

**RETHINKING THE ORGANIZATION OF CHILDREN'S
PROGRAMS: LESSONS FROM THE ELDERLY**

Study Report

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**Rethinking the Organization of Children's Programs:
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The Child and Adolescent Health Policy Center (CAHPC) at the Johns Hopkins University was established in 1991 by the federal Maternal and Child Health Bureau as one of two Centers to address new challenges found in amendments to Title V of the Social Security Act (MCH Services Block Grant) enacted in the Omnibus Budget Reconciliation Act (OBRA) of 1989. The purpose of the Center is to draw upon the science base of the university setting to help identify and solve key MCH policy issues regarding the development and implementation of comprehensive, community-based system of health care services for children and adolescents. Projects are conducted to provide information and analytical tools useful to both the federal MCH Bureau and the State Title V Programs as they seek to meet the spirit, intent and content of the Title V legislation and the challenges of addressing the unique needs of MCH populations and programs in health care reform.

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FOREWORD

As maternal and child health professionals, we would want to be excited and encouraged when key national policy issues -- such as deficit reduction, ensuring global competitiveness, and welfare reform -- are couched by our political leaders in terms of "we do this for the children." Yet the health and educational status, social functioning, and income security of children in the United States continues to trail that of other industrialized countries. While our politicians from the left and the right tout "for the children," we have no national policy for those citizens we refer to as our future and our most valuable resources. We have no charter declaring what we as a country aspire to for our children. We have no legislation that affirms our commitment.

It is to address these dualities that the Johns Hopkins University Child and Adolescent Health Policy Center (CAHPC) has undertaken this study of the national policy principles, program organization, and implementing legislation that exists for America's elderly. While at the time we began this investigation, our questions focused on general trends in national policy priorities and debates, more recent national discussion and action in areas such as the reinvention of government appear to heighten the relevance of our analysis.

As we prepare to send the manuscript to print, committees are meeting within the Administration and Congress to deliberate reorganization to achieve efficiencies and greater constituent control of policy and programs -- both worthy goals which we support. Proposals proliferate, however, that aim to solve intractable problems of national policy through reorganization, or devolution to states, alone. The findings of our analysis argue instead for a **strengthened national focus on children and families**, and underscore the benefits found in the approach undertaken in our own country to assure a national policy focus and commitment our children's grandparents.

This study of legislative and organizational structures builds on analysis of the system for the elderly for two reasons. First, while many investigators have reported on the strengths and positive outcomes of children's policies and service structures found in other industrialized countries, our collective national tendency is to promptly dismiss that which is not our own. As importantly, we find that the elderly have done *relatively* well through these features of the Older Americans Act legislation. Our premise should not be construed in any way to support the argument that what is provided for the elderly should be less than what it is now. Rather, we seek to draw upon what we believe to be the best elements of national policy for our older citizens, and combine it with strengths found in the extant national Maternal and Child Health Program embodied in the Maternal and Child Health Services Block Grant (Title V of the Social Security Act) to secure a sound foundation for our younger citizens.

In the current context of great interest in the subject of organization within government, we suspect that temptation may exist to pull out of the analysis only those components that focus on administrative structures, or fit with other political or economic agendas. We caution readers who might bow to this temptation to regard reorganization as a "silver bullet" solution to addressing concerns about the well-being of children. Our recommendations in regard to organizational structures must be understood as but one element of a model for strengthening national policy for children and families. The OAA model is comprised of several interdependent components which also include national legislation, as well as health care coverage and economic security. Based on our analysis, we remain convinced that it is this multi-component approach that has served the elder population well, and that the model proffered must be considered en toto.

Finally, we would acknowledge up front that "models" such as that discussed in this report do not solve all problems. Our hope, however, is to generate vigorous discussion among policymakers and advocates about our national commitment to our parents' grandchildren -- our future.

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EXECUTIVE SUMMARY

Basis for the Study

Despite alarming statistics regarding the health, economic and psychosocial status and academic achievement of children and youth, the United States does not have a "system" of care for our youngest citizens. Rather, there are more than 300 separate programs that have been categorically established and implemented over the last three decades to address the health, social and education needs of children and families, creating a complex, fragmented patchwork of services and programs. Fragmentation in and of itself would not be a serious national policy issue if America's children were doing well. Unfortunately, this is not the case.

In contrast to children, the elderly in this country enjoy universal entitlement to national health insurance through Medicare, a uniform base level of income security, and an organized system of community-based health, nutritional and social services. Therefore, in this paper, we argue that the system which seems to work for grandparents ought to be available for grandchildren. We apply the models from services for the elderly to inform the national debate on health, education, and welfare reform for young people and their families.

Legislation for the elderly was chosen as a model because there are a number of fundamental similarities between the elderly and children: each is an easily identifiable population based on age criteria alone; both children and the elderly exhibit particular developmental vulnerabilities; as individuals at the ends of the age spectrum, both populations are characterized by a certain level of dependency, requiring that service responses involve families and/or community caretakers; and both populations have traditionally been considered deserving of special societal protections.

This monograph analyzes the organizational structures and functions of the Older Americans Act (OAA) of 1965 to propose a model for reforms to meet the needs of children and families. The analysis includes reviews of the legislative and organizational histories of both maternal and child health services and the Older Americans Act; information gathered in key informant interviews; and a side-by-side comparison of two statutes -- the OAA and Title V of the Social Security Act.

History and Current Context

The Nation's initial response to the plight of children in the first half of this century resulted in a unified approach through the Children's Bureau to address "all matters pertaining to the welfare of children and child life among all classes." However, federally legislated child-oriented programs implemented today represent a mix of income-based entitlement programs; quasi-entitlement programs; categorical population or disease-specific programs; age-specific entitlement programs; as well as "gap filling" formula grant funded programs. As such, this current body of federal

authorizing legislation for children and their implementing regulations are not coordinated. Despite ardent calls for major modifications of the Nation's policies and programs affecting child health and welfare, the "system" (or non-system) of services for children remains in disarray.

In contrast, the national program established through the Older Americans Act (OAA) legislation was designed to address in a consolidated fashion multiple aspects of the lives of the elderly. The overarching purpose of the Act was to establish a framework for a comprehensive system designed to assist older individuals in maintaining and maximizing independence by removing barriers to access and by providing for a continuum of care at the community level. While never intended to meet all needs, the OAA has provided the major legislative infrastructure for "planning of, and advocacy for, services and activities to benefit older persons."

The OAA establishes a high level, visible national locus for information, policy development and coordination, advocacy, research, demonstration and professional training. Legislation provides the foundation for a "network on aging," linking a federal Administration on Aging, State Units on Aging, Area Agencies on Aging, citizen advisory committees, and local public and private agencies. The OAA also provides the legislative structure for a uniform consolidated program of comprehensive, community-based planning, and preventive and social services which complement the medical care financing and income support provided the elder population through Medicare and Social Security. Approximately thirty categorical services for the elderly are incorporated. A uniform set of core services is required for all communities, however, flexibility is permitted in the array of optional supportive services a locality supports with program funds. The OAA establishes a Federal Council on the Aging, and specifies program linkages and roles with respect to federal programs serving the elderly that are not implemented under its authority.

Framework for Comparison

The side-by-side analysis of the legislative bases for community-based services for the elderly, and for children compares the best features of the OAA, and of Title V of the Social Security Act, the Maternal and Child Health Services Block Grant.

Several policy and organizational principles applicable for meeting children's needs are threaded throughout the provisions of the Older Americans Act's seven titles, including:

- a single, highly visible, national locus is assured for policy development and coordination, and for providing public advocacy for and information on the population;
- an administrative infrastructure at the national, state, and local levels wherein consolidated planning with respect to all issues of concern to the population is conducted;
- program services are universally available to the population, which is defined by age, irrespective of income status;
- community-based services funded are those which complement and enhance access to major income and health entitlements;

- a broad and flexible scope of community-based services is administratively consolidated at the state and local levels, with a uniform set of core services (eg., nutrition, supportive services and multipurpose centers, elder rights protection programs) protected federally through line item funding and statutory and regulatory assurances;
- community level information and referral resources are centralized, and services co-location is maximized;
- advocacy, and consumer/public participation in program planning and oversight is legitimized; and
- research, training and service demonstrations specific to population issues and needs are used to promote improvements in quality of care and services.

Title V of the Social Security Act is used to provide the child focus of the analysis because the legislation incorporates a number of features which we believe allow it to serve as a vehicle, or starting point, for systems reform. These include:

- permanent authorization under the Social Security Act, providing stability for administration of the policy and program infrastructure and indicating a priority for child health as part of a larger national commitment to the well-being of its citizens;
- specified responsibility for planning and reporting related to national objectives, including recognition of a broad responsibility for **all** children that extends beyond a narrowly defined programmatic focus;
- requirements for substantive state matching funds which promote development of constituencies within communities and state legislatures and which leverage funds well beyond those allocated federally;
- support for a structure of population-based, universally-oriented preventive and support services, and for highly specialized services which are targeted to particularly vulnerable subpopulations;
- specified requirements for coordination with Medicaid, especially, to ensure access, and quality of care provided through the federal insurance program for low-income children;
- promotion of a family orientation, influencing the structure of service delivery such that care for children is developmentally appropriate and responsively planned; and
- inclusion of a component for research, training and demonstrations to assure quality throughout, and to promote system improvements.

Comparison of the Older Americans Act and the national program for Maternal and Child Health Services reveals a number of important parallels in underlying policy principles and legislative intent. However, key differences between the two pieces of legislation point to at least four central aspects of the OAA federal organization, programs, and policy principles that may apply to a new maternal and child health organization at the federal, state, and community levels.

Analysis: Implementation of the OAA and Title V MCH at Federal, State and Community Levels

The report includes a structured and detailed analysis of those features found in the OAA that are missing from, but highly important for, community-based services for children and families. The OAA exhibits significant advantages with respect to meaningful representation of population concerns in the upper echelons of government, constituent access to policy-making, centralized, clearly identifiable government accountability and increased access to services at the local level. Functions of and relationships among public programs, agencies, private sector providers and consumers are outlined in statute. These provisions establish the foundation for a systems approach to planning at all levels, and providing vehicles for supporting community programming which relates the multiple domains of health, social services, educational, and family support, which allow holistic interventions for individuals and families in need. Universally available core services facilitate understanding of the system among legislators and other policymakers, as well as taxpayers. While a uniform core of services is mandated, the OAA promotes local flexibility in how services are delivered, and in constituting the array of ancillary preventive and support services that wrap around the core. Legislated mechanisms for consumer protection and advocacy, and a prominent consumer role in local, state and federal policy formulation assure protections for the elderly not enjoyed by children in this country.

Conclusions and Recommendations

We thus find the OAA instructive as to how health, welfare and education reform initiatives might be envisioned to create structures nationally that are linked horizontally and vertically requiring consolidated policy development, planning and accountability addressing the full scope of issues and public programs key to child and family health and well-being. Based on the analysis, we propose that the first and most fundamental step to achieving parity between children and the elderly is a major rewrite of federal legislation authorizing key health, social services, and education programs. Revisions are needed to eliminate conflicts, overlap, gaps and fragmentation, and to maximize coordination within and among systems. While progress in achieving consolidation and coordination objectives is possible at the local, and even state levels, we are convinced that federal legislation will continue to drive the system, and that significant change based on principles of equity cannot occur without this step.

Further, we believe that revisions to national legislation must occur consistent with the following principles:

- 1.a national policy focus and vision for healthy children and strong families, as well as governmental accountability for outcomes consistent with that vision, through creation of a free-standing statutorily authorized National Council on Children and Families;

2. structures and authorities necessary to address service access and coordination complexities, fragmentation, overlap, and barriers at all levels, and to increase efficiencies and effectiveness of the planning, data, resource allocation functions of government, implemented through federal legislation, reorganization within DHHS, and creation, in each State, of a mandated independent Single State Authority for Child and Family Policy and sub-state Children and Families Authorities;
3. a universally available uniform core of preventive and support services established through federal legislation which can be configured with local flexibility to promote service availability and access in **all** communities; and
4. child advocacy, and consumer participation in services and system design and oversight at all levels of government, implemented through ombudsman services, and mandated Family Advisory Councils.

In many ways, these recommendations reflect a return to the national principles first enunciated by the Children's Bureau, but lost through the evolution of health and social service program development of the last three decades. This approach, however, moves beyond the tenants of the past by promoting bureaucratic efficiencies consistent with contemporary management practices which would eliminate overlap and duplication in planning, data, and prevention and support services programming. Implementation of these recommendations would allow for consolidating funds at the local level, as well as for consumer-directed flexible service design and resource allocation within communities.

This paper demonstrates how effective legislative, structural, and programmatic elements can be borrowed from one population to serve the needs of the other. As a nation we need to have the political courage to extend the attributes of a system that works for grandparents to their grandchildren.

Introduction

President Clinton began the national debate on health care reform by declaring that the "system" is broken and needs to be fixed (Clymer, 1993). Nowhere is that statement more true than for the network of services that are meant to serve the needs of America's children.

Quite simply put, the United States does not have a system of care for our children and families. Rather, we have a collection of activities and funding mechanisms that create a complex, fragmented patchwork of services and programs. Such fragmentation was not always the case. The Nation's initial response to the plight of children in the first half of this century resulted in a unified approach through the Children's Bureau to address "all matters pertaining to the welfare of children and child life among all classes" (U.S. Stat., 62nd Congress, Part 1, Chapter 73). Since then, however, more than 300 separate programs have been categorically established and implemented to address health, social and education needs of children and families (National Commission on Children, 1991). And while developed with the best motivations, these service expansions, unfortunately, have served at times to complicate and fragment, as much as to enhance access and improve care. With few exceptions, these programmatic services are not universally available, regardless of how significant a family's functional needs might be. Excepting education programs, services to children and families have not been developed as true entitlements and, as such, have been subject to the vicissitudes of economic and political trends, suffering most significantly in times of fiscal constraint (Benjamin et al., 1991).

Programmatic fragmentation, in and of itself, would not be a serious national policy issue if America's children were doing well. Unfortunately, this is not the case, and many of our nation's children continue to suffer the most devastating consequences of social disadvantage. In 1991, nearly one-in-five children lived in poverty (National Center for Health Statistics, 1993), and approximately 8.3 million (12.4%) children were without insurance in 1992 (U.S. Bureau of the Census, 1994). Children are increasingly likely to be the victims and/or perpetrators of violence (Children's Safety Network, 1991). And nearly one-third of American children were living with one or neither of their biological parents in 1990 (The Annie E. Casey Foundation, 1993). Disabling health conditions, substance abuse, teenage pregnancy, poor academic performance and high dropout rates from school threaten this country's global competitiveness. Despite the fact that the U.S. expends more on health care than any other industrialized country, our children are far less well off, as measured by simple indicators like the infant mortality rate or the level of full immunization coverage (GAO, 1993; "Child", 1990; Starfield, 1992; Williams & Miller, 1991).

The national debate on health care reform during 1993 and 1994 failed to focus broadly on the system of public and private health care programs that address the health status and health, academic

and social functioning of children and their families. Rather, the debate was focused narrowly on financing medical care. Although children and their mothers have not been well served by this country's health insurance industry (Guyer & Thompson, 1991), nearly all the proposals relied on an indemnity insurance structure. Even highly touted reforms in health care delivery, like managed health care, may not necessarily improve the health of children (Arnold & Schlenker, 1992; Cartland and Yudkowsky, 1992; Fox et al., 1993). Therefore, we believe that while insurance is necessary, it is not sufficient to assure the health of a population, and that a reformed health care system based on universal insurance coverage and managed care delivery alone is unlikely to provide adequate solutions to the basic challenges of the service system needs of children. Assuring improvements in children's health status may require complementary reforms in the statutory protections, organizational structures and fiscal resources that link health programs, income security programs and education entitlements. The purpose of this paper is to examine a model for such a system.

In contrast to children, the elderly in this country enjoy universal entitlement to national health insurance through Medicare, a uniform level of income security, and an organized system of community-based health, nutritional and social support services. Other authors have compared the ways in which the U.S. treats the elderly versus children, pointing out inequities in both national investments and outcomes (Benjamin et al., 1991; Cook, 1979; Hudson, 1978; Preston, 1984). We take this approach one step further by examining the organizational structures of the service system for the elderly to propose a model for those reforms that may better the needs of children and families.

This paper analyzes the national program for community care for the elderly under the provisions of the Older Americans Act (OAA) of 1965 and compares it to the program of maternal and child health services. The analysis includes reviews of the legislative and organizational histories of both maternal and child health services and the Older Americans Act; key informant interviews; and a side-by-side comparison of two statutes - the OAA and Title V of the Social Security Act. Notwithstanding its documented shortcomings, the Title V MCH program is used to provide the child focus of this analysis because the legislation incorporates a number of features which we believe may allow it to serve as a vehicle, or starting point for systems reform.

Specifically, we argue that basic features of the national policy, and core program and administrative infrastructure embodied in the OAA may serve as a model to meet the special challenges for child and family services. We make the assumption that there are a number of fundamental similarities between the elderly and children: 1) each is an easily identifiable population based on age criterion alone; 2) both children and the elderly exhibit particular developmental

vulnerabilities; 3) as individuals at the ends of the age spectrum, both populations are characterized by a certain level of dependency, requiring that service responses involve families and/or community caretakers; and 4) the vulnerabilities and dependency needs of both populations have traditionally been considered deserving of special societal protections. A major difference, of course, between children and the elderly is that the elderly have become a powerful political force that votes in its united interest, unlike children who, without representation, must rely on parental, community, and legislative commitment to look after their needs and best interests.

Current conservative thinking proffers that governmental protections and programs for children are not needed because families should take primary personal responsibility for their children, and private philanthropy and community religious social institutions should step in where families fail. We reject this argument. We prefer to argue that the system which seems to work for grandparents ought to be available for grandchildren. Our thesis is based, therefore, on the belief that federal legislation enacted to implement special protections is fundamental to the rational organization and delivery of services, and to assuring a permanent national policy focus for children and families.

Overview and History of Public Programs Addressing Maternal and Child Health Concerns

The special needs of women, children and families were addressed at the beginning of the 20th century by a single agency - the Children's Bureau, and later incorporated in a single piece of federal legislation - the Social Security Act. Title V and its predecessor program implemented through the Maternity and Infant Act of 1920 originally provided a single national focal point for the study of health and welfare concerns, public information, advocacy, prevention services, development of a cadre of specially trained professionals contributing to State and national leadership promoting high quality care for children and families, and for prompt attention to emerging health needs and challenges. Importantly, Title V also provided the foundation for a system of state-based health services for mothers and children.

Current Context: Today, however, health and related care for children is provided through multiple and uncoordinated service delivery structures, evolving from 30 years of enacting separate pieces of legislation. Families must sort through many small and often inconsistent pieces of information to find their way to those several (frequently overlapping) public programs/services that might assist. Child health services are found in public health departments, private physician offices,

community health centers and other non-profit community agencies, schools, hospitals, etc., with no centralized source of information, intake or coordination at the service delivery level. All too often, inconsistent and/or rigid eligibility requirements confound or preclude access and care. Efforts of policy-making bodies, public program administrators, and the public to address children's needs are similarly thwarted by the sheer numbers of programs, as well as the complete absence, or complex pathways, of linkages among them.

Federally legislated child health programs implemented today represent a mix of income-based entitlement programs -- such as the public insurance program Medicaid, and EPSDT; quasi-entitlement programs -- such as the WIC nutrition program; categorical population or disease-specific programs -- such as immunization, Pediatric AIDS, lead poisoning, care for the homeless, and family planning; age-specific entitlement programs -- such as early intervention services for infants and toddlers with actual or potential disabilities; as well as "gap filling" formula grant funded programs such as Title V prenatal and child health services. Health services are also embedded in education (special education, and school health services) and social services (Head Start, Family Preservation) entitlement and categorical programs. This array is even more complex when one looks beyond to income maintenance, employment, housing, justice programs, etc. By and large, this body of federal authorizing legislation and their implementing regulations are not coordinated (National Commission on Children, 1991; Institute for Educational Leadership, 1993).

More recent legislative initiatives to improve services to children, such as those found in the Child and Adolescent Service System Program (CASSP -- mental health) and the Individuals with Disabilities Education Act (IDEA) early intervention program for infants and toddlers, attempt to redress some of these problems through a "systems" focus, incorporating requirements for interagency coordination of policy development, planning, service provision, and financing. However, states and localities are now grappling with "system" as well as program overlap and complexity.

Medicaid and its Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) component represent the single most important source of financing for public child health programs, but only as resources for low income women and children.

Legislative and executive branch authority for establishing, funding and administering domestic policies and programs is widely distributed across congressional committees and executive branch agencies at the federal level (National Commission on Children, 1991; Institute for Educational Leadership, 1993). Results of this piecemeal, largely categorical and often incremental approach to addressing child health needs include uneven implementation at the state and local

levels, and gross inequities in public services to individual as well as sub-groups of children and their families.

Brief History: The evolution of maternal and child health services in the United States has been described as having three major formative periods (Guyer, 1990). The earliest period between 1912 and 1935 involved first the creation of the Children's Bureau with a broad mandate to investigate and report on critical children's health and welfare concerns, including infant mortality, the birth rate, orphanages, juvenile courts, child labor issues, child health and injuries. Several years following establishment of the Bureau, legislation was passed (1920, the Maternity and Infant, or Sheppard-Towner Act) to provide resources for state health agencies to establish and improve services promoting the health of women and children. While this legislation expired in 1929, a service infrastructure was developed in most states, providing a foundation for the national MCH program established in 1935 through Title V of the Social Security Act.

Inclusion of a title focusing on child health in the landmark social security legislation reflected a governmental commitment to the well-being of children as well as other dependent groups. Further, this action reflected a "conviction that special measures for the protection of children were an essential part of a program of economic security" (Guyer, 1990; Lesser, 1985). Under Title V states received formula grant funds to establish state units to develop and oversee clinical preventive health services, and treatment services for "crippled children." Case finding, and a comprehensive multidisciplinary approach to service delivery were emphasized. In addition to service provision, the act stimulated development of a system of high quality services with a mandate to "extend and improve services," and by requiring that state plans be developed and approved by the Children's Bureau before funding.

The social action agenda of the Kennedy and Johnson administrations, the "Great Society," significantly impacted the future development of health, social welfare, education and economic opportunity programs for children and families, including Title V. With creation of Maternal and Infant Care (MIC) projects, Comprehensive Children and Youth (C&Y) projects, and OEO Neighborhood Health Centers, and passage of Title XIX of the SSA (Medicaid, including the EPSDT program) between 1963 and 1965, federal funding streams and program authorities for services began to by-pass state government, and the threads of the state-based infrastructure began to unravel.

Over the following fifteen years, additional expansions in categorical services for special populations and problems, such as for family planning, dental care, child development (Head Start), and nutrition (WIC) continued with little or no attention to interprogram relationships. Similar

trends in child welfare and education program development during this period developed. The 1970 relocation of the Title V program out of the relatively independent Children's Bureau into a lower level administrative unit of the Public Health Service further reflected the diminution of importance of the program for providing state and national leadership for child health.

The third major era in the history MCH services in the U.S. commenced in 1980 as the Reagan Administration sought significant change in governance through a "New Federalism." Though not as far reaching or generic as originally proposed, the block grant approach to human services program administration initially effected major reductions in resources for public services and all but eliminated federal agency responsibilities for program administration. Paradoxically, the Report of the Select Panel for the Promotion of Child Health, which called for greater federal oversight and leadership roles, including development of national program standards, was released just as new federalism principles came into play.

And while some child health program consolidation occurred with the creation of the Maternal and Child Health Services Block Grant using Title V as the core, the few, relatively weak, protections remaining in the statute allowed some state programs to wane, especially as the major national recession began to drain state coffers. However, concurrent growing national attention to infant mortality rates coupled with strong leadership and advocacy allowed some states to capitalize on the inherent flexibility in the block grant to begin to rebuild an MCH infrastructure.

Thus throughout the decade of the 1980s, the health service system for women and children continued to be characterized most prominently by extreme variability in programming, and major inequities in access to care (Guyer, 1990; AMCHP 1991). Moreover, the complexity of the services system was further exacerbated by major new federal programs such as PL 99-457 Early Intervention Services, and by Medicaid expansions and enhancements, which while representing major advances in terms of generating resources for services, were implemented through multiple annual changes for discrete subpopulations and services.

In the wake of several years of growing congressional and advocacy concerns about the MCH services in the states, substantive amendments to Title V were enacted in 1989, attempting to more clearly define (or redefine) MCH program mission and leadership roles nationally. Major new provisions were intended to affirm the program's importance in achieving national health policy goals and objectives as promulgated in the Year 2000 health objectives; buttress state accountability; re-initiate the program role in national reporting on MCH health status and service needs; strengthen coordination with Medicaid; and to strengthen federal oversight roles. Thus, in 1995, despite ardent calls for major modifications of the Nation's policies and programs affecting child health and

welfare, made as early as 1981 and as recently as 1993, the "system" (or non-system) of services for children remains in disarray (Select Panel for the Promotion of Child Health, 1981; National Commission on Children, 1991; Institute for Educational Leadership, 1993).

Overview and History of Services for the Elderly

The national program established through the Older Americans Act (OAA) legislation was designed to address in a consolidated fashion multiple aspects of the lives of the elderly. The overarching purpose of the Act was to establish a framework for a comprehensive system designed to assist older individuals in maintaining and maximizing independence by removing barriers to access and by providing for a continuum of care at the community level. While never intended to meet all needs, the OAA has provided the major legislative infrastructure for "planning of, and advocacy for, services and activities to benefit older persons" (O'Shaughnessy, 1992).

Current Context: As set forth in Title I the OAA, the ten (10) broad objectives to be achieved on behalf of older persons are:

- an adequate income in retirement;
- the best possible physical and mental health;
- suitable housing designed and located to meet special needs;
- full restorative services for those who require institutional care, and a comprehensive array of community-based long-term care services including support to family members and other persons who provide voluntary care to older individuals needing long-term care;
- opportunity for employment without age discrimination;
- retirement in health, honor, and dignity;
- pursuit of civic, cultural, educational, training, and recreational opportunities;
- efficient community services with emphasis on maintaining a continuum of care for the vulnerable elderly;
- benefits from research designed to sustain and improve health and happiness; and
- freedom for older persons to plan and manage their lives, participate in the planning and operation of services designed for their benefit, and protection against abuse, neglect, and exploitation (P.L. 102-375).

With the vision of its creators and as it has evolved over the past 28 years, this legislation provides the foundation for a "network on aging," linking a federal Administration on Aging (AoA), State Units on Aging (SUA), Area Agencies on Aging (AAA), citizen advisory committees, and

local public and private agencies in efforts to expand and improve services and care for older persons. In signing the legislation, President Johnson declared that the Older Americans Act was "an orderly, intelligent and constructive program ... under this program every state and every community can now move toward a coordinated program of services and opportunities for our older citizens" (as quoted in O'Shaughnessy, 1992, p.2). And although funding does not represent a significant portion of federal expenditures on the elderly, the OAA's significant emphasis on planning and coordination is recognized for its capacity to attract other resources thereby promoting service system improvements beyond the resources found in the Act (O'Shaughnessy, 1992).

Currently, the OAA is composed of seven titles providing the legislative framework for a uniform but flexible consolidated national program of comprehensive community-based planning and preventive and social services complementing the medical care and income support provide the elder population through Medicare and Social Security. Approximately thirty categorical services¹ for the elderly are overseen by a single DHHS agency at the federal level, are administered by state agencies singularly responsible for services to the population, are planned and operated through area agencies in collaboration with consumer advisory boards, and are provided under contractual arrangements with community provider networks. A uniform set of core services is required for all communities, however flexibility is permitted in the array of optional supportive services a locality supports with program funds.

The OAA further authorizes and supports a Federal Council on the Aging reporting to the President, established to review and evaluate federal policies, provide ongoing public visibility to the needs of the elderly, and to provide public forums on issues of concern to the population. Specific OAA program linkages and roles are outlined with respect to federal programs serving the elderly that are not implemented under its authority.

The legislation provides authority and appropriations for federal administration of a program of training, research and discretionary demonstration projects. Funds are to be used to expand knowledge about aging and programs for older persons. Specialized training or career preparation for employment in the field of the aging has traditionally been emphasized: multi-disciplinary centers of gerontology provide consultation as well as training.

¹ Prominent among the service continuum are nutrition services; in-home services; preventive health services; information, outreach and case management; legal services and abuse prevention and intervention; and supportive activities for caretakers providing in-home services. A community service employment program is also authorized under the Act, administered at the federal level by the Department of Labor, but implemented locally in conjunction with other OAA program services.

Brief History: Federal attention to the needs of the aging population began most visibly with passage of the watershed legislation of the Social Security Act of 1935, which established an income floor for individuals leaving the workforce at retirement age. Evolution of public social and medical services specific to the needs of the elderly, however, occurred much more slowly. Throughout the 1940s and 50s, access to social services in particular continued to be quite limited.

National concern about the status of the aging population began to heighten during the decade following the Second World War. This growing attention was marked in 1950 by the first National Conference on Aging, and establishment of a Federal Council on Aging through a 1956 Executive Order. The first White House Conference on Aging was convened in 1961. Conferees called for a statutory basis for the Federal Council on Aging, adequate funding to support federal coordinating activities (through a proposed federal agency on aging), and a federal grant program for community services for older individuals (U.S. Department of HEW. Special Staff on Aging. The Nation and Its Older People. Report of the White House Conference on Aging, Jan 9-12, 1961. Washington, DC, April 1961). Based on these recommendations, the first legislative proposal for a federal program for the elderly was proffered in 1962. It was not until 1965, however, when seniors advocates were successful in negotiating passage of legislation. The year 1965 also marked enactment of Medicare (Title XVIII, SSA), second only to the Social Security retirement benefit program in the significance of its impact on the lives of the elderly.

The major roadblock to passage during the 1962-65 period entailed significant disagreement between Congress and advocates for the elderly, and the executive branch over the placement of the proposed federal oversight agency for aging policy and services (O'Shaughnessy, 1992; hearing transcripts). The original sponsors of the Older Americans Act (OAA) conceived of placing such an agency at the White House level so it would not be subordinate to any one agency or department, but could carry out broad interdepartmental functions. The placement, however, was strongly opposed by executive branch officials. A compromise position placing the federal Administration on Aging (AoA) within the then-DHEW was negotiated to expedite passage. However, discussion about the proper placement of the AoA has continued over the years, with policy makers frequently questioning whether AoA could carry out its interdepartmental functions and serve as a federal coordinator, spokesperson, and advocate for the elderly as well as influence federal programs and policies from its position within a federal department (OAA 1993; O'Shaughnessy, 1992).

In 1973, amendments placed the AoA within the Office of the Secretary of DHEW, made the Commissioner of AoA directly responsible to the DHEW Secretary, and prohibited any delegation of the Commissioner's functions to any officer not directly responsible to the Commissioner. At

several points in time the agency has been administratively placed within other DHHS units through executive branch reorganizations (Office of Human Development Services, 1975; Administration for Children and Families, 1991). However, following each such action by DHHS, Congress has responded to the concerns of seniors advocates, using the reauthorization process (1984, 1987, 1992) to strengthen statutory language requiring a direct reporting relationship between the AoA commissioner and the HHS Secretary, and assuring fiscal independence (O'Shaughnessy, 1992; OAA, 1993). The AoA Commissioner position was elevated to that of Assistant Secretary in the 1992 reauthorization.

The Act has been amended thirteen times since 1965, adding the research, demonstration and training programs in 1967, and the foster grandparent and retired volunteer programs in 1969. Significant program changes occurred in 1972 and 1973, when the national nutrition program, the substate area agencies on aging, and the community service employment program were established. To improve coordination, major structural changes were enacted in the 1978 reauthorization consolidating social services, nutrition services, and multipurpose senior centers under the authority of the State and area agencies. The long-term care ombudsman program, and new authorities for grants to tribal organizations were established in that same year (O'Shaughnessy, 1992).

In the 1980s, few substantive changes were made until 1987, when new priorities began to emerge with respect to targeting services to more vulnerable subgroups of the elderly, and to program advocacy. Six additional categorical authorizations were added to be implemented through the State and area agency grants.² The most recent reauthorization, in 1992, restructured the OAA, consolidating the several protection and advocacy programs into a single title, creating an office for ombudsman programs within the AoA, and establishing two national resource centers addressing advocacy concerns. Provisions with respect to resource targeting for special populations were further strengthened, as were requirements for federal agency leadership in data collection and analysis.

Framework for Comparison of the Older Americans Act of 1965 (PL 102-375) and Title V of the Social Security Act (PL 101-239)

² These included: in-home services for the frail elderly; long-term care ombudsman services; assistance for special needs; health education and promotion services; abuse prevention; and outreach activities.

Our side-by-side analysis of the legislative bases for community-based services for the elderly, and for children compares the best features of the OAA, and of Title V of the Social Security Act, the Maternal and Child Health Services Block Grant.

Several policy and organizational principles applicable for meeting children's needs are threaded throughout the provisions of the Older Americans Act, including:

- a single, highly visible, national locus is assured for policy development and coordination, and for providing public advocacy for and information on the population;
- an administrative infrastructure at the national, state, and local levels wherein consolidated planning with respect to all issues of concern to the population is conducted;
- program services are universally available to the population, which is defined by age, irrespective of income status³;
- community-based services funded are those which complement and enhance access to major income and health entitlements;
- a broad and flexible scope of community-based services is administratively consolidated at the state and local levels, with a uniform set of core services protected federally through line item funding and statutory and regulatory assurances;
- community level information and referral resources are centralized, and services co-location is maximized;
- advocacy, and consumer/public participation in program planning and oversight is legitimized; and
 - research, training and service demonstrations specific to population issues and needs are used to promote improvements in quality of care and services.

As stated earlier, the Title V MCH Program is used here to provide the child focus of this analysis because the legislation incorporates a number of features which we believe allow it to serve as a vehicle, or starting point for systems reform, including:

- permanent authorization under the Social Security Act, providing stability for administration of the policy and program infrastructure and indicating a priority for child health as part of a larger national commitment to the well-being of its citizens;
- specified responsibility for planning and reporting related to national objectives, including recognition of a broad responsibility for **all** children that extends beyond a narrowly defined programmatic focus;
- requirements for substantive state matching funds which promote development of constituencies within communities and state legislatures and which leverage funds well beyond those allocated federally;

³ While the Act continues to prohibit means testing, resource limitations have prompted amendments over the past decade which require increasing emphasis on targeting particularly vulnerable subpopulations.

- support for a structure for population-based, universally-oriented preventive and support services, and for highly specialized services which are targeted to particularly vulnerable subpopulations;
- specified requirements for coordination with Medicaid, especially, to ensure access, and quality of care provided through the federal insurance program for low-income children;
- promotion of a family orientation, influencing the structure of service delivery such that care for children delivered by a broad spectrum of health and related service providers are developmentally appropriate and responsively planned; and
- inclusion of a component for research, training and demonstrations to assure quality throughout, and to promote system improvements.

While Title V and the OAA exhibit certain commonalities -- such as longstanding emphases in both programs on a national locus for study and reporting on population issues and needs, a universal approach to addressing concerns, planning within States, support for State and local flexibility in configuring the service infrastructure, and resources for research, training of professionals and service demonstrations -- the service system for children and families lacks a core structure and uniform services, resulting in great variability and inequities.

To strengthen the power of what federal and state governments can do for children and families, we next report on a structured and detailed analysis of those features found in the OAA that are missing from, but highly important for, community-based services for children and families. These include: 1) assurances with respect to high-level national visibility of population concerns; 2) specification of organizational structures and functions at national, State and local levels, including horizontal and vertical coordination of all policy development, planning and service delivery by multiple public programs addressing population concerns; 3) definition of a national core uniform set of community level services and activities; and 4) legitimized population advocacy and consumer and community participation in policy development and program implementation. These analyses are reported for the federal, state and local levels.

Comparison of Program Structure and Functions of the Older Americans Act and Title V/MCH at the Federal Level

While the effectiveness of any health or human services intervention depends heavily on the scope, quality and process of service delivery at the community level, the policy framework established at the national level is of critical concern. There are at least four central aspects of the OAA federal organization, programs, and policy principles that may apply to a new maternal and

child health organization that accommodates to the pending changes of health, education, and welfare reform.

Visible Single Authority for Population Concerns: High visibility of the concerns of the elder population is facilitated with establishment of a single federal administrative entity for addressing all policy issues and service needs--the Administration on Aging in DHHS. While organizational placement of the agency has been a subject of vigorous debate since its inception, the OAA legislation largely has maintained a direct reporting relationship between the agency head and the Secretary. Testimony presented on behalf of legislative provisions assuring prominent organizational status in the federal bureaucracy noted, "Thus, the older population would be meaningfully represented in the upper echelons of the Federal government...with power and responsibility to take action" (House Committee on Education and Labor, Report # 1477, June 1964). The establishment in statute of a complementary organization independent of the bureaucracy, the Federal Council on Aging, with responsibilities for articulating population needs to the President and Congress and providing forums for public policy debate further strengthens the potential for national attention and action. With mandates to study and report on the needs of the elderly, both the Administration on Aging and the Federal Council on Aging serve as focal points for public accountability for addressing population needs, including those extending beyond the program services administered in the Act. While recent Congressional hearing testimony reveals a need for the agencies to strengthen their roles in monitoring and influencing policy and practice in other sectors of the services system, the federal AoA and state counterparts are deeply involved, for example, in analysis and design of the long-term care system (Senate Special Committee on Aging, 1993).

As noted by Guyer and others, the organizational status and authority for child health diminished over the years (Select Panel for the Promotion of Child Health, 1981; Guyer, 1990). Even with a recent elevation of the Maternal and Child Health program to Bureau status, the unit continues to operate under several layers of bureaucracy significantly removed from the top levels of decision making. Furthermore, while Congress at times in recent decades established independent commissions to study, debate and report on the status and needs of children (Select Panel for the Promotion of Child Health; National Commission to Prevent Infant Mortality; National Commission on Children), these initiatives did not have continuing authorization, and therefore ultimately were unable to fulfill the potential offered by a permanent body such as the Federal Council on Aging.

With the broad charge to provide federal level leadership to gather facts, identify problems and design methods to address them, the work of the Children's Bureau of the early years contributed to

the development of legislation impacting the larger system. Major legislative initiatives growing out of the Bureau included data development (birth and death registries), child labor protections, and family income supports (Wallace, ed., 1988). However, authorities and expectations for the federal maternal and child health agency today are less clear. The 1989 amendments to Title V requiring data collection, planning and reporting with respect to MCH-oriented national health objectives and to specified health status and service information items attempted to reorient the program towards its original missions and functions, yet full implementation of this mandate remains unrealized. Congressional, executive branch and public understanding of the importance of these Bureau functions remain circumscribed. Buried in the HHS bureaucracy, the MCH Bureau's role in influencing the content of health care proposals with respect to children is compromised at best.

Comprehensive Policy Development and Coordination: The responsibilities and authorities of the Administration on Aging and the Federal Council on Aging for addressing all matters relating to the broad, cross-cutting objectives to improve care and services to the elderly outlined in the Act provide a single focal point for a national constituency to present issues and concerns to government. No such consolidated locus exists for consideration of the multiple and related needs of children and families with regard to health and social welfare. The essential disappearance of the Children's Bureau charged with responsibility for addressing the broad range of issues related to children, coupled with the independent development of several hundred categorical federal programs for children and families scattered administratively throughout the DHHS organization and 10 additional cabinet agencies defuses public debate and constituency advocacy, and promotes fractured policy development on behalf of families with children.

The Select Panel for the Promotion of Child Health studied this situation over several years, ultimately proposing "a major modification in the Nation's policies and programs," to "better harness existing policy functions applying to all public health programs." Recommendations included establishing a higher level MCH Administration combining Title V, Family Planning, Adolescent Pregnancy Prevention and Parenting Programs, and others, and specified functions for program administration, review and comment on major policy issuances (including budgets and legislation), setting national standards, coordinating DHHS MCH programs with the Departments of Education and Agriculture, research, and for advocacy. Also recommended was a National Commission on Children, established using Title V as the vehicle (Select Panel for the Promotion of Child Health, 1981).

There was some intent to ameliorate this situation when a DHHS reorganization occurred in 1991 creating an Administration for Children and Families (ACF) with direct reporting relationship

to the Secretary. In the end, however, the potential in creating ACF was not fully realized as the core programs constituting the administration -- which included child welfare (AFDC as well as Child Protection), Head Start, disability programs, child care -- omitted key health service and prevention programs for children and youth such as Title V/MCH, immunization, school health, family planning, substance abuse, and others. The Individuals with Disabilities Education Act establishes a Federal Interagency Coordinating Committee (nearly 20 agencies represented), however, the focus is limited to the needs of only a small subpopulation of children and families.

Designation of authority for national policy development for children and families at disparate and frequently lower levels within the federal agency is problematic in several additional ways. First, as alluded to previously, no single "rallying" or access point for the voice of the constituency exists. Second, when entre does occur, issues presented must find their way up through any number of sub-agency administrators who have competing interest of adult populations to contend with: attention and/or action may be stopped or significantly delayed at any of these levels of the bureaucracy. Lastly, since child health/human service needs in any one domain are often related to or dependent on interventions in other domains, the need for

The demographics of an aging population plus the needs of the younger disabled will dramatically increase the future demand for home and community-based services. The Administration on Aging, at the direction of the HHS Secretary and under the leadership of the Assistant Secretary for Aging, has been charged with developing a Long Term Care Agenda which extends across all federal agencies and programs. The Long Term Care agenda is a comprehensive series of multi-year plans and activities for the continued development of consumer-driven home and community-based systems of care for all persons who need services.

AoA unveiled the Long Term Care Agenda at an AoA- sponsored event in January 1994, The Health Care University. This event provided a forum for the Aging Network to dialogue about the issues surrounding home and community- based long term care, as well as provided greater visibility to the issue nationally. AoA is continuing to work in partnership with State and Area Agencies on Aging to strengthen and build a comprehensive policy on long-term care, with a special emphasis on the frail elderly.

With the AOAs advocacy responsibilities outlined under the OAA, and the elevation of the agency within HHS, the AoA has utilized its entree to other organizations and components of the Department such as the Public Health Service, Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to move the long term care agenda forward. This has led to close cooperation and strong working relationships, evidenced by, for example, signed interagency agreements with ASPE on a number of issues, such as assisted living and a study of state infrastructure for home and community based care. AoA staff also serve on a HCFA internal workgroup for long term care issues within the Medicare and Medicaid programs.

Since the Health Care University, AoA has continued to support the Agenda by awarding discretionary grants to support efforts in long term care. AoA has awarded funds for various projects designed to assist in the development of model strategies that will enable states and localities to promote the informed participation of consumers in the planning and development of systems for home and community-based care. Five National Long Term Care Policy and Resource Centers have been recently funded by AoA to serve as the focal points for the continuing development of home and community-based long term care services.

intra-agency/program communication, while significant, can be cumbersome and become protracted. Inordinately slow government response to urgent health and social needs of children and their families results.

Not only does the OAA provide a clearly labeled "front door" to policymakers with entree to key decision-makers (the Secretary, President, and Congress) for constituency groups, the legislation further squarely places responsibility for coordinating all federal programs and activities impacting on the population not otherwise consolidated under the Act with the Assistant Secretary for Aging (OAA, Sec. 202). Section 203 (OAA) further directs heads of other agencies and departments proposing policies, programs or services substantively related to the population to consult and coordinate with the AoA head, as well as to collaborate with activities initiated within the Administration on Aging.

Again, these statutory provisions were enacted in response to an awareness that, "The Federal programs affecting older persons cut across the responsibilities of many departments and agencies, yet at the present time [1964] these programs are without a central core of direction and

coordination" (House Report # 1477) -- a situation we continue to face today with child and family services. By legislative design, therefore, information and reporting on the population is consolidated, and federal policy and program development for the elderly is addressed in a comprehensive manner, facilitating joint deliberation on cross-cutting issues and coordinated service system responses.

While the Title V statute calls upon the federal MCH program unit to "promote coordination," reciprocal provisions are not routinely incorporated in authorizing legislation for related child-serving agencies. Coordinated policy and program initiatives therefore occur inconsistently, dependent primarily on the extant political environment, and the strength of the goodwill and/or leadership skill of agency administrators (Select Panel for the Promotion of Child Health, 1981; Guyer, 1990; National Commission on Children, 1991). Congressional hearing records reveal that sponsors and supporters of OAA legislation held strongly that coordination needed to be institutionalized through legislation and not administrative fiat (House Committee on Education and Labor, 1963).

Identification of a Nationally Uniform Core of Services: Yet another strength found in national level programming for the elderly involves mandates for a uniform set of core services and service administering agencies which extends to every community in the country. While this feature of the OAA program has positive aspects at the state administration and service delivery levels, positive attributes are noteworthy also from the national perspective. The specification of several universally available categorical service programs--supportive services,⁴ nutrition services, in-home services, preventive health services, community service employment, and elder rights protection activities--facilitates understanding on the part of policy makers, the constituent population and the voting/taxpaying public of what is provided through the program. Further, the administrative organizational structure specified for both the state and local levels provides the means for federal oversight to assure that the core program remains protected through AoA development and monitoring of regulations. This quasi-categorical aspect of the OAA legislation and program implementation also may contribute to the fact that program appropriations for the service infrastructure for the elder population is approximately double that made available by Congress for nearly the same infrastructure activities and a similar range of services for the MCH population.

⁴ Including transportation, information and referral, outreach, case management, legal assistance, housing assistance, and others.

While, again, there are remarkable similarities in MCH and OAA services, the Title V program, clouded by the block grant approach, is poorly understood, often at bay when needing to justify requests for additional federal resources and/or to garner constituent advocacy. This is due in large part to the extreme variation in service provision nationally both within and among states. Moreover, although some program activities are undertaken to address the needs of the population irrespective of income or geography (eg., development of standards, or information campaigns), many MCH services are means tested, thereby diminishing the program's appeal to the larger voting population.

Although community level providers and area agencies on aging at times have expressed frustration over certain limitations in program service and funding flexibility, the categorical protections are largely valued (Hudson, 1990; Binstock, 1990). Funds and mandates for the nutrition components in particular are regarded as an organizing force for community level planning and advocacy, as well as for other required and optional services.

Advocacy and Citizen Participation: Finally with respect to OAA-MCH comparisons at the federal level, sanctions, authorities and resources for advocacy roles and activities, and vehicles for public participation in policy formation and program implementation are noteworthy. What is clear in the legislative history from the outset is that Congressmen, acting as agents for their constituents, put a high priority on advocacy for the elderly population. This priority is meaningful not only in concrete actions supporting constituent access to quality care and entitlements, but also in the symbolism of the mandated national ombudsman program office and White House Conference on Aging, and of requirements for majority membership on the Federal Council on the Aging of older individuals. The duty to "serve as an effective and visible advocate for older individuals" is first among the many functions of the AoA Commissioner specified in statute. These mandates and entities reflect Congressional recognition of the vulnerability of the population, and federal responsibilities in this regard, and assure resources for documenting system deficiencies and activities to promote their amelioration.

However, despite the even greater political vulnerability of children as a disenfranchised class of citizens, responsibility for child advocacy remains voluntary, and outside of the scope of any federal agency. While some federal child-serving programs have ombudsman components, the overall scope and depth of the nation's commitment to public advocacy for children is quite limited. Unlike the elderly, without specification of advocacy roles in statute, and with federal children's programs scattered and administratively buried, children remain without a strong voice in the federal bureaucracy. Outside organizations and coalitions have evolved (CDF, AAP, HM/HB, MOD), but

without the ability to enter into sanctioned partnerships with federal programs for children, these groups most often take concerns directly to Congress. In the case of the elderly, such advocacy partnerships have been noted to be fundamental to influencing and protecting Social Security and Medicare benefits, and to shaping the Administration's proposals for health care reform.

As noted, Title V continues with certain mandated information collection and reporting functions, however, potential impact of these functions is compromised without a clear advocacy role, or independent arm, such as the Federal Council on Aging. Despite well-documented concerns, children remain a low priority in the political arena, and system inequities abound (eg., insurance): and with no vote, children remain without a national policy or program to protect them (Johnson, Hughes, Rosenbaum, in Wallace, ed., 1988).

Comparison of Program Structure and Functions of the Older Americans Act and MCH/Title V at the State Level

The importance of the policy framework established at the national level also is found in analysis of the OAA and Title V/MCH programs at the level of state government where a number of issues are mirrored. Here, too, elements of the OAA--including the visibility and level of agency placement within the bureaucracy, program structures and authorities supporting comprehensive policy development and facilitating implementation of a coordinated continuum of services, and an emphasis on population advocacy and citizen participation--feature characteristics instructive in refashioning the child and family service system. Additionally at this level of comparison, review of OAA provisions related to planning and resource allocation strategies provides alternatives which may be considered.

Visible Single Authority for Population Concerns: The organizational placement of State Units on Aging (SUAs) and Administrative units for MCH services mirrors the placement of their counterpart federal agencies. Although no level is identified in either statute, approximately one-half of the SUAs nationally are free-standing cabinet level agencies, and others exist as major administrative units of umbrella human services agencies. Great variability exists with respect to MCH: in a number of states, Title V is administered in conjunction with state health agency administration of other MCH and related programs such as WIC/Nutrition, Family Planning, Part H Early Intervention, etc. Most frequently however, even when there is oversight responsibility for multiple programs, these units are located two or more levels below the SHA director. Thus, health

programs and advocates for children and families in the State face the same bureaucratic complexities in access to information, and to key political decision-makers as at the national level.

Both the OAA and Title V (SSA) require that a single state agency receive federal program funds, however, in the case of allocations for the elderly, that agency must be a designated unit established for the specific purpose of planning and overseeing resources for that population. Maternal and Child Health Services Block Grant funds are administered by statutory requirement, by the State Health Agency (SHA). There are no clear federal legislative provisions for establishment of MCH - specific organizational units within State health departments, although some form of MCH program unit exists in all states.

Within broad parameters, the Title V block grant cedes authority to the SHA for resources allocation to any entity (or entities -- private, or state or local administered) for providing services and implementing activities consistent with the general purposes outlined in the legislation. Tracking MCH funds and activities within states' Title V framework, and within the larger context of the full array of program funds for child-specific activities, can therefore be confusing, if not confounded. This makes federal oversight (which in the case of Title V is limited to review of state applications and reports) less than straightforward, and can diminish effectiveness in protecting service dollars for the population. The OAA provides protections through both categorical design for core services, and location of accountability in a State agency whose single purpose is to address the needs of the population. These administrative arrangements and the mandated core program further promote equity across states.

Further, while significant potential for state-level accountability for MCH exists in legislative requirements for monitoring the system of care through reporting on an array of health status and service indicators and on progress in achieving national health objectives for children, lower organizational status limits access to data and compromises ability to realize this potential. The fact that MCH program offices, resources, and mandates are regarded as "little fish in a large pond" detracts from attention to assuring capacity for or visibility of these efforts.

Comprehensive Policy Development and Coordination: As at the federal level, the OAA outlines state agency functions to include primary responsibility for planning, policy, administration, coordination, priority setting and evaluation of **all** State activities related to the objectives of the Act (Sec. 305 (a)(1)(C)), with statutory authorities for review and comment on all state plans, budgets and policies affecting the population. Excepting standards development for Medicaid EPSDT services, the Title V legislation is essentially silent on state agency functions related to MCH policy development across other child-serving programs. Even where several MCH and related programs

are administered within a single SHA unit, child health activities administered by the Centers for Disease Control (i.e., immunization, lead poisoning, school health) frequently are not included in these units, and key financing (i.e., Medicaid), social service, developmental (i.e., Head Start) and mental health programs most often are implemented out of completely separate government agencies. MCH coordination agreements with Medicaid are required, and the Title V statute directs SHAs to "participate in coordination activities with related federal grant programs"; however, without strong reciprocal statutory requirements in related MCH programs, these provisions have been found inadequate for institutionalizing or otherwise assuring cooperation, coordination or collaboration among other key child/family serving programs (AMCHP, 1991).

A single state plan addressing needs and services for older individuals is mandated through the OAA. Annual state plans for MCH, family planning, early intervention, child welfare, child care, child development, Medicaid, immunization (and others) required by federal programs are in most instances developed independent of one-another, despite the fact that the children and families served by each are often the same. And again, although Title V requirements for planning and reporting with respect to Year 2000 Objectives infer a responsibility for coordinated, broad-based efforts, federal (as well as state) planning and reporting requirements for multiple categorical programs mean costly parallel plan development. Each child health service expansion, including those emphasizing a "systems approach" and coordination, imposes yet another layer of state responsibility for categorical planning, thus diminishing the importance or potential effectiveness of any of them.

Since 1974, the Maryland State Office on Aging (OOA) has functioned as an independent agency at the cabinet level within the executive branch of state government. It receives and expends state general funds as well as federal funds from the Older Americans Act and other sources to carry out its mission. Programs are administered across the state through a network of 19 local Area Agencies on Aging. In addition to federally and state mandated programs, the Office pursues partnerships with the private sector and other public agencies to enhance the well being of the state's elderly. The Office conducts public information and consumer education programs on a range of issues of importance to older Marylanders and their families.

Pursuant to state legislation, the Office on Aging, along with the Department of Health and Mental Hygiene, and the Department of Human Resources were constituted as an Interagency Committee on Aging (IAC) in 1982 to improve state level coordination of services. The OOA has served as lead agency for the Committee's work since its inception. As the complexity of public and private programs serving the population grew over recent decades, the IAC was expanded to include the Departments of Transportation, Economic and Employment Development, and Housing and Community Development, and representatives of the University of Maryland School of Medicine Division of Gerontology, and of the state Association of Area Agencies on Aging. The IAC reports to the legislature annually. The IAC is responsible for maintaining a governmental focus of aging policy, leaving client and other planning issues to the AAAs.

Recent policy foci identified by the IAC include 1) the Problem and Challenge of Medication Management, 2) The Promotion and Improvement of Community-based Service Systems, 3) The Promotion and Improvement of Mental Health Services to the Elderly, and 4) Employment Issues. Taking up the charge of helping seniors stay in their community as long as possible and of reducing or eliminating premature institutionalization, several major initiatives have been undertaken to expand system capacity with respect to adult day care, transportation, and appropriate housing to aid seniors in their transition from one service to another in the continuum of care. Specific initiatives included:

- securing a Medical Assistance Home and Community-based Services Waiver for Senior Assisted Housing Facilities,
- conducting a major public information campaign on the different types of community living arrangements available for elderly who are frail and adults who are disabled,
- a "retrofitting" initiative to promote actions on accessibility-related home improvements,
- collaboration with the Milbank Memorial Fund to convene representatives of the General Assembly, Governor's staff, cabinet members, staff for IAC agencies, providers, consumers and advocates around issues such as expanded Medicaid Waivers, developing standards for nursing home admission, and broadening the system of multidisciplinary assessment for those considering entering nursing homes,
- creation of special housing developments, and
- new transportation initiatives.

To promote improvements in the availability and quality of mental health services to the elderly, the OOA and IAC participated with the University of Maryland's Center on Aging to design and implement a survey to study how mental health services for the population could be better coordinated at the local level, and sponsored a statewide conference to examine survey results and best practice models.

Cross-agency initiatives are implemented through carefully negotiated roles of the various executive agencies in developing programs and garnering federal and state resources on behalf of the elder population. Commitment of the agencies to the population and to working together has been demonstrated in the fact of the agency directors testifying jointly before the state legislature with respect to general fund appropriations and allocations. Commitment to extending the coordination capabilities of the aging network and the IAC is demonstrated in Office on Aging's outreach to other populations and agencies, such as with its 1995 legislative proposal submitted to the State General Assembly to include the Director of the Governor's Office for Individuals with Disabilities on the IAC.

Advocacy and Citizen Participation: Mirroring language on federal Agency on Aging functions, the OAA mandates that State Units on Aging provide "effective and visible advocacy" for the elder population through a number of vehicles, including reviewing and commenting on state plans, budgets and policies impacting on the elderly, evaluating needs, and administrating

a four-component comprehensive program of elder rights protection activities (Section 301). Title V is silent with respect to a government role in child advocacy at the state level. Voluntary groups, largely state chapters of national advocacy organizations, "carry the water" alone in this regard in many states: the existence and strength of such organizations varies widely geographically and over time. Again, we see that the OAA defines a government role in protecting the elderly as individuals, and as a class with recognized vulnerabilities, whereas children's advocacy remains completely in the voluntary sector.

While the OAA addresses citizen participation in program planning and monitoring at the state level through provisions for public hearings, requirements for constituent involvement are much stronger at the community level. In this respect, Title V statutory provisions, which require facilitating public comment on the annual state MCHS block grant plan, are nearly equivalent.

The absence of an identifiable service core and uniformly identifiable service planning, administration and coordination structures for MCH/child and family services at the state level compromises political clout as well as service delivery. Clearly, while the scope of services provided under Title V can translate in the states into a broad range of care for women and children, the MCH program is primarily a health program, and therefore without authority, expertise or resources to coordinate or to address in an integrated fashion the concurrent multiple and interrelated needs of contemporary children and families. The social and educational service and support needs of the child population are targeted through programs and structures independent of health, compromising access to information and services. Thus, a major appeal of the OAA as a model is the broad, cross-cutting scope of health and human service activities organizationally consolidated in the states as well as the federal government under an omnibus authority and public agency with a singular focus on population services and advocacy.

Comparison of Program Structure and Content, and Service Delivery Mechanisms of the Older Americans Act and MCH Services at the Community Level

While the same four key OAA characteristics analyzed at the federal level are relevant also at the community level, our focus in this part of the discussion specifically addresses those characteristics most related to services planning and content.

Single Authority for Population Concerns: The organizational structure for the OAA program extends vertically to the local level through federal mandates requiring states to establish sub-state units, called Area Agencies on Aging (AAA). These units are to provide a "focal point" in each community for information, planning and services. Approximately 670 such units operate in the 57 U.S. jurisdictions. The organizational location, structure and functions of these entities are outlined in statute, and provide the third element of the "national network on aging" whereby a population-specific locus of authority and accountability for advocacy, policy development and coordination, planning and services administration is identified at all three levels of government. AAA functions specified in the OAA parallel those outlined for the federal, and state agencies on aging, and additionally include service delivery and/or administration roles.

No such organizational visibility or accountability for children as a class is established at the local level in a national, uniform manner by Title V or otherwise.

Comprehensive Service Planning and Coordination: The OAA provides for a planning process within States where each area agency is required to work with service provider organizations and citizen advisory boards to develop plans for comprehensive services for the elderly specific to that geographically defined community. These AAA plans which, again, must address all issues of concern to the population and involve all pertinent public programs, must be analyzed and combined at the state level to develop the required State Unit on Aging annual plan which is reviewed by the federal AoA for approval. Requirements for public hearings also legitimize and promote citizen participation.

Provisions for State planning outlined in federal MCH legislation do not speak to processes for local level planning or to involvement of service providers or consumers/constituents. Without such provisions, not only can the foundation for community level programming thus be circumvented, but opportunities for constituency development can be missed where State MCH programs do not by their own design establish policy and program development processes involving the service delivery and other community structures as major players.

The Area Agency on Aging in Montgomery County, Maryland draws upon both the core requirements and the flexibility of the OAA to establish itself as the focus of leadership and accountability for the elderly in this geopolitical subdivision with approximately 110,000 senior residents. Flexibility allows the AAA to contract out direct service functions such as the Nutrition, Guardianship, and Health Promotion Programs, freeing up the staff of 20 to focus on what it has established as core functions of information and referral, and community services planning, coordination, and resource development. Other agencies with similar service programs, such as home health and health promotion, pool funds with the AAA to promote a consolidated county-wide service operation. Direct services -- such as meals -- are targeted for the low income population, but all other AAA activities are broadly conceived for the entire population of senior citizens. The I & R service processes over 35,000 calls each year. With the statutory requirements for the Citizen Advisory Board, the agency allocates substantial funds to staff the activities of its Commission on Aging, which meets monthly. The Commission reviews with each public agency director that agency's annual budget allocated to elder services and activities, and interviews the County Executive regarding the county budget at least annually. AAA staff assist the Commission with strategic planning whereby each year one or more special initiatives are identified by the Commission for implementation. Members of the Commission commit their time and connections to seeing the project(s) through to completion, supported with OAA funds and other public and private funds they solicit.

In Montgomery County, the original intent of the OAA with respect to providing leadership is strongly held -- the mission is implemented by "getting others to do what they do best," and to market concepts on behalf of the population. The AAA staffs a monthly meeting of the "Provider Council," which is comprised of over 100 proprietary, public and community agencies. There is also a Public/Private Partnership Program which develops joint ventures among Provider Council members and outside (particularly profit making) organizations. This has included developing a monthly newsletter (The Senior Beacon), sponsoring conferences and collaborating in publishing the senior resource directory. AAA staff promote private sector development of new products and services, e.g., lighting products. The Public/Private Partnership Program collaboratively produces a monthly magazine insert for a local newspaper, The Montgomery Journal, called "Senior Insights." The magazine is entirely funded through advertising sold by the newspaper and reaches 75% of all households in the county. The AAA compiles and edits the insert, but other agencies prepare most of the articles. The agency additionally staffs a "Marketing Support Group" which meets monthly. This represents a training and technical assistance approach to support government and proprietary agencies in better reaching their target populations and promoting their services. This initiative of the AAA has, for example, helped some adult day care centers to stay in business and assisted a local hospital develop a multidisciplinary geriatric assessment service.

Uniform Service Core and Flexibility for Delivery Mechanisms and Service Priorities: The uniform core of program services has been detailed, as well as the advantages of the categorical protections found in the OAA for this core. Although a uniform core, flexibility is provided for in the OAA at the community level for determining the appropriate scope, mix and priorities of supportive services (transportation, information and referral, outreach, case management, housing assistance, etc.). In recent years, area agencies have been able to capitalize on this flexibility to configure supportive services to become community access points for the broad array of health and human services potentially needed by older individuals. Many communities utilize the OAA-funded multipurpose senior centers as the local "hub" for these services.

As a number of services traditionally directly provided through AAAs have become increasingly available through the private sector (e.g. home health), AAA roles have begun to shift more in the direction of evolving as one-stop sources of intake that older persons and their families can rely on for access to needed services such as long-term care, emergency response to acute illness, abuse, or unanticipated shelter needs, and in-depth assessment and longer term case management as appropriate (Binstock, 1987; Justice, 1988; Binstock, 1990; hearing records, Senate Special Committee on Aging, 1993). In addition to addressing assessment and linkage and service coordination needs of significantly vulnerable elder persons, this community service access function can be performed in relation to recreation, volunteer opportunities, and age-related entitlements like Medicare and Social Security, etc., thereby avoiding stigmatization and maintaining universal appeal to the population (and enhancing the potential broad-based political support).

Although community level MCH services differ significantly from elder services in that they are not defined nationally and operate without a nationally identifiable uniform organizational structure, this latter trend in OAA service functions is strikingly similar to trends in maternal and child health. Medicaid expansions over the past eight years have diminished the need in some areas of the country for direct service delivery by Title V programs and have increased agency roles in outreach, and in linking families to private sector service providers and to resources for financing care. This role for MCH and other child/family serving public programs has snowballed, as the complexity of entitlement programs for low income families (e.g., Medicaid, AFDC, etc.), insurance for higher income families, and of specialized care programs (e.g. special education, home and community care for chronically ill or disabled children), has increased. The inclusion of mandated ombudsman functions and resources in the OAA to address linkage and other access problems further points to a strategy that could additionally strengthen system response to child and family service needs.

Advocacy and Citizen Participation: An active constituent role in services planning and oversight and strong consumer protections are provided for through the OAA's required ombudsman services, and through requirements for establishment of Citizen Advisory Boards for each area agency. Local citizen boards, comprised of consumers as well as civic, religious and business leaders, provide a community locus for pooling of public and private fiscal resources, and for organization of volunteer initiatives benefitting the elderly and expanding the reach and capacity of the area agency staff. Mandated ombudsman programming applies to both protection and advocacy services for neglected and abused individuals, as well as to consolidated outreach and counseling programs which provide assistance to individuals in linking or resolving problems with insurance or public benefit programs.

These boards and ombudsman services promote contributions of local financial and human resources, and citizen access to public leaders responsible for services to the population assuring both local ownership and accountability.

No clearly delineated citizen involvement exists to promote this sort of advocacy and consumer orientation for children's services. Where some children's programs may sponsor advisory committees and or ombudsman activities, resources for their support are usually meager or non-existent, and span of interest and/or authority is largely narrowly defined to categorical program concerns and not the needs of the population. Fragmentation weakens potential of citizen power in this regard.

Therefore, while OAA and Title V/MCH programs share the advantage of flexibility in configuring services at the local level, legislation for the elderly provides a protected and visible core around which comprehensive, cross-cutting health, social and other service planning and advocacy can be built. Required AAA citizen advisory boards, and constituent advocacy can coalesce around core service and planning mandates, providing a base of political support nationally that does not exist for children and families.

Conclusions and Options for Public Organizational Structures to Complement System Reforms in Health, Social Welfare, and Education

Analysis of the design of services for the elderly in the United States reveals apt policy and program design lessons for child and family health services. The Older Americans Act establishes a high level, visible national locus for information, policy development and coordination, advocacy, research, demonstration and professional training. The OAA also provides the legislative structure for a uniform consolidated program of comprehensive, community-based planning, and preventive and social services which complement the medical care financing and income support provided the elder population through Medicare and Social Security entitlements.

Constituent and congressional support for this approach has been ongoing and substantive, with reported achievements summarized in relation to continual identification of needs and development of exemplary strategies, programs and services; direct and indirect assistance to "innumerable" older Americans; development of a nationwide infrastructure and focus on the elderly; and recruitment of professionals into the field of the aging (Binstock, 1987). Through this federal legislation, the nation has committed to a rationally organized service structure for a population it believes deserving special protection. Consumer participation is legitimized; infrastructure development and maintenance is articulated and supported; structures for coordinated policy development at all levels are outlined; information resources and access to services are streamlined; and a broad and uniform core of community-based enabling and support services complementary to health and income entitlements is assured in all states and localities through mandates and ombudsman services.

The OAA provides a model for reorganizing health, welfare and education services for children and families so as to create structures that are linked horizontally and vertically and so as to result in consolidated policy development, planning and accountability. Such an organizational scheme for child and family services would further provide avenues for population advocacy, with respect to both rights protection activities for individual children/families (i.e., through a cross-cutting ombudsman program addressing health, social, and educational concerns) and a locus for addressing concerns for children as a class. Assurance of discipline-specific expertise (i.e., for MCH, social services, education, mental health, etc.) to address service needs through national legislation and resources for federal and state programs, coupled with organizational structures at the community level that consolidate all plans and activities for the population, may hold significant promise for children and families.

We believe that the first and most fundamental step to achieving parity between children and the elderly is a major rewrite of federal legislation authorizing key health, social services, and education programs. Revisions are needed to eliminate conflicts, overlap, gaps and fragmentation, and to maximize coordination within and among systems. While we concur that progress in achieving consolidation and coordination objectives is possible at the local, and even state levels, we are convinced that federal legislation will continue to drive the system, and that significant change based on principles of equity cannot occur without this step.

Further, we believe that revisions to national legislation must occur consistent with the following principles:

- 1.a national policy focus and vision for healthy children and strong families, as well as governmental accountability for outcomes consistent with that vision;
- 2.structures and authorities necessary to address service access and coordination complexities, fragmentation, overlap, and barriers at all levels, and to increase efficiencies and effectiveness of the planning, data, resource allocation functions of government;
- 3.a universally available uniform core of preventive and support services which can be configured with local flexibility to promote service availability and access in **all** communities: and
- 4.child advocacy, and consumer participation in services and system design and oversight at all levels of government.

Implementation of these principles would move the system of services for children and families in a direction more directly parallel to the infrastructure design for the elderly. However, a central assumption that we make is that the OAA's effectiveness relates in part to the fact that basic health and income needs of the elderly are universally met through Medicare and Social Security. Were the system to continue to allow the currently high numbers of children to remain uninsured and/or in poverty, the potential for impact would be significantly diminished. The organizational changes we recommend cannot replace these critical aspects of ensuring the well-being of children, and should be part of a comprehensive reform initiative for children and families.

While we argue for strong leadership roles and authorities at the state level, our proposals recognize that an entirely state-based program cannot overcome the variability and the instability of state capabilities (Benjamin et al., 1991; Guyer, 1990). Our recommendations therefore rely on federal mandates and resources to assure a uniform structure at state and local levels as well as a uniform core of prevention, support and access enhancing services, and system monitoring, reporting and advocacy roles and activities. Federal legislation should be used to clarify

complementary roles of public agencies at federal, state, and local levels, and to promote local effectiveness and efficiencies in the private sector as well.

1. At the federal level, we specifically recommend:

- **Creation of a free-standing National Council on Children and Families** to consolidate 1) information collection and dissemination for the public, the President, and Congress, 2) advocacy for public response to population needs, 3) policy development, review, and oversight with respect to all matters related to the health and well-being of children and their families, and to 4) provide the President and Congress counsel on the needs of and policies impacting children and families. Membership should be external to government, however, with government agencies (ACF, HRSA, CDC, NICHD, USDA FNS, Education, Housing and Urban Development, Labor, Justice, etc.) having liaison appointments. This Council should be represented on the Domestic Policy Council.

- **Reorganization within DHHS to consolidate major health/human services programs for children and families under the Assistant Secretary for the Administration for Children and Families.** This administration would: 1) serve as Secretariat for the National Council on Children and Families; 2) include Social Services, Child/Family Health programs (such as Title V, Immunization, Family Planning, School Health, Injury Prevention, Emergency Medical Services for Children, Lead Poisoning Prevention, and others), developmental, and child/adolescent mental health programs; 3) have liaison membership on the Domestic Policy Council, and 4) be responsible for consolidated data/information collection and reporting to Congress regarding population needs and services.

- **Legislation that coordinates federal agencies and guides state and local efforts by**

- 1) requiring uniform state organizational structures and designation of sub-state/community authorities for consolidated advocacy, policy, planning and reporting with respect to the health and well-being of children and their families; 2) creating statewide programs incorporating a uniform core of community-based child and family services; 3) enacting parallel reciprocal legislative provisions requiring coordination between the reconfigured DHHS Administration for Children and Families and the Departments of Education, Agriculture, Housing and Urban Development, Labor and Justice (and others) with respect to policies and programs impacting on child and family health; and 4) outlining ACF functions to include responsibility for children's advocacy, review and sign-off of all proposed policies, programs and initiatives impacting on child and family health and well-being, administration of the statutorily-defined core child and family community services program, evaluation of programs and activities related to child and family health and well-being, and development and maintenance of vehicles for on-going consultation and collaboration with state governmental entities, consumers, professional organizations, and academic institutions.

2. At the State level we specifically recommend creation of:

- **An Independent Single State Agency for Child and Family Policy** in each state which addresses (minimally) child and family health, developmental, social services, and education issues and programs, and which has advocacy and policy functions and authorities parallel to that established for the federal ACF, including state administration of the core community services program, and development of a comprehensive, consolidated state plan for child and family services.

3. At the regional/community level, we propose:

- **Sub-State Children and Families Authorities** having expertise and policy development and coordination responsibilities with respect to all child/family-serving public agencies and programs. Statutorily defined responsibilities of the Children and Families Authority would include: 1) community needs assessment and planning; 2) centralized information and referral services; 3) community-based prevention programs; 4) contracting for the provision of community-based outreach, home-visiting, enabling, social, and other family support services defined in the core program; 5) developing services linkages between the medical care system and social, education and other relevant services; 6) administering a consolidated program of ombudsman services for children and families; and 7) as appropriate, creating multi-purpose family service centers to implement co-location of services.
- **Family Advisory Councils** established to: 1) provide consumer participation in state and regional/community level agencies and entities with public responsibility for services to children and families; and to 2) provide ongoing consumer advocacy on behalf of children and their families.

We acknowledge that these recommendations are not a panacea. Implementation of the OAA has been characterized by many of the same weaknesses of government administration of other programs (GAO, 1991; Hudson, 1992), and reasoned approaches to addressing deficiencies must be deployed to optimize potential impact. Neither can legislative structures remedy the lack of resources. However, these proposals are intended to represent modest, but important, next steps for improving the system through consolidation and coordination.

Our recommendations for a consolidated national program for children and families, based on the model of the national program for the elderly created under the OAA, are intended to promote access to a system that coordinates a broad spectrum of health, social and educational services at the federal, state and local levels. In many ways, these recommendations reflect a return to the national principles first enunciated by the Children's Bureau, but lost through the evolution of health and social service program development of the last three decades. This approach, however, moves beyond the tenets of the past by promoting bureaucratic efficiencies consistent with contemporary management practices which would eliminate overlap and duplication in planning, data, and

prevention and support services programming. These recommendations would allow for consolidating funds at the local level, as well as for consumer-directed flexible service design and resource allocation within communities. It should be clear, however, that we are not recommending what is generally called a block grant, or complete devolution of government roles in care of the child population. Our recommendations will only be successful if federal legislation is accompanied by federal oversight, accountability at all levels and adequate funding to achieve the national objectives for the health and welfare of children and families.

In the current national debate over the role of the federal government, critics often choose to ignore the positive aspects of federal programs that are effective. Pejorative terms like "welfare" or stigmatized concepts like "block grants" are rarely applied to services for powerful constituencies like the elderly. Few proposals are being made to cut their benefits. The tools of government that have been used in building this system of services for the elderly are available to us for use in improving the lives of a politically weak population -- women and children. This paper demonstrates how effective legislative, structural, and programmatic elements can be borrowed from one population to serve the needs of the other. As a nation, we need to have the political courage to extend the attributes of a system that works for grandparents to their grandchildren.

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APPENDIX A

Comparison of the OAA and the Title V (SSA)

Table 1: Implementation at the Federal Level

Table 2: Implementation in States

**Older Americans Act
PL 102-375**

**Title V (SSA) - MCH Services Block Grant
PL 101-239**

I. ADMINISTRATION

| | | |
|---------------------------------|--|---|
| <p>A. Authority</p> | <p>1) <u>Administration on Aging</u>. Mandated administration reporting directly to Secretary; agency functions (over 30) specified in statute, (Sec. 201, Sec. 202).</p> <p>2) <u>Federal Council on the Aging</u>. Membership (15 individuals/designated representation), roles, and operating resources established in statute (Sec. 205).</p> | <p>1) Statute directs Secretary to designate identifiable administrative unit, within HHS, with MCH expertise. Eight (8) functions specified in statute (Sec. 509).</p> <p>No comparable entity.</p> |
| <p>B. Level of Organization</p> | <p>1) <u>Administration on Aging (AoA) In DHHS</u>. Commissioner appointed by the President, reports to Secretary DHHS (Sec. 201).</p> <p>2) <u>Federal Council on the Aging</u>. Established in statute to meet at least quarterly. Chairperson designated by the President (Sec. 205).</p> | <p>1) <u>Maternal and Child Health Bureau (MCHB) In DHHS</u>. Director appointed by and reports to Administrator of HRSA, one of 5 organizational units of the Public Health Service, overseen by the Deputy Secretary for Health. (Specific administrative arrangements not specified in statute).</p> |
| <p>C. Functions</p> | <p>1) <u>AoA</u>. Statute specifies 30 functions of the AoA including (selected functions):</p> <ul style="list-style-type: none"> ● provide visible advocacy; ● active review/commenting on all federal policies affecting the elderly; ● gather statistics and coordinate all federal programs and activities related to the elderly; ● coordinate and assist public and private sector efforts to establish nationwide network of comprehensive, coordinated services; ● administer all OAA grant programs (except Title V/OAA); develop plans, provide technical assistance to states; ● issue regulations and monitor state compliance; ● design and implement uniform data collection procedures; | <p>1) <u>MCHB</u>. 8 specific responsibilities outlined, including for:</p> <ul style="list-style-type: none"> ● promoting coordination; ● data collection, maintenance and dissemination related to health status and service needs (in cooperation with the National Center for Health Statistics); ● assisting in preparing required reports to Congress; ● providing technical assistance to states on request; ● disseminating information to states; ● assisting states in developing care coordination services; and ● the Federal set-aside research, training and demonstration program; ● for developing and disseminating a national directory listing of required state toll-free numbers (Sec. 509). |

Implementation at the Federal Level

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| | <ul style="list-style-type: none"> ● provide technical assistance training and assistance to State, area and local service providers regarding data collection and analysis; ● develop national plan for trained personnel, and conduct or provide for needed training; ● encourage and provide technical assistance regarding outreach services pertaining to eligibility for SSI, Medicaid, Food Stamps; ● evaluate programs and activities related to the OAA with special attention to impact of medicare and medicaid; <p>2) <u>Federal Council</u>. Five (5) specific responsibilities outlined:</p> <ul style="list-style-type: none"> ● advise and assist the President on matters relating to the special needs of older Americans; ● review and evaluate federal policies and other activities; ● serve as a spokesman and make recommendations to the President, Secretary [DHHS], the AoA Commissioner and Congress with respect to federal policies; ● inform the public about problems and needs of the elderly through information collection and dissemination, and commissioning studies/publishing reports; and ● provide public forums on problems and needs of the aging. <p>Interim and annual reports to the President are required (Sec. 205).</p> | <p>No comparable functions.</p> |
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**Older Americans Act
PL 102-375**

**Title V (SSA) - MCH Services Block Grant
PL 101-239**

I. ADMINISTRATION (continued)

D. Programs

- 1) Administers Categorical Grant Program to states authorized under Title III.
 - 2) Administers Special Studies and National Centers specified in Title II.
 - 3) Discretionary Programs (under Title IV) for: training and education; multi-disciplinary centers of gerontology; research; demonstration projects(including those addressing 13 specified priorities).
 - 4) Grant Program for Native Americans (Title VI) to promote delivery of supportive services - administered through tribal organizations (Indians), public, and non-profit private organizations.
 - 5) State-Administered Vulnerable Elder Rights Protection activities specified in Title VII, including: Ombudsman programs; programs for prevention of elder abuse, neglect, and exploitation; elder rights and legal assistance development program; and outreach, counseling and assistance program (for insurance and public benefits).
- Note: Title V of the OAA, Community Service Employment for Older Americans, is administered by the Department of Labor.

- 1) Administers Formula Grants to states for MCH Services outlined in Section 501(a)(1)(A), (B), (C), & (D).
- 2) Administers set - aside/grant program specified in Section 501(a)(2) for: Special Projects of Regional And National Significance (SPRANS); research; training; genetic disease testing, counseling and information development and dissemination; hemophilia services; and for newborn screening and follow-up for sickle cell anemia and other genetic disorders.
- 3) Community Integrated Service Systems (CISS) Projects. Set-aside grant programs established under Section 501(a)(3) for 6 specified MCH priorities.
- 4) Emergency Medical Services Programs for Children Authorized under the Public Health Service Act. (P.L. 102-410)
- 5) Pediatric AIDS Demonstration Programs Authorized under Title IV of the Ryan White AIDS Care Act (Sec. 2611, Public Health Services Act).
- 6) Federal Healthy Start Program.

E. Funding Mechanisms

- 1) Categorical authorizations and allocations under each title, with selected subtitle projects/services having designated line-item allotments (5 programs in Title III, and 3 in Title VII).
- 2) Formulae for state allotments established in statute for Title III

- 1) Single amount authorized for Block Grant with formula specified for state grant allotments (Sec. 502(c)) and set-aside grant programs (Sec. 502(a) & (b)). Earmarks specified for expenditures for 1) preventive and primary care for children and 2) care, and development of systems of community-based,

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| | <p>State and Community Programs (Title III, Sec. 304 (a)(1)-(3)); and Title VII Vulnerable Elder Rights Protection Activities (Sec. 703(a) and (b)).</p> <p>3) States required to support $\geq 25\%$ of costs of administration of state plan (Sec.308(a)(1)). Appropriation of additional state funds for OAA-related services and activities reported to occur.</p> | <p>family-centered, coordinated services for children with special health care needs (Sec. 505(a)(3)).</p> <p>2) State matching funds required: ratio--3 state dollars for every 4 federal (Sec. 503(a)). States may, and often do, appropriate additional state funds above level of required match. Statute requires maintenance of state funding at FFY 1989 level (Sec. 505(a)(4)).</p> |
| F. FFY 1994 | \$1,400,000,000 | \$687,300,000 |
| G. Data Collection, Reporting and Other Accountability Provisions | <p>Annual Report by the Commissioner to the President, and to specified Congressional Committees and federal agencies required. Specific information requirements include (but are not limited to):</p> <ul style="list-style-type: none"> ● statistical data on services, activities and target populations, expenditures, etc; ● analysis of effectiveness of State and area plans ● needs for trained personnel in the field of the aging ● information collected and compiled by States on complaints and conditions related to long-term care ● outreach activities. (Sec. 207). <p>AoA required to collect (for each FY) statistical data regarding OAA programs and activities (Sec. 202(a)(19), and design and implement uniform state reporting procedures (including standard definitions, participant identifications and description system, and procedures for identifying unmet need) (Sec. 202(a)(29)).</p> <p>Commissioner to establish the National Aging Information Center to annually compile, analyze, publish and disseminate required program data, census data and health, social and economic status data on the elderly (Sec. 202(e)(1)(A)).</p> <p>Certain evaluation studies and reports to Congress required, including (but not limited to) those pertaining to:</p> | <p>Annual Report by the Secretary, DHHS, to specified committees of the Congress required. Specific components of the report include:</p> <ul style="list-style-type: none"> ● description of each project funded under the set-aside grant programs; ● summary of information reported by States; ● compilation of specified measures of maternal and child health, and services/providers (nationally, and for each state); and ● assessment of progress in meeting applicable health status goals and objectives for the year 2000 (Sec. 506(a)(3)). <p>MCHB to provide technical assistance to State on request on "developing consistent and accurate data collection mechanisms" (Sec. 509(a)(4)).</p> <p>In cooperation with National Center for Health Statistics, MCHB to collect, maintain and disseminate information on MCH status and service needs (Sec. 509(a)(5)).</p> |

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| | <ul style="list-style-type: none"> ● the effectiveness of all OAA programs (Sec. 206(a) and (d)); ● effective targeting to low-income, and rural elderly (Sec. 202(27)); ● the Title III nutrition program (Sec. 206(g)); ● the effectiveness of the long-term care ombudsman program. | |
| | Older Americans Act PL 102-375 | Title V (SSA) - MCH Services Block Grant PL 102-239 |

II. COORDINATION

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| | <p>Mandates for coordination incorporated throughout the Act; selected examples of requirements at the federal level include:</p> <ul style="list-style-type: none"> ● AoA Commissioner to "coordinate federal programs and activities"; "coordinate... with public and private organizations... with a view to... network of comprehensive coordinated services..."; coordinate in development of national plan for training; develop planning linkages with health systems agencies established under the PHSA, SSA, SAMHSA, and ADD, especially related to long term care (Title II, Sec. 202). ● Reciprocal advice, consultation and cooperation between AoA and agencies proposing or administering programs/services substantially related to the Act mandated. Among the approximately 18 related programs/agencies listed are: DOL/JTPA Census Bureau SSA (Titles XVI, XVIII, XIX, & XX) National Housing Act Public Health Service Act (including Block Grants) Higher Education, and Adult Education Acts Developmental Disabilities Act (Title II, Sec. 203). ● Required coordination with State agencies, area agencies, and grant recipients under Title VI in developing Federal goals, regulations, program instructions, and policies under the OAA (Title II, Sec. 204). | <p>Legislative provisions for "promoting coordination" with federal medicaid agency, Departments of Agriculture, and Education, and other DHHS - administered block grants and categorical programs (such as immunizations) (Sec. 509(a)(2)), and for cooperation with the National Center for Health Statistics with respect the data collection and dissemination on MCH health status and service needs (Sec. 509(a)(5)).</p> |
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III. ADVOCACY

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| | <p>Statutory provision declaring that the Commissioner (AoA) to "serve as an effective & visible advocate..." (Sec. 202(a)(1).</p> <p>Statutory provision for the Federal Council on the Aging (FCA) to "serve as a spokesman on behalf of older Americans..." (Sec. 204(c)(4)).</p> <p>Both AoA and FCA statutorily assigned duties with respect to informing [others] on problems and needs of the aging; data collection and dissemination; study and reporting (Title II: Sec. 202 and 204).</p> <p>Title II of the OAA additionally establishes an office of Long-term Care Ombudsman Programs in AoA, a National Center on Elder Abuse (Sec. 201(d) and Sec. 202(d), respectively), and a National Aging Information Center (Sec. 202(e)).</p> <p>Requirements for a White House Conference on Aging are found in Title VIII.</p> | <p>Advocacy role not specified in statute, excepting provisions relating to "collection, maintenance, and dissemination of information relating to the health status and health service needs of mothers and children..." (Sec. 509(a)(5)).</p> |
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IV. CITIZEN PARTICIPATION

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| | <p>Membership of the Federal Council on the Aging must reflect representation of rural and urban older individuals; at least 9 members (of 15) must be older individuals (Title II, Sec. 205).</p> | <p>None specified at federal level.</p> |
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**Table 2: Comparison of the OAA and the Title V (SSA)
Implementation in States**

| | Older Americans Act PL 102-375 | Title V (SSA) - MCH Services Block Grant PL 101-239 |
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| I. ADMINISTRATION | | |
| A. Authority | <u>State Unit on Aging (SUA)</u> . Required designation a single state agency to receive funds and administer OAA programs (Sec. 305). | <u>State Health Agency (SHA)</u> . Requirement for State Health Agency responsibility for administration (or supervision of administration) of programs implemented with allotments to states (Sec. 509(b)). |
| B. Level of Organization | Level not specified in statute. Approximately one-half are free-standing, cabinet level agencies, others exist as major administrative units of umbrella human services agencies. | No federal provisions for establishing MCH-specific organizational units in SHA; however reference is made in Title V (Sec. 505 & Sec. 506) to "State Maternal and Child Health agency" responsibilities with respect to application for funding and for meeting reporting requirements. Great variability in implementation. |
| C. Functions | <p><u>SUA</u>. Statute outlines five (5) primary functions to be carried out consistent with regulations of the Commissioner (Sec. 305(1)). Functions include:</p> <ul style="list-style-type: none"> ● Development of State plans for a two-, three-, or four-year period determined by the AoA, with annual revisions as necessary and which meet criteria prescribed in federal regulation. ● Administration of the State plan. ● Primary responsibility for planning, policy, administration, coordination, priority setting, and evaluation of all State activities related to the objectives of OAA. ● Serve as an effective and visible advocate for the elderly, through review of pertinent State plans, budgets and policy, and through provision of assistance. ● Designate (in consultation with others and consistent with federal guidelines) distinct planning and service areas. <p>Reporting part of state plan requirements (Sec. 307(a)(6)).</p> | <p><u>SHA</u>. Statute outlines general conditions for state receipt of allotments with specifies:</p> <ul style="list-style-type: none"> ● Annual transmittal of an application prepared in a standardized form specified by the Secretary, DHHS (Sec. 505). ● Administration (or supervision of the administration) of programs carried out with allotments to the State (Sec. 509(b)). ● Submission of annual reports in standardized form on health status, and on services, activities, and expenditures related to Title V allotments (Sec. 506(a)(1) & (2)). |

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| <p>D. Funding Mechanisms</p> | <p>Allocation of funds at the state level determined by:</p> <ul style="list-style-type: none"> ● Federal line-item appropriations for specified categories of services (Sec. 303 & Sec. 701); and ● SUA formula distribution of funds to area agencies and for specified program activities developed consistent with federal guidelines, with public review and comment, and approved by the Commissioner. Formula must take into account best available data with respect to a) geographic distribution of individuals over age 60, (b) distribution of older individuals with greatest economic need and greatest social need, and assuring "particular attention" to low-income minority individuals (Sec. 305(a)(2)(c) through (G)). <p>Not more than 10% of State allotments under Title III can be utilized to support costs ($\leq 75\%$) of State administration of area plans (Sec. 304(d)(1)(a) & Sec. 308(a)(1)).</p> <p>Area agencies may request waiver of funding earmarks for certain Title III program categories with sufficiency of services documented and following public notice and hearings. Required SUA reports to the federal AoA commissioner on approved area waivers (Sec. 306(b)). Process outlined for federal waivers to States of transfer prohibition (Sec. 308(b)(5)).</p> | <p>Statutory provisions related to state funding allocations are specific to:</p> <ul style="list-style-type: none"> ● 30% earmarks for preventive and primary care for children (Sec. 505(a)(3)(A)); ● 30% earmark for CSHCN services and service system development (Sec. 505(a)(3)(B)); ● 10% cap on expenditures for administration (Sec. 504(a)(4)); ● Maintenance of effort to FY 1989 levels (Sec. 505(a)(4); and ● Establishing a "fair method" for allocating funds consistent with MCH needs (Sec. 505(a)(5)(A)). <p>States' allocations for service provision based on a variety and combination of factors including historical funding patterns and needs-based formulas.</p> <p>States may apply to Secretary for a waiver of the earmark requirements (Sec. 505(b)).</p> |
| <p>E. Data Collection, Reporting, and other Accountability Mechanisms</p> | <p>State Plan required (for 2, 3, or 4 year periods with annual revisions). Statute outlines over 40 major plan components which includes (but are not limited to) assurances and information with respect to:</p> <ol style="list-style-type: none"> a) State plan based on required area plans; b) evaluation of service needs and gaps; c) allocation and targeting of funds; d) public hearings, periodic evaluation of activities, and grievance procedures; e) core OAA services, and f) coordination activities (Sec. 307(a)). | <p>Required annual application for state allotments (Sec. 505(a)). Mandated components include:</p> <ol style="list-style-type: none"> a) a Statewide needs assessment (each 5 years); b) a plan for meeting needs identified in the assessment and consistent with national health goals and objectives; c) a description of use of funds and services (i.e., types, geographic areas, information collection); d) assurances and information on compliance with mandated earmarks for expenditures, maintenance of effort and other fund allocation, activity and coordination requirements (Sec. 505). |

**Older Americans Act
PL 102-375**

**Title V (SSA) - MCH Services Block Grant
PL 101-239**

I. ADMINISTRATION (continued)

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| | <p>States must make reports to the federal agency as required by the Commissioner (Sec. 307(a)(6)); specific annual reports required related to evaluations of area outreach activities (Sec. 705(a)(7)(D)), and to State Long-Term Care Ombudsman program (Sec. 712(h)), and others.</p> <p>State Unit of Aging required to make periodic evaluations and hold public hearings on activities funded under the Act, (Sec. 308(a)(8), Sec. 731(b)(8), and others). Public hearings required also with respect to Title VII ombudsman programs (Sec. 705(a)(2)).</p> <p>Required statewide uniform reporting system to collect and analyze data on complaints conditions relating to long-term care facilities (Sec. 712(c)).</p> <p>Required assurances and provisions related to standard fiscal control, fund accounting, audits, non-discrimination, etc.</p> | <p>Annual reports required in standardized form on activities and expenditures. Statute details health status and services reporting items (Sec. 506(a)(1) & (2)).</p> <p>See IV, Citizen Participation, below regarding public comment.</p> <p>Required assurances and provisions related to standard fiscal control, fund accounting, audits, non-discrimination, etc.</p> |
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II. COORDINATION

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| | <p>Provisions requiring State and Area Agency coordination with other programs and entities found throughout Titles III and VII, including:</p> <ul style="list-style-type: none"> ● at the State level, "be primarily responsible for the planning, policy development, administration, coordination... of all State activities related to the objectives of the [OAA]" (Sec. 305(a)(1)(C)). Additional provisions for coordination and working agreements related to State Developmental Disabilities agencies (Sec. 307(a)(25)); long-term care services (Sec. 307(a)(26)); health, social services, rehabilitation, mental health (Sec. 307(a)(27); employment programs, State attorney general, federal entities (Sec. 731(b)(9)); transportation (Sec. 307(a)(42)); and others. | <p>State application requirements that agency administrating the state program:</p> <ul style="list-style-type: none"> ● participate in coordination with Medicaid EPSDT programs; ● implement coordination agreements relating to coordination of Title V (SSA) and Medicaid (Title XIX SSA) care and services; and ● participate in coordination activities in the State with related federal grant programs including WIC/nutrition, education, other health, developmental disability, and family planning programs (Sec. 505(a)(5)(F)). |
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| | <ul style="list-style-type: none"> • at the Area level, "serve as the... focal point for older individuals within the community (in cooperation with agencies, organizations and individuals participating in activities under the [State] plan)..." (Sec. 306(a)(6)(D)) and "...coordinate with organizations that have a proven record of providing services to older individuals," (Sec. 305(a)(6)(E) & Sec. 306(a)(6)(H)-(M), & (Q) where long-term care, case management, mental health, abuse prevention, housing entities and authorities are referenced). <p>Several provisions are found requiring SUA consultation and coordination with Area Agencies on Aging, including regarding for example:</p> <ul style="list-style-type: none"> • development of fund distribution formulas (Sec. 305(A)(2)(C); • access to and assisting older individuals in securing benefits (Sec. 705(1)(3) & Sec. 741(b)); • services for the protection of "...vulnerable older individuals..." (Sec. 721(d)). | |
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III. ADVOCACY

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| | <p>Both State and Area Agencies on Aging required to provide visible and effective advocacy on behalf of older individuals (Sec. 305(a)(1)(D) & Sec. 306(a)(6)(D)).</p> <p>Title VII provides authority and funds for vulnerable elder rights protection activities in each state through:</p> <ul style="list-style-type: none"> • Ombudsman Programs (re: long-term care); • Programs for Prevention of Elder Abuse, Neglect, and Exploitation; • Elder Rights and Legal Assistance Development Programs; and • Outreach, Counseling and Assistance Programs (to ensure access to insurance and public benefit programs). <p>Separate funding categories established for ombudsman, abuse</p> | <p>Advocacy role not specified in statute.</p> |
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prevention, and pension counseling services.

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IV. CITIZEN PARTICIPATION

SUA mandated to take into account views of service recipients in "matters of general policy...in the development and administration of the State plan..." (Sec. 305(a)(2)(B)).

Area AoAs must meet parallel requirements for addressing recipient views in their plans (Sec. 306(a)(6)(c)), and must establish an advisory council consisting of older individuals, their representatives, local elected officials and the general public (Sec. 306(a)(6)(F)).

Multiple provisions found throughout requiring public hearings at state and area levels to obtain the views of older individuals, experts in the field of aging, and interested individuals and entities (Sec. 307, 705, 712, and others).

Statute requires that the annual application for state allotment be made public to facilitate comment (Sec. 505(a)). Public participation implementation strategies vary across states and include (but are not limited to) holding public hearings and convening advisory committees/councils.

V. PROGRAM SERVICES

A. Content

Title III of the Act details the basis for development and implementation of comprehensive and coordinated service systems (in each state and for Native Americans) for the planning and provision of supportive services, nutrition services, and multipurpose senior centers. Approximately 30 components of the service system are outlined (and defined) with specific categories which include:

- supportive services (transportation, information and referral, outreach, case management, legal assistance, housing assistance, and others);
- congregate nutrition services;
- home delivered nutrition services;
- school-based meals;
- in-home services (homemaker and health aides, home visiting and telephone assistance, in-home respite, housing modifications,

In statement of purpose of appropriations (Sec. 501(a)) statute outlines four (4) major areas for services and activities in the states to include:

- providing and assuring for mothers and children access to quality MCH services;
- services to: reduce infant mortality and child morbidity; reduce the need for hospital and long-term care; increase immunization and receipt of child health services; prenatal, delivery, and post-partum care; and preventive and primary care for children;
- rehabilitation services (not available through Title XVI (SSA)) to blind and disabled children under age 16 receiving SSI; and
- providing and promoting family-centered, community-based, coordinated care and care coordination for children with special health care needs, and facilitating development of

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| | <p>etc.);</p> <ul style="list-style-type: none"> • preventive health services (screening, injury control, educational programs, counseling and follow-up services); and • supportive activities for care takers providing in-home services to the frail elderly. <p>Title VII specifies requirements and allotments for four (4) major categories of "vulnerable elder rights protection activities" in each state (and for Native Americans) to include:</p> <ul style="list-style-type: none"> • ombudsman programs; • programs for prevention of elder abuse, neglect, exploitation; • state elder rights and legal assistance development programs; and • outreach, counseling, and assistance programs (related to insurance, and public benefit programs). | <p>community-based systems of services for CSHCN and their families.</p> <p>Also required are toll-free telephone services to access information on MCH (Title V), Medicaid (Title XIX) and other health-related providers (Sec. 505(a)(5)(e)), and assistance in linking eligible pregnant women and infants with Title XIX assistance (Sec. 505(a)(5)(F)(iv)).</p> <p>Under these broadly enabling provisions, states design, develop, implement, administer and/or fund a range of health promotion, service delivery, quality assurance, and capacity development arrangements and activities which are highly variable both within and among states.</p> |
| <p>B. Service Organization and Delivery Mechanisms</p> | <p>Each state required to designate (under Title III) a single, or multiple <u>Area Agencies</u> (with an established office of aging) to develop an area plan for providing and administering services specified under Titles III and VII. Over 650 such area agencies operate nationally, which represent units of government or public or non profit agencies conforming to federal guidelines, approved through State plans, and under the supervision of the State Unit of Aging (Sec. 306).</p> <p>Extensive statutory direction provided with respect to Area Agency planning and coordination functions and to the content of area plans. In parallel fashion to federal and state agencies under the OAA, mandated Area Agency roles include advocacy, technical assistance, coordination, and monitoring and evaluating all policies, programs, hearings on [community] actions which affect the elderly (Sec. 306(a)(6)).</p> <p>"[W]here feasible," Area Agencies are to designate a focal point for comprehensive service delivery in each community, with preference to be given to multipurpose senior centers (Sec. 306(a)(3)). Area Agencies</p> | <p>None specified in federal statute.</p> <p>A wide variety of provider entities are utilized, with local health departments, state and regional health agencies, hospitals, and medical centers, non-profit community agencies and schools being prominent sites for the organization and delivery of services. In some areas, local and/or regional health agencies have designated MCH administering units. The scope and level of State roles and authority for oversight of MCH planning and service delivery at the community level vary widely.</p> |

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| | establish and coordinate service networks through arrangements with community agencies. | |
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V. PROGRAM SERVICES (continued)

C. Targeting Populations for Services

Services provided under the act to be available to all older persons needing assistance. Means tests for program participation are prohibited (Sec. 307(a)(13)(M)), but voluntary contributions for nutrition services are allowable (Sec. 307(a)(13)(C)).

In all aspects of program planning, administration and implementation, however, priority is to be given to older individuals with the greatest social and economic need (Sec. 305(a)(1)(E); Sec. 305(a)(2)(C)(ii); Sec. 306(a)(1) & (5); Sec. 307(a)(8); as well as parallel provisions in Title VII). Further, numerous statutory provisions emphasize particular attention to low-income minority individuals, and to the rural elderly.

Certain specific subparts require additional targeting to those with Alzheimer disease and related disorders (for example, Sec. 306(a)(4)), those with severe disabilities (e.g. Sec. 306(a)(5)(B)(i)(V)). Targeting for services to Native Americans is assured through provisions of a separate Title (VI) specifying fund/services for these populations.

Targeting accomplished through specific requirements related to State designation of distinct planning and service areas (Sec. 305(a)(1)(E)); development of the state allocation formula (Sec. 305(a)(2)(C)(ii) and area and state plan assurances (Area--Sec. 305(a)(5)(A)(i)-(iii) & Sec. 306(a)(6)(G); State--Sec. 307(a)(23), (24), & (29) & Sec. 705(a)(7)(A)(i)) which include requirements for setting specific objectives for serving low-income minority older individuals.

The terms "greatest economic need," and "greatest social need" are defined (Sec. 102(29) & 30 respectively); economic need is indicated by

Program established to improve the health of all mothers and children, with state appropriation for provisions and assurance of services to be targeted in particular for:

- low income mothers and children or those with limited availability to services (Sec. 501(a)(1)(A) & (B));
- low income, at-risk pregnant women (Sec. 501(a)(1)(B); and
- children with special health care needs and their families (Sec. 501(a)(1)(C) & (D)).

Formula for state allotments considers the number of low income children with the State (Sec. 502(c)(1)(B) & (2)(B)).

State plan to be developed for meeting needs identified in the Statewide needs assessment (Sec. 505(a)(D)).

Statute prohibits charges for services for low-income (< 100% FPL) mothers or children (Sec. 505(a)(5)(D)).

Two 30% earmarks (Sec. 1.D., Funding Mechanisms).

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| | below poverty income, and social need is related to physical/mental disabilities, language barriers, and cultural, social, or geographic isolation. | |
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