

MCH/CSHCN Director Webcast (July 10, 2003)

>>PETER VAN DYCK: Well, good afternoon, everybody.

I'm Peter van Dyck.

Director of the Maternal and Child Health Bureau.

It's good to have a chance to chat with you and to have a session today on MChcom.com.

Slides will appear in the central window and should advance automatically.

And the slide changes are synchronized with the speaker's presentation.

You really don't have to do anything to advance the slides.

There is a little slide, though, over on the upper right-hand part of your screen that you can plus or minus the advancement of the slides by sliding the bar.

We are going to have questions today.

And we are going to have a poll today.

So we encourage you to ask questions.

We will tell you when.

And all you do is type your question into the box.

It's the white message window on the right at the interface where it says question for speaker.

Use that from the drop down menu and then hit send.

It's nice if you state your organization so we know who you are and can attribute the question to you.

Then we'll relay the questions to the speaker periodically during the session.

On the left of the interface on your screen is the video window and you can adjust that volume with the audio using the volume control slider which you see on the -- screen and you can also do it by clicking the icon and pressing the bar.

There is text captioning beneath the video window and at the end of the broadcast I think you know this, too, there will be an automatic interface after closing that will give you a chance to fill out an evaluation form.

We really appreciate you doing that.

It helps us know what you would like and again, you can call us or email us during the week or month for suggestions of what you might like to hear.

So today we have three speakers -- four speakers, actually.

Jamie Resnick from our Office of Program Development is going to make an announcement.

Cassie Lauver, the director of the Division of State and Community Health is going to be available for questions.

Particularly around the block grant.

And then we'll have a presentation on the Women's Health Data Across the Life Span by Debbie Maiese, who is the director of the Office of Women's Health.

So we have, I think, an exciting 50 or 60 minutes for you today.

Remember now that Cassie is going to come second.

But I want you to be prepared to ask questions of Cassie.

So think about your question ahead of time.

Get ready to type it in so when she comes on, you have your questions ready to ask her.

But first to Jamie, who is in the Office of Program Development for an announcement.

>>JAMIE RESNICK: Thank you very much, Dr. van Dyck.

My name is Jamie Resnick.

Recently the Maternal and Child Health Bureau sent out marketing material entitled an

Advanced Care Workshop covering Maternal and Child Health populations in Medicaid.

The workshop curriculum will be based on the Medicaid and SCHIP pediatric and children with special health needs developed by George Washington University.

Topics include writing, negotiating and monitoring fiscally sound Medicaid SCHIP Medicare contracts and ensuring enrollees get the highest degree of care.

The Maternal and Child Health Bureau has made resources available to fund approximately ten state or regionally-based workshops. The funding will be available to have faculty from George Washington University lead workshops, as well as customize these workshops to address local Medicaid and S-CHIP contracting issues.

This workshop actually builds off of a conference which we sponsored in November of 2001 in Little Rock, Arkansas. In which we brought together six state-based directors. Medicaid directors, urban health departments and others. They came together to discuss the pediatric purchasing specifications and managed care issues in Medicaid and S-CHIP. If you have not received this material and want to get more information, go directly to the Maternal and Child Health Bureau's website at www.mchb.HRSA.gov. It's the third one down. It will take you to the actual mailer that went out and it will also include information on how you can actually request to co-sponsor this workshop with the bureau. If you would like to call me directly my number is 301-443-2778 and I can assist you in starting the development of this workshop. Thank you very much.

>>PETER VAN DYCK: Thank you, Jamie.

If there are questions for Jamie, you can type them in any time and we'll take them in a little bit.

Secondly, we're going to have Cassie Lauver, director of the Office of State and Community Health who I think will say a few words and wanted to make herself available in case there are any questions, I believe, about the block grant. Cassie.

>>CASSIE LAUVER: Thank you, Peter.

Good afternoon.

Good morning I guess to those in the far west.

Just as Peter said, I'm available here with other staff from the division to answer any questions that you might have regarding the block grant application.

I know that you're all very busy working on that right now with the due date beginning next Tuesday, the 15th.

Although with talking at the call center today I know some states have already submitted their final block grant application.

The pressure is on as we get into the end.

Then our work will begin working with the outside reviewers, individuals from the bureau and regional office staff as well as parents who will be part of the review process.

We do have all of the review scheduled now for all of the states.

They will be conducted primarily at the regional office sites with some teleconferencing and audio conferencing back to the states so we can enrich the number of people who are available to sit around the table for the review.

So I'll turn it back over to Peter and we'll be here and as you have questions, type them in and hopefully we'll be able to respond to you.

Thank you.

>>PETER VAN DYCK: Thanks, Cassie.

So remember, if you have a question for Jamie about the Medicaid workshop, or a question for Cassie, please be sure to type it in and we'll take those questions later.

For our main presentation today we'll talk about women's health data across the life span and Debbie Maiese is going to share that presentation. Debbie.

>>DEBBIE MAIESE: Thank you very much, Peter.
Good afternoon and good morning to those of you on the west coast.
We were here to talk about women's health data across the life span.
I hope all of you have seen or used our Women's Health USA 2002.
In fact, we're about to do a poll that will ask you whether or not you've used this resource.
The 2002 edition was our first women's health book.
It's a companion piece to Child Health USA in its 13th edition.
We are really pleased to show that this is a collaboration between the Maternal and Child Health Bureau, Office of Data and Information Management, Maternal and Child Health Bureau Division of Perinatal Systems and Women's Health and the HRSA Office of Women's Health.
Take a few moments and answer our poll as I tell you about the processes we pursued to update this resource.

We first turned to our HRSA women's health coordinating committee that has representatives of all bureaus in HRSA to look at this table of contents to see what new data are available to update this resource or what additional topics could or should be covered to cover the range of women's health issues.

We asked the same soul-searching question of our HHS women's colleagues and got input from many organizations, as well as the downtown office on women's health.

Last December we convened a group of women's health and data experts.
Again, to see what topics should be covered in the next edition of Women's Health USA.
We also took into consideration public comments that we receive from groups such as the men's health network, the national WIC association and the U.S. breast feeding committee.
Women's Health USA is structured like Child Health USA in that there are three sections.
One addresses population characteristics, the second addresses health status issues and the third focuses on health services utilization.
In the health status section there is data on health behaviors, health indicators, maternal health and special populations.

I'll address some of the special population issues in just a moment.
Women's Health USA 2003 will have additional information on a variety of new topics.
Let me preview some of those for you today.
These include the subject of activity limitations, of arthritis, bleeding disorders, breastfeeding, home and hospice care, maternal morbidity.
Medicare and Medicaid utilization by women.
Medication use as in prescription drug use by women.
The Title V abstinence education data and information on vitamin and mineral supplement use.
Under a new section on special populations we're really focusing on the populations and programs for which HRSA is responsible.
We'll look at the insurance status of women who are served by Title V.
We'll compare the Pap smear rates and mammography screening rate with women in the centers with those in the nation.
Because of our special responsibility along the U.S./Mexico border we'll focus on teen pregnancy.
We'll focus on immigrant health comparing whether or not people with citizenship status versus non-citizenship status have a usual source of care.
We'll also look at the troubling subjects of increasing numbers of incarcerated women and the health issues they present in prison.
Because of our Office of Rural Health Programming and Policy, we'll look at rural women compared to urban women.
And we also focus on older women, particularly on the subjects of flu and pneumonia vaccinations.
Let me turn this over to Reem to cover some of the population characteristics.

>>REEM GHANDOUR: Thank you, Debbie.

The population data presented here were updated for 2001 current population survey.

Based on this data females account for 51.2% of the population.

Of the 142 million women in the United States, nearly one half are under the age of 34.

Because we're becoming an increasingly diverse population, Women's Health USA also includes data on the proportion of women aged 25 years and younger by race and ethnicity.

As you can see from the slide, nearly 1/2 of the female Hispanic population, 44% of the female American Indian and Alaskan native population and black population are under the age of 25.

This is in contrast to non-Hispanic white women among whom the largest proportion are between the ages of 35 and 64.

This is the first time that we've presented data on the number of degrees awarded to women and men.

In 1999, women received a greater proportion of the associate, bachelors and masters degrees than men.

Accounting for 60% of the associates degrees, 57% of the bachelor's degrees and 58% of the masters degrees.

Unfortunately these advances in educational attainment have not necessarily translated into income parity for the nearly 61 million women in the U.S. labor force.

In 2001, women earned 76 cents for every dollar earned by men.

And accounted for less than one-third of those who earned 50 to 99,000 and less than one fifth of those who earned an annual income of \$100,000 or more.

As in other professional degree programs, women have continued to swell the ranks of health profession schools.

As noted in the graph between 1980 and 2000 the proportion of female dentistry students doubled and the proportion of female medical students increased to 44.6%.

However, as the number of women engaged in traditionally male-dominated medical fields have been increasing.

The number of nursing students has declined to 90.3% in 2000.

I'm going to turn the presentation back over to Debbie now to talk a little more about health status indicators that are presented in women's health, USA.

>>DEBBIE MAIESE: We thought we would begin today with a very important indicator of physical activity.

Because it clearly demonstrates male/female disparities.

Across all adult age categories, men are more physically active than women.

These data from the national healthy interviews survey also show that physical activity declines with age.

The highest levels among women are found in young adults at the rate of 35.3% but declines to 13.1% among women 75 years and older.

This slide clearly illustrates the challenges we face in getting Americans moving.

For older women, activity limitations preclude participation in activities of daily living.

The question on the national health interview survey asks individuals whether they are limited in any way in any of their activities.

Here we see that 31.5% of women over the age of 75 report activity limitations.

Among women who are 65 to 74 years of age, 21.4% report having some activity limitations in the year 2001.

There are five conditions that are most frequently reported as the cause of these activity limitations.

Nearly one quarter of women report arthritis and rheumatism as the source of their activity limitations.

Back and neck problems account for 20% of women's activity limitations.

Heart problems and hypertension also account for a significant activity limitation.

But striking to me, and I think interesting to think and talk about today, is the fact that 11.7% of women with activity limitations ascribe these limitations to their emotional problems, be it depression or anxiety.

Another condition that women suffer disproportionately higher rather than men is asthma. In mid-life between the ages of 45 and 65 years of age women are nearly twice as likely as men to have told their providers, their healthcare providers that they suffer from asthma. There are also ratio disparities that are quite striking with black women having the highest rate of reported asthma. Let's turn this back over to Reem so we can discuss other chronic conditions as they face women.

>>REEM GHANDOUR: Data presented on cancer includes both the absolute number of female cancer deaths in 2000 as well as updated estimates for 2002. As reported by the National Cancer Institute program. It's estimated that in 2002, one quarter of the female deaths were due to lung cancer followed by 15% attributed to breast cancer and 11% attributed to cancer of the colon and rectum. While the incidence of new lung cancer diagnoses has remained relatively stable for women overall. Racial disparities still exist. As you can see in 1999 the incidence of new lung cancer cases varied from 55.7 per 100,000 black women to 20.2 for 100,000 Asian and Pacific Islander women. In 2001 the rates of diabetes including type 2, the most prevalent increased with age for both men and women. Among women the rate of diagnoses increased with age such that the rate for women between the ages of 65 and 74 was four times that of women between the ages of 45 and 64. And seven times that of women between the ages of 18 and 44. Rates were also higher among racial and ethnic minorities with non-Hispanic black women. This is a rate two times that of non-Hispanic white women and one and a half times that of Hispanic women. Heart disease is the number one killer of women. And it is diagnosed in more women than men among U.S. adults age 45 and younger. However, after age 65, men report higher rates than women. Increasing to a rate of 248 cases per 1,000 men at age 75 as compared to just about 180 cases for 1,000 women of the same age. As you know, risk factors for heart disease include obesity and smoking, both of which are covered in this edition of Womens Health USA.

Women's mental health and access to mental health treatment have taken on a new significance for women health advocates and practitioners. Using updated data on drug abuse as well -- Women's Health USA includes information on serious mental illness as well as suicide. Among women non-Hispanic white and Native American commit suicide at the highest rates. That said, almost two times as many women receive mental health treatment or counseling than men. Which for our purposes here are defined as out patient, inpatient or prescription drug coverage.

Unfortunately 8.4 million adults in this country still report an unmet need for these services, the majority of which, 5.7 million, are women. Overweight and obesity are risk factors for a host of conditions. Nearly 62% of American women were overweight with one-third considered to be obese in 2000. The prevalence of obesity is greatest between the ages of 40 and 59 years and between non-Hispanic black women.

Over three quarters of this population is considered overweight and one half are considered to be obese.

I'll turn back over to Debbie now to talk a little bit about the maternal health indicators that are covered in Women's Health USA.

>>DEBBIE MAIESE: Thanks.

Let me begin with prenatal care.

Here is something for all of us to celebrate.

I want to congratulate you.

The year 2001 marks the highest percentage of women who began first trimester prenatal care.

Thanks to your efforts, more women are getting connected with healthcare providers at the beginning of their pregnancy.

That's the good news.

The bad news is that racial disparities still persist.

Among whites, the rates of prenatal care were very high.

88.5%.

Among Asian women, were higher but lowest of all were among American Indian and Alaskan native women at 69%.

And very sadly, 42,000 women of the four million births received no prenatal care whatsoever. While we can celebrate successes, there is always more work to do.

Again, another celebration slide is in breastfeeding.

The data are record setting accomplishments with higher proportion of women reporting breastfeeding while they're in the hospital than ever before.

With the highest rates being among Hispanic women at the rate of 73%, followed by whites at 72%, but again a racial disparity among black women less than 53%.

Looking six months post partum the percent of women still breastfeeding reached a record high of 32.5%.

We're a long way yet from our Healthy People 2010 targets.

Women's Health USA looks at demographic, economic and geographic statistics to help us target where breastfeeding rates are high as compared to where they are low in our populations to help us better target our intervention.

New in Women's Health USA will be a maternal morbidity section.

Here we focus on the three most frequently recorded medical risk factors for women having live births in the year 2001.

With rates of hypertension being 37.7 per 1,000 live births.

Diabetes being a rate of 31.1 per 1,000 live births and anemia being 25 per 1,000 live births.

Nearly one-third of women discharged from hospitals experienced a maternal illness or a pregnancy complication during labor and delivery.

And that rate for teenagers, females 15 years and younger, is even higher.

Almost 50%.

Turning next to maternal mortality.

Sadly, there are still women who die from childbirth and pregnancy complications, as well as post partum.

In the year 2000, 396 women died, a rate of 9.8 per 100,000 live births.

Once again, we focus in this graph on racial disparities with black rates being more than double those of whites.

In the U.S./Mexico border area we focus on teen births.

When we talk about the U.S./Mexico border we're talking about the region that extends from California to Brownsville, Texas, a border that is 2000 miles long.

It reaches 62 miles north into this country is the legal definition of that border.

It encompasses 48 counties.

When we sum that data and in addition we'll look at it in the book by state, we see that the border has far higher teen birth rates in both the 15 to 17 years of age cohort as well as the 15 to 19 year age cohort with the highest rates being in the State of Texas. Let me turn this back to Reem to focus on another area of her responsibility, namely rural health.

>>REEM GHANDOUR: Thanks, Debbie.

In keeping with HRSA's responsibility for rural health, Women's Health USA provides updated health information on rural women as one of the special populations we highlight in this edition.

In 2000, 59 million or 21% of the population lived in rural areas.

Some of the unique health challenges found in these regions include predominantly older population, limited supply of healthcare providers and in many cases an extensive geographic difference between where clients are and where healthcare services are provided.

These challenges can adversely affect rural women's health.

As illustrated in the graph, rural women are non-MSA, experience higher rates of cancer, hypertension and heart disease than their urban counterparts.

I would like to turn now to the third section of the data book.

Usual source of care which is one of the topics covered in this section has been positively associated with the receipt of preventive care, continuity of care and reduced healthcare costs.

In 2001, over 90% of U.S. women reported having a usual source of care.

This proportion increased among older women to 96.7%, while young women between the ages of 18 and 34 reported a lower proportion at 82%.

Among women who received care in office-based settings, white women were the largest proportion.

Among those who received care in hospital outpatient or emergency room settings, non-Hispanic black women were the largest proportion and one fifth of Hispanic women reported having no usual source of care.

In 2000, women made 488 million visits to a healthcare provider.

Far outnumbering their male counterparts who made 355 million visits.

Of these visits, one-third for preventive, prenatal or non-illness care.

They reported receiving some counseling from their healthcare providers.

Three of the most popular topics were diet, exercise and prenatal instruction.

It is interesting to note despite the high prevalence of overweight or obesity, only 15% of women reported having counseling on diet and less than 10% reported receiving counseling on exercise.

On a more positive note, however, the majority did report receiving Pap smear in the last three years, which is an important measure of preventive health services.

Black women reporting the highest rate overall there by challenging a lot of the racial and ethnic disparities we've seen so far in the data.

Part of a comprehensive approach to preventive care can include testing for H.I.V.

Over one-third of all U.S. women reported ever having been tested for H.I.V.

With younger women age 25 to 34 and non-Hispanic black women reporting the highest rates of testing.

51.4% and 51.3%.

Many of the younger women contribute to the last statistic you see on the slide that notes among adults age 44 and younger women are much more likely to report having been tested than men.

>>DEBBIE MAIESE: Let me turn next to the issue of vitamin and mineral supplement use.

Because there are times during a woman's life cycle where taking vitamin and mineral supplementation is very important.

As you well know, prior to pregnancy, during pregnancy, as well as to prevent conditions like osteoporosis.

Using data from the national health interview survey we found women report 56.9% of women report that they have used a vitamin or supplement in the last year.

White women are most likely to report being vitamin and supplement users with 61.7% of those women using some kind of supplementation followed by Hispanic women at 43% and black women at 42.3%.

We also see that there is an age gradient here.

As women age they're more likely to take vitamin and mineral supplementation with the highest rates being reported in women 65 and older at a rate of 65%.

It's also interesting to look at overall prescription medication use.

In fact, nearly 66% of all doctors visits resulted in a medication being prescribed or given during that encounter.

Women had far higher rates of medications prescribed.

A rate of 156 prescription drugs per 100 visits, compared to 149 drugs per 100 visits for males.

Also interesting to look at the types of medication.

They followed somewhat the conditions and diagnoses that women have.

Be reminded that these are year 2000 data and so the leader, these are in rank order in frequency at which women reported using these medications, Premarin, a hormone therapy, Synthoid, Claritin, Celebrex and Lipitor was fifth.

We also wanted to note for you that nearly 20% of women in mid-life.

45 to 64, reported using a central nervous system drug such as an antidepressant, an anti-anxiety or other types of sedative.

So before we wrap up, let me turn to you to do another poll.

And the poll we would like to put in front of you today is one we know we've covered a lot of different topics but there is always opportunities to address those issues that are of interest to you.

So the question we're putting before you now is to ask, what additional populations or health subjects would you like to see covered in future editions of Women's Health USA?

There is a limit to the choices we can give you and we can't have you write and fill in the blanks, we'll give you our email addresses or you can communicate through this website.

Additional considerations that you would like us to make in future editions of Women's Health USA.

As we wrap up one of the things I wanted to make all of the users of Women's Health USA aware of is that we established some rules about second edition of this.

Namely, that we would not repeat topics for which there were no new data.

We really decided to save trees and also be able to expand the coverage of topics by creating this rule.

But that means that some subjects covered in the year 2000 edition will not be found in the year 2003 edition.

And among these are caregiving, osteoporosis, household composition, labor force participation rates, vitamin -- rather fruits and vegetable nutrition consumption, as well as the non-medical use of prescription drugs.

Therefore, I really urge all of you to continue to keep your women's health 2002 as a companion to the 2003 edition.

You'll find that the information on our HRSA.gov women's health webpage.

You'll see a P.D.F. file as well as information for ordering.

All of you who are Title V leaders will receive copies of the 2003 edition as it's released.

So as we wrap up, I thank you for listening to all these complicated facts and figures.

But I hope they're useful to you as you wrap up your block grant applications, as you pursue other grant applications, and please feel free to give us your feedback on this edition as well as others.

We have supplied the names and email addresses, phones and fax numbers of our partner in the Division of Perinatal Systems, the Office of Data and Information Management and we in the HRSA Office of Women's Health.

Thank you for listening today and we look forward to your questions and the results of the poll.

>>PETER VAN DYCK: Thank you, Debbie, thank you, Reem.

Remember, you can still type in questions.

We are getting some questions, so please take a moment and type in the questions and Chris, do we have a couple of questions that we can ask before we go to the poll?

>>CHRIS DEGRAW: We do.

A couple of questions for Debbie and Reem.

First for Debbie related to your slides.

Do we know specifically what vitamins and minerals were taken?

>>DEBBIE MAIESE: We know some of that.

We can tell you whether it was a multi-vitamin.

We can tell you whether it's calcium supplements and we could delve deeper but those characteristics are available from this data source.

>>CHRIS DEGRAW: Another question.

When will the new Women's Health USA be available?

>>DEBBIE MAIESE: We had hoped to say it was here today.

But it's not yet done from the printer.

We expect that it will be released in the next couple of weeks.

So its release is imminent and we're excited about making this an annual edition just like Child Health USA.

Watch our website and we anticipate that as soon as it's delivered, the mailing will go out from the HRSA information center to all of you who are on our contact database.

>>CHRIS DEGRAW: And finally, a viewer would like to know if your slides will be available in Power Point format for the viewers to use.

They responded these will be downloadable from the website at www.mchcom.com and available as part of the archive on that website.

>>DEBBIE MAIESE: Feel free to use this.

This document is in the public domain.

You're able to reproduce any of the pages.

We really encourage that kind of use.

There is also a citation that's provided so that if you are using the information in some kind of publication, we would really appreciate the recognition.

We want to thank all of the partners who sort of advertise the availability of the first edition of Women's Health USA and would encourage all of you to reach out to your constituents in your respective states to make it known that this resource is available for their use.

>>PETER VAN DYCK: And before we go to a few more questions, Cassie, Chris, how about the results of the poll for the women's health?

>>CHRIS DEGRAW: The results of the first poll question, which was, have you used Women's Health USA 2002, the results showed that 44% of the audience said yes. And 56% responded no.

>>DEBBIE MAIESE: That's helpful to know.
That really is helpful to know.
In the event that we can make it a majority you with the 2003 edition it's why we're interested in your feedback of making this a useful resource to you.

>>CHRIS DEGRAW: The second poll question was asked, what additional populations or health subjects would you like to see covered in future editions of Women's Health USA?
26% of our viewers stated that they would like to see more state-specific data.
29% would like to see adolescent health indicators.
21% maternal health indicators.
12% health data related to mid-life women.
And 9% older women's health data and 3% of our viewers had other topics that they would like to see covered.

>>DEBBIE MAIESE: Great.
Good.
That's very helpful.
This is a work in progress.
We're going to get done with one and start the next.
So keep those ideas flowing to us about how to make this a useful resource to you.
For those of you who couldn't write in those other topics please use our email addresses to do so.

>>PETER VAN DYCK: Well, let's go to a few more questions.
Chris, do you have questions for Cassie.

>>CHRIS DE GRAW: From New York state the question is with regard to the block grant application.
The online guidance differs from the hard copy.
Section III B lists the page limit of point 5 while the hard copy asks for much more.
Is this a disconnect?

>>CASSIE LAUVER: Actually I'm not quite sure of that question, Chris, whether they're talking about the original hard copy we sent out, which was a draft copy.
And there was some changes in the page limitations between the hard -- that hard copy, the draft copy that went out, and after the state piloted it we found areas we needed more space for states to write.
And whether that's the issue, or whether it's an issue of talking about page limitations as opposed to actual character.
So for that question, I would invite the individual from New York to give us a call at the call center number which is 1-877-go 4 HRSA.
Are email it to the call center at HRSA.gov and we would be able to look at exactly what you're looking at to make sure we answer the question that is intended.

>>CHRIS DEGRAW: Another question, this one from Iowa for Cassie. Given that all states are using the estimates for national performance measure 6, is it expected that state specific target objections be formulated using the national estimate as the baseline value?

>>CASSIE LAUVER: Performance measure 6 is the performance measure that relates to transition into adulthood where the slate did not provide a large enough sample to have state-specific estimates except for one state and that's Maine.
Maine was the only state where there was -- the sample size was large enough.
The expectation, in fact, is that it is not mandatory for you -- for states to have to fill in an objective there.
We welcome you in doing that and let us now how you calculate that.

Iowa did their own survey or a similar survey to the state survey so you may have your own data source that can respond to that and you're certainly welcome to do it.

What we really wanted states to do, since we weren't able to come up with state-specific estimates was to talk about the activities that you have going on in the state because we know many states have activities as it relates to transition into adult services and we certainly want to capture those and have you share them and talk about your story in the narrative.

If you choose to put an objective in there, while we wait to have state-specific data, invite you to do that.

>>CHRIS DEGRAW: Thank you, Cassie.

We have another question for Debbie.

Regarding data.

This one from Rhode Island.

What do we know about the women's health/preconception variables such as stress, infection, contraception use, etcetera?

>>DEBBIE MAIESE: I am not the expert on this subject.

I'm looking at Dr. van Dyck to see if he wants to help answer this.

I know that--

>>PETER VAN DYCK: My picture isn't on the screen.

[LAUGHTER]

>>DEBBIE MAIESE: He's sitting right here to my left.

I think that's an example of some of the data that we should search for to see whether we can incorporate.

I think it's a combination of trying to find national data sources is what we've used in Women's Health USA.

I think many of the questions you've posed and the variables that you're seeking information on really will come more from scientific study rather than nationally representative surveys.

And so I think it's a subject that we need to look to the literature base for.

>>PETER VAN DYCK: Hard data on each one of those.

There is new data on stress from CDC.

And I think the best source for that would be if you call Michael Kogan.

You can call our office or the main MCH number.

And that ask for Michael or his office because they have written quite a bit on this area.

And would be happy to point you to those data points.

Michael's direct number, or at least to his office is 301-443-3145.

And either him would be able to point you to the literature.

>>CHRIS DEGRAW: A question for Jamie.

We would like to hear the contact information for further information about your announcement.

>>JAMIE RESNICK: Two places.

One is you can go directly to the Maternal and Child Health Bureau website at www.mchb.HRSA.gov.

You'll see at the top of the page a section called news and it says the third link down, schedule a workshop on fiscally sound Medicaid and S-chip managed care contracts or call me directly at 301-443-2778.

>>PETER VAN DYCK: Any other questions, Chris?

>>CHRIS DEGRAW: That's all.

>>PETER VAN DYCK: We want to thank all of our speakers today.
Jamie, Cassie, Debbie and Reem.
And thank you, Chris and thanks to the University of Illinois and their crew for managing the call from Chicago.
Remember, as the call ends, the interface will close automatically but you'll have this wonderful opportunity to fill out an evaluation form.
So please take a couple of minutes, fill out that form, your responses help us to improve the calls and certainly as you have topics that you would like to discuss, please let us know.
The polls worked nicely and everything seemed to work well today.
We thank all of you.
We look forward to talking to you again in two weeks.
Have a wonderful rest of the week and a good weekend from all of us here in beautiful, cloudy, downtown Rockville.
Good afternoon.

[END]