

## **MCH/ CSHCN Directors Webcast, March 11<sup>th</sup>, 2004**

CHRIS DEGRAW: Good afternoon and welcome to MCH com.com webcast coming to you from Rockville, Maryland. This is our latest in the series of internet webcast for children with special healthcare needs directors. I'm Chris DeGraw if the burr -- I'm filling in for Peter van Dyck. He's sorry he can't be here today but got called into a meeting at the last minute. I think we have an interesting program for you today. But before I introduce today's speakers I would like to review technical information about the webcast.

Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You don't need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the drop-down menu and hit send. Please include your state or organization in your message so we know where you're participating from. The questions will be relayed onto the speakers periodically throughout the broadcast. If we don't have an opportunity to respond to your specific question during the broadcast we'll email you afterwards. We encourage you to submit questions at any time during the broadcast. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning

underneath the video window. At the end of the broadcast the interface will close and you'll have an opportunity to fill out an evaluation. We encourage you to take a couple of minutes to do so. Your responses will help us plan future broadcasts in the series and improve our technical support.

Again I think we have an interesting program for you today. First joining us from Boston are Dr. Judith Palfrey, Ms. Karen van Unen who will tell us about Anne E. Dyson foundation. The Dyson initiative which has sites in ten states across the U.S. is an educational demonstration endeavor to equip pediatric -- to advocate for the health and well-being of children. Dr. Paul Free is the director. She's chief of the Division of general pediatrics of Children's Hospital, Boston, Professor of Pediatrics. She also led MCHB's bright futures initiative for several years. Karen van Unen is also involved. Following their presentation Jeff Koshel from the Division of state and community health will give an update on Title V block grant application process. Renee Schwalberg will present preliminary findings from HRSA's report on promising approaches to the Title V needs assessment. We're happy to have all of our speakers here with us today. Remember, we encourage you to type in questions for our speakers at any time during the webcast. At this time I'll turn the program over to Dr. Palfrey in Boston.

JUDITH PALFREY: Thank you, Chris, so much. It's a tremendous pleasure to meet with all of you around the country. I feel like the guy? Sea business cat trying to give you a good view of the horse races out there. We'll try to make this work for everyone. This is a wonderful opportunity to tell you about the Anne E. Dyson pediatric training initiative. It

was really a brainchild of a wonderful person, Anne E. Dyson who was a pediatrician and philanthropist, an unusual combination. Unfortunately Anne died a year or two ago so we're all trying to continue her enormous vision that she had for this initiative. She was asked at one point by another woman to provide the emergency services for the stand for children. I'm sure many of you were involved with that opportunity. At the end of the day, everyone had been standing out on the mall and so forth. Annie looked forward and said what do we take on from this? What is the next step in our commitment to young children? And she began to think about the opportunity that she might present with the philanthropy funds that she had to train young physicians in blending private and public health initiatives. And one of the things that made her so interested in doing this was that she had been meeting with residents from around the country and finding kind of a new generation of people who have wanted to have a grass roots response to the problems that they've been seeing in their communities. And this all tied in a very good way with the cache initiative of the am academy of pediatrics.

If we go on to the next slide, one of the reasons that we were so delighted to have the opportunity to meet with you all today is that the Anne E. Dyson training program offers an opportunity for pediatrics and public health to have a true, meaningful interface. Obviously we all talk together. Many of us are trained in both pediatrics and public health but oftentimes our direct integration is not as optimal as we'd like. But both the community pediatrics and public health have a population base, both have a focus on health promotion and prevention, and as Chris mentioned, a number of us have been involved for many years with the bright futures program. One of the things that Annie was very

interested in was the opportunity for young residents really to get out onto the streets and to see what was actually happening and then take that information and really inform public policy and health systems with it. And this program has been seen as a real enrichment of local level collaborations. That's one of the things that we're valuing so much in this opportunity to talk with you all as the representatives of the collaborative efforts at the community level. Now, if we go on to the next slide, which should be number four, all of this activity is coming at a time when we have huge health crises in front of us with the social determinants of child health with obesity, asthma, HIV have their roots deeply in the community. We also know, for those of us interested in children's special healthcare needs, the importance of the increasing numbers of children with chronic health conditions and this late data coming out saying we have 13% of our young people with chronic health conditions. Any of us who are in the hospital base know that these youngsters are getting sicker and sicker.

Also, no matter what we do, in the healthcare coverage for children remains a severe challenge with 11 million children uninsured and then if we go on to the next slide, just because sometimes looking at the stark realities of numbers, the disparities that we have in healthcare with our black/white disparities remain just simply shocking and unacceptable. No group of people should have a 15 times different rate of something as terrible as homicide. Now, on the opportunity side if we go over to slide six, many people have been calling for more of a public health interface with the medical opportunities. There is a big report from the Institute of Medicine on the -- calling on the academic health centers to get more involved. The new competencies from the ACGME are calling for

much more community-based medicine. The American academy of pediatrics has put out a community pediatric statement and a new one is on its way. Future pediatrics two is calling for this. What has happened in terms. Dyson initiative is that Annie provided an enormous gift to help put some practical and pragmatic actions into some of these ideas. Now, if we go on to the next slide, this should be the Dyson initiative goal. The goal of this program is to enhance pediatric training through interdisciplinary collaboration and partnerships. It should sound a lot like public health in order to equip pediatric residents in the course of this program with the knowledge that they will need to practice community-based medicine and to advocate for the health and well-being of children in general.

Now, if we go to the next slide, which should be number eight, there is a real match up between that goal of the Dyson initiative and the public health goals. This is a way that we can get academic health centers, hospitals and residents engaged. We're seeing residents requesting to be involved in community-based medicine training. There is a huge section of residents at the American academy of pediatrics and when you go to their meetings what they talk about continually is public health, community medicine advocacy. Also residents are talking with their feed in terms of coming in great numbers to the programs which are addressing these issues more forcefully. Community-based organizations also are seeking involvement from medical providers through the Dyson initiative we have had some wonderful interactions with CBO's. Finally, we've had our sense has been that there is really an openness on the part of the public health center to be involved with these type of training initiatives and one thing we hope today in this conversation with you to hear a little bit more about that.

Now, if we go to slide number nine, this is just a description of the current Dyson initiative. There are ten sites across the country that are involved. The participation was staged so that we had six groups come in early on and then more have joined that group and six will be finishing up their initiatives funding at the end of 2005 and the other four will continue on. During that period of time, we'll have over 300 faculty involved, we have 21 principal investigators and we actually will be training 1300 residents. That turns out to be about 1/10 of the residents trained in the United States. So there is a fairly big impact, particularly if some of these people become leaders in their field. Slide ten is just a slide map of the United States just to give a sense that as we selected the programs, we did try to get a good distribution. I think some of our stars have ended up a little bit in the ocean there but basically we tried very hard to get a distribution not only geographically but also because we have a very heavy emphasis on cultural competency we wanted to have a good distribution of programs serving different populations of children.

If we go to slide 11, I'm not going to go into any great detail with these but each of these programs serves large numbers of children. We wanted to be sure that we were impacting both pediatrics and med Peds and interacting through the Department of Defense through the navy in our San Diego program. You can download these two slides that are here and look in more detail later at the populations, the residents and highlights. I'm just going to put that up for a second on slide 12. And then go ahead to slide 13. Karen van Unen who is with me and myself and a small group of other individuals constitute a national program office here in Boston and it's our job to provide assistance to the

individual sites to make sure that we have some consistency in the program model that is being delivered to the residency programs. That we abide by guiding principles and that we gather together the lessons that we're learning from each other. We're also helping the sites through technical assistance to garner institutional awareness and visibility in their own communities. And then this is an area where we think that there may be some real interface with the MCHB programs across the country, each of the sites has taken on certain issues based programming, whether it be promoting breastfeeding or promoting the medical home or working with children who have H.I.V. infection or working with children with sickle cell and these are areas where we hope that there could be some real overlap with the public health infrastructure. In addition, the national program office is the site for coordinating across our different sites, making sure that if one group of people learns a new technique, that they can share that with the other sites. And our residents are so clever. They're always coming up with new ideas and then we get those out to the other sites so that they can work on them. And then finally we, through the national program office, are trying to assume a proactive role because we believe that our job will not be done until there is more of a community-based focus in all residency programs across the country.

Now, if we go on to slide 14, what we're really trying to do with this is what Annie used to talk about as really transforming, Annie Dyson used to talk about it as transforming pediatrics. We're trying to use the residency program lever to change pediatrics from focusing only on biology. Of course, we have to focus on biology but not focusing only on biology but enhancing our care by addressing social debt determinants of child health as

well and to practice in a way integrated with the community. We want to care for children individually but we also want to expand our intervention services to community of children. So if we learn something about one child in foster care, we want to be able to apply what we've learned to all children in foster care. We want to be providing responsive medical care when somebody comes through our door. Of course, we want to do as best we can to meet their needs. But in addition, we'd like to include a focus on prevention. So that that child doesn't fall off the bicycle and end up in the emergency room in a coma. And finally, we want to move from being culturally insulated in our own little world and that is both medically and in terms of ethnic and racial issues, to being culturally proficient to really understanding what it means to work with different communities of children and families.

So if we go on to number 15, the way that we are moving to do this is by assessing the resources of our local communities. That's -- you know, that's not just words, that's really saying let's learn who is out there, who can we work with, where are the strengths. And I give some examples in a minute of the way that we've done this. We've also been working to develop faculty in their leadership to cultivate community-based partnerships and to implement community-based projects. The projects really are the parent arm of what we do. And if we go to number 16, you'll see that over the period of time of this project we anticipate graduating 1300 or more residents. And what has been very meaningful to us is that over the time that we've already been working, this group has become increasingly ethnically diverse and also increasingly involved in faculty/resident projects. I think I'll show you that in just a second.

If we look at slide 17, you'll see that this is just one of our programs, Rochester has moved from some sporadic faculty development work in community pediatrics, which they were doing in 2000, to a much more regular and expected faculty development now in 2003. So that the community pediatrics issues have become very much part of the mainstream and accepted portion of what they do. Also, if you look at number -- the slide on number 18, you'll see that the projects which are being carried out by the academic health center residency training programs are increasing greatly. And the red there are service and clinical projects and you'll see that those have almost doubled for the -- in the communities. If we go to number 19 you'll see that there are wonderful interactions that are going on between the various Dyson sites and their state organizations and some of those would be the public health as well as national organizations, CBO's and interactions with other departments in their university-based health centers. If you go to number 20, we really see that there is a huge opportunity kind of a crossroads coming now for the Dyson program to help in this transformation process and this is exactly what Annie had hoped would occur. On slide 21, the transformation should occur through these experiences, partnerships, and through the curricular innovations that our groups are putting in.

And on slide 22 you will see a model that we have been working with and working toward where we're looking for integrated community pediatrics and working on all of these levels of policy infrastructure, working within the residency programs and then specifically working on partnerships and we see as a very important and valued partner our public health colleagues. If we go on to slide 23, just show you a couple of examples of the way that this has worked out and the way that children and families, we hope, are benefiting

from the work of these residency programs and slide 24 is a better map there. The stars got aligned a little better.

And we'll move on to slide -- I think this is slide 25. Where we have a little story about what is going on in Rochester and just to give you a sense of this, the residents in Rochester discovered that the foster care programs and pre-natal programs were going to be defunded in their area and they worked through petitions and public testimony and actually were successful in reestablishing programs. In New York City I mentioned that we would be talking about some of the assets in the community and the collaborations that our residents have had. Had a little marriage between the Harlem hospital and the Harlem children's zone and this is with Jeffrey Canada who is an incredible leader in the New York area. You may have read about this collaboration in the "New York Times." it's been on the front page several time where the residents in the Harlem hospital actually screened children all through this particular Harlem children's zone and unfortunately detected asthma in 26% of the children. They're following this up with home visits and with a whole range of public health interventions and already have cut down on hospitalizations and emergency room use. I'm not going to go into detail in these next examples. They're there for you to take down.

So I'm going to go through the slides just -- there is one that says Hawaii on it. One that was Milwaukee and Indianapolis on it. The Indianapolis one is quite fun. They're just like I'm on the radio with you right now, they're on the radio picking up questions from the community of Spanish-speaking families. It's been really exciting. We're just now going

under the slide that has Jacksonville in it. And Miami. And in these two Florida sites one of the exciting things that they not only have been working with their public health departments but they've been working together on some initiatives for the entire state. As well, I'm going to the California slide, the folks in Sacramento and San Diego have been working with collaborators that involve the Native American culture, the naval culture, as well as the youngsters from the Mexican border. Now I'm going to switch and go on. I hope, Don, you're with me. We should be on number 30.

It always is important to work with the end in mind. Begin with the end in mind. So we tried to do that and we know that we'll arrive at our goal when the majority of our pediatric training programs have curricula in community pediatrics. When the faculty are supported for their time and effort in teaching community pediatrics. We'll know this when there is a sustained operational commitment to community pediatrics and when health centers themselves practice community pediatrics. We're interested in scholarly efforts that assure the innovation and quality in community pediatrics. So the final slide is number 31. And we see that there are tremendous opportunities through the activities of this Dyson program but then really around the country in all of the academic health centers to engage residents in public health work. Now, we see this at the level of community health projects, educational infrastructure support, evaluation at the community level. Faculty development and program coordination and we look forward to discussing with you ideas that you all have for this important integration. I want to thank you so much for allowing us to share with you our excitement about working at the community level with our pediatric residents. Thank you so much.

CHRIS DEGRAW: Thank you very much, Judy. I just want to remind you folks to please, you're encouraged to ask questions of the speakers at any time during the presentation. Just type your questions in the white message window on the right of the interface, select question for speaker from the drop down menu and hit send. We'll proceed with our program now. I think we'll hold off and field the questions after all of our speakers have had a chance to give their presentation. I want to turn things over to Jeff Koshel from the bureau's Division of state and community health.

JEFF KOSHEL: Hello. I hope that many of you had a chance to go to the skills building workshop that was held at AMCHP on Saturday morning -- Saturday afternoon. It was a very well-received session. What we'll do today is give you a capsule version of what was presented at AMCHP and give you some references to where you can go to see the entire presentation. The important thing to remember about this block grant application, the online electronic version is it has worked very, very well and everyone is to be commended. This year we anticipate being able to allow you to log on at April 1. My bet is that based on last year's experience most states will have their applications in well before the July 15th deadline and the sooner you get them in, the sooner we can begin to schedule a block grant reviews that we intend to do in person as we've done in the past. Next week just to give you an update, next week you'll be able to log on to the Title V webpage and actually see the -- what we're calling the highlights of the system's changes. Chris was able to review at the AMCHP session. Next week you'll also be able to go to our technical assistance webpage. For those of you who haven't logged on before it's a simple

URL. We can give it to you after the conference or if you just remember it's MCH state TA project.com.

Underneath the resource section you'll be able to see all the power points Chris presented last week and it will be a preview of what you'll receive in a less pretty version when we post them on the web next week at our TBIS webpage. They'll look just as normal technical notes section there. The bottom line on the application itself is that we've increased the amount of space you have in the narrative to tell us what is going on. It's a 10% increase in the number of characters in each of the sections. It's 100% increase in the number of characters that you have for talking about systems capacity. Some people worried about the slate data and what we'll do this year as opposed to last year. Last year's numbers will be pre-populated on your application when you open up the forms. And this year you'll also be able to do something with the health system capacity indicators that you weren't able to do last year. You'll be able to tell us in a note if for some reason that data are not available and be able to print the form in a pdf format. Some people were concerned about that. I think the staff has done a really good job in responding to the comments that we received last year. Now, the other presentation that we can do better than what I've just summarized for you when it comes to the needs assessment section, because we have Renee Schwalberg here from HSR who can go into the findings presented at AMCHP in greater detail.

Just let me say that one of the things we're trying to do in the Division of state community health is do a better job of providing technical assistance where it's needed. And

especially learning from state to state and peer to peer technical assistants. Some of you may have attended the conferences we had on needs assessment around the country. People went over all the things you should keep in mind in looking at needs assessment and what is really important for the next round. We're very fortunate to have a contract now with HSR who evaluate -- their job is to evaluate what we call now promising practices. In the last rounds of needs assessment done four years ago and to glean what lessons we can learn from the last round and provide that to the folks now in the field doing the next wave. The HSR session was very well received at AMCHP. We ran out of the reports. Good enough to bring at least 100 reports. We ran out of those within minutes and they were able to give us an electronic versions which we've distributed and we'll give you information on how to get ahold of those if you're interested. The full report is due in the summer. HSR was kind enough to give us a preliminary version of it at this point because a lot of states are beginning to get into, if not well along, some of their needs assessment activities. So let me just thank Renee for coming today and turn over the camera and the microphone to her.

RENEE SCHWAL: Thank you, Jeff. It really is a pleasure to be here and I hope that some of this will give you some useful tidbits to think about as you start to plan your 2005 needs assessments. I hope not too many of you heard this already have Vivian at AMCHP. If you did I hope you pick up something new this time. As Jeff said, we are pleased to be working with the bureau to assess and evaluate the needs assessment process and to identify some promising practices. The design of our study I'll just review briefly on the next slide. We started with the review of the literature and needs assessment to update

ourselves on what has been going on in the field. We then reviewed the needs assessments of 15 states from 2000 and I can talk a little bit about that in a minute. We will be following those document reviews with in-depth interviews with the states to find out -- get a little more information about what they did and a little more about the process than was actually in the document. I know there were character limits explained a lot to us. I think we will be needing to talk to some of you so you may be getting a call. We'll also be looking a little more closely at the block grant applications themselves to see how the allocation of resources and program planning actually lined up with the identified needs and then we will be following that with a final report in the summer as Jeff said. With a discussion of the things we found as well as a generic template that might be useful as you approach the next needs assessment.

A little more about the review we did on the next slide. We developed an abstraction tool six or seven pages of questions and tables we could use to pull out specific information from each state. We selected 15 states. I should point out this was not a scientific process. We wanted geographic distribution and states with different sizes and different kinds of programs. In order to find out what \*r who might have interesting ideas we talked to folks in the regional offices and got suggestions from them. Being chosen or not chosen isn't a reflection of the quality of the needs assessment. We reviewed the documents and I'm glad to hear you have access to what we found. As we are emphasizing these are not best practices. We aren't saying who has the best needs assessment we're trying to identify good ideas. The next slide is a map so you can see the states that are distributed across the condition -- country. We may look at a few more as well. The bottom line of the

findings is there are lots of interesting things going on out there, lots of promising approaches. We aren't holding out any one state as a model for needs assessment. Rather, we're looking at some of the individual components in needs assessment and identifying interesting practices in each areas.

Those areas are on the next slide. The assessment of health needs is only part of the needs assessment. Another being the assessment of capacity. And then we're sort of combining some categories here. The process of putting all that information together, setting priorities and the process -- the different processes used to conduct the needs assessment itself. So to get into some of the findings on the identification of health needs looking at the indicators and data sources that states use. You know what the common indicators in MCH are. Indicators of mortality, perinatal outcomes and largely driven that they're fairly easily accessible data on those. As you also know and I think this coincides with Judy's presentation, the real major needs for children and families in the real world today might be things like access to oral healthcare, asthma, obesity, nutrition, violence, access to health insurance. Those are things that define MCH as you know it now. So some of the promising practices that we saw reflect some of those real world issues.

The next slide some of the -- just to summarize some of the categories where we saw innovative indicators. One is sort of looking at the social and behavioral side of perinatal health women and child health as well. Eight states had indicators that reflected the number or percentage of women who experienced domestic violence before or during pregnancy. We saw three states who looked at physical abuse and reports of sexual

assault and rape. Five states looked at child abuse in their reports. On another perinatal health issues four states had indicators on the percentage of women of childbearing age who took folic acid. In the adolescent health area we saw lots of interesting indicators on both risk factors and protective behaviors. Several states had indicators of suicide risk in addition to suicide rate. Asked about suicide attempts or thoughts. A couple states used youth risk behavior survey data to look at adolescent sexual behavior. Several had indicators on violence, fighting, juvenile crime, and suspension from school. One attempted to count the number of homeless and run away youth. Some parents reported they were highly engaged if school. Looked at physical activity as a protective factor as well. Several states looked at asthma. Asthma rates, asthma death rates, hospitalization rates. And about eight states had indicators having to do with childhood obesity. Prevalence and some had some focus groups on nutritional practices. Those are all quantitative indicators.

As you know it's just as important to have qualitative information to give you some of the why on the -- to complement the how many. Some of the interesting focus group issues included reasons for racial disparities in infant mortality and poor birth outcomes among African-American women. The issues of stress, discrimination, access to care that black women face. Several states did focus groups of parents of children -- with parents of children with special healthcare needs looking at all kinds of issues, the health status of the kids, the stability of the kids' health, access to care, satisfaction with care. Once they actually they were doing survey work with parents of adolescents and adolescents themselves with communication within the family. Where did the information come from?

There are a whole range of data sources. Many states used the state components of national surveillance efforts survey. The behavioral risk assessment system. And the national survey with children with special healthcare needs. In addition to those national efforts several states are doing primary data collection surveys of parents on access to care, satisfaction with care, surveys with parents of children with special healthcare needs particularly. Often through family voices. And on several -- several did surveys about their experience themselves on healthcare. Many states do surveys and focus groups with special populations including children with special healthcare needs. Adolescents. A couple states did surveys with parents focusing on childhood obesity. Several did surveys of providers to get at their thoughts about the content and quality of care. Barriers to access particularly under Medicaid managed care. Surveys of dentists on their willingness to serve children enrolled in Medicaid and about their efforts toward cultural competency.

A few other data sources, some states have taken advantage of their risk screening programs and the databases those programs produce to really look at the extent of risk factors in the state. A couple state had screening databases of pregnant women as women entered pre-natal care and it produces a database that produces information on behavior, sociological, biological and medical risk factors. One state had a home visit for newborns that produced information about the children and family's risk. Another survey here. One state has a toddler survey that is asking the parents. The toddlers -- and a fourth source that several states used is their fetal and infant and maternal and mortality programs. Those are often can be very rich sources of information about systemic issues

especially for issues like maternal mortality. Where the numbers are small you can look at every case and see what the needs of the population is and issues within the system.

That's a quick overview of the needs assessment side.

Moving on then to capacity. This is where we saw much less variation, I would say. And -- some states did have some promising approaches that went beyond strictly the numbers served or the number of providers in the state. One was to look at accessibility, not just numbers of providers but access to providers by looking at the distribution across the state. And by asking families about access issues. Five states specifically looked at access issues on children with special healthcare needs in the capacity area. Access to primary care, technologies and so on. Some states also looked at access to pre-natal care, birthing centers. Mental health services for children. Several looked at the oral healthcare system. Looking at both the number of dentists as well as the number of full time equivalent dentists working who contribute their time through charity programs or community health centers. Looking at access specifically under Medicaid, looking at EPSDT dental screening rates as well as by counting providers who accept Medicaid and who are taking new patients. Quite a few states looked at capacity not just for service delivery but also as the MCH at their internal infrastructure to conduct their core public health functions. Specifically the infrastructure for data collection for planning, for data integration, for quality assurance, for training.

Looking at the public health side as well as the service delivery side. Several looked at structural environmental factors looking broadly at capacity some of the factors that might

affect capacity and need like Medicaid expansion. Medicaid managed care. Immigration and other sort of secular trends that might affect that capacity. Some other approaches included looking more quantitatively at access in addition to asking families about what their access issues were. But looking trying to quantify access by looking -- comparing the population in need to the population that actually received the service, including enrollment in Medicaid compared to the number of potentially eligible families and the use of family -- users of family planning services compared to the population in need. Focus groups also assessed the cultural competency of services on the measure of capacity. Many incorporated local level capacity assessments through mechanisms like regional planning councils, regional perinatal councils looking at capacity locally. Some ideas to think about as you think about new ways the approach capacity, one is as they say, like politics is local, all service delivery is ultimately local as well. Using locally can be a powerful way to get more detailed information looking at numbers from the state perspective. Another is to really try to align the needs assessment with the capacity assessment. You can get some -- it can be a powerful tool for identifying areas not just about need but whether it can be the capacity to meet the area of high need and high capacity can be rich opportunities to intervene whereas areas with high need and low capacity can be the really challenging ones.

And finally, as you know, children and families don't divide themselves up by funding source. Looking as the system of a whole, incorporating all the various systems that touch children from the schools, special education, to full intervention to Medicaid and chips and private insurers and everyone else. Looking broadly at the system can bring more

resources to your assessment. Finally, just putting it all together some of the interesting methods that we saw, it looked like it was important to have a defined protocol and criteria for identifying priorities. The more you assess needs the more you'll find and the more difficult it will be to select a dozen you can deal with. The criteria we saw were interesting. They tended to fall into criteria having to do with impact, health impact and economic impact. Practical considerations like are there resources to address this problem? Do we have data to monitor this problem? Some of the -- one of the interesting ones we saw one state looked at -- once they had a list it was still too long, they tried to identify which of the needs that they had selected might be pre-cursors to other needs on the list and focus on the ones upstream. If you're looking at bullying and violence and homicide you might want to start with the bullying and hope that will affect the other two. The others have a process that is inclusive that need percent peck tivs from the state including consumers and it includes input from local constituents. Finally to address multiple aspects of need and try to integrate the needs and the capacity.

One state had a very nice model of discussing the quantitative and qualitative indicators of need and the capacity that was available to address each one. So just to wrap up I know time is getting short. You've heard a lot about needs assessment. You've all been training and you've heard assessment is a process, not a product. There are a few things that seem to be requirements to make it work. Having a clear leader who can marshal and motivate resources and can make sure the data becomes available. Involving the right people, including as we said the diversity of percent spective as well as the right experts to help you with the data analysis. It can be fairly complicated and coordinating as much

as possible with other agencies and other systems that again touch our population. One state had a nice model of doing a joint needs assessment with H.I.V. and primary care services to really look at the system as a whole. So finally, some items to remember, the needs assessment is not an end in itself. It's a tool, part of a planning process, as you know. So the promising approaches are those that link needs to capacity and make that flow logically into selection of priorities and allocating resources. So I'd be happy to take questions but first I would like to make the offer to you, if you all are thinking about things or have done something in the past that you want us to know about please let us know. If there are specific questions about needs assessment that you would like us to look into as we continue our investigations, please by all means this is the time to do it because we still have a long way to go. Please feel free to email me or Vivian at HSR net.com and we'll be in touch with more than a handful of you, I hope, over the next couple months. Thanks very much.

CHRIS DEGRAW: Thank you very much, Renee. Again this is the time to submit questions if you have them for Renee or any of our other previous speakers. We do have a couple of questions now so why don't we proceed with them while we have some time. The first question is, this is directed towards Dr. Palfrey. What rules do you see for state Title V directors to work with the Dyson initiative training sites?

JUDITH PALFREY: Thanks for that question. Just listening a little bit to Renee I was jotting down a few things that were so important that I think Title V directors might want to think about. As we have these wonderful young residents who are coming along in their

training, they often don't have the wider view of the population. They don't really understand how needs assessments are done. They really don't know, you know, what goes into figuring out an outcome or a roadmap to knowing where things are going. On the other hand, they have tremendous energy and they have tremendous interest in being involved in the solutions. And so I think that one of the big places that the Title V directors really can come in on this kind of thing is meeting with the residency program directors and being kind of creative about looking at the residents as potential helpers in some of the work that you all do. There would be a wonderful opportunity for instance for a resident to help in one of these focus groups because with the specificity, for instance, of let's say meeting with a group of parents of children with H.I.V. or grandparents with children with H.I.V., what an eye opener that would be for some of our pediatric residents to see on a community base what is happening for the children that they're taking care of on an individual basis. So I think one of the big roles would be really to sit down with the program directors and the chief residents and so forth and just banter about some creative ideas of places where the residents could truly be helpful to your process but you also would be really opening their eyes to this much wider world.

CHRIS DEGRAW: Thank you, Judy. The next question also for Dr. Palfrey comes from Texas and the question is, how can other states that do not have a Dyson initiative such as Texas get involved with the Dyson initiative?

JUDITH PALFREY: Well, I think we would love to have you look onto our website which is [www.dysoninitiative.org](http://www.dysoninitiative.org) and you can look at some of the things we're up to. But I would

also urge you again at the local level to identify the residency programs that are near you and, you know, really to sit down with the program directors and see if this kind of grass roots interest on the part of the residents and the part of the junior faculty. You may find that there are some really intriguing people there who just don't quite know how to go about learning about public health. I will tell you that if in a talk that we give we say the word Title V they're just blank looks on the part of the doctors. They don't quite know what we're talking about, where it's coming from. And so a lot of the work that we all need to do is translation, education and getting to know each other. We're talking about the same constituents of children and the same goals. I would urge you in Texas to go ahead and identify some of the Children's Hospital -- probably getting down a little further in the hierarchy than you may typically and going on down to the residency program director and the chief resident.

CHRIS DEGRAW: Thank you, Judy. And another question directed to you comes from the New York state MCH program. Could you please comment on the economics of community pediatrics? How can a private pediatrician thrive while practicing community pediatrics in terms of time and finances?

JUDITH PALFREY: That's the \$64 question that everybody is asking at this point. We are working very hard with our group to look at certain issues around contractual arrangements that people may be thinking about working on with different group projects. Also the more that we think about these kinds of things in terms of quality and the actual cost savings that community pediatrics can have. For instance, for managed care or for

proprietary insurance companies, the proofing of that is always a little on the hard side but a lot of the projects we're doing have to do with demonstrating back to the managed care company that by getting out and doing the home visits. By getting out and doing the physical activity, etcetera, etcetera, they actually save some money. So that some of the work that we're actually doing with the residents and with the junior faculty is around those kind of demonstration projects. We don't think that people need to completely lose their shirts and we think this is one of the big transformation points that needs to occur in this whole activity is to begin to think about group care kind of activities. We are in touch with one group that is actually doing prenatal -- group prenatal visits and they're making it work just fine and much more efficient than seeing individual in a prenatal visit and the mothers learn so much more. We also have been doing some work with educating our legislators and you'll see, I think, on one of the slides the fact that in the State of Wisconsin, actually the activities of the residents have made it possible for -- you were talking about the dental issue. In Wisconsin now Medicaid will actually pay for the application of dental sealants in the pediatric office. So this actually brings in a new -- by going out into the community and find -- finding the needs it brought in a new activity and new source of revenue. We believe that this can be done in a revenue neutral way.

Nobody is going to be a billionaire but they are not going to lose their shirts.

CHRIS DEGRAW: Thank you, Judy. I would like to thank you and the rest of our speakers for helping us out today. I want to thank all our participants from the state who participated in the webcast. I would also like to thank our contractor, the Center for Advancement of Distance Education at the University of Illinois at Chicago School of Public Health for

making all this technology work. Today's webcast involves our MCHCOM.com will be available on the website. We encourage you to let your colleagues know about the website and find it useful. We want to make these webcasts as responsive to your information needs as possible. If you have suggestions for topics you would like addressed on future webcasts, or have comments in general email them to us at info@mchcom.com. Hopefully you'll fill out the surveys in a moment. We look forward to your participation again next month. Thank you.