, they need a new set of parenting skills to replace those that brought them to the attention of the child protection agency in the first place.”

Parenting techniques are only part of the services families may need, however, the report points out. “A major finding is that children with parents who have mental health or substance abuse

problems are themselves at greatly elevated risk for mental health problems,” which suggests that many parents need two kinds of services—mental health or drug programs for themselves and parenting improvement programs so they can provide better care for their children.

Overall, the report concludes that “children in the child welfare system are being shortchanged” not only in provisions for their safety and continuity of care but in the important area of education, where surveys show that many of the children in protection may need special education services but fewer than 40 percent receive them. “Statutes and a sense of equity for these children both dictate that the child welfare system improve its performance in making certain that children receive the educational services they need.”

*Information about the report, “Child Protection: Using Research to Improve Policy and Practice,” is available at [www.brookings.edu](http://www.brookings.edu).*

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## The Impact of Media Violence on Children

In a United States Senate committee hearing in June, witnesses agreed that violence shown on television affects children but disagreed about whether the government should restrict violent content on the airways.

The American Psychological Association (APA) told the Senate Commerce Committee that there is ample evidence of the harmful effects of television violence on children. Jeff McIntyre of the APA’s Public Policy Office said studies have shown that repeated exposure to violence in the media places children at risk for desensitization to acts of violence and increases in aggression, plus “an unrealistic fear of becoming a victim of violence, which results in the development of other negative characteristics, such as mistrust of others.”

In other testimony, the leader of a National Television Violence Study in the 1990s cited evidence-based conclusions that can be drawn from scientific research on television violence. For one thing, said Dr. Dale Kunkel, most violence on television is shown in a manner that increases the risk of harmful effects on child viewers—portrayals fail to show realistic harm to victims, both short- and long-term, and immediate pain and suffering is included in fewer than half of the scenes. “Most depictions sanitize violence by making it appear much less harmful than it really is.”

Tim Winter, president of the Parents Television Council, an advocacy group, told the committee there is no doubt that television violence is increasing and that it is being viewed by children even in the so-called “family hours” of 7 to 9 p.m. “Last year, nearly half (49 percent) of all episodes that aired during the study period contained at least one instance of violence. Fifty-six percent was

person-on-person violence and 54 percent of violent scenes contained either a depiction of death or an implied death.” The parent group gave the Senate committee a DVD with a sampling of violent scenes from recent television programs that aired during the “family hour,” including stabbings, dismemberings, sexual violence, oral sex, and bloody beatings.

But whether it is a violation of the First Amendment to the U.S. Constitution for parents and others to ask for laws restricting violence on television also came up at the June 26 hearing. Lawrence Tribe, a professor of constitutional law at Harvard Law School, told the committee that suggested legislative responses to the violence problem such as “time channeling” (banning certain content during certain hours) are likely to run into free speech challenges in the courts. “Although parents can have a legitimate interest in restricting the television their children watch,” the solution is not more intrusive government control over the free flow of speech, Tribe said.

And in the most voluminous testimony at the hearing, Peter Liguori, president of entertainment for Fox Broadcasting Company, claimed that while three government reports—from the Surgeon General, the Federal Trade Commission, and the Federal Communications Commission—have concluded there may be a *connection* between television and violence, “there is no *causal* link.” Without evidence that TV actually causes children to become violent, “We cannot justify imposing content limits on the media,” he said.

*The June 26 hearing was called by the full Senate Committee on Commerce, Science, and Transportation in advance of possible congressional action on pending legislation on television content. For a listing of related bills, see the Congressional record website at <http://thomas.loc.gov> and search for “TV violence and children.”*

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## Consumers and Health Care—Are We Ready for Retail?

They’re not words we usually associate with health care—“retail,” “wholesale,” and “competition”—but they may be the biggest factors in how we receive and pay for health services in the future, according to researchers.

The research firm Booz Allen Hamilton suggested in a report released in July that medicine, like other parts of the economy, may be feeling the effects of “the fundamental forces at work in retail consumer markets—supply and demand.”

So far, most purchasing decisions in the U.S. health care system have been “wholesale,” made by large operators such as HMOs and insurance plans that give consumers limited or no choice about where they can go, and whom they will see, when they

need medical help. But researchers speculate it may now be time to give consumers information so they can choose—“shop”—for health care in the same way they do when buying a car. That would make health care a “retail” operation—sometimes called “consumer-driven” care.

Early signs of an evolution from the wholesale model include walk-in clinics, personalized concierge health care, consumer-directed health plans, remote monitoring of patients’ health conditions, and care delivery by nonphysician professionals.

We’re still in the early stages of a transition, if it is going to happen, Booz Allen notes, but it might be a good idea for physicians and other health care providers to be aware that change may be coming. So far, it is mostly people with high-deductible health plans who are beginning to act like retail consumers, comparing cost and quality in their health care options, and it’s hard for even those consumers to get trusted information about providers and suppliers.

Doctors interviewed for the study placed consumerism at the top of the list of issues they expect will affect their practices over the next three to five years, equal to or exceeding other much-talked-about possible developments, such as “pay-for-performance” or “evidence-based medicine.” Fewer than 20 percent of the doctors thought, however, that giving consumers choice would produce better outcomes or make patient-physician relationships more rewarding.

And because physicians so far seem unable or unwilling to provide the information consumers are likely to want about cost, quality, and service, that may lead to opportunities for “new intermediaries” who will provide such information. Whether those intermediaries would include current stakeholders who have traditionally served in information-providing roles—health plans and the government, for example—remains to be seen.

What the research so far shows, according to Booz Allen, is that we need more research—to help us understand a possible sea change in health care delivery and to help consumers use information, make decisions, and change behavior.

*Information about the survey, “Consumer and Physician Readiness for a Retail Healthcare Market” is available on the Booz Allen Hamilton website, at [www.boozallen.com](http://www.boozallen.com).*

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## WORTH NOTING

### States Say Need for Citizenship Proof Denies Medicaid to Eligible Citizens

A federal law enacted in 2005 that requires states to obtain documentary evidence of U.S. citizenship or nationality from

Medicaid applicants and current beneficiaries is turning out to be a barrier to Medicaid for many eligible citizens, according to a review of state experiences by the U.S. Government Accountability Office (GAO). Two aspects of the law seem to be causing the most problems: the documents provided have to be originals, and the list of acceptable documents is complex and doesn’t allow for any exceptions. Previous to enactment of the law, applicants for Medicaid could simply self-claim citizenship and nationality. The new requirements were expected to save money by preventing ineligible noncitizens from receiving Medicaid. Twenty-two of the 44 states that responded to a GAO questionnaire confirmed they have experienced declines in Medicaid enrollment as the result of the citizenship requirement, and a majority of those states said a lot of people “who appeared to be eligible citizens” lost Medicaid because they were unable to come up with the necessary documents.

### National Children’s Study to Look at Environmental Exposures

The federal National Institute of Child Health and Human Development (NICHD) is inviting comments and suggestions on the National Children’s Study, a long-term study of child health in the United States that will follow 100,000 children from birth to age 21, to examine the effects of environmental exposure and gene-environment interactions. Since a focus of the study is to assess effects of exposures that occur early in pregnancy, enrollment in the first four years will include pregnant women and their partners, couples planning pregnancy, and women with some probability of becoming pregnant. The study will then look at the impacts of environmental exposures at specific stages in the children’s development. Information about the study is available at [www.nationalchildrensstudy.gov](http://www.nationalchildrensstudy.gov) and procedures for commenting are at website [www.nationalchildrensstudy.gov/research/research-plan/index.cfm](http://www.nationalchildrensstudy.gov/research/research-plan/index.cfm).

### Children 5-18 Years Risk Sports-Related Brain Injury

The highest rates of sports- and recreation-related traumatic brain injuries are incurred by children between the ages of 5 and 18, according to the Centers for Disease Prevention and Control (CDC). In a report in *Morbidity and Mortality Weekly* (MMWR), the CDC points out that an estimated 65 percent of emergency department visits for sports- and recreation-related traumatic brain injuries are by persons in that age group. The CDC also notes that persons in the age group are at increased risk of concussion and for long-term effects, delayed recovery, and cumulative consequences of multiple traumatic brain injuries, including depression and dementia. The report, “Nonfatal Traumatic Brain Injuries from Sports and Recreation Activities,” appears in *Morbidity and Mortality Weekly Report* for July 27, 2007, at [www.cdc.gov/mmwr](http://www.cdc.gov/mmwr).

*The following information appeared during the months of June and July 2007 in the News Alerts section of the website of the Center for Health and Health Care in Schools, at [www.healthinschools.org](http://www.healthinschools.org).*

### **June 12, 2007 HHS Sets \$81 Million for Family Planning Grants in 2008**

The Office of Population Affairs in the U.S. Department of Health and Human Services announced yesterday that it expects to make approximately \$81.1 million available for Title X family planning grants to public or nonprofit agencies in 21 specified states or population areas in fiscal year 2008. As in previous years, the grants may not be used for programs in which abortion is a method of family planning, and grantees must provide counseling to minors on how to resist efforts to coerce them into sexual activities. Recipients of grants are also required to conform to state laws requiring them to report child abuse, child molestation, sexual abuse, rape, or incest. Program priorities for 2008 include services to individual from low-income families and require that grantees assure access to a broad range of “acceptable and effective” family planning methods and related preventive health services, including “natural family planning methods; infertility services and services for adolescents; highly effective contraceptive methods; breast and cervical cancer screening and preventive services; STD and HIV prevention education, counseling, testing, and referral; and adolescent abstinence counseling. The announcement of 2008 program priorities appears in the Federal Register for June 11, 2007, which can be accessed at [www.access.gpo.gov](http://www.access.gpo.gov).

### **June 14, 2007 Kellogg Says It Will Market Only Nutritious Food to Children**

The Kellogg Company said today it is changing “what and how” it markets to children between the ages of six and twelve, using “nutrient criteria” that set an upper threshold per serving of no more than 200 calories, 2 grams of saturated fat, zero grams of trans fat, 230 milligrams of sodium, and 12 grams of sugar. The new criteria will apply to advertising on TV, radio, and the Internet, as well as in print, and include in-school marketing, the company said. The change will require reformulation of some products to meet the nutrient criteria, and products that do not make the cut will not be marketed to children under 12 by the end of 2008, according to a press statement. The company also announced that beginning later this year, consumers will see Guideline Daily Amounts on the front of ready-to-eat cereal packages in the United States, Canada, and Mexico. In the U.S., new packaging will feature a label on the top, right-hand corner of cereal boxes, identifying percentages of calories, total fat, sodium, and grams of sugar per serving. The labels will also identify nutrients Americans need to consume more of, including fiber, calcium, potassium, magnesium, and vitamins A, C, and

E. Kellogg brands include Kelloggs, Keebler, Pop-Tarts, Eggo, Cheez-It, Nutri-Grain, Special K, Rice Krispies, Murray, Austin, Morningstar Farms, Famous Amos, Carr’s, Plantation, Ready Crust, and Kashi.

### **June 14, 2007 HHS Steps Up Domestic Influenza Vaccine Production**

The U.S. Department of Health and Human Services (HHS) said today it has awarded contracts to two U.S. manufacturers to retrofit their influenza vaccine manufacturing facilities and set up “warm-base” operations in which the factories will be active year-round. The grants to sanofi pasteur, who makes an inactivated egg-based vaccine, and MedImmune, who makes a live, attenuated vaccine also based on eggs, will expand U.S. pandemic vaccine manufacturing capacity by 16 percent and will afford year-round production of pre-pandemic influenza vaccines for the national stockpile, the HHS said. A pandemic preparedness plan issued in 2005 calls for stockpiling enough vaccine to vaccinate 20 million persons in critical workforce positions at the onset of a pandemic, with “surge” manufacturing capacity capable of providing vaccine for another 300 million persons within six months of the beginning of a pandemic.

### **June 15, 2007 NY Awards \$13 Million in SBHC Grants**

New York State Governor Eliot Spitzer announced today that the state is awarding \$13.2 million in grants to health care institutions that have agreed to sponsor health centers in schools. “School-based clinics are an innovative way of ensuring that children receive quality health care,” Spitzer said. “These clinics provide easy access to health care professionals for checkups and treatment without missing classes and without parents needing time off from work. This is especially important for children who need routine treatment for asthma, diabetes, and other chronic conditions.” The New York school-based health center program was established in 1981 and is now the largest program of its kind in the nation, with approximately 190,000 children accessing centers at 197 schools each year. The grants announced today range in size from more than \$1 million to Lutheran Health Center in New York City to the smallest grant—\$9,942—to a sponsor in the western part of the state.

### **June 19, 2007 'Children's Congress' Calls Attention to Diabetes**

As they do every year, advocates for more federal spending to research and cure both forms of diabetes—type 1, formerly known as “juvenile diabetes” and type 2, formerly known as “adult onset diabetes”—brought a Children’s Congress made up of young diabetes patients to Capitol Hill this week, for a conference and congressional testimony sponsored largely by Novo Nordisk, manufacturer of insulin products and delivery devices

such as the insulin pen. In a fact sheet on diabetes mellitus, Novo Nordisk pointed out that diabetes is a chronic disease in which the body does not produce or properly use insulin, a hormone that is needed to convert sugar, starches, and other food into energy. People who have diabetes have high levels of sugar in their blood, and untreated diabetes can lead to health complications, including heart disease and stroke, kidney disease, high blood pressure, blindness, nerve problems, and amputations. Currently, an estimated 20.8 million people, or 7 percent of the population, have diabetes in the United States, according to the fact sheet, and 6.2 million of them remain undiagnosed and are not being treated. Nearly two-thirds of people diagnosed with type 2 diabetes are not successfully managing the condition, exceeding the recommended sugar levels and putting themselves at risk for complications. “The incidence of diabetes is growing rapidly among children: more than 13,000 young people are diagnosed with type 1 each year,” the fact sheet points out, “and health care providers are finding more and more children with type 2 diabetes—a disease usually diagnosed in adults aged 40 years or older.” Treatments for type 1 diabetes, in which the pancreas does not make insulin and insulin shots are required to use glucose from meals, include rapid-acting or “bolus” insulin taken after eating and long-acting or “basal” insulin that provides a steady amount of insulin for up to 24 hours. Persons with type 2 diabetes are usually treated with medication and urged to adopt a healthful eating and exercise program, but most will eventually require insulin. More information about both types of diabetes is available at the American Diabetes Association website, [www.diabetes.org](http://www.diabetes.org).

### June 22, 2007

#### Senate Bill Would Give SBHCs Medicaid and SCHIP Payments

Legislation introduced in the U.S. Senate June 20 would allow states to make school-based health centers (SBHCs) eligible for reimbursement under Medicaid and the State Children’s Health Insurance Program (SCHIP) for comprehensive health and mental health services provided to children and adolescents who are enrolled in Medicaid and SCHIP. The bill, S. 1669, introduced by Senator Debbie Stabenow (D-MI) and five co-sponsors, would amend the Social Security Act to make SBHCs eligible entities under the two federal programs that insure children and adolescents whose families are unable to afford private health insurance. Under the proposed legislation, states would be able to pay under Medicaid and SCHIP for “covered items and services” furnished by school-based health centers that deliver primary pediatric and mental health services. The bill, Healthy Schools Act of 2007, can be read and tracked at <http://thomas.loc.gov>.

### July 5, 2007

#### New Guidelines for Chicken Pox Vaccination

It was the last of the common childhood diseases to be prevented by vaccination, and since a varicella vaccine was introduced in 1995, there has been a marked reduction from the estimated 4

million cases of chicken pox that occurred annually in the United States. Initially recommended by the Advisory Committee on Immunization Practices (ACIP) for administration to healthy children aged up to 12 months, and to previously unvaccinated adolescents and adults, the vaccine seemed to be highly effective, but increasing reports of outbreaks of chicken pox among highly vaccinated populations have caused the ACIP to upgrade its recommendations. The most recent suggestions, published June 22 in the CDC publication *Morbidity and Mortality Weekly Report* (MMWR), note that in the 10-year observation period, comparisons of one-dose and two-dose regimens showed onset of chicken pox after vaccination was more likely when children and adolescents were given just one dose of the vaccine. That is leading the ACIP to recommend that infants and young children be given two doses, one at 12 to 15 months of age and another at 4 to 6 years. For adults and adolescents, two doses 4 to 8 weeks apart are now recommended for all adolescents and adults that have no evidence of immunity, with a catch-up of two doses for persons who received the previously recommended one catch-up dose. Varicella vaccination is now recommended for children attending child care centers, students in all grade levels, and persons attending college or other postsecondary education institutions. The report, “Prevention of Varicella,” dated June 22, 2007, is available online at [www.cdc.gov/mmwr](http://www.cdc.gov/mmwr).

### July 9, 2007

#### Congress Will Consider Extending SCHIP

As the U.S. Congress returns from a Fourth of July break and settles down for the July/August session, major debate is expected on whether to continue and expand the State Children’s Health Insurance Program (SCHIP), which provides health insurance to children in families too poor to buy private insurance but too well off to be on Medicaid.

The Bush administration in its 2008 budget proposed to continue SCHIP but to increase funding for the program by \$5 billion over the next five years, which is the amount expected to be needed to keep the current number of children enrolled in SCHIP. Congressional Democrats have vowed, however, to authorize an increase of \$50 billion more for the program over the next five years, which would allow for a major expansion of the number of children with health insurance. The administration and some Republicans in Congress oppose any major increase in SCHIP as an opening wedge for universal health coverage and have pledged to oppose the Democratic increase. For further information about SCHIP, see [www.healthinschools.org/ejournal/2007/April4.htm](http://www.healthinschools.org/ejournal/2007/April4.htm).

### July 19, 2007

#### President Pledges Veto of SCHIP Extension

President Bush said yesterday that he will veto an extension of the State Children’s Health Insurance Program (SCHIP) if Congress sends him legislation increasing spending for SCHIP by \$35 billion over the next five years. A Senate committee is recommending the \$35 billion figure after scaling down a pro-

posal for a \$50 billion increase. The added funds would allow the program to expand SCHIP to more children, a move the Bush administration opposes on what the President described yesterday as “philosophical” grounds. The administration has said it regards expansion of SCHIP as a first step toward government-provided health insurance for all Americans. The SCHIP program, which was enacted 10 years ago, is due to expire this year unless Congress acts and the President agrees to reauthorize it. The program is intended to provide affordable health insurance to families too well off to qualify for Medicaid but not earning enough to buy private insurance.

### July 20, 2007 Journal Reports on ADHD Follow-up Studies

Four reports in the August 2007 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry* discuss outcomes of various types of treatment for children with Attention Deficit Hyperactivity Disorder (ADHD). In an analysis of the studies released today, the National Institute of Mental Health in the National Institutes of Health reported improvement following ADHD treatment in most children. “We were struck by the remarkable improvement in symptoms and functioning across all treatment groups,” said Dr. Peter Jensen of Columbia University, who led one of the studies. The studies found, however, that children treated in a variety of ways for ADHD were at higher than normal risk for behavioral problems such as delinquency and substance abuse. And although half to two-thirds of children in the treatment groups were taking medication for more than three years, the studies found continuing medication was no longer associated with better outcomes by the third year. One of the studies found that taking medication slowed growth in children, and although growth became normal in the third year of medication, children never made up for the earlier slowing. The studies, funded by the National Institute of Mental Health, expect to continue as the participating children go through adolescence and enter adulthood.

### July 25, 2007 Researchers Look at Pre-K TB Screening

States and school districts differ on whether all children should be tested for tuberculosis infection before they enter kindergarten, and an article in the July issue of the journal *Pediatrics* asks whether such universal testing is cost-effective. Using California as an example, researchers noted that public officials have made decisions about whether to require testing “based on the available evidence and local preferences.” A universal TST (tuberculosis skin test) is mandated as part of the screening component of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, and the researchers note that routine skin testing of all children is still practiced in many parts of the United States. That’s despite a recommendation by the Pediatric Tuberculosis Collaborative Group, which recommended in 2004 that universal TST should be replaced by “risk factor screening” based on

responses to questions such as country of birth, travel history, exposure to TB, and close contact with someone with positive TST results. When they looked at the cost-effectiveness of universal versus targeted screening (in terms of the costs of full-blown tuberculosis to the health system), the researchers concluded that they “strongly support” the recommendations of the Pediatric Tuberculosis Group for discontinuing universal TST of children. The article, “Cost-effectiveness of Alternative Strategies for Tuberculosis Screening Before Kindergarten Entry” appears in the July 2007 issue of the journal *Pediatrics*.

### July 27, 2007 Texas Offers Schools \$20 Million to Fight Childhood Obesity

The state of Texas is offering public and charter schools opportunity to apply for grants that will total \$20 million over two years, to support physical education, nutrition, and fitness programs for middle school students attending schools where enrollment is at least 75 percent economically disadvantaged. The new Texas Fitness Now grant program will be administered by the Texas Education Agency, which will evaluate grant applications and award funds to schools. An estimated 700 schools are expected to qualify for grants of no less than \$1,500 each. Described as part of the state’s “continued fight against childhood obesity,” the grant program is expected to benefit more than 270,000 students.

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