MCHB/DCAFH

Setting State Health Priorities in Tough Budget Times

March 12, 2009

AUDREY YOWELL: Good afternoon, everyone. Thanks for joining us today about a conversation of maternal and child health, setting state priorities in the tough budget times. I'm Audrey Yowell, the program direct for the alliance for information on maternal and child health, which we call AIM, and the health resources and services administration's maternal and child health bureau.

Before we get started I'm going to review the ways you can use your computer interface during the webcast. Slides will appear in the central window on your screen and will advance automatically. The slide changes are synchronized, you don't need to do anything to advance them, though you may need to advance the timing of the slide changes to match the audio. You can do this by the slide control at the top of the messaging window. We encourage you to pose questions for the speakers at any time during the presentation. Simply type your question on the right of the interface, select question for speaker from the drop down menu and hit send. Please include your state or your organization in your message. If time allows, they will address the questions near the end of the webcast but if there isn't sufficient time, an email response will be sent to you after the broadcast. Again, we encourage you to submit questions at any time.

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Our webcast today is going to focus on a collaborative effort among several national professional membership organizations funded by the Maternal and Child Health Bureau. It's to foster collaboration among state policy makers helping them identify specific steps they can take together in their own state to improve the health of women, children and families within the context of broader health issues. The organization's responsible for planning and carrying out this project are all participants in the AIM program, a collaborative of Maternal and Child Health Bureau grantees. AIM grantees are all national membership organizations representing professionals responsible. They include organizations of state and local government officials, Maternal and Child Health professionals, foundation, legal professionals, health insurance industry and large businesses, as well as family advocates. AIM grantees work with the bureau on two levels. First, each is funded individually to educate the constituents and promote dialogue among them about Maternal and Child Health issues, and second, each individual grantee participates in the AIM collaborative. The purpose of the individual grants is to promote really a two-way communication, by making new research findings and policy information accessible to professionals to help them make clearly informed decisions affecting public health policies and programs for women, children, and families, and in the other direction, by creating a channel for professionals in the field to alert the bureau to emerging concerns and issues that they are facing. On the second level of the AIM program, each grantee organization participates in the collaborative. The AIM collaborative itself was

formed when all these individual grantees began meeting together, and initially this was to share information and ideas, but later as time went on, we started to meet the partner in improving Maternal and Child Health. The partners meet twice annually all together but they also work on specific issues and smaller groups between meetings. You are going to see the 16 grants funded AIM partners listed on the slide that's now on the screen. And you'll see the Maternal and Child Health Bureau is the 17th and equal partner in this collaborative. And from this list you can also see really the diversity among the types of organizations participating in the AIM collaborative. So you can see beyond the value of the individual grants, there's an added value from convening all those folks together. This provides opportunities for them with their very different perspectives to share expertise and concerns and also to educate one another, as well as the bureau, about emerging issues and promising maternal and child health practices. If you would like more information about AIM or the webcasts, archived at www.mchcom.com, please feel free to contact me. You can see my phone number and email address on your slide. A Yowell at HRSA.gov, and feel free to give me a call.

Today our presentation highlights the response of a consortium of AIM partners to challenges faced by states trying to support maternal and child health programs and set priorities in these times of fiscal problems, as well as the national dialogue on health reform. I'm pleased to introduce our first presenter, Martha King, director of health programs at the national conference of state legislatures and she's director of the project using limited state health care dollars wisely, what states can do to create the health system they want. Martha.

MARTHA KING: Thank you, Dr. Yowell. And thanks to those of you who have joined us today. We are real excited about this collaborative project and hope it will interest you as

well. I hope you forgive me for my voice and occasional tough. I'm fighting a cold today. When Dr. Yowell asked us to share information in the webcast, the major concern, whether it would be relevant to people not directly involved in the meetings and activities. In thinking about it, we hope it will encourage you all as members of the public health community to become more involved in the broader health reform effort and debate in your own states. Maternal and Child Health voices need to be at the informed table. More important than ever in the time of severe budget constraints. At the same time, it's important that we all realize the public policy debate involves not only maternal and child health, but also health issues of all kinds, and other public policy priorities such as education, transportation, welfare, economic development, agriculture, etc. So the bottom line is that we encourage all of you to be more informed about and involved with the current policy issues in your own states. Think about how you can be a more active resource related to highlighting maternal and child health roles in promoting health, preventing disease and remaining a wise investment of public resources.

Okay. Let's move on to our next slide and I'll give an overview of our health priorities project. As Dr. Yowell noted, the broekt -- noted, the project is a collaborative among organizations, the next slide lists the organizations involved. Dr. Yowell fears as our fearless leader at the Maternal and Child Health Bureau and we have staff from each of these organizations involved and we have a lot of fun together, that makes it even a more worthwhile project. I have listed contact information from each organization at the bottom of the, the back of the slide show, but I would like to acknowledge our great team now. We have Sharon Corle and Brent, Lauren and Ellen, from CityMatCH, Nat, and Sharon, and Jodi and JoAnne, and at the national governor's association Gabriella Garcia. And Dr. Helpel who created the concept of the broader AIM partnership and also of this particular collaborative project. Thanks, David. I was going to call you the grandfather of the project

but I doubt if you would appreciate that. Let's go to the next slide, number 13. To see the smiling faces of the key project staff and wonderful interns at one of our meetings last June. You can see Dr. Yowell right behind the white sign in the middle there. Okay. Next slide, 14. Brings us to the nuts and bolts of the so-called health priorities project. Our goals are listed here and include the following. We intend to convene state teams of key health policy makers to foster communication and collaboration about state health goals and opportunities. We intend to raise greater awareness of state health goals, resources, and the value of establishing priorities because as we all know, state dollars are limited. We intend to improve the understanding of maternal and child health issues within the context of larger health priorities. We consider the health status of the state's children and families and identify strategies for improvement. And we intend to have participants identify the next steps they will take in their own states once they go home. The next slide 15, frames the even more challenging context that we face today. We have been with this project, we have been in good times and bad times and this certainly is a bad economic climate, and we believe it's more important than ever for policy makers to establish spending priorities, and we believe the maternal and child health voice needs to be a very important part of that. Spending for health care accounting for 32% of the average state's budget, state budget cutters certainly have to eye health programs. It is good for maternal and child health add have -- advocates to understand the budget deliberations that face states.

The next slide shows familiar headlines across the country. It's not just health programs that face problems, it's everything, and policy makers must consider all spending policy programs, such as education and transportation as seen here.

Slide 17 is pretty depressing. It shows the results of the recent NCLS survey of state budget conditions. Bright blue, a budget gap of more than 10% to close out this fiscal year which ends June 30. And since there is only a few months to the end of that, as many of you know in your own states, some of the cuts are looking pretty serious. If you, with Arizona, they reported a gap of just nearly 18% of their general fund to close out this fiscal year. Nevada is almost 17%.

And as bad as this news is, the next slide, 18, is even more depressing. We hope to have a silver lining pretty soon, but if you look at the FY2010 budget gaps, this slide shows even more bright blue, 24 states report an anticipated budget gap of more than 10% in next year's budget, which begins for most states on July 1.

Next slide. NCSL is tracking actions of states to balance their budgets. In this particular slide, it shows some of the states that ordered across the board cuts to close this year's budget. 20 states during our survey had reported across the board cuts and at that time the survey was done in November, ten more were considering such cuts. This particular slide shows those that were anticipating the highest number of cuts. In Hawaii, it shows two different numbers there, and it reflects two rounds of across the board cuts that they have implemented. As we all know in times of economic downturn, the number of uninsured increases, and the demand for publically funded assistance goes up, which increases the budget problems, and makes it possible for states to do some selective trimming at times. For example, in these across the board cuts, some states are making exceptions, for example, with Medicaid. And I do have to say that the economic stimulus package certainly will help backfill some of the holes that states are experiencing. Pardon me. Experiencing in their Medicaid budgets. Again, our major concern is to help state

policy makers make informed and strategic decisions about program and budget priorities. So how do we do that?

The next slide 20, highlights that this project is collaborative project, sponsors one multi-state seminar each year for six or seven states at a time. We invite state teams made up of key health decision makers, including our co-sponsor organizations constituents. Those are state legislators and legislative staff, and I want to note here with the state legislator, in our recruiting process, we are targeting legislators who are key decision makers, not necessarily those who are maternal and child health advocates. We go for health chairs or subcommittee chairs or even appropriations chairs who deal with health issues, and it makes it more important than ever that our agenda include topics that go beyond maternal and child health so that they can figure out where MCH issues fit in. Don't be surprised if you hear recommendations out of a team that deals with long-term care, as well as children and family health. We also invite the governor's health policy advisor, state health officer, Title V director, local health officers, and it doesn't include Medicaid directors and insurance commissioners, we invite those people as well because they are important decision makers at this table. I want to turn to Sharon Corle. Sharon, are you there?

SHARON CORLE: Yes, thanks, Martha.

As it states in the slide, the state health officer and the local health officer, and the Medicaid and insurance commissioner because they are a part of health and health care in the states. The public health folks bring awareness of the resources currently available. They know what money comes in and is going out into the larger community for public health programming. They have data capacity and evaluation skills that can assist in making evidence-based or databased decision making. They are making sure they are

making the identified needs of the people living in the state. They are knowledgeable of the current programs and gaps, knowledgeable of emerging issues in their states. That would stem from the data and surveillance that they do. They have knowledge of evidence-based approaches, and evidence-based programs save money in the long run. They carry the prevention message, which is really important preventing a lot of these conditions that actually are more costly as they progress like chronic diseases and things like that, that if you invest on the front end, will not have those repercussions on the tail end. And they bring an understanding of the life course perspective of health. That is circumstances throughout childhood and adolescence impact adult health. And in bringing all of this knowledge and information and capacity to the state teams, they actually can contribute to state goals and priorities that are based on data evidence and the needs of the family. They are an important part of the team as they undergo these interesting dialogues and conversations. What do the public health folks that contribute all the great things get for participating in the teams? They get opportunities. Opportunities to participate in dialogue and strategic planning with other key state decision makers. It's a forum that's less formal that allows them to talk about lawmakers and commissioners in an informal way so there can be dialogue. A lot of times there are restrictive state policies that prevent, or state policies in general that prevent the informal dialogue so it's a real opportunity to have that, and you know, they can also hear from the lawmakers firsthand and other department staff of what their priorities are and what their concerns are. So it's really a two-way dialogue. The public health folks can promote the need for a particular focus on maternal and child health populations on the in-state health efforts, they can share successes, viewed as resources as they are participating in the informal forum. They get to present a lot of information about the data collection and needs assessment that they do, and a lot of times, you know, they are, can be looked at as resources for lawmakers when they are looking to propose a bill or when they have a concern or a

need. And they also build relationships. Hopefully what we are promoting here is a team environment where we increase communication and collaboration, and after this meeting is over, that they continue to engage in these conversations and as they move forward their action plan that they continue the collaboration that was started at the meeting. And also, you know, this will be further elaborated further on the call with the state examples. I'm going to turn it back over to Martha. Thank you.

>> Great, thanks, Sharon. Slide 23 lists the meetings and participating states that we have conducted during this particular grant cycle. And we have gone back years before this. Many people ask how we select states, and our formula remains a well guarded secret. Over time it is on various criteria, including need, interest, partisan makeup, etc. I'll talk about the partisan in just a minute. I will let you know that for our October 2009 meeting, for example, we plan to target states that have year around legislatures, and/or have the greatest budget problems so that we can hopefully help them zero in on some of the critical choices in health.

Slide 24 shows the partisan makeup of state government, taking into consideration the party control in both state legislative chambers and the governor's offices. This is a reminder that in selecting our states, we also work hard to ensure bipartisan representation. So for example, if there was all Democrat control or Republican control, we try to mix it up.

Slide 25 shows a plenary session. We show a mixture of plenary sessions and small group meetings, and in the plenary, we spread the participants out and have them sit at U-shaped tables with their own team members, and let's look at 27, which lists the sessions that we feature, and this is, has been our model for this grant cycle. As you can see, we

feature more than just maternal and child health scenes. We try to make sure each session considers MCH issues. We all know and love Peter van Dyck and Maxine Hays and what they have brought to the program. Dick Lamm shakes things up how we can't have it all and we must make tough choices. I know he stirred things up last year. His key role is to get participants to think about the reality of limits and rationing that already takes place, and to think strategically about establishing priorities. He notes that if he were running for office today, he would have to promise to cut our services and raise our taxes, which is true, but how many votes would he get? The next two slides show Peter van Dyck presenting and two meeting participants chatting with Dick Lamm. So there is Dr. Van Dyck on 27, and two of the meeting folks having Dick Lamm sign his book for them.

Okay. Let's move on to slide 29, which shows what we hope to accomplish during three facilitated breakout sessions we conduct at each meeting for the state teams. So interspersed we have the state team folks meet. We ask them to discuss health priorities from their own perspective and then agree to some common health goals, objectives and action steps to work on together when they return home to their states. We also set the expectation that the state team will reconvene, and we, once they get home at some point in the near future, and we offer to send the facilitator from the project to meet with them.

Slide 30 shows the state team meeting of Virginia in June 2007 when we met in New Orleans, and Gabriella Garcia is writing on the flip chart there, the lead facilitator for that team meeting.

And 31 shows the overambitious Sharon Corle and another with the Alaska team priorities at the Denver meeting 2006. Slide 32 shows an Affinity group meeting. We also allow opportunity for Affinity groups such that, for example, all the state legislators meet

together for an hour to discuss their own issues, and trade information. The other Affinity groups are the state health officer in one group, Title V directors, etc. So that's always a popular forum as well.

Slide 33 shows Dr. Brown from the Mississippi Department of Health reporting on her state's team and priorities. All the teams report out to the larger group at the end of the meeting. In this case Dr. Brown is highlighting the maternal and child health goals. We don't prescribe to the teams what type of topics they should be working on. So if they want long-term care as a priority, more power to them. But we ask them to identify at least one maternal and child health related goal and also ask them to identify at least one strategy related to broader goals that relate to children and families. Okay.

On slide 34, as I mentioned earlier, we also expect the state teams to meet again once they get back home. Here is the final page of the Mississippi team's group report in 2007 that says here is one of our goals, we will reconvene our team, plan for the next meeting, and other follow-up. In fact, the Mississippi state team helped sponsor a three-day legislative hearing on decreasing health disparities last fall, we provided several speakers for that meeting.

Slides 35 and 36 show some state team successes over time. For example, the Arkansas childhood obesity initiative that included measuring students' body mass index stemmed from a health priorities meeting that Arkansas attended several years ago. In one state there was an agreement on a state funded Medicaid expansion to cover undocumented pregnant women because it needed to fly under the political radar we don't identify the state, it was very sensitive and partisan tension related to the issue and the state team in a quiet room without people hearing them agreed to do that, which was really interesting.

There was also a joint effort by team members in Minnesota during the last economic downturn to band together to help protect children's health programs, when the state was looking at budget cuts.

Slide 36 shows that in Iowa, West Virginia and Wyoming, they participated in testimony to encourage certain decisions or actions within the larger context. Also saw sponsorship of instate meetings for stakeholders about Mississippi and New Hampshire and we will hear of New Hampshire very soon. And an optional volunteer service event in New Orleans in 2007 after the conclusion of the meeting. We worked with hand on New Orleans and cleaned up an elementary school that had been in the flood zone. Volunteers refurbished the interior courtyard, planted flowers and bushes, and cleaned up. And then planting during the volunteer effort. All of us agreed it was a worthwhile and rewarding experience. Okay. Let's move on and hear from some of our meeting participants. You can see on slide 39 we have four panelists. State representative Peggy Welch from Indiana, Tom Newton from Iowa, director of the department of public health, Marsy Nielsen, and Lisa Bujno, chief of the community health services in New Hampshire.

Slide 40 shows the Indiana state team and state representative Peggy Welch is there in the red blouse. In the next slide she's making her state team presentation. So let me do a very brief introduction of our four speakers.

Slide 41, as well as being a state legislator for 20 years, and representative Welch, you don't look that old, 20 years, a practicing nurse in the Bloomington hospital cancer unit. She currently chairs the Indiana house subcommittee on Medicaid and health and vice chair of the public health committee. Also a member of the family and human affairs committee. And Iowa, Tom Newton with us on the call. He's director of the Iowa

department of public health and can be seen in the back row between the gentlemen in the blue shirts. Director Newton is a registered environmental health specialist with a master's degree from the University of Northern Iowa. He has over 13 years of experience in local and state level public health.

Slide 43 shows the Kansas team from the 2006 meeting. Dr. Marcia Nielsen is in the front row, third from the left. Dr. Nielsen has experience in Washington D.C., as both congressional staff and as a lobbyist. She has also served in both the army reserves and in the peace corps, what a combo. Peace corps, she worked in Thailand with the Ministry of Public Health.

Last but not least, slide 44 shows the New Hampshire team from 2007. We have Lisa Bujno joining us, and she serves as the chief of community health services at the New Hampshire division of public health services, to ensure statewide health services to underserved populations. Previously a Title V Maternal and Child Health Director. She holds a masters of science at the University of Pennsylvania and worked as a family practitioner in private and clinical practices, including the Department of the Army in Germany. So, we are thrilled to have these folks. Let's hear from our meeting participants. We will be posing a series of questions to them and ask them to respond. And we are going to mix up the order of the respondees. So the first question we would like to pose is for the panelists to comment on the state team process and highlight the major benefits of the meeting. Especially convening the decision makers from the state. Did the meeting live up to your expectations. Start with Indiana, Representative Welch.

>> Thank you, Martha. I sound like I'm from Mississippi, that's where I'm from originally, but now a hoosier. We had the deputy health commissioner, legislators, and also an

attorney. Health department doc and also a local health department representative. Some of of -- of the highlights for us, we all learned something, we had different take away points when we would come together and talk about the presenters. So we learned from each other. In the team meetings we all brought different perspectives, as you can see from the different folks we had attending. And we were able to develop relationships there, especially learning how to understand each other's stresses and roles that we are playing in trying to provide the best health services for our citizens. Something else that was very helpful for us was it was out of our normal environment, therefore that reduced the distractions and we could really concentrate on this particular set of issues and to come up hopefully with some solutions. The thing that was very helpful for us was when we reconvened with your help, and were able to review the goals and strategies that we set out, and to kind of keep us fresh and on our path. So, that was, it was a wonderful experience and we are so glad we were able to participate. I would like to turn it over to Tom Newton from Iowa now.

>> Sure. Thank you, Representative Welch. Just as Indiana had a great experience with this, Iowa did as well. I personally thought it was a great meeting. As a new state health officer, I believe I had been on the job for nearly a month by the time this meeting rolled around. I really appreciate the opportunity to get away, interact with not only my governor's office, but also some of the legislative staff and legislators who played key roles in our policy committees, as well as some of our appropriation committees. I also found it to be very helpful and I think the other members on our team would agree, to just get away from the state capitol to a remote location and actually sit down and have the opportunity for executive branch, legislative branch to work through some issues, get the facts without some of the background noise that we sometimes struggle with in the legislative process. Stakeholder involvement, stakeholder background noise that can

sometimes confuse things. And I think this was just an excellent opportunity for us to sit down and try and set some priorities for the state of Iowa. I thought the facilitators did a wonderful job of keeping us on task, making sure we were mindful to keep focused. The real purpose is what can we do with limited resources. But they also challenged us creatively and really look at some other examples as in states that are doing things a little bit differently than we are, and maybe a little bit better. So, all the way around, I thought it was an excellent opportunity for us. And I will pass the ball now to Marcie from Kansas.

>> Good afternoon. I did, and team Kansas did find the meeting to be very beneficial. The timing was interesting for us. We had recently done a major reorganization of the health care agencies in our state. And joining our team were representatives from the legislature, legislative staff, folks from the insurance commissioner's office, folks from the public health agency, and then folks from this new authority which was just getting its sea legs, as it were. So it was a terrific opportunity for us in a nonpartisan environment to really share information, I certainly having not come out of the agency, but having been in academia for the last couple years found it to be very helpful in terms of setting the stage for how we could collaborate and I'll be telling you a little bit more momentarily about some of the great things we have been able to do out of that initiative. I think it is very important to consider that there aren't many opportunities to put together a varied group of individuals under a pressure-free setting, and I'm trying to think of the other opportunities we have had really since that time. Extremely limited. So if I were to say that there was one thing that struck us as being particularly valuable, it's really the opportunity to get to know one another and talk about broad goals outside of the state in a nonpartisan environment. And with that, I am going to turn this over to Lisa Bujno.

>> Thank you. So for us we had similar things that we felt were very, very helpful. It was an interesting time in New Hampshire. We had come through some tough budget times. We had had some turnover in personnel and had a period of time when there was quite a constraint on meetings between the executive branch and the legislative branch. So, in our team there was a representative from the insurance department, Medicaid director, public health director, myself as the MCH director at the time, and three legislators. And I think it was probably the first time that many of us had all been in the same room together. One of my favorite pieces of trivia about New Hampshire is that it has the third largest legislative body in the English-speaking world behind the British parliament and the U.S. Congress. So, with 425 legislators you get a whole bunch of representation, and it can be very difficult to make, to build very significant relationships. So it did offer dedicated time with some key legislative representatives and other executive branch agencies, and then the point about everybody hearing the same messages at the same time, and being able to see the impact on others' perspectives was one of the key, key things of the meeting. Being able t get away from the state capital, and also that the structured format took all of those things and allowed us to push forward to make some greater progress in looking at goals than we probably would have made without those structured meetings. I think we are going forward to the next slide on concerns and apprehensions.

>> Great. This is Martha again, and we did want to bring up and ask you if you had any concerns or apprehensions about participating in a meeting, especially with this makeup of members. This particular state is not represented here, but a few years ago we had a state where there was quite a lot of partisan tension between the House and Senate members and we understood there could be some difficulty. So I actually volunteered to facilitate that state. When we walked into the first state team meeting you could cut the tension in that room with a knife. And it took us that first meeting to kind of warm people

up and even get them talking to each other and quit throwing Barbs at each other and blaming each other. In the end it turned out to be very, very good. So I want to throw that out to the members today and start with you, Lisa.

>> Some of the things I just mentioned, there were some tensions between folks within the executive branch, and even within the department. Some of the people were new and really hadn't had a chance to forge relationships, and then there also was kind of a very firm boundary in the recent years between HHS and the legislative branch having a commissioner and a governor that didn't quite see eye to eye, and in fact, for this meeting the governor's office was unable to attend. So, I think we'll hear from Marcie in Kansas.

>> Hello, can you hear me? I'm trying t -- trying to get off of the hands-free.

>> Did we lose her?

>> I think we lost you, Marcie.

>> Okay. Let's move to Iowa, Dr. Newton, and then we'll come back when she comes back on.

>> I had no apprehensions about going through and participating in this meeting. I actually thought it was, I welcomed it just because I was a new state health officer and thought this would be a great opportunity to interact with not only my governor's office but also the legislators who are active in Health and Human Services. I did not have any real concerns partisanship-wise. We tend to play nice in Iowa, I did not anticipate a whole lot of problems related partisanship. Do you want to go on to Peggy Welch then?

>> Okay. I'll jump in here. Thank you, Tom. I think for people who have never done something like this, they may think is it a waste of time, am I going to get anything out of it, is it worth the effort and I can say yes, I have done several team type meetings so I had no apprehension and was excited about doing it. One of the things difficult for us at first was getting our legislative staff there with us, because they work as nonpartisan, and to get them to share opinions and give insights from their perspective, we had to give them a lot of assurance that they could do that. Also we ended up not having a representative from our family and Social Services agency, specifically from the Medicaid division. We felt it would have been very helpful to have somebody from that particular division. Obviously having the Department of Health was important, but as we were talking about how to best use our fiscal resources, we needed to have somebody from the Medicaid office and for whatever reason, no one attended so that was I think in some way a hindrance to make comprehensive plans.

>> Great, thank you. Did you come back on?

>> I am, I'm back on but my phone is very touchy. My apologies. I think I'm not actually to able go back and forth between speaker phone. Can you hear me all right?

>> Yes.

>> Okay. Terrific. And again, my apologies. In terms of apprehensions, I think I was too green and perhaps dumb to have many apprehensions before going into the meeting. And that wound up speaking for me and my colleagues from this new agency. Wound up being something, we didn't have preconceived negotiations of how legislators worked with the

various agency folks. We quickly learned where some of the hot spots were, but because we were engaging one another in a very unthreatening environment, I think it set a very nice stage for the agency and for our colleagues to share information that maybe wouldn't be as easy to share during a legislative session, and under heated debates. So we didn't have apprehensions. We learned maybe we should have walking in the door, and the timing was perfect for us.

>> Great. Thank you all. Okay. We'll move on to the next question which is to have you highlight the goals and key strategies that your state team identified and move to slide 47, and with these we do have a series of slides for folks. We'll start with Director Newton from Iowa, and his goals and strategies start on 48.

>> Okay. Thanks, Martha. Moving to slide 48, then. You are going to see on 48 and 49 the goals and strategies that our Iowa team was able to come up with. I would add at the outset that this was probably our biggest challenge, honing down what we were going to focus on, you know, Iowa right now is in a tough budgetary time. But as we were meeting in New Orleans in 2007, Iowa was looking fairly good budgetarily. So we had a number of resources available to us that are not available to us now. So the thinking was pretty broad and expansive, and folks were really geared up to do something big. But here are the four goals and strategies that we came up with. The first of which provide accessible, affordable health care for all children in Iowa, including dental and mental health services. Dental -- a major shortage of dentists and mental health providers in Iowa. Therefore, we thought it was important to include that on the end of it. Improve outreach, essentially they are talking there about improving outreach to parents whose children qualify for Medicaid and also the Hawkeye program, or SCHIP program. We know we have been able to pick up additional kids who qualify for that. So we wanted to enhance our abilities to use those

existing programs before we expanded into something new. And second piece of that is to investigate mandating coverage, a number of folks on the Iowa delegation, familiar with the Massachusetts model and had some real interest in examining the possibility of mandating coverage for all children. The second goal we identified was create a comprehensive prenatal and newborn home visitation home program for every newborn Iowa child, state support for the programs. We have some pockets of best practices across the state in communities and counties in Iowa. But this was a goal, specific legislator whose county actually has this service and thought hey, we need to make resources available to do this all across the state. He was familiar with the success of the program within his direct, and said this is something that is working in my district. We need to have this all across the state of Iowa. Third goal was to design a process to set health priorities so we can fund the highest priorities. This really tags onto some of the lecture we heard from former Governor Lamm, as well as the Oregon model. We wanted to identify options and key stakeholders who needed to be involved in that discussion and develop a timeline and initiative process to really get the ball moving. The fourth and final goal was to create wellness enhancements for state employees. One of the people on our committee was very concerned about the cost associated with health care for state employees. And the state currently does not do a whole lot around wellness. And he believed that we needed to really focus some effort towards getting our state employees healthier. Wanted to see some, a ban of smoking at the capital complex, as well as creating some wellness, physical activity, nutritional officials to encourage them to adopt healthy lifestyles. I will move on to Kansas and Marcie next.

>> Great. Terrific. I think my phone must be from the 1900s, there's no turning off this hand set. I'm going to speak close to the phone. As I mentioned, we were a brand-new entity, that is the Kansas health policy authority, as you'll see referenced on slide 50. And

we grew out of an idea that the governor had to put together health care agencies that purchase health care for various populations and achieve economies of scale. The legislature made some different ideas, and some of the authors are with us on the Kansas state team. It was an interesting opportunity to talk about what the goals were when the governor and the legislature created the health policy authority. You'll see that they are quite broad. Both to develop and maintain a coordinated health policy agenda, and we have a very significant policy presence, both under the governor's leadership, as well as under the legislature, but then they have an expectation that we combine effective purchasing with health promotion and public health strategies. That really is taking us out of the realm of what is typically thought of as health care policy and health care reform, which I think many of you in the public health community are more than familiar with. We talk about improving our overall health system, but we are often focused on health care.

So you'll see referenced on slide 51 that the conversation we had around goals in Kansas were to expand the perspective beyond health care to have a bigger picture focus, and shift from health care to health, and that, we have been quite successful at doing. It is both the legislature and key members of the legislature who continually remind people that that is the impetus for creating the health policy authority. But I think also under the governor's leadership and willingness to be supportive of the agency despite its origins as an independent authority. We have really been able to shift the conversation from health care to health. We did focus specifically on some public health initiatives, and you'll see those listed. We have been able to bring the state of Kansas up to national standards on newborn screening, that has been a significant success that we have had. We continue to focus on tobacco cessation, and obesity is a struggle for Kansas. And quality of care, these were not all the original things that team Kansas discussed. Much of what we have been doing over the last couple of years is focused on data and public reporting, and

that's something we have been able to do sort of outside of the legislative realm where too often a lack of financing has thwarted the efforts in terms of expanding access to health care. We have focused on expanding access to care, and have not been as successful as we would have liked. We looked at the, team Kansas looked at the healthy start home visitor program. That remains a program that is fairly small in nature, but you'll see this integration of mental health, dental health, preventive services through medical home initiative. That was something we were able to pass into law last year. We continue to look at ways to expand telemedicine, and we have been able to have two pretty successful pilot project, one aimed at chronic disease management, the other at utilizing health information technology and exchange. Unfortunately, both of those programs are at risk now that we find ourselves in such a financial dire straits. I will say one bit of success we can share, we were able to expand eligibility up to 250%, and the legislature does fund that, and also expand the funding for safety net clinics. I am going to refer you back to Representative Peggy Welch.

>> Thank you, Marcie. I'll focus on the results and successes we came away with. Indiana wanted to prioritize to maximize the health of the population. Things we needed to do, gathering data, convene stakeholders, look at what was the best practices across the country and always depending on NCSL with help on that. And needed to be a development of a better relationship with CMS, federally, and our Medicaid office. Our second major goal, we needed to start preparing our Indiana residents to go into long-term care, and as we all know, as the population ages, it's going to cost the state a whole lot more to be able to provide services. So if we can encourage them to prepare and take care of the sales, having some own personal responsibility that would be helpful. So, we were going to look at possible legislation to do that. So we could incentive the long-term care insurance. And look at a report card on long-term care in the state of Indiana. We

have been working over the years to make sure we were moving the people from institutional care to home care. And make sure we had a good understanding of the deficit reduction act and the requirements in that, especially regarding artificial impoverishment, so people of means become artificially impoverished to be eligible for Medicaid. And how do we increase -- several strategies, and we'll talk about successes and how we moved forward. An action step, Department of Health not for profit organization, with establishment of a think tank that would focus on changing health behaviors. We also really thought it was important to focus on public health, but make sure that the state program and then the local program, the state program in Indiana does not control the local health departments, but there is better coordination between the state and the locals in the message that they were giving to legislators, to the public, about issues and also how to improve health. There needed to be a greater outreach to nontraditional public health partners, such as the restaurant industry, the state chamber of commerce. Also needed to look at the amount of money given to the state for public health and then to the locals, and to figure out what we could do to help with that. So, those are just some of the goal, three goals we had and some of the action steps, and so I would like now to turn to New Hampshire.

>> Thank you. New Hampshire also had three goals, and we took a slightly different tack. One of the things we were talking about a lot was the early childhood information we were hearing over the course of the few days, and it was a great opportunity for some folks who hadn't really been exposed to some of that content to hear the messages about prevention and prevention as it's focused particularly on early childhood. So that was one of our goals was to assure optimal early childhood developmental services, and we discussed a variety of strategies, including reestablishing a cross agency kids cabinet which we had had previously, but which had been disbanded, to really bring together the heads of all the

state agencies to look at the issue, fully funding our home visiting program, which provides home visits for pregnant women and their children up to age 1, with nearly a statewide coverage. And then a variety of prenatal projects, including things to look at birth spacing and other activities that would help assure better outcomes for infants. Our second strategy, or second goal was to raise greater awareness about the cost savings of investing in high quality of public health services, and I think this is where some of our most interesting and rich conversations took place, because this was actually the first time that the legislators who attended were able to really understand the message of prevention. And so it took getting past some of our usual, our usual sayings and our usual arguments for people to really understand how that feeds into the cost savings and Dick Lamm's presentation was just instrumental in getting us to that point, I think. So we talked about also bringing similar speakers to New Hampshire to try to get that key point across, and about convene a legislative task force and working on a family planning waiver. And then our final goal was increasing communication within and between stakeholders to include the executive and legislative branches and their stakeholders, and we talked about, you know, what a great opportunity this meeting had been for us, and how moving forward with a collaborative team at home would be very helpful for all the branches in government, talked about doing, you know, maybe even going down to some planning process between the executive and legislative branches, to look at priorities for a five-year legislative policy direction, and then establishing a preventive health kind of caucus as well. So, those were the goals and strategies that we ended up with in New Hampshire.

>> Great, thank you all. Okay. Let's move to slide 57. The next question has to do with follow-up activities and successes. Sometimes where

-- we know it's easier we are going to say something, but when we get back we get busy. How that went. Let's start with Dr. Nielsen in Kansas.

>> Well, we certainly have been busy, thank you, Martha. And I wish I had more slides to report in terms of our successes. But we felt like we needed to do a number of things as we trade to hit the ground running. One was to reorganize some of our programs, and that is specific to the programs that we manage, Medicaid, the state children's health insurance program, the state employee health plan, worker's compensation for state employees. There was an expectation that we managed those programs better in a more transparent fashion, etc. But at the same time, we had been given the responsibility of setting the state's health policy agenda, and of course the governor having a great interest in health policy, and she along with the insurance commissioner had been pushing expansion of health care, specifically health insurance for poor children, we wanted to piggy back on those efforts and have a comprehensive health care plan, look at access, public health, and the transformation of the health care system. We came up with a 21-point plan to do that. We have gone around the state, had 60 different meetings, actually two summers in a row, talking with others in Kansas to see what their priorities were. We focused on the issue of personal responsibility, promoting and paying for public health, as well as affordable public health insurance. In terms of our limited success, we were able to advance all of those items on the 21-point list that didn't cost anything, and is so often the case it is in fact the financing that stands in the way of promoting more comprehensive reform. I noted earlier we were able to expand the SCHIP program, and Medicaid for pregnant women up to 200% of poverty. Able to make expansions for dental care of pregnant women, and a medical home and statute. Working with a broad set of stakeholders, include health plans, private businesses, certainly the state, and providers, consumers, to figure out in Kansas how might we leverage the new federal stimulus dollars to promote a medical home in Kansas looking at those standards around health information technology. We have also been able to make a number of Medicaid

improvements. Many administrative in nature than necessarily legislative. We have been able to pull down a significant amount of federal dollars that Kansas was formerly leaving on the table without spending state general funds. Hospital programs and better targeted those dollars. Able to expand our graduate medical education program, and pay those providers who train medical students, pay them better. And we have also been able to implement what is a very large transformation process. If you are bored at night and would like to read the 357-page Medicaid review, we have a very thorough data-driven process in place to review Medicaid. One program at a time. We started with 14 different programs. And looked in great detail at what was working and not working and made recommendations to the legislature. Just this year we will be able to save $17 million on general funds based on the recommendations that came out of that process.

Slide 59, we have been able to again internally, the health plan. It's an administrative process and we have been able to significantly change the health and wellness prevention benefits that we offer. We have changed the focus from health care, acute health care after folks are sick, to a focus on primary care and prevention. We have partnered with a national vendor to offer health coaching, health risk assessments, biometric screenings, incentives for participation and we changed our health insurance premiums so if you were a nonsmoker you would see a discount in your health insurance premiums, or if you were trying to quit smoking. And then I mentioned earlier this issue of data and transparency. You'll see in addition to the 357-page Medicaid document we were asked to complete 20 studies for the legislature, focused on various items that pertained to health policy. We have started a weekly E newsletter available on our website. We have a new website redesign that's hopefully more user-friendly. I had mentioned all the work we do with our stakeholders, it isn't just visiting them. We have about 150 individuals who come and sit on advisory councils as we try and craft the health reform policies amenable to the

legislature. And finally taking the existing data structures around the programs I mentioned earlier. We have inpatient hospital data. We have data, essentially all of the health insurance from the state outside of our ERISA plans. We can merge it into an interface. It's key for us as we move forward with health reform, having that at our fingertips to drive health policy. With that, I'll turn back over to Representative Peggy Welch.

>> Thanks. One of the things I did not mention, not only learning from your own team but learning from other teams and what other states are doing and I have already picked up good ideas. A lot of things we are doing in Indiana. But I have learned some new things we might be able to try to implement here. As far as the three goals that we had, prioritizing our health services, and I really appreciate what she was saying earlier from moving from the mindset of health care to health. That's what we are doing in Indiana. We only, we met in June of 2008, so we have not had as much time to be as successful as the other states, but we have done a few positive things. We do have two pieces of legislation moving forward that would require a statewide smoking ban. And also would mandate menu information. Both things that we know would improve health and reduce chronic health problems. Regarding the long-term care goal that we had, we also have legislation moving forward. We had had meetings throughout the summer and the fall, attempting to come up with some type of strategy for making incentives for folks to purchase long-term health care. We have probably one of the better programs in the city of Indiana and only a small fraction of the population that should be buying it has bought it. And didn't get much out of that particular meeting but came up with an idea that would establish a long-term health, a long-term care savings plan like a health care savings plan. We'll see if it continues to move forward as it's in the Senate. We did have a committee meeting of the health finance commission which is all the members of the house and Senate health committees coming together each interim and did discussed the deficit reduction act and

the artificial impoverishment problem. We kind of had them back off of that. But it was a good discussion to help us understand what we need to be doing to improve long-term care in the state of Indiana. I feel like we have made most of our, have most of our success in the areas of infrastructure, and I have to give credit to our health commissioner, Dr. Judy Monroe, and her commissioner, Mary, the participant for team Indiana. There is an executive order moving forward to establish a public health not for profit. They are trying to decide how to best do that. A commitment from our governor to do that. And we believe coming out of that will be a think tank that will be very helpful, especially looking at behaviors. I think it's been one of the things we talked a lot about was the importance of communtation between the state health department and the local health departments. So Dr. Monroe established an advisory commission that has the local health officers involved with that. And she has regular phone meetings with them, but also had a retreat back in August, and they talked about a lot of different things but really provided for them education and tool kits regarding marketing strategies for public health messaging. They talked about how to advocate for the priorities, and also the health system improvement project. And ethical issues and public health preparedness. We feel we have really helped push forward the communication, which is only going to benefit everyone for that. We are working under the budget, don't think we'll be able to do much to enhance the budgets for the local health departments and the state but if we can just keep them whole, we'll be doing something really extraordinary there. Really proud of Dr. Monroe. She went to Kentucky and met with the Kentucky legislature and talked to them about the cigarette state tax. It was only 30 cents per pack and explained to them how their low tax was affecting Indiana residents, because those on the border were traveling to Kentucky to get cheaper cigarettes. They doubled it from 30 cents a back to -- a pack to 60 cents a pack. Our health commissioner went and visited with another state and helped them see how

they were impacting the health of not only their own citizens but those in Indiana. There is still a long way to go and so I'm looking forward to hear from Iowa. Back to you, Lisa.

>> Thank you, Tom Newton here.

>> Tom, I'm sorry.

>> That's all right.

>> We have had quite a lot of work around health care reform, actually, since the meeting in New Orleans in 2007. During the same period of time, actually during our 2007 legislative session that runs to January through may typically, we had language passed that established an affordable health care commission. It set up that this commission would meet on a monthly basis throughout the rest of the year, so June through December we had a broad group of stakeholders and legislation really spelled out all the stakeholders that they wanted at the table to come together and sit down and really this was our process for setting priorities, areas in which resources could be dedicated that would have an impact on not only the health insurance side of things, but also on the overall health of the population. This process, affordable health care commission and the report that was generated as a result of it, really culminated in a piece of legislation that was adopted last year, the health care reform act of 2008. This was a comprehensive piece of legislation that addressed access, cost, quality, health care, garnered stakeholder and bipartisan support. I believe it had very significant bipartisan support, I believe in the Senate. 50 senators in the state of Iowa, and I would be hard pressed to probably name five people who voted against it. So this was very much a comprehensive piece of legislation that was supported on both sides of the aisle. Some successes that we have

experienced as a part of our health care reform act of 2008, it expanded the hawk eye program to children at less than 300% of the federal poverty level. Endorsed a commission that was to explore expanding low income adult coverage. Established advisory councils for health information technology, medical homes, chronic care management, patient autonomy and health work force, all of whom have been meeting on a regular basis and in their own right are developing reports with policy recommendations that can be taken before the legislature. One area that I was particularly interested in as a public health professional, established a division on prevention and wellness. Created a healthy communities grant program by which communities could apply for resources to change their environment to encourage access to fresh fruits and vegetables in the community. We have one community that built a walking path all the way around, a small community of 5 or 600, but they got connected with the concrete manufacturer uptown, as well as other construction folks and they built a walking path all the way around the community, and we have got pictures of little grandmas that are riding in their wheelchair around this at the time that families are walking on the path. It's been a huge boom to some of the communities to increase physical activity. There was a governor's council on physical activity and nutrition established really to move the ball forward with elementary and high school children, and create a competition for those individuals and schools that want to participate. It outlined an expectation to set forward a small business tax credit for qualified wellness programs, so if you have a qualified wellness program, you would receive a tax credit. One of our biggest accomplishments, now I'm on slide 64, a smoke free air act passed last year that banned smoking in nearly all public places. We also had a healthy kids act that set guidelines for nutrition and physical activity and school settings passed last year. And then for this legislative session, we have got health care reform round two going on right now with a proposal that is out there, Senate file 48 here in Iowa that would expand coverage to all kids, and also examines mandating coverage and

expanding that coverage to legal, as well as undocumented aliens within, within Iowa. So really, all kids means all kids. So we have some very exciting things going on. And I will now pass it off to New Hampshire.

>> Thank you, Tom. So New Hampshire's main activity was planning and implementing a full day conference for key legislators within some selected committees of our legislature. And our team felt that we could really hit several of our goals and activities that I had described earlier through this kind of action. It was a lot of work. And there are two administrative support folks here in this division that it wouldn't have happened without, and they did really the brunt of the work as we went forward. So it was a full day conference, as I said, for key legislators. They came from the committees for health and human services, finance and commerce. We had 120 attendees, 75 of those were legislators, and if you recall, as I said before, we have a very large legislative body in New Hampshire, so that was only about 20% of the legislative body, but that was a lot of legislators to go to any conference. Probably 40 times what I had ever seen before. So it was a great success, and what we did was replicate key aspects of the meeting in New Orleans, and focused on some additional items specific to New Hampshire health policy. So we structured the day with a keynote in the morning, and that was Dr. Elliot Fisher from the Dartmouth Atlas project who spoke on health care costs, and breakouts topic specifics, ranged from early childhood to containing health care costs and integrating mental health with primary care. We then had lunch. We had a doctor from Boston University speak on the importance of interconception care and prenatal period and a life course perspective, and then afternoon breakouts where we had folks get together within their own kind of committees and answer questions that we had preselected. So, we asked them, for example, given the information you heard here today, what do you think are the health priorities for New Hampshire, what are you hearing from your constituents

about what they think are health priorities, how does that fit in with current initiatives that we know are going on, and then how can public health help to foster policy and legislative action. And so we really did get quite a lot of information back from the small group sessions in the afternoon. There was a great concern on the part of legislators about health care versus public health, and how to pay for both things and meet the needs of all people. There was a great amount of talk about the need for health leadership to guide legislative branch in all of the areas that we had talked about, and then also for an overarching plan for the health system. And those listed on slide 66. And so since that time I think we have had more attention to feeding information to the legislative committees as needed related to a whole bunch of health related bills that have come in New Hampshire last session, as well as this session. And we have also are planning to kind of have a touch base day for legislators again this spring that we are planning in concert with the citizens health initiative in New Hampshire. So that was quite a bit of progress, I thought, given New Hampshire's large legislative body. An -- great, thank you all so much. It's gratifying to see the wonderful things you have done and the enthusiasm you bring. I want to combine the last two questions and have you answer very concisely. Ask you to limit your comments to about 30 seconds, if you can. And answer the two. Did your team have any challenges or barriers that you were able to overcome? And what advice would you give to others who may have the opportunity to participate in such a meeting with their own state colleagues? Lisa, start with you in New Hampshire.

>> Okay. Well, I can tell you the first thing was finding time for the group to meet, and for everybody to be able to try to make it a priority and that's always hard when you get back to the real world. So the work following that, and I think my advice to others would be do it. This was a fabulous opportunity, but definitely prepare beforehand, bring specific information to frame the conversation and define very concretely how you will continue

activities when you are back home. And then most of all, be realistic about who can really carry this forward because sometimes it's not going to be the director of public health, and ill not -- and it's not going to be the Medicaid director or the governor's office. Sometimes it's going to be my support staff in my office. And so next I think we'll hear from Tom Newton in Iowa.

>> Sure. I would say one of the key challenges that we had as a state that we also had this other process going at the same time, affordable health care commission meeting on a regular basis. I think once we got back to Iowa, many people thought that that process would take the place of what we had set up in New Orleans and while it did provide an opportunity for us to get together and talk about health, and health reform, there were two key legislators who were driving that process that didn't necessarily participate in our trip to New Orleans, and somehow I think along the way some of our material got lost, and some of these other competing agendas got included in what was accomplished overall in Iowa. So, you need to make sure, and this is my recommendation to anyone who participates in this, make sure you have all the players at the table when you go to, when you go to take this trip and make sure that they have buy-in from them as to what you are trying to set for your agenda as well as your goals and objectives. If you don't, you are going to have a mixed match of what gets accomplished and that's kind of what we have seen. Now we will go on to Representative Welch.

>> Thank you so much, Tom. Just repeating very quickly some of the things that were problems, we have legislators who don't have the same vision of health and health care, that can get in the way when you are trying to accomplish your goal. And obviously budget constraints, every state is facing right now. We have already heard about business and distraction once you get back from your team meeting and try to get back together when

you get home. As far as advice with others, I agree with Tom, you have to have all the stakeholders involved as possible and if they are holding back, then pursue those people who are holding back and encourage them to be at the meeting and to go away. To recognize the significance of such a meeting yourself, and then really prepare for that, I think we heard that from Lisa. And then set ground rules within your team meetings about how do you trust each other, and what is said there, stays there, as you are really exploring possibilities. And really just dream big, but you've got to be realistic and not set too many goals, but set some realistic ones. And now, to Marcie.

>> Thank you Representative Welch. For us it was a terrific opportunity because we were so, we were so newly created. I wish I could tell you that the team, the same team that attended this meeting continues to meet. It's not the same team. The same has shifted some over time. But I have, I think, a realistic perspective on what that meeting could provide for us and it met my expectations. So if there was a challenge for other team members, it might be that they needed a little something different out of the meeting, for folks who created the, for folks who created the health policy authority I think it was appropriate to almost indoctrinate us. That may have been a challenge for others, in the insurance department, friends with the Department of Health and environment. So in terms of the advice I would offer, everyone needs to think before they head to the meeting what they intend to get out of the meeting. Because it's not going to be the same for all of the players. And I think being realistic, for us we needed to get folks, we needed to understand other departments' priorities, needed to understand what the he can peck -- expectations were for others of us, and our goals were met. But I do think the group interacting provided a benefit for everybody. I can't speak to whether everyone found it as beneficial as folks who worked at the authority found it to be. And I am all done.

>> Thank you all so much. The last two slides show a recap of the broader context and the pep talk from Maternal and Child Health needing a seat at the health table. Folks need to hear from you and discussions about health reform. The last slide is contact information for the partners from the various organizations. And with that, let me turn it back over to Dr. Yowell.

>> Thanks, Martha. You know, even though I was at these meetings, I'm always amazed at what states can achieve out of a 2 1/2 day meeting and I want to acknowledge the state speakers for their commitment and hard work in the state and Martha and her whole team for their outstanding work. Before we conclude, I have three quick reminders. We did have a couple of questions and we are out of time, so we will be responding to you by email very soon. Second, don't forget, please fill out your short evaluation online at the end of the webcast. And finally, the webcast is going to be archived in a week, and will be available at www.mchcom.com. Thanks again to our presenters and we really want to thank all of you who are listening for tuning in to our broadcast this afternoon and for your concern for the health of women, children and families. Have a great afternoon. Thanks.