Matern Child Health J (2014) 18:396–404
DOI 10.1007/s10995-013-1309-7

Building Economic Security Today: Making the Health–Wealth Connection in Contra Costa County's Maternal and Child Health Programs

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Published online: 22 June 2013

Abstract In recent years, maternal and child health professionals have been seeking approaches to integrating the Life Course Perspective and social determinants of health into their work. In this article, we describe how community input, staff feedback, and evidence from the field that the connection between wealth and health should be addressed compelled the Contra Costa Family, Maternal and Child Health (FMCH) Programs Life Course Initiative to launch Building Economic Security Today (BEST). BEST utilizes innovative strategies to reduce inequities in health outcomes for low-income Contra Costa families by improving their financial security and stability. FMCH Programs' Women, Infants, and Children Program (WIC) conducted BEST financial education classes, and its Medically Vulnerable Infant Program (MVIP) instituted BEST financial assessments during public health nurse home visits. Educational and referral resources were also developed and distributed to all clients. The classes at WIC increased clients' awareness of financial issues and confidence that they could improve their financial situations. WIC clients and staff also gained knowledge about financial resources in the community. MVIP's financial assessments offered clients a new and needed perspective on their financial situations, as well as support around the financial and psychological stresses of caring for a child with special health care needs. BEST offered FMCH Programs staff opportunities to engage in non-traditional, cross-sector partnerships, and gain new knowledge and skills to address a pressing social determinant of health. We learned the value of flexible timelines, maintaining a long view for creating change, and challenging the traditional paradigm of maternal and child health.

Keywords Life Course Perspective · Social determinants of health · Health equity · WIC · Medically Vulnerable Infant Program · Home visiting

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Introduction

Since the introduction of the Life Course Perspective (LCP) into maternal and child health (MCH) by Lu and Halfon [1], MCH professionals around the nation have been seeking innovative ways to apply the LCP and test new LCP-based approaches to MCH practice. The LCP suggests that a complex interplay of biological, behavioral, psychological, environmental, and social protective and risk factors contributes to health outcomes across the span of a person's life. Recent publications [2–5] provide guidance for practices and policies based on the LCP. In particular, the "12-point Plan to Reduce the Black-White Gap in Birth Outcomes" provides a framework for strategies that cross-sectors and

address social factors, such as reducing poverty, in order to improve maternal and child health [5].

Wealth, or lack thereof, is a strong predictor of health and well-being [6–12]. Adler et al. [9] state, "People who grow up on the bottom (rungs of the socioeconomic ladder) die younger and are sicker throughout their lifetimes than those who are born to the rungs above them." There is a "social gradient" to this effect: low-income families have worse health outcomes than those in the middle class, who in turn have worse outcomes than the upper class [6–9]. Socioeconomic status also affects the well-being and development of children, including their health [8, 13–15], behavior [16], and educational achievement [14, 16, 17]. Children in families with the highest incomes are seven times less likely to be in poor or fair health than children in the lowest income families [8], and the accumulation of poverty and other social disadvantages has been associated with poor children's health [13]. In addition, socioeconomic status in childhood has been linked to health in adulthood [15, 18, 19], with early and lifelong exposure to chronic stress due to financial instability and poverty a potential pathway for these risk factors to "get under the skin [10, 20, 21]."

Various strategies have been employed to improve the health and well-being of children and families through financial asset building. In the U.S., programs that provide economic resources to low-income families, such as the Earned Income Tax Credit [22, 23], Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) [22], Supplemental Security Income (SSI) [22], Supplemental Nutrition Assistance Program [22, 24, 25], and home energy assistance [22, 26] improve the well-being of children. In addition, a long-running conditional cash transfer program in Mexico has been correlated with improved children's health, including lower rates of low birth weight [27], improved nutrition and growth [28, 29], decreased likelihood of becoming overweight [28], increased cognitive ability [29], and lower rates of behavior problems [29].

After learning about the Life Course Perspective from the work of Lu and Halfon [1], the Family, Maternal and Child Health (FMCH) Programs of Contra Costa Health Services (CCHS), a local health department in California, launched the Life Course Initiative (LCI) in 2005 to respond to the unchanging high rates of low birth weight and infant mortality in our county, especially among African Americans, despite our best efforts to increase access to quality prenatal care. The goal of the LCI is to reduce inequities in birth, infant, and maternal outcomes and improve the health of the next generation in Contra Costa County by promoting and achieving health equity, optimizing health, and shifting the paradigm of the planning, delivery, and evaluation of maternal, child, and adolescent health services to a Life Course approach. In a previous paper, Pies et al. [30] detailed the development and implementation of the LCI, including: (1) creating LCP educational and training materials; (2) conducting LCP educational sessions with FMCH Programs and Public Health Division staff and leadership, and community partners; (3) evaluating the effectiveness of the educational sessions with our staff; and (4) establishing a Life Course Planning Team that oversees LCI program planning and evaluation activities.

By the beginning of Year Three of the LCI, we decided that we were ready to develop a formal intervention that would address the social determinants of health, specifically the connection between financial stability and health. Several crucial factors had set the stage for this: (1) the findings of our photovoice projects [31, 32], where community residents raised issues related to their social environments as ones they wanted us to change; (2) the release of "Unnatural Causes," a documentary series highlighting wealth as the strongest determinant of health [33]; (3) critical new publications emphasizing the effect of wealth on health [9, 34]; and (4) the charges to "reduce poverty" and "support working mothers and families" in Lu et al.'s "12-point Plan."(5) In addition, as we examined the results of our educational sessions, particularly staff feedback, we determined that our programs were not formally addressing financial stability across the life course, a key protective factor leading to positive health outcomes for women, children, and families in Contra Costa County.

After a year of discussion, our LCI team created an intervention that would increase the financial stability and security of our clients in an effort to improve their financial status and ultimately, their health. This effort became Building Economic Security Today, or BEST, in 2008. BEST was an LCP-based project that utilizes innovative strategies to reduce inequities in health outcomes for low-income Contra Costa families by improving their financial security and stability, making the connection between health and wealth. BEST helped families maximize their income for daily living, and preserve and increase their financial assets. The project offered (1) one-on-one support to families in home visiting programs, (2) financial education classes for WIC clients, and (3) asset development educational materials and referrals for all clients. Staff guided clients as they manage financial concerns, such as applying for public benefits for which they were eligible, repairing credit, opening a bank account or prepaid debit card, and obtaining free tax preparation assistance.

Aims

This paper describes the planning and implementation of BEST, including the development of client interventions and an evaluation plan; results from two FMCH Programs,

WIC and the Medically Vulnerable Infant Program (MVIP); partnerships and national reach; and challenges and lessons learned.

BEST Project Development

During the first 2 years of BEST project development, the Life Course Planning Team created a logic model and evaluation framework. Our process was grounded in the philosophy that simultaneous creation of the program interventions and evaluation framework would result in both being more precise and effective than if these steps were undertaken independently. We first determined the long-term outcomes for the project (Fig. 1). We knew that it would be unrealistic for us to measure our impact on these long-term outcomes, so we developed measurable markers of success on the path to improving our clients' financial stability and health outcomes, and created strategies that would help us achieve those intermediate outcomes. These successes included changes in clients' and staff's knowledge, skills, and practices around financial asset development; clients' confidence and stress; and the functioning of our local health and human services system (Table 1).

The WIC Program was a logical home for BEST for several reasons. WIC was one of the largest public health programs in Contra Costa County, with a caseload of 22,875 families in October 2010 [35], and WIC client families, all living at 185 % of the federal poverty level or below, were struggling with limited financial resources. Furthermore, WIC clients have been shown to change their behavior based on education [36], and per federal guidelines, WIC clients are required to participate in a class every 6 months to receive their food vouchers. In addition, at different points in time, WIC clients had indicated their interest in financial education and resources. Finally, we wanted to adopt a class approach and WIC was the best program for this. We believed that educating WIC clients together about such an important, yet complicated topic might encourage them to talk with and become resources for each other.

To inform the development of the BEST project strategies, we conducted 10 focus groups with WIC clients in July and August of 2009, during regularly scheduled WIC classes for families with children ages 1–5 years. A total of 115 WIC clients participated in the focus groups (58 English-speaking and 57 Spanish-speaking). We gained valuable insights from the focus group participants. Clients reported that not having enough money leads them to feel stress, frustration, sadness, anger, body aches, low energy, and disruption of daily activity. In contrast, they stated that having enough money enables them to feel happy, calm, active, and energized. They had learned financial values and developed financial skills through challenging, often negative, experiences with financial institutions; from family and friends; through educational programs; and out of sheer necessity. Clients expressed interest in attending financial education classes at WIC and wanted to learn about credit and debt, teaching children about money, budgeting, access to benefits and social services, and talking with their partners about finances.

Launching BEST quickly propelled FMCH Programs staff into the financial asset development sector. New and innovative collaborations became essential to the success of our project, and FMCH Programs staff needed to be trained. Two of our non-profit partners, Strategies and Community Financial Resources (CFR), each conducted initial staff trainings on understanding the role of health workers in promoting family financial security, building relationships with clients to identify underlying financial challenges, and referring clients to local financial resources. CFR also provided a third training and consultation with home visiting staff to assist in the development of client financial questionnaires. Pre- and post-tests from the three trainings showed that staff knowledge and skills increased in several areas, including understanding the health–wealth connection, feeling comfortable talking about financial issues with clients, increasing clients' knowledge of financial issues, helping families obtain asset development resources, identifying life situations that may indicate underlying financial issues for clients, and understanding the purpose of financial assessments.

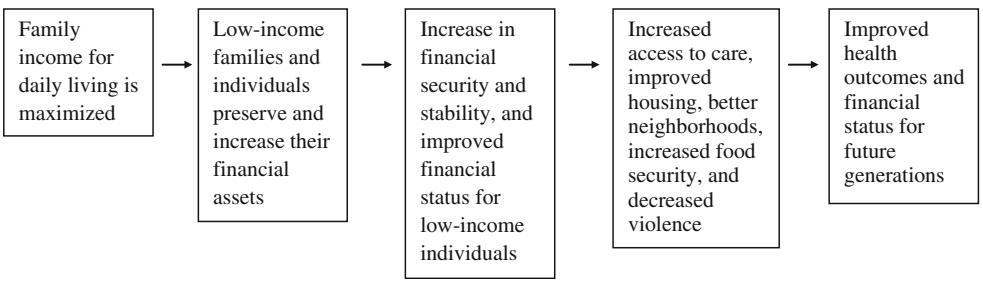

Fig. 1 BEST long-term outcomes

Table 1 BEST intermediate outcomes

Staff
1. Staff have increased understanding of the health-wealth connection
2. Staff have increased knowledge of asset development strategies and resources
3. Staff have increased skills to engage clients in improving financial behaviors
4. Staff adopt new practices for implementing knowledge and skills with their clients about asset development
Clients
5. Clients have increased understanding of the health-wealth connection
6. Clients have increased knowledge of asset development strategies and resources
7. Clients have increased confidence and readiness to improve their financial behaviors
8. Clients adopt improved financial behaviors
9. Clients' stress levels decrease
System
10. Stronger community partnerships to create a supportive environment for asset development
11. Health and human services system that supports clients in improving financial behaviors
12. Integration of asset development strategies into FMCH Programs' infrastructure
13. Documented BEST project development process
14. Increased awareness of BEST project

Though we intended for BEST to improve our clients' financial stability, we did not expect staff to become financial counselors. We determined that one of their primary roles would be to connect clients with the resources they needed to improve their financial stability. As such, staff requested tools to provide information about and refer clients to financial services. They also asked that the referral tool provide specific information about each agency, including services provided, languages spoken, intake procedures, eligibility, and an agency contact person to whom they could make a "warm handoff." In response, we collaborated with our partners in the Contra Costa Family Economic Security Partnership to research financial education curricula and local asset development resource agencies based on the interests identified by the focus groups. We then developed two different resources new to Contra Costa County—the BEST Asset Development Resource Guide and BEST Resource Packets.

BEST at WIC: A Wide-Reaching, Group Intervention

To build upon findings from the previously mentioned client focus groups, we conducted four focus groups with WIC staff in July and August 2009. Each group consisted of 8–10 staff. During the focus groups, staff suggested that class design and implementation should: (1) assist clients in understanding how their health is related to their financial stability and security; (2) recognize that clients may feel frustration and discouragement around financial issues; (3) provide opportunities for clients to build skills and develop existing financial knowledge; (4) present information in an engaging, interactive and supportive format; and (5) provide staff with training and learning opportunities.

We worked with WIC staff to finalize a class lesson plan based on the research of curricula and local resources described above, and train staff that would be teaching the classes. The lesson plan covered how having or not having money affects health; money values and beliefs; clients' strengths and areas for improvement around managing money; bank accounts and credit; setting financial goals; and asset development resources. Materials from the BEST Resource Packets were available for clients, and staff utilized the BEST Resource Guide to make any needed referrals. Financial education classes were taught by WIC staff and offered in English and Spanish several times a week for 5 months, from June through October 2010. All client families with children ages one through five were required to attend the class once during this time period in order to receive their WIC vouchers.

A total of 6,248 WIC client families attended the classes and received asset development resource materials. Of these families, 1,592 (26 %) completed post-class participant surveys designed to assess the impact of the classes; 54 % were in English classes and 46 % in Spanish classes. We had a low rate of survey completion because surveys were not distributed consistently to clients, and not all clients who received surveys completed them, as it was voluntary.

The BEST classes were well-received. When asked how much they learned in the class about their values and beliefs about money, 76 % responded that they learned a lot and 20 % responded that they learned a little. In addition, 54 % responded that they learned a lot and 25 % a little about getting a bank account; 52 % learned a lot and 25 % a little about credit; and 70 % learned a lot and 18 % a little about resources to help them with their finances. Also, 95 % reported that the class either definitely or somewhat helped them feel more confident about handling their money; and 93 % said that the class helped them understand how money could affect their health. Survey results varied by the language of the class: 73 % of Spanish-speakers reported that the class definitely helped them feel more confident about money, compared to 57 % of English-speakers.

Building Economic Security Today Project staff observed seven English and four Spanish BEST classes in order to understand clients' impressions of the classes and the fidelity with which instructors implemented the lesson plan. From these observations, we learned that instructors employed a wide range of teaching styles, and each modified the lesson plan to accommodate the needs of clients in a particular class. Most instructors utilized teaching styles that encouraged client participation and discussion. Clients interacted most with each other when they were sharing tips on financial resources in the community and how to maximize income. Although the lesson plan covered several financial topics, a few topics especially captured the attention and interest of clients: "needs" versus "wants," budgeting, and utility assistance programs. Clients also raised topics that were not part of the lesson plan, such as how to communicate with family members about money and how to choose the right kind of bank account. In addition, at the end of all of the observed classes, clients picked up resource materials before leaving.

Building Economic Security Today staff also conducted semi-structured interviews with all five WIC staff who were teaching the classes, after they had been teaching the classes for 2 months. The interviews helped us understand their successes and challenges teaching the classes, and obtain their suggestions for improvement. During these interviews, the WIC instructors stated that they liked that the BEST lesson plan began with a discussion about the health–wealth connection, because it motivated clients to improve their financial situation. Instructors also felt that the lesson plan engaged clients because money is a basic need, and finances affect all family members. All of the instructors acknowledged that the most positive aspect of teaching BEST classes was giving clients asset development resources and tools that they may not find elsewhere, giving them hope that they could improve their current financial situations. Finally, the instructors observed some cultural variation between the English- and Spanish-speaking classes. They perceived Spanish-speaking clients to be more eager to learn during class, yet not as comfortable participating in discussions about family finances. One instructor commented on how English-speaking clients seemed to already know the basics of what the class was teaching and therefore enjoyed participating more in class discussion.

Overall, the BEST classes were well received by both WIC clients and instructors. Clients were engaged and interested in the topics discussed, and the classes increased clients' awareness of financial issues and gave them hope that they could improve their families' financial situations. In addition, clients and WIC staff gained knowledge on asset development resources in the community.

BEST in the Medically Vulnerable Infant Program (MVIP): A Home Visiting Approach

In July 2010, we launched BEST with MVIP, a nurse home visitation program. MVIP aimed to prevent or ameliorate the impact of developmental delays and disabilities, reduce unnecessary hospitalizations, and promote optimal health by supporting at-risk infants and their families. To be eligible, infants had to be at risk for neurological problems and developmental delays because of prematurity, low birth weight or other medical conditions experienced at birth, and discharged neonatally from a California Children's Services approved neonatal intensive care unit. Following discharge, Public Health Nurses (PHNs) in MVIP-initiated home visits over a 24-month period, providing health and developmental monitoring, parent education and support, and case management.

Building Economic Security Today was well-suited for MVIP, as medically fragile infants are a particularly vulnerable group due to long neonatal hospitalizations and complex medical procedures and treatments that can exhaust health insurance benefits and impact parental employment, causing undue stress and economic difficulties. PHNs are ideal health providers to talk with clients about money because the foundation of their practice is developing trusting and therapeutic relationships with clients [37]. Our goals for implementing BEST in MVIP were to: (1) increase families' awareness of their personal financial situations and asset development strategies; (2) enhance PHNs' knowledge of family economic situations; and (3) provide families with information on local financial resources. We adapted BEST for a one-on-one approach instead of a classroom setting given the program delivery model of MVIP.

To assess the financial perceptions of families and provide a basis for program interventions, we developed an MVIP BEST financial questionnaire. The questionnaire, based on a review of the literature, assessed five areas including: (1) financial impact of having a child born with medical concerns, (2) adequacy of income, (3) financial difficulty and strain, (4) knowledge of Supplemental Security Income (SSI), and (5) perceived financial stress [38–40]. In addition, we asked families to identify financial topics they would like to learn more about from a list of seven topics. The primary caregiver of a baby in the program completed the questionnaire within the first three home visit encounters. The PHN offered resources to the family based on the caregiver's responses, using the BEST Asset Development Resource Guide, and also provided them with a Resource Packet.

Between July 2010 and May 2012, 163 new infants were enrolled in MVIP. Of the infants enrolled, approximate half were on Medi-Cal. Annual family income ranged from less

than $15,000 (21 %) to greater than $70,000 (15 %). Primary caregivers of 139 (85 %) infants completed BEST questionnaires. Reasons that BEST questionnaires were not completed included: transferred to long-term therapeutic services, moved out of service area, lost to follow-up, or declined services.

Medically Vulnerable Infant Program BEST questionnaire results revealed that 47 % of the caregivers strongly or very strongly agreed that having a child with medical concerns at birth affected their financial health, while 55 % strongly or very strongly agreed that it affected their emotional health, and 44 % their physical health. When asked about adequacy of income, caregivers' primary concerns were that their income was not at all adequate to cover child care expenses (23 %) and heath care (12 %), followed by housing (7 %), food (6 %), and transportation (6 %). Caregivers were also asked about perceptions of financial stress, and 37 % reported feeling very or extremely stressed, while 13 % reported feeling no stress at all. Many also reported experiencing financial strain and difficulties. They reported having problems affording basic expenses (29 %), supporting their family (29 %), living on their income (21 %), making ends meet (34 %), and paying bills (18 %). Although all caregivers should have been notified by hospital personnel about potential SSI eligibility, approximately one-third (32 %) reported that they had not been informed of this when discharged from the neonatal intensive care unit. Overall, the most common topics about which caregivers requested more information included free tax preparation (28 %), low cost health coverage (26 %), and credit repair (12 %), followed by money transfers (9 %), check cashing fees (7 %), and establishing checking/saving accounts (6 %).

To explore PHNs' perceptions of BEST implementation, the MVIP Nurse Manager discussed BEST at weekly team case conference sessions. For the PHNs, the most significant outcomes were the conversations the questionnaires evoked. Caregivers frequently spoke with PHNs about the inadequacy of health insurance to cover the cost of their infants' medical care. Some caregivers described the need for one parent to quit their job to care for the special needs of their infant. These caregivers also shared that as a result of the unanticipated decrease in household income, some faced home foreclosures. PHNs felt that their conversations with caregivers were cathartic. Caregivers and PHNs agreed that there were very few other professionals who could empathize with the caregivers' new financial situations. The emotional support caregivers received from PHNs was invaluable, providing an avenue to release stress by sharing their stories.

Building Economic Security Today provided MVIP with vital insights into the financial experiences of families with medically vulnerable infants. Although an array of circumstances contributes to a family's financial situation, the increased long term resources needed to support medically fragile infants can increase levels of caregiver financial stress, thereby affecting their overall health and well-being, and ability to care for their children. Caregivers appreciated BEST and felt that the questions provided new information and helped them look at their financial situation from a new perspective. They benefited from processing their experience with the PHN but seemed less interested in adopting new financial practices. This is likely because BEST was introduced relatively soon after infants were discharged from the NICU, and caregivers were managing many other challenges at that point in time. We now see the value in waiting until after infants have completed their transition home to focus on financial issues.

Challenges and Lessons Learned

We faced many critical challenges during the development and implementation of BEST. It has been documented elsewhere that trying to change a long-standing paradigm and embark on a project that incorporates an entirely new field, such as financial stability and security, requires strong leadership and commitment to redesigning how MCH professionals conduct their work [30]. In particular, BEST required that staff learn and apply new concepts. Not everyone was ready and willing to do this. Enlisting the enthusiasm of staff leaders and others who were open to this change and providing opportunities for staff to discuss their concerns helped move things forward. Furthermore, we needed to spend considerable time ensuring that staff were comfortable shifting long-standing approaches to MCH practice. We found that this necessitated slowing the pace of project implementation and frequent revising and simplifying program scopes of work, timelines, and evaluation plans. We learned several lessons from this experience: (1) change takes time, therefore it is essential to be flexible with timelines; (2) staff need to be met where they are in terms of their readiness for changing practices and integrating new ideas; (3) take every opportunity to acknowledge what staff are already doing in the service of their programs and clients, and work with them to find ways to build on that; and (4) maintain a long view, as this type of change takes time, and people come to new ideas and interventions with caution and some trepidation.

Once staff began implementing BEST strategies, they were confronted with some unanticipated outcomes with which they required assistance. One situation that arose repeatedly, particularly for MVIP staff, was that of clients who had never before discussed their financial issues with anyone now expressing distress once they started to discuss

their "financial health" with their PHNs. Also, not surprisingly, we met reasonable resistance when we asked staff to incorporate new BEST activities into their already busy WIC classes and MVIP home visits. This called for us to work with them to determine how to do this without creating additional burdens on their workload and increasing their stress. Ongoing training and support for staff is essential, particularly on topics one might not anticipate, such as the anxiety this type of work may create for the individual staff around their own financial status, the financial stress clients may project onto the staff, and the change in focus from health to other pressing social factors

The innovative nature of BEST brought FMCH Programs into several new collaborative efforts, some out of the realm of traditional public health work. This generated more exposure and interest in BEST and created more responsibilities for staff to juggle; however, these strategic partnerships were vital to us as we attempted to navigate a non-traditional, cross-sector effort of this nature. For example, as described earlier, the development of the BEST Resource Guide and Resource Packets would not have been possible without the expertise of the asset development organizations with whom we had connected through the Contra Costa County Family Economic Security Partnership. We also utilized our expertise to advance the field by co-founding the Health–Wealth Connection Collaborative (HWCC), a cross-sector coalition of economic justice and public health organizations in the Bay Area, primarily Alameda and Contra Costa Counties. On June 23rd, 2010, HWCC hosted the first ever Health–Wealth Connection Symposium, bringing together nearly 200 economic justice and public health professionals to learn from each other and begin cross-sector collaboration.

Assessing the success of BEST was also a considerable challenge. In planning our evaluation strategy, we debated several complicated issues, including how to measure intermediate outcomes, whether or not we could measure long-term outcomes, and what data to collect for this measurement. Given that BEST was implemented as part of direct service programs, most data were self-reported, response rates were low, and data collection tools were designed primarily for practicality. We could not mandate that clients complete evaluation forms, these were voluntary. These issues need to be considered by others who embark on similar efforts, and support is needed from partner organizations with greater evaluation capacity.

Operational and structural changes to FMCH Programs interrupted the ongoing implementation of BEST at WIC and MVIP. The WIC Program was moved to the Community Wellness and Prevention Program of the health department, and outside funding for MVIP was no longer available, causing it to end. In addition, several of the key BEST project staff left the health department during and shortly after the activities described here were completed; therefore, the leadership support to carry BEST forward was not present. The remaining FMCH Programs staff were committed to other responsibilities and priorities, and without staff dedicated to BEST it became difficult to transfer BEST strategies into other MCH programs. Lastly, addressing the connection between health and wealth was not yet an institutionalized priority at the health department; at this particular point in time, the attention of the department's leadership was focused on promoting other important, innovative initiatives and programs. Thus, as key staff left and programs shifted and closed, FMCH Programs was not able to actively sustain BEST strategies. For others who initiate a new project such as BEST, having organizational leadership and infrastructure that prioritizes the project will be essential to its viability and sustainability.

Conclusion

Building Economic Security Today was one of the first attempts in the MCH field to operationalize into concrete programmatic strategies the scientific evidence of the strong relationship between health and wealth, and its resulting health inequities. BEST connected public health and economic justice, two sectors that have not typically worked together, and exemplified the initial paradigm shift of a local health department towards integrating the LCP into its MCH programs.

Building Economic Security Today had a ripple effect locally and around the nation. We shared our work with thousands of professionals at conferences and meetings, inspired both a neighboring county health department and a local community-based organization to launch their own LCP-based health–wealth connection projects, and provided the BEST Asset Development Resource Guide to numerous County and community-based public health and social services agencies.

We learned many practical lessons from both staff and clients through the implementation of BEST. In particular, we gained insights into how to introduce a new project to staff in existing programs that are already pressed for time and resources, what financial asset building methods and information resonated with our clients, and how our staff could influence client's lives by simply starting a conversation with them about money. Furthermore, we found that our clients had even greater understanding of, experience with, and desire to address the effects of wealth on health than we had expected.

Incorporating basic financial asset building strategies into health services is a versatile approach with multiple

applications, as demonstrated by the successful execution of BEST in two very different programs, WIC and MVIP. One involved a widespread, brief, group intervention at clinic sites, and the other an individual, longer-term intervention in clients' homes. We believe that the adaptability of BEST is one of its greatest strengths; it can be implemented by MCH programs in local health departments, community based organizations serving families and women and children, youth-serving agencies, and most other direct service providers. Organizations seeking to introduce financial asset building and educational strategies into their services can learn from the concepts that we explored and modify our methods to incorporate them into their own programming and organizational structure.

The basic premise of BEST is that health and wealth are closely linked. The direct impact of programs and strategies like BEST on health outcomes still needs to be examined; however, the early signs of impact are promising. If we can work with our clients to improve their financial stability and security, perhaps this will help reduce the risk factors and increase the protective factors in their lives, ultimately leading to improved health and well-being.

Acknowledgments The authors want to thank the following individuals for their significant contributions to and critical review of this article: Debbie Casanova, MPH; Chuck McKetney, PhD, MPH; Mary Jane Kiefer, RD; Beverly Clark, RD; Raz Moghbel, RD; Bette Lucey, RN, BSN; Linda Black, RN, BSN; Alicia Grand, RN, BSN; Nayeli Zavala, RN, BSN; Kristina Kutter, MPH; Lauren Leimbach, MBA; Kayley Harrington, MSW, MPH; and Wendel Brunner, MD, PhD. Funding for BEST and the writing of this article was provided by Contra Costa Health Services; California Department of Public Health, Maternal, Child and Adolescent Health Program; The San Francisco Foundation; East Bay Community Foundation; Kaiser Permanente Diablo Area; Kaiser Permanente East Bay; and Y & H Soda Foundation.

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