POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Poverty and Child Health in the United States

COUNCIL ON COMMUNITY PEDIATRICS

Almost half of young children in the United States live in poverty or near poverty. The American Academy of Pediatrics is committed to reducing and ultimately eliminating child poverty in the United States. Poverty and related social determinants of health can lead to adverse health outcomes in childhood and across the life course, negatively affecting physical health, socioemotional development, and educational achievement. The American Academy of Pediatrics advocates for programs and policies that have been shown to improve the quality of life and health outcomes for children and families living in poverty. With an awareness and understanding of the effects of poverty on children, pediatricians and other pediatric health practitioners in a family-centered medical home can assess the financial stability of families, link families to resources, and coordinate care with community partners. Further research, advocacy, and continuing education will improve the ability of pediatricians to address the social determinants of health when caring for children who live in poverty. Accompanying this policy statement is a technical report that describes current knowledge on child poverty and the mechanisms by which poverty influences the health and well-being of children.

STATEMENT OF THE PROBLEM

Poverty is an important social determinant of health and contributes to child health disparities. Children who experience poverty, particularly during early life or for an extended period, are at risk of a host of adverse health and developmental outcomes through their life course.[1] Poverty has a profound effect on specific circumstances, such as birth weight, infant mortality, language development, chronic illness, environmental exposure, nutrition, and injury. Child poverty also influences genomic function and brain development by exposure to toxic stress,[2] a condition characterized by "excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships."[3] Children living in poverty

DOI: 10.1542/peds.2016-0339

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

To cite: AAP COUNCIL ON COMMUNITY PEDIATRICS. Poverty and Child Health in the United States. *Pediatrics*. 2016; 137(4):e20160339

are at increased risk of difficulties with self-regulation and executive function, such as inattention, impulsivity, defiance, and poor peer relationships.[4] Poverty can make parenting difficult, especially in the context of concerns about inadequate food, energy, transportation, and housing.

Child poverty is associated with lifelong hardship. Poor developmental and psychosocial outcomes are accompanied by a significant financial burden, not just for the children and families who experience them but also for the rest of society. Children who do not complete high school, for example, are more likely to become teenage parents, to be unemployed, and to be incarcerated, all of which exact heavy social and economic costs.[5] A growing body of research shows that child poverty is associated with neuroendocrine dysregulation that may alter brain function and may contribute to the development of chronic cardiovascular, immune, and psychiatric disorders.[6] The economic cost of child poverty to society can be estimated by anticipating future lost productivity and increased social expenditure. A study compiled before 2008 projected a total cost of approximately $500 billion each year through decreased productivity and increased costs of crime and health care,[7] nearly 4% of the gross domestic product. Other studies of "opportunity youth," young people 16 to 24 years of age who are neither employed nor in school, derived similar results, generating cohort aggregate lifetime costs in the trillions.[8]

Child poverty is greater in the United States than in most countries with comparable resources. In a 2012 report from the United Nations Children's Fund,[9] the United States ranked 34th of 35 member nations of the Organization for Economic Cooperation and Development, a reflection of the rate of child poverty during and immediately after the Great Recession of 2007–2009. A later 2014 report from the Organization for Economic Cooperation and Development[10] ranked the United States 35th of 40 nations, only above Chile, Mexico, Romania, Turkey, and Israel. This policy statement specifically addresses child poverty in the United States but reflects the 2015 United Nations' Sustainability Goal to end poverty in all its forms everywhere.[11]

According to 2014 Census data, an estimated 21.1% of all US children younger than 18 years (15.5 million) lived in households designated as "poor" (ie, in 2014, incomes below 100% of the federal poverty level [FPL] of $24 230 for a family of 4*) and 42.9% (over 31.5 million) lived in households designated as "poor, near poor, or low income" (ie, incomes up to 200% of the FPL). Nearly 9.3% (6.8 million) lived in households of deep poverty (ie, incomes below 50% of the FPL).[12] In 2014, an estimated 16 million children lived in families who received Supplemental Nutrition Assistance Program (SNAP) benefits.[13] Between 2007 and 2010, foreclosures affected 5.3 million children.[14]

Demographics have a profound influence on the likelihood that a family or community will experience poverty or low income. For example, African American, Hispanic, and American Indian/Alaska Native children are 3 times more likely to live in poverty than are white and Asian children.[15] Infants and toddlers more commonly live in poverty than do older children.

Children may be born into poverty, remain in a poor household throughout childhood, or, most commonly, rotate in and out of poverty over time. Approximately 37% of all children live in poverty for some period during their childhood.[16] Children who are born into poverty and live persistently in poor conditions are at greatest risk of adverse outcomes. However, even short-term spells of poverty can expose children to hardships, such as food insecurity, housing insecurity/homelessness, loss of health care, and school disruptions.

Equality of opportunity is central to the American dream and is reflected by social mobility or the potential of intergenerational economic betterment. However, social mobility is difficult to measure, because the usual method compares incomes of 30-year-old persons against the incomes of their parents. Despite the difficulties, most researchers agree that social mobility in the United States has faltered as the wealth and opportunity gaps between rich and poor have widened in the past decade. In comparison with European and other wealthy industrialized countries, social mobility in the United States ranks among the lowest.[17] A 2015 Pew Charitable Trusts report documented that the effect of parental income advantage is persistent over all levels of parental income but is especially strong for children born to wealthy families. Persistent parental economic advantage means that a son's income is strongly influenced by his father's, indicating low social mobility. The result is a dramatic decline of the possibility of economic improvement for the poor.[18] Poor children tend to remain poor and live

* The FPL is determined by comparing a family's pretax cash income to an income poverty threshold that is 3 times the cost of a minimum food diet. This measure does not take into account government benefits (eg, SNAP), income tax credits, or family expenses (eg, child care, income taxes) and has not fundamentally changed since 1969 except for annual adjustments for food price inflation. In 2010, the SPM was instituted to provide a more comprehensive measure of a family's financial circumstances. The SPM includes the value of certain federal in-kind benefits, federal tax benefits, and family expenses. For additional details on these measures, see the accompanying technical report, "Mediators and Adverse Effects of Child Poverty in the United States."

in neighborhoods of low opportunity. Wealthy children continue to be wealthy as adults and enjoy academic and employment advantages.

The drag on social mobility resulting from income and opportunity inequality is even more striking for people of color. During the recovery of the Great Recession, income inequality in the United States accelerated, with 91% of the gains going to the top 1% of families.[19] Left out of the recovery were African American families who, during the downturn, lost an average of 35% of their accumulated wealth.[20] African American unemployment increased, home ownership decreased, and child poverty deepened to approximately 46% of children younger than 6 years.[21] Because social mobility is lowest for people in the lowest income quartile, half of African American children who are poor as young children will remain poor as adults, approximately twice as many as white adults similarly exposed to poverty as children.[22]

Although legacy residential segregation and environmental racism persist as regions of deep poverty in mostly urban areas,[23] the epidemiology of poverty has shifted over the past decade, in part because of the housing crisis and the Great Recession. Since 2008, suburbs have experienced larger and faster increases in poverty than either urban or rural areas.[24] This significant shift in the location and demographics of children and families dealing with financial stress makes necessary a reevaluation of the current engagement and service delivery systems that may not meet this emerging need.[25]

Because pediatricians work to prevent childhood diseases during health supervision visits and with anticipatory guidance, the early detection and management of poverty-related disorders is an important, emerging component of pediatric scope of practice. With improved understanding of the root causes and distal effects of poverty, pediatricians can apply interventions in practice to help address the toxic effects of poverty on children and families. They also can advocate for programs and policies to ameliorate early childhood adverse events related to poverty. Pediatricians have the opportunity to screen for risk factors for adversity, to identify family strengths that are protective against toxic stress, and to provide referrals to community organizations that support and assist families in economic stress. This policy statement builds on previous policies related to child health equity,[26] housing insecurity,[27] and early childhood adversity.[3] The accompanying technical report from the American Academy of Pediatrics (AAP), "Mediators and Adverse Effects of Child Poverty in the United States,"[28] supports this statement by describing current knowledge on childhood poverty and the mechanisms by which poverty influences the health and well-being of children.

WHAT WORKS TO AMELIORATE THE EFFECTS OF CHILD POVERTY

Programs that help poor families and children take many forms and often involve stakeholders from multiple communities, including governmental, private nonprofit, faith-based, business, and other philanthropic organizations. The following paragraphs describe several antipoverty and safety net programs that are particularly important for child health and well-being. These programs help families by increasing access to cash, providing "near-cash" benefits, and investing in child development.

Individual program outcomes, including financial cost-benefit estimates, are documented where possible. However, the cumulative effect of safety net programs has been demonstrably positive. Longitudinal studies from 1967 to 2012 that used the Supplemental Poverty Measure (SPM) revealed that government programs have had a significant effect on family poverty. Without these programs, the rate of child poverty would have increased to 31% in 2012, 13 percentage points more than the actual SPM child poverty rate of 18%. Therefore, the income supports and direct benefits provided by these government programs have cut family poverty almost in half, from an estimated 31% to approximately 16%.[29]

Tax Policies and Direct Financial Aid

The earned income tax credit (EITC) is a refundable federal tax credit that helps low-income families. The EITC helps reduce poverty by incentivizing employment and supplementing income for low-wage workers. In 2012, 25 states had established their own state-level credits to supplement the federal credit.[30] The Center on Budget and Policy Priorities estimates that the federal EITC lifted 3.1 million children out of poverty in 2011.[31] The EITC has been shown to increase workforce participation among single women with children and help families pay for basic essentials.[32] Additional research also has connected the EITC to improvements in infant health. An analysis of families who received the largest EITC under the 1990s expansions of the credit showed lower rates of low birth weight children, fewer preterm births, and increased prenatal care among these families.[33]

The child tax credit provides tax refunds to low-income working families who pay payroll taxes but who might not owe federal income tax. Although only partially refundable, this direct cash benefit in 2012 helped approximately 1.6 million children and their families maintain an income above the FPL.[34]

Taken together, the EITC and child tax credit represent tax policies that reduce childhood poverty and its effects.

Temporary Assistance for Needy Families (TANF) is a block grant program by which the federal government provides money for states to fund work and family support programs with specific goals and time limits. The Personal Responsibility and Work Reconciliation Act of 1996 (often referred to as welfare reform) created TANF to replace Aid to Families with Dependent Children, thereby creating block grants for state administration, work requirements for eligibility, and lifetime limits on receipt of federal support. Because of unchanging federal funding levels and limits of the amount of time individuals can access benefits, the number of families receiving TANF has decreased, despite the increased need since the Great Recession. National TANF caseloads, especially those receiving cash benefits, have declined by 50% since 1996, with state caseload reductions varying from 25% to 80% despite the steadily increasing numbers of families in poverty and deep poverty.[35] The latitude that states have to designate how the funds are used adds to the limitation of TANF as a national safety net program.

Income stagnation in recent decades and the erosion of purchasing power have contributed to the financial instability of working poor families.[36] Raising the minimum wage has been shown to help some low-income families reach 200% of the FPL and to be considered out of poverty.[37] The benefit to children of improved family income stability is both general and specific. Financial stability means that basic needs, such as housing and transportation, are more dependable and family stress may be reduced. School readiness and academic performance of children are sensitive to family income. In a 1999 analysis by the Brookings Institute, statistically significant increases in math and reading performance were associated with only a $1000 increase in family annual income.[38] A retrospective review of population data drawn from the Panel Study of Economic Dynamics and covering the years 1968 to 2005 correlated the date of birth and family income during early childhood with eventual adult educational and economic attainment. The results suggest that an increase in annual family income of only $3000 during early childhood may result in significant improvements on both SAT scores and adult labor market success measured by an earnings increase of almost 20%. The association is strongest at the low end of the family income scale and becomes statistically nonsignificant for wealthy families.[39]

Work requirements for cash and other benefits have been advanced, especially since welfare reform in the 1990s, as a way to promote self-sufficiency and reduce welfare rolls. However, as a consequence of young mothers being required to work, infants may be placed in child care at a very early age, and mothers often require a patchwork of solutions, some of which may be substandard.[40] Quality child care and early childhood education are extremely important for the promotion of cognitive and socioemotional development of infants and toddlers.[41] Yet, child care may cost as much as housing in most areas of the United States, 25% of the budget of a family with 2 children, and infant care can cost as much as college.[42] Many working families benefit from the dependent care tax credit for the cost of child care, allowing those families to place their children in a certified or higher-quality environment.[43] However, working families who do not have sufficient income to pay taxes are not able to realize this support for their children, because the credit is not refundable or paid to families before taxation.[44] Therefore, some of the most at-risk children who might benefit from high-quality early childhood education are not eligible for financial support.

Access to Comprehensive Health Care

Children in poverty who otherwise would not have access to health care have greatly benefited from Medicaid and the Children's Health Insurance Program (CHIP) and many provisions and protections of the Patient Protection and Affordable Care Act. From 1984 through 2013, the rate of uninsured poor children decreased by 70%, from approximately 29% to just over 8%. During the first 3 months of 2014, the uninsured rate for poor children dropped further to 6.6%.[45] As a measure of benefit from expanded coverage, children enrolled in Medicaid or CHIP are more likely to access preventive care than are uninsured children.[46, 47] In addition, CHIP has resulted in a 9.8% increase in the coverage of children with chronic illness and a 6.4% decrease in uninsured children in the general population.[48] In 2009, CHIP programs expanded access to comprehensive care by covering dental, mental health, and substance abuse services in addition to medical and surgical care for all eligible near-poor children.[49]

Early Childhood Education

Early Head Start and Head Start are federally funded, community-based programs for low-income families with young children. Early Head Start serves pregnant women and families with infants and toddlers up to 3 years of age; Head Start serves families with preschool-aged children 3 to 5 years of age. In fiscal year 2011, the programs served more than 900 000 children nationally, with a budget of $7

billion. These programs provide educational, nutritional, health, and social services. In addition to child care and preschool services, Early Head Start and Head Start offer prenatal education, job-training and adult education, and assistance in accessing housing and insurance.[50] However, Early Head Start presently serves only approximately 3% of low-income families.[51] The Child Care Development Block Grants Act of 2014 and subsequent appropriations also provide child care subsidies for low-income working families and funds to improve child care quality, in addition to new and needed protections to keep children safe and healthy when they are being cared for outside the home.[52]

Early childhood interventions have been found to have a high rate of return in both human and financial terms. Early interventions in high-risk situations have the highest return, presumably through mitigating the effects of toxic stress by providing nurturance, stimulation, and nutrition. Child benefits include improved cognitive functioning, improved self-regulation, and advancement of development in all domains. Research as early as 2005 by the Rand Corporation found a range of return on investment from $1.80 to $17 for each dollar spent on early childhood interventions.[53] More recent studies of preschool (birth to age 5 years) education estimate a return on investment as high as 14% per year on the basis of improved academic and occupation outcomes, in addition to lowered costs of remedial education and juvenile justice involvement.[54]

Nutrition Support

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federal assistance program of the US Department of Agriculture that was first established in 1974 with the aim of improving the health of low-income women, infants, and children. WIC provides nutrition education, growth monitoring, and breastfeeding promotion and support in addition to food for pregnant and postpartum women, infants, and children younger than 5 years with incomes less than 185% of the FPL.[55]

WIC is associated with improved outcomes in pregnancy and early childhood development. A series of reports from the US Department of Agriculture has shown that WIC participation for low-income women decreased the rates of prematurity and infant mortality and increased involvement in prenatal care.[56] The promotion of breastfeeding has resulted in significant improvements in the rate and duration of exclusive breastfeeding among WIC participants.[57] Studies of the postinfancy period also have shown that WIC increases the quality of children's diets, with increases in micronutrient intake and resulting decreases in iron-deficiency anemia. Children participating in WIC have scored higher on assessments of mental development at 2 years of age than similar children who were not participating in the program. In addition, children whose mothers participated in WIC when they were in utero have also been shown to perform better on reading assessments than similar children of mothers who did not use the program.[58]

SNAP, formerly referred to as "food stamps," uses an electronic benefits card to provide nutrition assistance to low-income individuals and families. As with other federal programs, eligibility depends on income, age, family size, and citizenship. More than 45 million Americans currently receive SNAP benefits each month, including approximately 20 million children.[59] Using the SPM, SNAP benefits reduce both the rate (decrease of 4.4% attributable to SNAP from 2000 to 2009) and, more importantly, the depth of poverty for children in the poorest of poor families.[60]

The National School Lunch Program is a federally funded program that provides low-cost and free breakfasts, lunches, and, on a limited basis, summer food to school-aged children. The federal program supplies both public and private nonprofit schools with food and cash incentives. The meals are produced in accordance with the Dietary Guidelines for Americans. In 2012, 31.6 million children each day were served low-cost and free lunches at a total cost of $11.6 billion.[61] Students from families with an income less than 130% of the FPL are eligible to receive free meals, and those from families with an income less than 185% of the FPL are eligible for reduced-price meals. A recent analysis estimated that, using these guidelines, more than half of all US public school students are eligible to receive free or reduced-price meals.[62]

Nutrition support, such as WIC and SNAP, address undernutrition, but other forms of malnutrition, such as obesity, also may be responsive to supplemental programs. For instance, a recent study in preschool-aged children found that those who participated in Head Start had a healthier BMI at school entry than did children who did not have the benefit of food provided by federal subsidy.[63]

Home Visiting

The Maternal, Infant, and Early Child Home Visiting (MIECHV) Program was established as part of the Affordable Care Act in 2010. It provides support for federal, state, and community governments to implement established and proven home visiting programs for at-risk children. The stated goals of MIECHV are to improve maternal and newborn health; prevent child injuries, abuse, neglect, or maltreatment; reduce emergency department visits; improve school

readiness and achievement; reduce crime or domestic violence; improve family economic self-sufficiency; and improve coordination and referrals for other community resources and supports.[64]

MIECHV has identified 19 evidence-based interventions that target families with pregnant mothers and children younger than 5 years.[65,66] One example of an MIECHV program with evidence of success is the Nurse-Family Partnership. First-time, low-income mothers are enrolled during the prenatal period and visited weekly by nurses trained in a validated curriculum beginning in the second trimester. The benefit-cost ratio for high-risk mothers has been calculated at 5.68 to 1.[67]

Family and Parenting Support in the Medical Home

Programs designed for the pediatric medical home provide opportunities for low-cost, population-based preventive intervention with low-income families. An awareness of the protective factors that are present in children and families can help pediatricians to build on their strengths during health promotion conversations. A commonly used instrument to assess protective factors in high-risk families is available through the FRIENDS National Resource Center.[68] The Protective Factor Survey is used to assess current status as well as change over time in family resiliency, social connectedness, quality of attachment, and knowledge of child development.

In a medical home adapted to the needs of families in poverty, parents have the opportunities and resources to promote resilience in their young children, giving them the capacity to adapt to adversity and buffering the effects of stress. Healthy Steps for Young Children, a manual-based primary care strategy, and programs such as Incredible Years and Triple P, which integrate behavioral health into primary care, have been shown to promote responsive parenting and address common behavioral and developmental concerns.69–73 Early literacy promotion in the medical home with programs such as Reach Out and Read advances reading readiness by approximately 6 months when compared with controls.74 In addition, parents in Reach Out and Read practices are 4 times as likely to read to their children and more likely to spend time with their children in interactive play75 than are families who are not in Reach Out and Read. Another program, the Video Interaction Project (VIP), combines early literacy with guided parent-child interactions that support family relationships and social development of children.70

The AAP has promoted the National Center for Medical-Legal Partnerships model, which provides legal aid collocated with health services, especially to families in poverty. A pilot study of medical-legal partnerships found that addressing the social determinants of health by providing legal services and helping families negotiate safety net organizations improves child health outcomes, reduces unnecessary urgent visits, and raises overall child well-being.[76]

Care coordination, a fundamental service of the medical home model, can link families with community resources and support interagency coordination to address basic concerns such as food and energy insecurity. An example of a robust case management initiative is Health Leads,[77] an enhanced primary care strategy that uses college volunteers as advocates and advanced resource management techniques, which has improved coordination of care and utilization of collocated social services by low-income families with the intent of reducing the social barriers to good health.

Early Identification of Families in Need of Services

To link families to services as early as possible, pediatricians can use screening tools that have high sensitivity and specificity. The WE CARE survey[78] is a brief set of questions that alerts the pediatrician to families experiencing stress related to poverty. In the policy statement "Promoting Food Security for All Children," the AAP recommends the use of a 2-question survey that has a high sensitivity to detect food insecurity.[79,80] A single question, "Do you have difficulty making ends meet at the end of the month?" may be enough to alert the pediatrician with 98% sensitivity to a need for linking families to community resources.[81] Inquiring whether families have moved frequently in the past year or have lived with another family for financial reasons will reveal housing insecurity.[82]

Effective early identification of families in need may facilitate prevention services, including nutritional supplements for young children, preventive health services, age-appropriate learning opportunities, and socioemotional support of parents. Program evaluation has supported this multifaceted approach in multiple countries and settings.[83] Analyses by Nobel Prize–winning economist James Heckman reveal that early prevention activities targeted toward disadvantaged children have high rates of economic returns, much higher than remediation efforts later in childhood or adult life.[84] For example, the Perry Preschool Program showed an average rate of return of $8.74 for every dollar invested in early childhood education.[85] Targeted interventions foster protective factors, including responsive, nurturing, cognitively stimulating, consistent, and stable parenting by either birth parents or other consistent adults. Early

childhood experiences that promote relational health lead to secure attachment, effective self-regulation and sleep, normal development of the neuroendocrine system, healthy stress-response systems, and positive changes in the architecture of the developing brain.[86,87] Perhaps the most important protective factors are those that attenuate the toxic stress effects of childhood poverty on early brain and child development.[3,5,88]

Interventions for Adolescents and Parents of Young Children

In recent years, there has been a growing focus on "2-generation" strategies to reduce poverty and improve outcomes for low-income families. Two-generation strategies focus on helping low-income children and their parents simultaneously through high-quality interventions.[89] For example, a 2-generation program may enroll parents into job training at the same time as children are enrolled into quality child care. This type of approach aims to improve a family's earning potential as well as the child's developmental outcomes. Improved coordination of programs and services for low-income families is essential to a 2-generation strategy.

Recent research suggests that noncognitive skills, such as perseverance, empathy, and self-efficacy, remain malleable during adolescence[90] and build on the cognitive skills developed during early childhood. Interventions such as adolescent mentoring, residential training (eg, Job Corps), and workplace-based apprenticeship programs can increase academic achievement, employment success, and other nonacademic accomplishments over the life span.[90]

RECOMMENDATIONS

As the health care system increasingly focuses on efforts to improve quality and contain costs, there may be new opportunities to restructure the health care delivery system in ways that can improve care for children in low-income families. Policy decisions in other countries, such as the United Kingdom, [91] also may inform these efforts. Incentivizing care coordination and team-based care may help more children access quality health care through patient- and family-centered medical homes (FCMHs). Medical homes also can help families address unmet social and economic needs by using partners, such as community health workers, within the health care team.[92,93] As previously noted, home visiting is supported through the MIECHV.

State reforms and integrated health delivery systems in some regions are providing incentives for population health approaches, facilitating collaboration in healthy neighborhood initiatives.[94] Collaborators with health care organizations may include education systems, social services, faith-based groups, and community development organizations. Although all children may benefit from greater collaboration between health care organizations and community resources, children and in poor and low-income families may experience even greater gains.

Opportunities for Public Policy Advocacy

Public policy efforts are needed to protect the health of children affected by poverty and to help families become economically secure. The specific recommendations made in this and the following section are based on positive outcomes in peer-reviewed literature or preliminary studies that show sufficient promise that rigorous long-term evaluations are underway.

- Invest in young children. Funding quality early childhood programs can have a significant financial return on investment, but more importantly, making healthy development of young children a national priority while addressing social determinants of health helps families and communities build a foundation for lifelong health.
- Protect and expand funding for essential benefits programs that assist low-income and poor children. Invest in children's health and development by appropriately funding evidence-based programs, including Early Head Start and Head Start, Medicaid, CHIP, WIC, home visiting, SNAP, school meal programs and other programs that increase access to healthy food, and Child Care Development Block Grant–funded programs. Streamline enrollment and renewal processes for public benefit programs.[95]
- Support 2-generation strategies that focus on helping children and parents simultaneously. Promote the coordination and alignment of adult- and child-focused programs, policies, and systems.
- Support and expand strategies that promote employment and that increase parental income. Programs that increase low-income parents' earnings have been shown to improve child outcomes. Support policies that help parents increase family income, including higher minimum wages, education and job-training programs, and the EITC, child tax credit, and child and dependent care tax credit.
- Support policy measures that improve community infrastructure, including affordable housing and public spaces. Ensure that all children have safe outdoor play areas as well as healthy, safe, and affordable housing.
- Improve access to quality health care and create incentives to improve population health with the goal of reducing health disparities. Strategies to improve quality and reduce costs should

include care coordination and team-based care that help families address nonmedical health-related concerns, such as food, housing, and utilities. Pediatricians and health care systems should be encouraged to partner with other stakeholders to advance community-level strategies that improve health and reduce disparities among populations of varying income levels.

- Enhance health care financing to support comprehensive care for at-risk families. All benefit plans should include coverage for enhanced services in the medical home for families in poverty. Care coordination, team-delivered care, and coverage for mental health services provided by pediatricians are examples of these enhanced services.
- Make a national commitment to fully fund home visiting programs for all children living in low-income or poor households. The Bureau of Maternal and Child Health has identified 19 programs, including but not limited to Nurse-Family Partnership, Early Head Start, Healthy Families America, and Parents as Teachers, that target families with pregnant women or children younger than 5 years.
- Support integrated models of care in the medical home that promote effective parenting and school readiness, such as Healthy Steps, Reach Out and Read, VIP, Incredible Years, Medical Legal Partnerships, and Positive Parenting Program. Both Medicaid and education funding agencies should provide support in the medical home for parenting and literacy promotion.
- Improve national poverty definitions and measures. The FPL underestimates the extent and depth of poverty in the United States. The SPM is an improvement, but more research is necessary to quantify the extent of poverty in the United States and its effects on children and families so that effective responses can be developed and promoted.
- Support a comprehensive research agenda to improve the understanding of the effects of poverty on children and to identify and refine interventions that improve child health outcomes. Research is needed to identify better ways to measure how poverty affects children, what works to help families in poverty, and how to translate the information gained into real solutions for the poor.

Opportunities for Community Practice

The following recommendations address how individual pediatricians can support the health and well-being of children living in poverty. Adaptations of the medical home to acknowledge the complex challenges that confront poor families require surveillance on the part of the practitioner of both risk and protective factors that characterize each family.

- Create a medical home that acknowledges and is sensitive to the needs of families living in poverty. Although every family wants to provide the best resources and care to their children, economic barriers can stand in the way. All members of the care team and practice should become familiar with some of the common challenges faced by poor families. Recognizing problems such as transportation barriers, difficult work schedules, and competing financial issues can help practices effectively communicate and partner with families. An enhanced medical home providing integrated care for families in poverty is informed by the understanding that emotional care of the family, including recognizing maternal depression, is within the scope of practice for community pediatricians and that the effects of toxic stress on children can be ameliorated by supportive, secure relational health during early childhood.
- Screen for risk factors within social determinants of health during patient encounters. Practices can use a brief written screener or verbally ask family members questions about basic needs, such as food, housing, and heat. Screening for basic needs can help uncover not only obvious but also less apparent economic difficulties experienced by families. As patient-centered medical homes continue to develop, care coordinators will fulfill the role of community liaison for families in poverty, connecting them with needed resources.
- Consider implementing integrated medical home programs, such as Healthy Steps, Reach Out and Read, Health Leads, and VIP, in addition to primary care integration with mental health interventions such as Incredible Years and Triple P. These programs help parents develop the capacity and confidence to build resilience in their children and improve the ability of the family to cope with adversity. Bright Futures guidelines provide the most comprehensive recommendations for health supervision and are enhanced by strategies to advance behavioral health care into the pediatric medical home and to address the social determinants of health.
- Identify and build on family strengths and protective factors. Although families in poverty face many challenges, each family has strengths, capabilities, and protective factors. Pediatricians can strive to identify and build on protective factors within families, such as cohesion, humor, support networks, skills, and spiritual and

cultural beliefs.[96,97] By approaching families from a strengths-based perspective, pediatricians can help build trust and identify the assets on which a family can draw to effectively address problems and care for their children.

- Collaborate with community organizations to help families address unmet basic needs and assist with family stressors. When unmet basic needs and poverty-associated risks are identified, pediatricians can refer families to appropriate community services and public programs. Key partners may include local and state public health departments, legal services, social work organizations, food pantries, faith-based organizations, and community development organizations. Some communities also may have innovative financial literacy programs that are helpful.[98] Practices may partner with local home visiting programs, community mental health services, and parent support groups that can help families address parenting challenges and other stressors.
- Engage with early intervention programs and schools to promote learning and academic achievement. Education professionals are often very involved in efforts to help children from low-income backgrounds with academic achievement and also may participate in initiatives focused on basic needs, such as feeding programs, clothing drives, and health screenings. Pediatricians can actively participate with these efforts as well as early intervention programs, after-school programs, tutoring programs, and social services provided through the school district.
- Promote the MIECHV program. Pediatricians should be familiar with local MIECHV programs and how to connect their patients with home visiting programs on the state and local levels. Pediatricians and the AAP should be aware that the MIECHV continually reviews home visiting programs for inclusion in the MIECHV and can submit programs for review that they have found successful. Opportunities for enhanced communication between the FCMH and home-visiting programs may be explored, including the possibility of collocation of visitors in the FCMH as an integrated service model.
- Support community programs that enhance the involvement of fathers in the lives of their children. Pediatricians can be an important support resource and advocate for community-based fatherhood initiatives. When possible, nonresidential fathers should be involved in all aspects of pediatric care.
- Advance strategies to address family and child mental health and development. Pediatricians are strongly encouraged to include routine screening for maternal depression at every health supervision visit during the first year of life and to be able to provide an appropriate referral for treatment when depression is suspected. Pediatricians can advocate for increased resources to address mental health and behavioral issues in poor communities, including separate payment for screening for parental depression and for care coordination activities.
- Advocate for public policies that support all children and help mitigate the effects of poverty on child health. Pediatricians can serve as important advocates for policies that help children and families in poverty. Pediatricians can add a unique voice to poverty-related advocacy by reframing poverty as an evidence-based health concern with lifelong health, social, and economic consequences.

CONCLUSIONS

Poverty and other adverse social determinants have a detrimental effect on child health and are root causes of child health inequity in the United States. Knowledge is expanding rapidly, especially regarding the neurobiological effects of poverty and related environmental stressors on the developing human brain as well as the life course of chronic illness. Understanding the causative relation between early childhood poverty and adult health status should inform and influence the decisions of policy makers, researchers, and community pediatricians. The evidence strongly suggests that the FCMH with its enhanced capabilities is an essential asset in efforts to ameliorate the adverse effects of poverty on children.

The AAP considers child poverty in the United States unacceptable and detrimental to the health and well-being of children and is committed to its elimination. The AAP calls for concerted action by its state chapters as well as governmental, private, nonprofit, faith-based, philanthropic, and other advocacy organizations to reduce child poverty by supporting and expanding existing programs that have been shown to work and to make efforts to develop, identify, and promote other potentially effective policies and programs. In 1935, the US Congress passed the Social Security Act and in 1965 enacted Medicare. Together, these 2 pieces of legislation have greatly reduced and nearly eliminated poverty in the elderly. It is time to enact similar reforms to eliminate child poverty. By embracing the policies and enacting the recommendations in this statement, the AAP joins with governmental, philanthropic, private, and other health care organizations in a concerted and dedicated effort to eliminate child poverty in the United States.

ACKNOWLEDGMENTS

We acknowledge the following University of California–Los Angeles pediatric and med-peds residents for their research contributions to this policy statement: Natalie Cerda, MD, Jeremy Lehman Fox, MD, Neil A. Gholkar, MD, Lydia Soo-Hyun Kim, MD, MPH, Rachel J. Klein, MD, Ashley E. Lewis Hunter, MD, Sarah J. Maufe, MD, Colin L. Robinson, MD, MPH, Joseph R. Rojas, MD, and Weiyi Tan, MD, MPH.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
CHIP: Children's Health Insurance Program
EITC: earned income tax credit
FCMH: family-centered medical home
FPL: federal poverty level
MIECHV: Maternal, Infant, and Early Child Home Visiting
SNAP: Supplemental Nutrition Assistance Program
SPM: Supplemental Poverty Measure
TANF: Temporary Assistance for Needy Families
VIP: Video Interaction Project
WIC: Supplemental Nutrition Program for Women, Infants, and Children

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Pediatrics; originally published online March 9, 2016;
DOI: 10.1542/peds.2016-0339

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