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**Technical Assistance Meeting**

**MCH Needs Assessment:**

**Concepts to Catalyst – Capacity to Competency**

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**Life Course Perspective**

MICHAEL KOGAN: Well, good afternoon everybody. Hello, again. I'd like to introduce today's luncheon speaker, Milt Kotelchuck. Milt Kotelchuck, is a name that sends an involuntary spasm through the intestines of any serious MCH researcher. Milt Kotelchuck, is a name well known to any ethics officer or parole officer on the East Coast. Milt Kotelchuck is a -- I am so sorry. Hold on one second, please. I am so sorry. That was the first draft.

I am honored today, to introduce my long time friend and colleague, Milt Kotelchuck. He has been a guiding light in maternal and child health for over 30 years. When people look to who's really a beacon, who's really leading the way. One of the people you automatically think about is, Milt Kotelchuck. He's currently a professor and chair emeritus at the Department of Maternal and Child Health at Boston University. He received his PhD and his Mph in Maternal and Child Health and Epidemiology from Harvard.

He has extensive experience evaluating Public Health Programs to improve birth outcomes and child health data. One of his early studies was on birth outcomes at WIC. It was a transformational study and influenced the practice and program of WIC for many years to come. His research interest include examination of the adequacy and content of pre-natal and internatal care, racial disparities of birth outcomes. Again, one of his early studies was on socioeconomic differences in childhood mortality in Boston, published in the New England Journal of Medicine. Again, a study that changed our perceptions in how we looked at the world. He developed a widely used Adequacy of Pre-Natal Care Utilization Index. His current research interest focus on MCH life course models, and the creation and utilization of the Massachusetts Pregnancy to Early Life Longitudinal Data System.

Dr. Kotelchuck has written extensively on these issues. He serves on numerous national committees to improve peri-natal and child health systems. Previously, he served as the Assistant Commissioner of Community Health Services at the Massachusetts Department of Public Health. He was also chair of the Maternal Child Health Department at the University of North Carolina, Chapel Hill. He's been a member of the Massachusetts and North Carolina Governors Commissions under reduction of infant mortality, and served as senior adviser in child health policy for HRSA. Currently, he serves as chair of the Technical Expert Panel on the evaluation of Healthy Start. He is also a senior and founding editor of the Maternal Child Health Journal.

In December, 2000, Dr. Kotelchuck was awarded the very first, National Maternal and Child Health Epidemiology Award, for advancing knowledge from the Coalition for excellence in Maternal and Child Health Epidemiology. Today, he's gonna talk about the Life Course. And in honor of that I want to talk a little bit about his life course.

Okay, let me take a couple of minutes to talk about, Milt's life course. Now, the first thing you should know, as you can see that developmentally Milt has had a very rich and long life course. Physically, he hasn't had such a long life course. Now, I actually knew Milt before I met him. In 1980, I was just out -- undergraduate school. I was living in a group house in Boston. A mixed gender group house and we were getting our Master Degrees. And I had, one of my room mates was doing an internship at the Department of Public Health in Massachusetts. And she would come home and she would say, "I met the nicest guy, he's so nice, but I think his interested me, he is asking me out." I said, "So what's the problem?" She said, "Well, I think he's much, I think he's a lot older than me." So, as you can see. She said, "I think he's around 40." I said, "Well, yeah, he might be a little old." So anyway, I don't think she went out with him. And then our paths drifted apart a little bit. And then, Milt continued to work on what are the important issues in Maternal and Child Health.

Milt, and one thing most people didn't know is that he saw the problems in how we measure prenatal care utilization. It is the fifth most utilized health service in our country. And we knew very little about it. And is probably miss measured too. Well, Milt actually took on that task and developed his own utilization of pre-natal care, his own pre-natal care index. Now, what most people don't realize is when he developed this index, it went nowhere. Nobody picked it up. Nobody paid any attention to it. And why was that? Well, a couple of reasons, he was pretty despondent so he went to a Life Coach. And the life coach, told him he had to make a couple of changes. His Index was first called, the utilization of inadequate, pretty much adequate, adequate, really adequate, and way too adequate prenatal care utilization. And they said, "You've got to shorten that, boy."

Now, the second thing you probably didn't know is, Milt, is not his real name. His real name is Bob Smith. And the life coach said, "You know what Bob." He said, "We got to change your name to something people will remember. Something that people will subliminally that will rhyme with things that you associate with conception, and pregnancy. Things like, good luck or diaper delivery truck. Or if the relationship isn't going well, why did I get together with that stupid schmuck?" And, well, you get the point, right? Okay.

Well, once he did this, here's a picture of Bob in 1986. And then when he became who he is today in 1987. So, in 1987, he changed his name. He

changed the title of the index and he presented it at the American Public Health Association. I happened to be presenting, this is a true story, I happened presenting at the session. It was the room was this crowded. There were people hanging from the chandeliers. There were people all over the place. They wanted to hear about this. I presented, people yawned. Milt presented, and when he got done presenting. Women were taking off pieces of clothing, men were screaming and fainting. This was my first professional meeting and I thought this was normal behavior at a conference.

So, he published that and as you know, it changed how we measure prenatal care in this country. It had a profound impact. But he wasn't done. One of the things I most admire about Milt is how he continues to think about ways that he can serve maternal child health. He founded the Maternal and Child Health Journal, in the mid '90s. There was a niche there. There were papers for clinical practice. There were papers that dealt with health services and maternal and child health, but they were part of larger journals like the American Journal of Public Health.

Now, it was a brilliant idea. Now, there were a couple of problems with it. Number one was, people would submit articles to the journal and they would wait, and they would wait, and they would wait for a response. And after about eight months, their 10 page paper came back with 15 pages of comments from Milt.

Now, after a while, when you're getting out one or two issues a year, somebody realized this is not the best business model. But, there's a bright side.

On the other hand, The New England Journal of Public Medicine published all of Milt's comments in a book in 1999. And in 2000, he was awarded the Pulitzer Prize for the longest editor's comments. Now, his next evolution was MCH and the Life Course. And he's been focusing on that for a while and that's where he is today. And so, it's my pleasure to introduce someone who's been, as I mentioned, a friend, a colleague, and more than that an inspiration to me in many ways, Milt Kotelchuck.

MILTON KOTELCHUCK: I don't really know what to say after that. You know, if you're bald when you're young, all my other friends of age talk about life course. All my other friends of age, I've looked the same for the last 40 years. You know, it's the one nice thing about balding when you're young and-well, I thank you, Michael for those really actually very nice words. And we will still be friends. He made sign a statement saying no matter what he said I would still be his friend. And I was willing to do that. I encourage you all to continue eating and doing other things as I talk. And let me just tell you I want to say to you that I stole all the slides and ideas from various other people.

So, if you don't like what I said, you can blame them. My goal today really is to try to advance the MCH Life Course paradigm in the MCH field. That's really what

I've been working on for the last many, many years now. And I want to try to blend together to here to fore unrelated MCH topics, Needs Assessments and the MCH Life Course. This actually wasn't an easy task. This isn't like a canned speech. I-this is the first time I'm trying this talk out, you know. I hope it will be good but, you know, we'll see. And it will it get better in the future times.

I want to explore how the emerging MCH Life Course paradigm might influence your upcoming needs assessments. And I want to place at this conversation in the Richmond Kotelchuck Health Policy Model. And I hope that I will motivate and energize your workshop, I'm sort of the kick off person. And maybe even reinvigorate our Children's Bureau roots and leadership. So, since I don't know how much time I will have since Michael took a fair amount of time. Let me just tell you what it is I'm gonna say in case I don't get there.

So I, basically, am here to ask you to participate with me and all of ourselves in really the development and implementation of the MCH Life Course and the MCH field. And I think, it should influence our needs assessments in three areas. It should expand the way define population needs both longitudinally, time, and also in breathe the number topics that we think about and should lead to improve MCH EPI capacity in our agencies. I also think it should expand the range of assessments when we look at the different problematic solutions that we offer. And we should be able to look at them in different ways and evaluate programs differently than we have before. And finally, the needs assessment with the Life

Course, a little bit of Life Course spin, I think will help us more effectively work with our community, professional and political colleagues to implement and articulated policy agenda. And provide a model for State MCH leadership to address the really wide range of social influences that-the social factors that influence MCH development to help us we move beyond what we're able to do today.

And finally, just to keep things on the lighter side, I hope we can examine how Slum Dog Millionaire is a good example to think about as an MCH Life Course needs assessment.

So, let me just-so I start all my talks by putting up this model that was develop by Julie Richmond who passed away this year. And I talk about a real true loss for our field. This was a model we developed many years ago that says if you want to make any improvements in Maternal Child Health Outcomes, you really need to examine three sets of factors. You need a knowledge base, some set of information that tells you what the problem is, what the needs are. Some social strategy a program, a practice that get-that takes that needs and is able to transform it in some ways. That's our programs. But we also need political will. We need the ability to command resources to be able to implement the social strategy that's dealing with the needs that underlie what we're trying to do. These three factors are critical, and you can analyze almost any of our problems and thinking about where we are in working. And all three are critical for the work that

we do. And all three turn out to be the central elements of your needs assessment as you will quickly see.

So, let's talk about the Academy Awards, forget the rest of this talk and get-how many people here watch the Academy Awards? Okay. And how many of you saw Slumdog Millionaire? Okay, this is good, because otherwise this speech is gonna bomb. So, I'm an Academy Awards fan. I've been going to-I've in a pool for 30 years, so I take this very seriously. Every year I vote, you know, I did well this year. I got 18 out of the 23 categories. I still lost to my good friend who got 20. But, be that as it may, I like to think about the Academy Awards, because I think it has all those same three elements. I think the Academy Awards has a knowledge base. I think that the Academy Awards is a perfect example of this thing. There's a knowledge base, it has a method to determine what is the most popular ideal image of the movie, it vote, there's a voting. It's got a knowledge base. It has a social strategy. Not only is the movie is, sort of, the strategy, but the whole movie making process: From beginning to end when a movie is first thought about, the people in that room start thinking, how is it gonna play out for the Academy Awards? Could this win? They think from the beginning. They have a Life Course model for their movie. In the same way that I hope we will have a Life Course. And finally, political will, the Academy garners a substantial financial and critical attention to the movie industry. That's really the purpose of the Academy Awards, is to get us all to watch movies. So, all three elements are there. And I advocated several years ago at AMCHP meeting that we should an

award every year in the MCH field for the best MCH movie of the year. Go with the Academy and that would it be a really nice 24th award. Every year someone gets up instead of the Hersch Holmes Award for Humanitarian, why not something from the MCH world? And this year they actually picked a movie that really was an MCH Life Course movie. I was-and it was also a great movie I might add.

So, let's look at this movie, it demonstrated from a Life Course perspective the importance of early experiences in life history. I'm going to go into more detail in a minute. It showed the breadth of social factors that influence life's trajectory. And frankly, it showed ineffective MCH public policy. I'm just getting a little ahead. But think of it from a needs assessment point of view.

It's knowledge base, what did we learn in this movie. Just step aside from the enjoyment of the movie. Well, here was a kid, Malik, who had no parents. There was tremendous amount of cultural insensitivity. I don't know, if you picked up, but he was actually a Muslim and his mother was killed during, you know, riots in the beginning of the movie that were religious based riots. There was exploitation of children. He had limited formal education. He had no health insurance, yet he did also show some resiliency. There was some family and community solidarity and that wasn't all negative there were some positive features. We have to think about how we look at this.

Social strategy, well, what was the social strategy? What was the program? Do MCH program that was put in effect make this kid's life better? Well, frankly, there were none. You know, maybe the strategy was chance. A chance to win big on TV. That's, kind of, external locus of control just for those who are into technical things. You know, maybe the issue of power and love. So, maybe this was a euphemism for marriage. Maybe this was, they really were pushing marriage in this thing. Not that they ever talked about that, but that was where that movie was going.

And political will, but frankly, there was no national MCH policies or programs articulated. There was clearly a lot of demonstrated strong negative social class biases, Slumdog is not exactly a nice name to be talking about this kid. Yet the hero generated a lot of political will. If you watched all those scenes with the populace watching him on TV as he's going into the sort of a last night. He built up a lot of political will, for him, his class in society.

The film itself, however, did a lot for political will. It drew a lot of attention to the issue of poverty in India. It enhanced global solidarity, by suggesting that people are fairly similar in all parts of the world. It was a really good feel good movie, with not much for the MCH systems.

So, let me ask you, how would you measure Jamal Malik's needs and strengths, sort of, cross-sectionally and longitudinally? What would you have measured? If

you measured him when he was young, would you ever guess he would turn out to be the kind of character that he was later on in life? Could we have measured; could we have seen that resiliency earlier and spotted that? Could we think about this? How would you measure this? It's a really challenge. You should think about this later after this talk. How would you look at this kid? And what solutions would you have proposed to this kid who was growing up in poverty without any parents? What would you have done? What are the kind of programs that we actually have to offer that would make a difference in this kid's life? How would you assess his problematic solutions on a population basis? Would you really advocate that everybody be given a chance to win a million dollars? Is that what we would do as MCH folks? Not so sure. And how would you think about this, obtain the political will and resources to implement proposals that would have made for a much healthier childhood, education, health care. You know, this is a challenge for us.

Okay, so, moving on to the MCH Life Course itself for just a second, you know, without boring you with a lot statistics, the health status in the U.S. has generally been stagnant. Disparities exists, our national rankings are a disgrace. Too many children are living-in the U.S. are living lives only slightly less horrific than those than the Slumdog Millionaire. Some new approaches are, sort of, needed. And that's where the MCH Life Course came a little bit out and out of. I've been talking with my friend Michael Lou, Sherry Pies, for the last several years by phone to see what we can do to try take what's an interesting concept and make

it real. Transform it from, you know, an interesting idea to something really concrete. And we thought that what we needed to do was to work on five areas. So to really try to make it more concrete. To work in the area of theory, the area research, practice policy, education and training. And we've gone to a several different meetings over this couple of years. The Preconception Conference in California, the MCH EPI meetings, CityMatCH. Some of you may have heard us talk at some of these meetings. What we've tried to explore each of these five topics. And I was actually honored to have a chance to talk about needs assessment, because now we can finally attract, draw needs assessment into this. So, the MCH Life Course developed, this is not a good definition. So there's a quote from Neal Halfon, "Life Course Development provides a framework to understand how multiple determinants of health interact across the lifespan and across generations to produce health outcomes."

So, really this model, this Life Course model is really a convergence of several different other Life Course models that are happening at the same time. The Reproductive Health Life Course, I'll talk about in a second. Child development models, Chronic Illness Models. The lot of different people who have served moving to thinking over a lifespan, course span. You've all seen Michael Lou, I'm sure everybody has heard Michael Lou he's a great speaker. This is the kind of slide that he uses to, sort of, talk about what brought me into this issue which is, I never could explain where are the disparities were coming from in birth outcome.

That's what motivated me, you know, Michael. When I first started doing work, why was there this gap between blacks and whites in our society? And Michael and others, and myself included, but particularly my oops -- they dropped my slides. Anyway the point of this slide was simply to say if, I have the two slides that seem to be missing. Is that in the prenatal period, if one who is pregnant. You can make a little difference, pre-natal care makes a little difference. But it only makes a little difference. You can't cure a lifetime of ills in nine months of a pregnancy. And maybe some of the explanations for the disparities is that really it's what people bring into the pregnancy, not what happens only during the course of it. I don't want to knock prenatal care but it's really thinking about what you bring to it that got us there.

And Michael, you know, suggest there are things that make this, may push the gap wider. And we can all hope that there are wonderful things that make it better. In a later slide I'm going to criticize this picture which I love, I use it all the time. Because I look at the arrows, I think, oh, this is a bunch of individual programs. We just have a program for each age group. And we miss the whole-the-we should be watching the line. What are we doing, in general, not a series of individual programs? That's a safety net thinking. We want to be more holistic on our thinking.

There's a lot of different things that have led us to being focusing on earlier and earlier periods for adult disease. Many of you seen the Barker hypothesis that

sort of says, “What happens to you in the womb makes a difference in terms of later life.” This is a slide showing that your birth weight size relates to whether you have coronary heart disease as an adult. These are all things that have led to thinking about this. CDC has taken this kind of idea and moved in into thinking about preconception and their interconception care. Moving, it’s starting to expand. Thinking more about women’s health over time. Neurons to Neighborhoods as in the pediatric area. They have a great quote in their book, somewhere that says, “We focus a lot on zero to three, that’s starting too late and ending too early for our focus,” a great line.

The Children’s Health Nations Wealth also worked on different ideas and developed and new concepts and definitions to children’s health. And I particularly like their addition of the development of the capacity allows children to interact successfully with their biological, physical and social environments. Interacting successfully that has, although, they don’t emphasize the time dimension, that’s a really brilliant concept to think about what it means to be healthy. I really like this definition of health. I love the World Health Organization has done this great study looking at growth standards. Many of you may not know this, but I like to get it into a lot of my talks, because I think it’s so interesting. They picked one city in every continent of the world. They picked upper-middle class families. Palo Alto was where they studied in the United States. So, you got the kind of town. They picked people who had every opportunity who’s-the women all breast fed their kids. That was very important.

Breastfeeding, upper middle class, every opportunity in the world. And then they measured, not norms but standards, what would you expect to happen, in terms of growth and in terms of development. Without boring you with all the details, the main findings they found was, there was no difference anywhere in the world. I actually thought they had done it in Mumbai, but actually I looked up and they did it in Delhi, was the city in India. Indians, Scandinavians, Middle-people from the Middle East, they all were the same size, had the same trajectories. Less than four percent of variance was due to ethnicity. They concluded that really the third point that, the longitudinal continuity for human growth and motor development under optimal conditions was the same everywhere. And that any insult or any growth retardation reflected environmental insult. This supported this kind of view of a kind of social justice model. That if things were optimal, everybody would come up doing really well. And it also established breastfeeding as a norm for growth standards which was another nice, nice feature of it.

So, the MCH Life Course posits a new scientific paradigm for the MCH field. It addresses enduring health issues with new perspectives such as disparities. Requires new longitudinal holistic approaches to MCH programs, policies and research. It provides integrative framework for facilitating MCH policy agenda and it links the MCH community to the adult, elderly, health and social service policy developments, where a lot of the action is, but we should be at those tables.

The next three, four slides are really just different people trying to grapple with what does this mean? Really how do we think about Life Course? And I'm just telling you this so you'll think about this as you do your work. So, Amy Fine and I have been writing that little paper on policy and we crystallized several points from this. Today's experience, exposure determines tomorrow's health. Health trajectories are particularly affected during critical and sensitive period. The broader environment, biological, social strongly affects the capacity to be healthy. Inequity in health reflects more than genetics and personal choice. And I'm going to skip that.

Michael Lou is giving a talk this day on reinventing the MCH field and his Life Course conclusions really came down to two. We have the transform Maternal and Child Health Care in America, that's things that are in our control. And we have to assure conditions in which all mothers and children can be healthy. And then he list the many areas that really determine health. And if you think about Slumdog Millionaire. In some ways it's amazing the kid wasn't sick given his background. And he was also rather tall which I thought was, sort of, also interesting for choice of this, but be that as it may, there's a lot of domains that affect health beyond health care which is the area we tend most predominantly to focus on.

Barbara Ferrer who's a good friend of mine in the Commissioner of Health for the City of Boston, was asked what did this mean? And she gave a great talk and

she said, "Well, I don't know much about this, I'm not an expert." Which is not true, and she said, "From her point of view the Life Course says there are multiple time points for interventions." For whatever you're interested in, you can think of many time points that you could intervene. Obesity being the obvious one. But at every topic, there are many time points. and more importantly there's many different settings for intervention. Everybody has a role to play in a life course model. And her view is it that literally everybody in the city of Boston makes a difference in the health of people, but and that also policy is real important.

I asked Debbie Allen who's a good friend of mine who also now works for the city. And was working with us and was the director of Children's Special Healthcare Needs for the state of Massachusetts for many years. And many of you in this room know her really well. And I said, "I have to give a talk on policy implications, the Life Course." And she said, "Well, here's what I think." She said, "Avoid the allure of categorical solutions. Focus on upstream population needs. Assure that needed programmatic collaboration happens. Partner with all sectors. Install visionary leadership, and invest in data for policy decisions."

This is the kind of thinking who were talking about Life Course is sort of thinking about. I'm just asking you to help us out. So, let's talk about needs assessment, That was a Life Course. So, let's talk about some definitions.

What do we mean by need? Well these are two quotes, one from the United Way. What a need is, is to discover and identify goods and services the community is lacking in relation to generally accepted standards and for which there exists some consensus as to the community's responsibility for provision. Needs are value judgments that suggest problems exists for target populations. It is the task of assumption of needs assessment process that these need problems can in some ways be resolved. I am a little bit dyslexic, so if I don't read what's up there I got to put general, just that Donna Peterson who's going to be working with you and Greg Alexander wrote.

So, what do you mean by assessment? I'm going to skip this slide just go to Donna's to purpose. She said, it has three basic process. The identification of problems or needs within a target community. The identification of effective, efficient, and socially acceptable solutions and getting those solutions enacted into policy. But let me just point out to you, those are the same three things as that model. A knowledge base, is the identification of problems. The affective solutions, is social strategies. And getting those solutions enacted into policy, is political will.

I hope in, even when I get my two extra minutes here or so a little bit of extra time. I'll, just explain to you how we can move even farther on the policy arena than these models. I think we're just still evolving our thinking about needs assessments. An area that's still developing.

So, let's talk about each of those three areas in turn and fairly quickly.

Knowledge base, what you assess or measure is how you conceptualize MCH problems and their solutions. Let me repeat that because this is actually my point I make all the time about measurement. I used to say it about prenatal care. How you assess or measure something is how you conceptualize it. What you choose to focus in on is how you're thinking about it. That's really important on our understanding of knowledge base.

The Life Course model tells us to broaden and more accurately define population needs. It's going to tell us to look at needs more longitudinally and look at more breadth of needs because currently we lack data on longitudinal health status. We tend to think categorically by ages and stages, or by program. And not really longitudinally or teleologically, we don't think where we want people to go and how are we getting there. We lack data on the breadth of factors that influence the child's life course development. We tend to explore only a very limited set of the risk factors that we all in this room really know are what's influencing the broader health of the populations that we serve.

We are strongest and getting even better at measuring population health. There's a lot of improvements, Michael talked about some things his agency is doing to fill in gaps that we have. But there are still some groups as he started. Only a few years ago, we just didn't have any data after birth until school, for example, or

even in the middle school years. There plenty of places where we tend to be weak. Though we have nurtured the MCH EPI field to really get us making some progress.

And I don't think our field is yet equipped to support a Life Course approach. We have very limited longitudinal analytic abilities. Very few people actually know how to analyze longitudinal data. We have very few longitudinal data bases. We have no way of measuring all these wonderful concepts and life course, you know, that we have about how much stress people have over life. How would you measure stress over the lifetime? How would you measure Malik's stress over his life? You know, we don't have measures. We don't have longitudinal measures. Sometimes we measure age, but that's not the same thing.

Confidentiality issues, and the few-and the very few training sets yet there are a lot opportunities that exists. In Massachusetts, we have a really interesting innovative data system that 's a partnership between BU and the State, and CDC. And has been-now got financial support from the bureau in different ways. To try to actually link data from birth to all possible programs kids have starting in 1990. All of Public Health programs from 1990 and onward, this started as a Reproductive Health Database it's now a child health data base, because we're following these kids over time. You can do things. Linking data is another way, that's a very efficient way. Linking data always involves longitudinal things. So, how are we going to move forward? So, what I really want to tell you do is be

imaginative. You know, think more about chronic disease in MCH, and less about episodic thinking. Thinking dyadic and multigenerational thinking, what's the impact of prenatal care not on birth outcome but on the next generation. Think over time. Maybe we should give a little less attention to technical, clinical, and health service, and even behavioral things. When we look at our sort of summary outcome measures, because that tends to make us miss the bigger picture that many of our community proves tells us are really the issues that are at hand. And think more creatively about broader longitudinal life events. Like, readiness for school, ability to work, things that actually map them out, maybe we should do more when people get married or are in relationships. I mean, those are, kind of, important times in people's lives. Maybe that's what we should be focusing on. More than a particular health at eight years of age which is also nice.

I think we need to a better self assessment of our own agencies to make sure we actually have the capacity. I'll skip most of this slide. And in the end, I would just say on the knowledge base, the main thing I would say is, use your imagination. We're just beginning to think longitudinally, it's not there yet. Our measures aren't there, but what you measure is how you define it. And that we have the ability to broaden our definition of need. To think about things longitudinally in the breadth of factors and to motivate us to strengthen our capacity. Until nothing else comes out of this process is to strengthen our own capacity, not for this needs assessment, but for the next needs assessment.

What about social strategies? Well, I would just say that a lot of different Life Course Programs are being conceptualized. People don't know quite what this means, I don't either. We're all trying to figure out what this means, but I also know that our needs assessments need to look at things in some slightly different ways than we have before. And I would say to you that programmatic needs assessment is the topic most under our control. And the one in which we are actually held the most accountable.

We can't always be held accountable for the health of the kids, we should be and we are. But in a sense, what we do we are accountable for. And that's why we need to worry about it. So I already told why that Life Course is not categorical safety net programming. This is something that you'll help inroad to some ideas of child health three. That the new way of thinking about child health might be integrated and comprehensive approaches greater flexibility of services, and improved coordination to look over. The ability to work across programs is kind of a central element.

So, what are the real needs of kids, not what are the needs of our programs. Increased community and consumer participation, prevention, health promotion, early intervention, developmental optimization focus, focusing on outcomes to improve systems performance, and innovative funding accountability systems. A lot of people see us at the nexus of many different programs. I couldn't find a really good slide of Mario Drummins, his MCH Life Course organization in

Northern Manhattan. If you haven't heard him speak, he's a really good speaker. And he emphasizes time dimension and also sort of social determinants that we need to think about things that have individual impact, group impact, organizational impact, community impact, public policy, and he thinks about how his organization addresses each of those levels. He says, "We have to be much more organizational and systematic in our thinking." That's the kind of Life Course thinking.

So, we also need to assess -- our assessments needs to be done differently. We have to ask whether the program being assessed has an MCH Life Course orientation. And if it, if we are assessing it, it doesn't have programmatic flexibility, can we do things in it that we haven't traditionally being able to do. Does the program being assessed demonstrate an integrative framework? Do we have a kind of longitudinal integration in our program, ability to think overtime longitudinally? Does it have vertical integration? Can we get a kid who's got primary care into specialty care without any problems, but can we also relate horizontally from our MCH programs to the education world.

You know, Julie Richmond died but he's-he worked on Head Start for years and he always would say, "The most impressive thing that came out at Head Start, Dental Care." You know, every kid was screened. That makes a huge difference in people's lives. But that's a good example of an integration of Health

Development MCH. And then, I also just think, you have to ask whether your own organization has this kind of model.

I wrote out a long list of ways you can start thinking about longitudinal, vertical, horizontal, and holistic in thinking, but holistic integration just means, do we think about the kid? Do we think about, is it kid focused? Does it think about the person as a whole and not just, are we in a program? The classic question I always like to ask is, when I talk to poor families, "How many people are doing home visits to you?" You know, how many people, some families have eight and ten home visitors coming. Every program has got a home visitor. This is crazy, that's what I'm talking about.

Okay, you can also think I was asked to put this plug in, because I believe that Life Course approach not only focuses on individuals and populations, but organizations have a life course, programs have a life course. And we need to be monitoring them on a continuous basis. I always say whether you are doing evaluation or needs assessment, it has to be incorporated into every part of program planning. It has to be incorporated into the design when you were thinking about programs, what's the needs for it. When you're implementing it, is it actually meeting the needs? When it's done, has it met the needs? And then learned from that. And this has to be a continuous cycle.

This is Donna Petersen's slide. I am sure she will show it to you the next few days where there is a whole circle for Needs Assessment and you can sort of read your way around. But basically Needs Assessment is one part of a large circle of thinking about how programs work. Programs have a life course also. And we need to think of them as learning environments.

Every one of our programs we need to learn from. Okay. We need to do a self-assessment of our own agency whether we actually are capable. The main thing I would just say is, do we have the capacity to do this new kind of thinking and evaluations? So, and I 'm not sure because it involves new skills that we haven't trained. Life Course is not, requires us to have people who work for us with different kinds of skills. These are just some of the ones that, you know what, I thought of with Michael and Shirley (inaudible).

So, I would just say on the social strategy, you know, a lot of different models are being tried out and there is not a single model there we need to find and assess our needs assessment in the middle sector in our programs differently with different approaches Life Course Orientation Program flexibility and integration. Programs have Life Courses. Agencies should enhance their capacity and this is still our most important area for our work.

Political will, I'll keep two more minutes they I'll finish up. Needs assessment is an inherently political and professional enterprise. You know what, just

remember, it's a political enterprise. That's why everybody is so nervous about it. It is also a very professional enterprise, that's why we are here, too. It necessitates commanding resources whether it's funding, legislation, community buy in, professional buy in. Our goal should be to work more effectively with our community, professional, political colleagues implement and articulated, policy, agenda that enhances Life Course development and to be part of a larger progressive coalition to address the full range of conditions that are needed to ensure healthy mothers, children, and families. And in reality, the main barriers to most of our real desire to work is in the political will sector. We have to think about that sector much more systematically than we have, before including in our needs assessment.

I just thought, there are four things that came out of this. Most important I would say is, it had to develop and articulated set of policy needs. You can't just say we want things to happen. You actually have to have an agenda. And you have to have an agenda in some ways of meeting that agenda. And this will lead to us working better with our allies, strengthening, we need to strengthen our capacity and as I'll argue in a minute to help us return to our children's bureau heritage as a way of providing leadership.

I think that when I looked at needs assessment, I just think we haven't thought enough about this third-policy stage in our thinking. There's work to be done in our continuing evolution in needs assessment. We do not sufficiently use our

needs assessment to gain political support for ourselves. Let me just repeat that. I can see people nodding their head. You know, this is a chance to get people to support us. Tell them the truth. Don't lie if you know, we're not doing a good job or they're only reaching 40%, give them the ammunition to be our advocates. We're missing using working collaboratively with them in defining what the issues are, interpreting results, and providing that information, because our communities want to know this information. And it will build political support for us. It will give voice to community groups. We spend a lot of time talking about family voices. Well, give voices to community. This is the information that they can use. And the needs assessment process is really a critical moment for doing that.

We under utilize. We don't think about analyzing our political support. We don't do, frankly, a real serious assessment of where our political standing is in the world. We could do that during these needs assessment. Yes, we talked to some of our stake holders and yes we get some feedback. But we don't really ask them a lot about their real views about where we stand and how we could work. And I just wanted to say to our friends who are sitting here too, you know, this isn't only something the states have to deal with, something the Feds also have to think a little bit about. And we suffer and also are blessed both by this. To having people like me, and other speak, so they're very interested. But there is a tension between categorical needs of programs and a sort of holistic program objectives, infant mortality is a holistic measure. But how many people you serve in a given program is a categorical program. And there is a tension there, and all that

tension is palpable when we have these meetings. We just have to acknowledge this. We have to work with the bureau. I just came from the DGIS meetings. You know, the Discretionary Grant Information System. If you don't like that Grant, you complained to me and some of our other colleagues who are not advocating well, but it was fascinating to see which of these, some of these things began to have a life course some where really narrow. We have to work with the bureau to encourage even greater flexibility, and openness towards the Life Course paradigms. And the development of new Life Course objectives and performance measures. This is not a one-time thing; you have to work at it overtime.

Life Course in the Children's Bureau will end on this soon. The Life Course model can be seen as part of their continuing legacy of the Children's Bureau with its emphasis on the broad range of factors that impact on child health and well being. The Children's Bureau effectiveness was derived from its participation in the multi issue progressive movement of its times. MCH issues were not isolated, from related issues of labor, immigration, women suffrage, they were thought one and the same and that's the model we need to re-examine. We moved so far down the health service path that we sometimes lost track of these other factors. And I think that, as I said the needs assessment provides us the political will opportunity to emphasize these larger determinants of population health.

I think that the last point there is, it is important for State Title Five Agency, leadership to reassert the Children's Bureau Heritage and to address the wider range of social factors influencing MCH population health. And we can create, but we can basically create coalitions with other sectors that are working on MCH, and we can provide leadership for that. That's a route that we need to be thinking much more. If we are really gonna examine issues, we are gonna examine issues that have to do with the Life Course issues that affect us.

Last point and then just to say, I ask you're support as we think about. You wait for the last slide it's a good, I don't want you to miss it, you know, I worked on it. All right, concluding observations, I already gave you the summary, .here's my concluding observations. The MCH Life Assessment can be a critical tool for the MCH field to help improve the health life course of mothers, infants, and families. Needs assessment is an evolving capacity in MCH. It needs to be further development, developed, and we need to help it incorporate more of the life course prospective in this model.

Needs assessment in turn, is a critical area to help foster the paradigm shift to the MCH Life Course. When you make that needs assessment have more of the life course focus. You, also, in turn helped move this. And I just want to remind us, that the Slumdog Millionaires of the World remain our continuing challenge. And I just wanted to say to you, I am dyslexic and while typing this up the other day and I thought, well, you know, I've been working for MCH for a long time. I

have long MCH life course and as I expect, actually everybody in this room. This is a dedicated crowd to the MCH future. We put our lives on this topic. But this is what I typed. So maybe, this is an MCH life curse that we have, but the Slumdog Millionaires of the world and in our country, you know, need our good work. So, thank you very much.