

HRSA/MCHB 2007 FEDERAL/STATE PARTNERSHIP MEETING

Building Blocks for Promising Practice Models

October 14 - 17, 2007

MCHB Divisions and Offices

DAVID E. HEPPEL: Good afternoon. How many of you are really new? Can you raise your hands? I'm sorry, I wasn't here earlier. Okay. Okay. Good. Thanks. So am I. I actually became a federal civil servant on the 2nd of September of this year, so I can appreciate your situation. Of course I've been here in another capacity for a while, but that's the way it goes. Normally, when you think about things, you put your best speaker at the end. You want to try to keep people awake. I have to tell you the truth. Today, there was a walk for ALS, for amyotrophic lateral sclerosis, which I attended in Baltimore. Normally, they put me in the middle. And if you think about when you were writing papers in school, you put good things in the front and good things in the rear, and you'd sort of stick the stuff that you hope the professor wouldn't read in the middle. So, sorry, next year I'll be in the right position.

My division, the 16 of us there, the reason that there are numbers--the telephone numbers or the numbers on the desk of the individuals, and the reason that the numbers are there is this; if you notice, these are the activities that are--that this division does, and the numbers are the people who do those activities. So, you can take this information home. If you can see it, it used to be--I could do that

without glasses, now, it's even harder with glasses. But you can take this home, and if you need to talk to somebody about any of these topics, go back to the previous slide, that will tell you who the human being is, and it will also give you their telephone number.

Dr. van Dyck talked about the MCH budget. We do have a lot of responsibilities; we don't have a lot of money. That means that we have to make decisions about where resources go just the way you have to make decisions about where resources go. And probably, you would like to do a lot more than you're able to do. That certainly was true with us.

What I'd like to do for the next couple of minutes is tell you some of the areas where my group is focused, and if you have similar interest, perhaps, you can follow up with them. In the area of adolescent health, there's--the program has a broad comprehensive view of young people's health. It frames its efforts to improve adolescent health status and health programs using the principles of positive youth development. It considers the transition from middle childhood into formal adolescence as well as the transition from adolescence into young adulthood. It depends on the multiple partnerships in approximately 30 bureau-sponsored and CDC-supported grantees that have formed with each other and the National Network of State Adolescent Health Coordinators as part of the national initiative to improve adolescent health. It support state MCH programs in

their efforts to advance the health and safety of their adolescent populations, and I'll have more on that in just a sec.

Our adolescent health program has long supported the ability of school-based health centers to provide quality services to students in elementary and secondary school settings. Historically, state MCH programs were early supporters and champions of school-based health care. Today, 20 states helped to fund school-based health centers, and seven of these 20 states used funds from their MCH program to contribute financial support. We have a center on school-based health care which provides technical assistance, training, and resources to individual school-based health centers as well as the state school health associations. Our adolescent health program also supports the mental health of young people in two ways. It has a special focus on mental health in schools and has had that for more than 12 years. Currently, we support two programs and a policy in (inaudible) center that moved the field forward from a pioneering effort to a general recognition of the importance of mental health to learning and how school systems can bring about change to support the mental health and well-being of their students.

A newer program, State Agency Partnerships for Promoting Child and Adolescent Mental Health, currently supports four state MCH programs that collaborate with their colleagues in the state children's mental health and health financing programs. They're also encouraged to add additional state agencies as

needed to work on more effective coordination of state agency activities relevant to young people's mental health, including promotion, prevention, and service efforts. An additional four states are graduates of this funding program.

Our adolescent program has developed a variety of strategies to support state MCH staff in their efforts around adolescent health. First, it relies on a trio of grantees that work closely together to provide resources and technical assistance to states on both the collective and individual bases. The grantees include the National Adolescent Health Information Center, well-known for its fact sheets and other publications; the State Adolescent Health Resource Center, popularly referred to as the Konopka Institute, which works directly with individual states adolescent health coordinators as well as with them collectively through their organization; and AMCHP, which has recently assessed the needs and wants of state MCH and Children with Special Health Care Needs directors regarding adolescent health and is working toward increasing resilience of adolescent health among its membership, as well as providing them with new knowledge and skills for strengthening state adolescent health programs. The grantees have worked closely on two complimentary approaches, the state system capacity assessment tool, which is being streamlined for ease of use and a guide for a strategic planning.

In particular, the Konopka Institute staff have worked with interested individual states on an intensive basis to help them build effective adolescent health

programs. In addition, our Adolescent Health Program supports regional conference calls for State Adolescent Health Coordinators which promotes a vigorous sharing of ideas and experiences across states. At this time, regions 1, 5, 7, and 8 are holding calls on a regular basis, and we can assist states in other regions that are interested in starting this activity.

The electronic contact information for each grantee as well as our federal staff is listed on this slide. Each person would welcome your questions, suggestions, and ideas. Sharon Adamo and Trina Anglin will be at the meeting starting tomorrow and we'll be happy to talk with you. (Inaudible) infant and child health, there are three areas of emphasis. SIDS has been an area of concern for MCH for decades now. Things are changing and that program is in transition at the moment. Health and Safety and Child Care is something that MCH and the Child Care Bureau with the Administration for Children and Families started in the early '90s and has evolved into the ladder program here in the state MCH Early Childhood Comprehensive Systems grants. The purpose of the Early Childhood Comprehensive Systems Grant Program is to build collaborations and partnerships that support families and communities in developing healthy children who are ready to learn. This school embraces the central role of families and communities in the development of children that are healthy and ready to learn and also recognizes that sometimes the services and systems needed may not always be accessible and acceptable.

The ECCS program has five component areas. Why these five areas? Our decision was based on data derived from a number of sources including the Institute of Medicine's report "From Neurons to Neighborhoods" and the National Association for the Education of Young Children's School readiness definition. ECCS program components are consistent with the bureau focus on systems building. Previous bureau work specifically around issues of access to medical homes and a number of other initiatives that could and were enhanced by the results of ECCS. Both the Healthy Child Care America initiative and the Child Care Health consultants' training have been supported by the ECCS program. These components are good fit with other national early childhood efforts including the administration's "Good Start, Grow Smart" initiative and various efforts of the Children's Bureau.

All ECCS grantees have had to develop statewide Early Childhood Comprehensive Systems' plans that address each of the five components that I just mentioned. Each final plan had to go--undergo a review process centered around the achievement of these implementation readiness criteria. Currently, ECCS grants include 47 states, the District of Columbia, Puerto Rico, the Republic of Palau, Guam, and the Marianas Islands. In the area of Injury and Violence Prevention, these are four components of the program.

The National Center for Child Death Review policy and practice. A child death review is a process to discover why children and adolescents die. CDR teams

are comprised of professionals from variety of disciplines with one common goal: preventing child deaths. Child Death Review has developed partnerships with local, state, and national groups in order to raise public awareness and to prevent child and adolescent death. The national center works with state and local teams to build capacity for high-quality Child Death Review processes to improve reporting on findings, data analysis, and the translation of CDR findings into action and prevention. The center supports--provides support for a multi-state standardized case reporting system. Presently, 20 states are using this case reporting system to analyze their data and then we are able to take the data from these 20 states and aggregate them, so we have more powerful information for you, and this is available for any MCH program.

The Children Safety Network serves as a national resource for Maternal and Child Health Injury and Violence Prevention professionals. Services provided by CSN is a state and territorial health departments in developing and implementing effective injury and violence prevention activities. The Children's Safety Network as a state and local MCH agency is to strengthen their abilities to address national performance measure that are motor vehicle-related and suicide prevention-related, and to strengthen their activities to address state performance measures related to injury and violence. The CSN can help improve and enhance a state's Injury and Violence Prevention Program. It also is providing data to the Child Death Review Resource Center, so that when Child Death Review teams provide information into the center, the center can, in

return, provide information about effective injury prevention activities to address specifically the concerns that are identified in CDR.

HRSA's Stop Bullying Now! Campaign is the largest national public campaign created to raise awareness, maximize partnerships, and address bullying prevention, provide information and prevention strategies for schools and communities. The Stop Bullying Now! Campaign is designed to reach youth, nine to 13 and adults, and provide educational and programming resources. The campaign's interactive website is the hub of its activities and is updated by monthly to encourage youth and assist adults in community organizations to be actively involved in bullying prevention. Campaign has over 80 active partnerships with agencies and organizations working together.

In the area of oral health, the MCH program has something called the Targeted MCH Oral Health Service Systems Grants. These grants are to support the state's capacity to expand preventive and restorative oral health service programs for Medicaid and SCHIP eligible children and other underserved children and their families.

There are three specific strategies that are to be addressed by these grant areas: One is to increase the number of children receiving age one dental visits, the second is to expand services to children with special healthcare needs, and to—third is to increase the number of children completing restored treatment needs

identified through sealant programs. These activities may be accomplished through state oral health collaboratives that are designed to be statewide and to move the state's oral health program toward program sustainability. There are 20 grant awards that were awarded during this year; subject to availability of funds, a determination that continued funding is in the best interest of the government, continued funding is anticipated for another three years.

On your slide, you have three websites, which provide resource support to these grantees and to all states, and you are encouraged to use them at your pleasure. Dr. van Dyck mentioned the Emergency Medical Service for Children Program. This is a program that links with MCH but was started, originally, separately. There are state partnership grants, and the reason for these grants, primarily, is to make sure that there is someone in the state EMS office who really thinks that kids are important. Every state and most of all the territories have these grants and have had these grants for a number of years. The other resources that we used in the EMSC program target funding to specific issues of concern, providing—they also provide technical assistance in data collection for the overall EMS program, and finally, they provide a platform whereby pediatric emergency research can be done. The good thing about pediatric emergencies is that they are relatively rare, even though there are 30 million visits yearly by children to emergency rooms through significant emergencies are relatively rare, and that's the good news. The bad news is if you're trying to provide better services and provide better interventions, it's hard to know what to do because the numbers

aren't so big, so the applied research network includes 21 hospital emergency rooms, whose—which see in total somewhere close to 900,000 kids every year. Why is this important? Well, last year, last winter, if you had a child come to the emergency room who had a diagnosis of bronchiolitis, and that's the most common of the respiratory complaint of infants, the chances are that child would've received a steroid treatment for that. It turns out it doesn't work. Steroids, probably, don't do too much harm, but it caused about \$7 million a year to give those steroid treatments. This winter, when bronchiolitis comes out, because of the research that was done through this network, we won't be giving those treatments anymore. There are other activities that we are looking at such as treatment for status epilepticus and use of sedatives and anesthesia in the emergency room.

And finally, we've talked about partnerships. Most of the partnerships that we set up are partnerships that happened because of a particular focus. This alliance for information in maternal and child health was set up intentionally by the bureau to try to make sure that we are talking with decision makers and policy makers who influence both us at the federal level and you all at the state and community level. There've been some interesting products out of this partnership. Some of you maybe aware that there are state meetings between your legislative leadership and your executive leadership around health, these are sponsored by the National Governors Association, the National Conference of State Legislatures, the Association of State and Territorial Health Officers, and the

Association of MCH Programs. What we found over the years is this has allowed state MCH program directors to actually talk to legislative leadership, sometimes the bureaucracy above you isn't really happy about that, but it's made a difference in terms of being able to communicate. It's also made a difference in being able to communicate between the legislative and executive branches since they're now off on neutral territory.

Another activity--we have a relationship with the National Business Group on Health. The National Business Group represents Fortune 100 companies. Why is that interesting? Well, back in the '80s when there was healthcare reform, we hear now that it had to do with what we and the federal government did or what you all in the states did, I think, really, it had to do with what the private sector did. And the private sector that drove the changes that went on in the '80s where the buyers of health care and the buyers of health care are our business. So what--we thought it would be a good idea to be talking with these guys since they seem to influence what happens to us. What's happening now is that the National Business Group is about to announce a special benefits package for women and children. This benefits package is going to be pilot-tested by two companies: AOL and Marriott. If this benefits package works--and this is something that's been developed with the Academy of Pediatrics and the Academy of Family Practice. If this benefits package works, it will be passed on to the other large companies, the orisic companies. And we're hoping that this will provide some momentum to have good coverage for mothers and children.

These are the kind of partnerships that we do. It's because we don't have a lot of money, we have to involve other folks and Dr. van Dyck has, in his leadership, has allowed us to move into these areas. We hope it works. Thanks very much. I think you're almost done, and I'll turn it back to Jon.