

## **Federal/State Partnership Meeting**

### **Introduction and Welcome**

October 25-27, 2009

CASSIE LAUVER: Good morning everyone. Good morning. It's so good to hear the conversation going on in the audience this morning. It's a -- you're always such a great group to work with collegial. We feel like we are friends here in the group. Yesterday, I think that we had a very good start towards the -- our new thought about Maternal and Child Health, MCH, and that's make change happen. And I thought the presentation last night was fabulous, setting the stage and looking at the intersectional nature of the models out there, including social determinants, life course and health equity, and helping us frame where we are going at this point in Maternal and Child Health.

So this morning, we're very pleased to have both Dr. van Dyck and Dr. Mary Wakefield, the HRSA administrator, as part of our preliminary session. And I want to introduce Dr. van Dyck at this point so he can talk about a little bit about the strategic planning that we're just setting our course for -- in the bureau and how that incorporates the concepts that we begin with yesterday looking at the models of life course and social determinants.

Now, I know Dr. van Dyck needs no introduction to most of you, although we do have some new people here. So I want to introduce Dr. van Dyck by saying he was appointed the associate administrator of Maternal and Child Health in 1999. And before

that, he served as acting director of the bureau. And earlier than that was actually the first director of the office of the office of The Division of State and Community Health, which is now the division that I represent in the bureau. Not only in Maternal and Child Health do we have -- in the bureau do we have the black Block Grant states, but the bureau actually administers a number of other programs many of you are familiar with, including Healthy Start, Emergency Medical Services for Children, traumatic brain injury, and is also the executive secretary of the Secretaries Committee on infant mortality, which is very important work.

Before joining the federal government in 1992, Dr. van Dyck was the director of Family Health Services division in the Utah Department of Health and professor of pediatrics at the University of Utah Medical Center. So at one point, Dr. van Dyck was also a Title V director. He was president of the Association of Maternal and Child Health directors from 1978 to 1980 and shared the Maternal and Child Health section of APHA in 1989 and '90. And I'll have to say in terms of mentors, I cut my teeth in the early '80s, mid-'80s in Maternal and Child Health, and Dr. van Dyck, who was part of the Association of Maternal and Child Health programs at that time, was a great mentor to me as well.

He has received numerous awards and honors over his distinguished career, including receiving the Arthur Flemming Award given to exceptional federal employees by George Washington University and government executive magazine for computerizing something well and near to your hearts -- near and dear to your hearts, which is the Title V, MCH Block Grant system, and for standardizing the Maternal and Child Health

performance majors, which have grown to be a very well recognized nationally set of data that you all contribute every year in your application and annual reports, as well as in your five-year needs assessment.

Now, it wasn't long ago that reading Dr. van Dyck's bio that we realized that he's been here a very long time. In fact, his career bridges two centuries of work in Maternal and Child Health. So having said that, and while he still has memory here, let me introduce Dr. van Dyck.

PETER VAN DYCK: Make me feel old. Thank you, Cassie, Dr. Wakefield. Well, good morning, everybody. It's really pleasure to see all of you here this morning, and have you here for a few days to share ideas and concepts. What I'm going to do this morning is share ideas about our strategic planning process. Don't start snoring yet. We'll make it interesting. Last night, we heard about the life course approach and I'm going to relate where we are in this process of seeing if we can develop as a foundation we're exploring whether it's possible to -- foundation our strategic plan from the life course social determinants equity approach, which you heard in introduction, too, last night. So this is a major new direction for us. It will be a major new direction for you if we succeed in this exploration. And we'll begin this exploration together and continue with together as we progress.

Yogi Berra said, "If you don't know where you're going, you're going to wind up somewhere else." He also said, "You got to be careful if you don't know where you're

going because you might not get there." Well, this is the beginning of, hopefully, determining a little bit where we're going. And Henry Ford, just to quote, Henry at the last, "Whether you think you can or whether you think can't, you're right." That takes the second, doesn't it? So we think we can and we're going to be right. So, we don't begin from nothing. We begin by having a strategic plan. And a strategic plan is on our Web site and I'm sure some of you have used it for late night reading. And it was developed in 2002 and 2003 and was a five-year strategic plan in 2007.

In 2007, we thought about redoing it and thought about doing a life course approach. And with a previous administration, we just couldn't get traction. Now, we have a new administration and new forward thinking and it allows us to think more creatively. And so, we are beginning this process of developing a new strategic plan. The old strategic plan, though, has elements and basics that are, I think, important. It has four parts. We're going to talk briefly about part two, the goals and key strategies and the conceptual framework for the plan, part three. And as you read through these key strategies, and you're thinking social determinants life course, think about there is a lot good and forms the basis for this strategic plan that we can build from as we move forward.

Goal one: to provide national leadership for MCH. Each goal has key strategies and each of the key strategies have performance measures related to them to measure them. Well, I'm not going through all of that, but just read through these key strategies with me. Provide national leadership for MCH. Create a shared vision. Strengthen the

knowledge-base and support scholarship. Forge strong, collaborative, sustainable MCH partnerships both in and beyond the health sector. Promote family leadership in MCH service delivery. Provide both graduate level and continuing education training in the disciplinary for leadership nationwide.

Goal two: promote an environment that supports MCH. Key strategies: using the best available evidence. Develop and promote guidelines and practices to assure social, emotional and physical environment that supports the health and well-being of the MCH population. Work with states. Work with communities to plan and implement policies and programs to improve social, emotional and physical environment.

Goal three: eliminate health barriers and disparities. Develop and promote health services and systems designed to eliminate these disparities across the MCH population and train a workforce that can do this, that's culturally confident and reflects an increasingly diverse population. As I read through these each time, and I don't do that real often, but I do it periodically, I'm impressed by some of the thoughtful statements here that were developed in conjunction with you, yeah, and us, and the others. And I think they're nice that they're down on paper.

Key strategies for goal four: improve the health, infrastructure and systems of care. Build analytic capacity. Use the best available evidence. Assist states and communities to plan integrated health service systems, work with states and communities to ensure that we target the appropriate populations and deliver to them,

and work with states and communities to address selected issues within targeted populations. And the last goal, goal five, to share quality of care, again, build an analytic capacity not to report but to assess and ensure quality of care; develop and promote health services and systems designed to improve the quality of care and to develop and promote health services and systems that assure appropriate follow up services.

Now, also contained within the strategic plan and those of you that have aged with me have heard me talked about this before. But this is the basis for our strategic plan and grantmaking. This is the core. This is the foundation, this and the next slide, for our current strategic planning process and what you do in the Block Grant and the other grants. It begins on the left with needs assessment or health status indicators or healthy people 2010 or legislative priorities or input from your governor or whatever, and you develop a set of goals or health service indicators. And those goals then drive, hopefully, and hopefully for us too, our priorities and goals. And I just read five goals including decreasing disparities, increasing quality and improving the infrastructure.

So, data-driven to priorities and goals. Once these goals are set by us or by you, you allocate resources both monetary, budgetary, personnel, et cetera. And just you often described these resources to us related to this pyramid, which I'll go through in a minute, but related to direct health or wraparound services, enabling services or population-base services or infrastructure services. And I'll show a diagram of the pyramid in a minute because I think it's important as we move forward.

Once we allocate those resources, we try to measure how we're doing in providing the services that those resources allow us to provide. And so, we have performance measures, and we have separate performance measures for the State Block Grant, for the SPRANS Grant and the Discretionary Grant Information System or the DGIS, Healthy Start, EMSC programs, Traumatic Brain Injuries and all the other programs and grants that you participate in. You know you report to us on performance measures as well as other measures and indicators. And then, we try to measure all of these. How we're making difference in these performance measures but then, what about outcomes? And everybody always says, "Well, look at these outcomes. They're all down. They're all death -- perinatal mortality, infant mortality, neonatal mortality, post-neonatal mortality, child mortality and infant death disparity, disparity between Black and White." But this is what OMB wanted us to do, and they are outcome. They're just not very sensitive, but they're outcome measures.

So this grid flows from left to right. It does relate. It does interlink. And if we don't do well on these performance measures and outcome measures and, particularly, the outcome measures, we have to rethink. So I'm going to show you a couple of slides later that talked about infant mortality and neonatal mortality and preterm birth, and we'll see how we're doing. But if we don't do well, we should rethink, recycle, go back and look at our indicators and goals and retool. And I think that's where we are beginning to see where we are.

Now, this pyramid. What is the group of services that MCH feels responsible for? Or we have direct healthcare services. We all know what that is. We have enabling services like transportation, translation, outreach, case management, care coordination, support services, education that help people attend, have access to, get into direct healthcare services. We have population-base services -- newborn screening, lead screening, immunization, sudden death counseling, injury prevention, oral health services that we deliver to a broad population, the population-base services. And lastly, at the bottom of the pyramid and supporting it, are infrastructure services -- needs assessment, evaluation, strategic direction, strategic planning, standards development, quality assurance, monitoring, information systems. The foundation or the core which support the base of the pyramid that we feel is terribly important now. I've drawn some lines on this, next to this pyramid -- the MCH, Community Health Center, CHC, EPSDT and SCHIP. MCH is the only federal and state program that deliberately and intentionally provide services at all levels of this pyramid.

Now, we would prefer -- I would prefer you -- I think you would prefer generally, to offer services at the lower part of the pyramid, the infrastructure and population and enabling-base services with our limited funds. We can have the most effect. Plus, nobody else delivers wide-base services at that level. Community health centers delivers wonderful direct healthcare, enabling services and some population-base services and some infrastructure services to their population, but not to populations without or outside of their own coverage area. EPSDT and SCHIP does the same and those lines are spotted because the services are often spotty. But they provide direct healthcare,

enabling and population-base services as well, and we would like to leave the service delivery to those kinds of folks. So this is the way they talk about MCH and I think these forms of basis for life course social determinant and equity approach. And within that solid line at all levels of this pyramid, we can find room to do this exploration.

Accomplishments. I didn't want to be down and say we haven't met any goals or we haven't met any objectives. But I just couldn't think of any and that's why the screen -- we're -- no. I've got a list but I'm just going to go through them very quickly, because I want to get on with the slides. We have part scores for the Block Grant Healthy Start which were the highest part scores, our highest category. We have the national surveys of child health and children's health, their special healthcare needs. We've had publications in the last year, 11 publications and periodic journals, nine in press and 12 submitted already -- publications from the surveys and other activities. Some, we've done jointly with you and your coauthors on those with us.

We post the Title V information system data within a month or six weeks of when we received it and do the Block Grant reviews with you and that's going up in the next week or so for the last year. We published with IOM the weight gained during pregnancy standards just two or three months ago. We've created an autism program of which many of you in the states are part of and have received new grants and managed to, I think, spend very well 50 million new dollars in autism and growing. We now have family program in every state. Most states screen the newborn screening for the 29

basic core conditions, and it's been a rapid increase over the last year or two. All states now screen for newborn hearing screening.

We have child death review, voluntarily I might add, in 29 states. We have the Early Childhood program in 47 states. We have this EMSC, Emergency Medical for Services Program, research network of over 20 hospitals which some data from emergency visits related to injury and has published two important publications, at least two, one on bronchiolitis treatment, one on head trauma just sort of -- which just appeared in land set a month ago. We have anti-billing legislation in 35 states now up from 10, two or three years ago. We trained fulltime students -- over 20,000 trainees in the last several years, 22,000 for continuing education credits.

We've published a major depression booklet and a business case for breastfeeding series of booklets in the last year or two which had been very, very, very popular. Child health USA, Women's Health USA, all the medical home staff which we began for kids with special healthcare needs years ago with the Academy of Pediatrics and has finally caught on as I think you know, particularly in the adult community but now even with SCHIP. And last but not the least, just to keep the list not too long, bright futures. We are implementing Bright Futures in a major way and it's been accepted as the standard for child healthcare by the academy and family practice and Medicaid as well as the MCH community.

So we do have a lot of accomplishments, and I'm very proud of those. And when I say we, I mean we. I really mean we because it's not us doing it, it's all of us doing it together. So what about some of these outcomes? 1940 to 2006, you can see the -- both red line is the African American community, blue line, all races. Green line, white, and the squiggly black line is the differential or the ratio of White to Black infant deaths.

So we've done well in the '40s and '50s and '60s and '70s. And the slope which you heard about last night has done quite well. But between 2000 and 2006, we've stagnated and the infant death rate's up a little one year, down a little of a next, up a little bit over next year. And the differential rate between Black and Whites has continued to slide upwards and has flattened down at over 2.4, not what I would consider, at least lately, success. Below birth rate percent, again, the same colored lines. While the infant death, Black, White or whether the low birth weight, Black, White racial has come down slightly, low birth rate as we all know is continuing to increase and it is increasing at an increasing rate some years as well. That's low birth weight percent. Preterm birth -- and I'm going to be talking about preterm birth here for a bit -- continued to go up since 1990. You can see slopes from 2004, 2005 that have increased even, but no downward trend and continuing preterm birth percentage going up.

And again, we know that these preterm birth and low birth weight contributes significantly to infant mortality. So while the differential is down a little bit, it's not down a lot and it's a significant increase. And if we look at obesity, one of the things that is a

precursor, perhaps, to true outcome measures and look at the NHANES data from '65 to 2005, we can see the top line, the light blue line is overweight, the black line is obese, and the red line has been added as a new category of extreme obesity and now has continued to increase as well in the red dots. So another example of us is not being very successful. And just to look at it in another way, blue bars are White, yellow, Hispanic, Black is red bar. We can again see this increase in this three time periods for children six to 18 who are overweight and the differential that exists between minorities and the White population. So this should be cause for us to -- what do you think? Because I'm sure all of you know, but just to highlight it.

So we need to get creative, like this chiropractor did. Having shrewdly cemented a solid gold bar of the sidewalk in front of his office, Dr. Northman, immediately experience the 70 percent increase in business. Do we need to rethink things? Well, from a new Policy Brief, which is being, which people in the room have that has been partly written by Michael Lu and Mil Kotelchuck and Cheri Pies [inaudible] among others, this is what it said, "A broad new paradigm as emerging in the field of MCH that has the potential to change MCH's practice particularly with regard in addressing racial and ethnic disparities and child and family health.

For the past several decades, MCH programs been focused on individual services during the nine-month prenatal period and subsequent pediatric care, paying less attention to the broad environmental determinants of health. A life course offers a new way of looking at health, not as disconnected stages infancy child, adolescence, child

bearing years, old age, unrelated to each other but as an integrated continuum. This perspective suggests that a complex interplay of biological, behavioral, psychological, social and environmental factors contribute to health outcomes across the course of a person's life. It builds on recent social science and public health and literature that suggests that each life stage influences the next and that social economic and physical environments interacting across the life course have a profound impact on individual and community health."

So borrowing from our good friends, Lu and Halfon, we have a kind of a summary overview of the life course perspective. In between the yellow lines are the period of pregnancy and we, over the years have said, if we can deliver prenatal care to all people and have good content of prenatal care and maybe get a little preconceptional care in there and maybe get a little post card on care in there, we can significantly influence the outcomes of pregnancy. And are we significantly influencing the outcomes of pregnancy related to preterm birth, infant mortality or low birth weight? Well, we have, but we've reached the stale mate. We are not increasing it.

So -- and when you look at a graph like this, it does seem kind of unusual to try to intervene at a such a narrow focus time and broadly affect the health of an individual and their newborn. But we've made much progress but we stalled. So the black line at the top are the White population -- and this is just an example, an illustration -- and the dotted line at the bottom is African American. And the Y axis is reproductive potential and the X axis is life span. And you can see that African-Americans begin with lower

reproductive potential at birth or before birth and that Whites begin were higher. And that the white line is higher and progressively gets higher, because look at all those arrows pushing that line up, all those protective factors that the Whites have advantage to. And the relatively few pressing down arrows, which are the risk factors, poverty, racism, lack of access to care, et cetera. And if you look at the line for African-Americans, look at all the arrows pressing down for the significant impact of the risk factors and the fewer or relatively fewer protective factors pushing up. Another line there are particular points of sensitivity at birth, at preschool, at puberty, at pregnancy where additional risk factors often occur and where if there aren't a co-opposing set of protective factors, there is potential for that line getting farther apart and having a great for differential.

So this is a schematic that helps us understand in just broad terms what we're talking about when we talk about a life course approach. And just to put it in the -- or just to highlight it a little bit from birth to five years of age, we can see that lack of health insurance, lack of health services, poverty, lack of access to care, family discords, single parent families, neighborhoods that are discordant or high risk, you can add your own risk factors in the green arrows that push down. And parent education emotional health literacy, reading to the children, appropriate discipline, access to health services and availability of healthy services, good preschool services, all push up to help these children and families improve their lives. If you have an overwhelming set of risk factors and not enough protective factors, your line is going to sink. And if you have appropriate risk factors -- or your protective factors, you're going to do okay, but if you

don't and the risk factors oppressed you and push downward and you don't have the accompanying risk or protective factors to go with it, you're going to have accumulated stress and accumulated potential and risk for bad health.

I'm going to talk just very briefly about cumulative factors and programming factors. Cumulative are the additive effect of multiple risks and protective factors. Geronimus has called it weathering. McEwen has called it allostatic load, and I think you heard Vijaya talk about allostatic load last night, additive effects of multiple risks and the body not being able to respond. And then programming, time-specific influence stimulus or insult during a critical or sensitive period on selection adaptation or compensatory processes: pregnancy, entrance into preschool, birth. In fact, time-sensitive factors where there are increasing risk and not often compensatory protective factors.

So first, talk about programming. From the nurse's study -- health study, look at the bottom. Big babies on the right, greater than 10 pounds; little babies on the left, less than five pounds. And the lines are the risk of developing cardiovascular disease, stroke, hypertension and type 2 diabetes. This is for the baby born prematurely or at these birth rates, grows up and becomes a reproductive age female, and then has these significant risks from her own birth weight. So if she -- this mother, this adult woman, was born weighing less than five pounds, she has almost two and a half times relative risk of having a stroke as an adult and almost two times having type 2 diabetes. So something affected her life course in the pregnancy as a fetus or before that has influenced her eventual health outcomes, impact of a sensitive period of time.

Next, we're going to talk about the cumulative effects, the adding effects, the weathering effect. And this is a study by Claudia Holzman and a whole series of authors in the American Journal of Public Health that just came out in October this year -- this month in the Journal of Public Health. It was funded by us five, six, seven years ago. The funding actually came from Michael Kogan's group. And it was to test the appropriateness of using multilevel modeling techniques and linking vital statistics with census data to look at contextual factors contributing to disparities. It was four states: Pennsylvania, Maryland, Michigan and North Carolina. It was university and health departments. Was there anyone in the room that was part of this study? Because many states, many people in the states were involved in this? And the purpose of the study was to build on the observations that adverse pregnancy outcomes increase with advancing maternal age, noting that the marked Black, White disparities in these adverse outcomes, Geronimus proposed a weathering or accelerated aging hypothesis. And this hypothesis states that, one, a decline in health status contributes to the poor reproductive outcomes as women's age -- as women age. And, two, social inequalities lead to an earlier and disproportionately greater decline in the health status of Blacks, which results in a widening health differential between Blacks and Whites with advancing age.

So just very quickly, left chart is primips, right chart is multips. The lines are -- from the bottom. Right, nonsmokers; solid black, White smokers; triangles, Black nonsmokers; and the top line, Black smokers. And you can see how, with age, the risk of having a

preterm birth baby is very significant and it increases as you add a risk factor, smoking, significantly, and these are significant findings.

Now, add to this, neighborhood deprivation. And this is what you can do when you match vital statistics or vital records with census data among other things. The bottom lines on this chart are low neighborhood deprivation level. The middle line is medium deprivation level and the dark dots are high neighborhood deprivation levels, bad neighborhoods. And we can see that in addition to the smoking risk, if you live in a bad neighborhood, it adds even more significant risk of preterm birth, the black dotted lines as the mothers age.

So not only do we show an increasing risk of preterm delivery with adding a risk like smoking, but we do it and show an additional risk by adding an additional risk factor of neighborhood deprivation. And these are really significant findings. And if you look at the difference between the beginning point in the left bottom chart and the beginning point in the right bottom chart, which are our multiparous Black smokers, you can see they begin at a different level. So this is representing chronic stress even at the point of entrance into the study. The group of Black smokers is higher on everything beginning at the beginning and continuing to increase with age.

So the conclusion from this study was that results support the weathering hypothesis or the allostatic load or the cumulative risk assessment, suggesting that Black women, women with high risk behaviors and women living in high deprivation neighborhoods,

may develop accelerated aging that increases preterm delivery risk and suggests an additional intervention to the typical health-related ones.

So key concepts of the MCH Life Course Model. "Today's experiences and exposures determine tomorrow's health. Health trajectories are particularly affected during critical or sensitive periods. The broader environment, biologic, physical and social strongly, affects the capacity to be healthy. And inequality in health reflects more than genetics and personal choice," Amy Fine and Milt Kotelchuck.

So, how can we keep what's best about the model we have? How can we add a life course approach to this structure or change it if necessary? How can we make a schematic that makes sense, including life course, and shows the determinants and build it on our database or data needs model that we have? Can we, in fact, do that? Or do we have to scrap what we have at the beginning, start from zero and build it up brick by brick? What can we use of what's old, what can we use of what's new, and how can we know meld them together? And this is the task that I see ahead of us. Not easy. And if any of you have ideas, please, please talk to us.

Now, timelines. We've been thinking about this for the last several years and have just been able to do it here this last year to make -- to really make progress. And it may be the due time because there is renewed interest, as many of us know. We had a group session with Milt and Michael Lu and Neal Halfon and Jeff Goldhagen and Deborah

Klein-Walker and Amy Fine with our MCHB staff. And we had a jam session, a rap session about it.

Next, we're going to invite local jurisdictions or states -- jam session. We're not quite to singing the song yet, but we're going to get there. Next, we're going to have local jurisdictions in or states that have begun the process of developing this model and there are some. And there are some of you here, Mario Drummonds and Cheri Pies among others. We're going to have them in now and see if we can gain from their experience in developing a model. Then, Amy Fine and Milt Kotelchuck are going to help us write a concept paper, which I hope will be done by AMCHP. When is AMCHP this year, February or March? Please say March. Oh, wonderful. I guess there's another month. So we hope to have a concept paper done by March. Then we're going to turn it -- which I'll report on with AMCHP, then we're going to turn it loose. We'll develop a concept, development committee. Those of you who are interested in serving on that, please let Michael Fraser know. If you have any ideas -- or any of us -- if you have any ideas of how to schematize this, if that's a word, how to draw it, how to conceptualize it, keeping what's good of what we have, let us know, please, because that's the stage we're in. And any ideas would be more than welcome.

So in summary, and again, this is from this policy brief I read from before: The life course perspective offers a new vision for MCH. It provides the beginning of an overarching understanding of what MCH should be doing in the next few years. Elements of a broad new vision statement would include changes in healthcare

practices, policy, research and advocacy at the federal state and local levels as well as the strategies that will reconfigure services to integrate this perspective in the MCH practices. These vision statements should recognize that a broad-based view of the entire life trajectory is necessary to improve health outcomes and have a goal creating equity in healthcare. It would include a focus on social determinants and environmental factors affecting health, building strategic alliances that include consumer involvement, advancing new practices, policy and research. In this statement we reorient our vision from a disease orientation to one of vibrant communities that focus on optimization of health. It would recognize the necessity of investing in upstream determinants of health, shifting more spending for early health and seeing healthcare as an investment in the future.

There's a quote that says, "Never be afraid to try something new. Remember, amateurs built the ark. Professionals built the Titanic." And when we were developing the Title V system years ago, I think it was some folks in Oklahoma created this cartoon for me: "High above the hushed crowd, Peter tried to remain focused. Still he couldn't shake one nagging thought. He was an old dog and this was a new trick." Well, now, as you heard, I'm an older dog, and this is a new trick, but working together, we can do it. And I appreciate your time and energy in helping us move forward. Thank you very much.

I have the great pleasure of introducing Mary Wakefield to you. Mary Wakefield is named administrator of the Health Resources and Services Administration by President Barack Obama in February of this year, 2009. She joins HRSA from the University of

North Dakota where she was associate dean for rural health at the School of Medicine and Health Sciences, a tenured professor, a director of the University Center for Rural Health. As a nurse, a PhD and a leading rural healthcare advocate, Dr. Wakefield brings expertise that will be instrumental in expanding and improving services for those who are currently uninsured or underinsured. She brings experience on Capitol Hill to her post. In the 1990s, she served as chief of staff to two North Dakota senators: Kent Conrad and Quentin Burdick. I might add, they're both Democrats. Dr. Wakefield is a native of Devils Lake, North Dakota. She has a bachelor of science in nursing from the University of Mary in Bismarck and a master's and doctoral degrees in nursing from the University of Texas at Austin.

People ask me, "How are things going now compared to the way they used to be?" You know, we've been struggling a bit and I'd say, "Better, better, better." And then they ask me, "Well, are you going to stay where you are a little longer?" And I'd say, "I hope so. It's all location, location, location." And then people ask me, "Why is it better?" And I say, "Because she has great ideas, ideas, ideas." "Oh, how are they shared? How does she share them? What did she tell you?" And I'd say, "Fast, fast, fast." "And how does that make you feel?" And I'd say, "Thrilled, thrilled, thrilled." Mary Wakefield.

MARY K. WAKEFIELD: That was perhaps the loveliest introduction I've had since I've been back in Washington, D.C. Peter, thank you very much for that. I'm also reflecting back on Cassie's remarks that Peter has now been formally in his position as bureau head for 10 years. I think I missed the invitation to the celebration that must have

occurred associated with that this year, so maybe you can do another one for him or with him or you could sponsor it yourself, Peter. And that's a remarkable -- and then invite all of us in the room to it. Of course, not with federal dollars, but...

It is really a privilege to be able to work with Dr. van Dyck and his team in so many -- and these are -- I'm off my formal remarks for just a second. In many ways, the Maternal Child Health Bureau is just leading edge in so much of what they do. I know that that is in no small part due to the partnerships that they have forged with people like you in this room moving collectively this very important agenda forward. I look to a lot of the innovation at HRSA coming out of the Maternal Child Health Bureau and from which many other parts of HRSA. And frankly, even other operating divisions of HHS can learn. That's a lot about the people who work there. As a matter of fact, it is primarily about the people who work there, its tremendous leadership associated with Dr. van Dyck, also with Jon Nelson here and with the wonderful staff of the Maternal Child Health Bureau. It is really a privilege to be able to be here and to be working with them and with my other colleagues at the Health Resources and Services Administration.

I want to thank each of you, too, for taking the time to be here in Washington for this meeting. I feel very privileged to be able to represent HRSA at what I think is quite an exciting time. It is clearly a time of change for us and the way that we view healthcare, and it is also a time of renewed alliances among partners who share common goals and common aspirations. That's certainly true between those of us who work at HRSA and those of you representing state governments and so on here in this room today.

Today I'd like to just take a few minutes of your time and outline some of the goals that I envisioned more broadly for the Health Resources and Services Administration. You've heard a lot in the last, oh, maybe half an hour from Peter about where the bureau is moving over the next little while, which I find absolutely exciting. I'm so enthusiastic about that. I was making notes to myself about some things -- yes, faster, faster and more, more, Peter -- that we could be doing even more broadly other than Maternal Child Health Bureau's working in form across HRSA. So it is a very exciting time. Peter has outlined his direction that the bureau is pursuing. And I'll share just a few minutes about some of the goals that I envisioned for HRSA, as I've mentioned, and the internal changes that we are making to position this agency in line with President Obama's efforts to reform healthcare in America.

But I do want to acknowledge the work of HRSA staff, some of whom are here today, beyond this bureau's leadership. If the HRSA staff in the room would please stand, I would like all of you to see where they are, who they are, and if there's an unfamiliar face among HRSA's Maternal Child Health Bureau staff and other staff here today, please seek them out over the course of the remainder of this meeting. So if the HRSA staff would please stand up, it'll be just terrific. Thanks to each of you for the good work that you do. And please, for those of you who are not HRSA staff, we're looking for a few -- no, I know that's not what I'm supposed to be doing here, but we are. But please be sure to introduce yourselves to my colleagues. They are more than willing to answer any questions that you would have, to hear your concerns, ideas and observations

about what we should be doing. Some of the folks who are here are from HRSA's headquarters here in the Washington, D.C. area. And others are here from HRSA's regional offices, the regional offices which will be taking on a new and expanded role as we go forward and I will be explaining that to you in just a few minutes.

As you know, the Obama administration is investing unprecedented resources into HRSA's work. This commitment has translated most recently into about \$2.5 billion for HRSA through Recovery Act funds. Those dollars will virtually double the number of National Health Service Corps clinicians, for example. That will provide all of us with a substantial boost to the number of women and children who are served in currently underserved communities with this new investment in just one part of the dollars, of the Recovery Act that have been made available.

Our annual budget allocates about \$662 million for HRSA's Title V programs. Those dollars touch, one way or the other, about 40 million people in 2008. That number included over 2.5 million pregnant women, over 33 million infants and children and over 1.8 million children with special healthcare needs. So it is a broad swath of individuals across the United States that are reached through the programs of the Maternal and Child Health Bureau. But HRSA is helping the nation's children in more ways than through Title V.

Peter, do you mind? This is just -- I'm going to drop this down. Is that okay? All right. I'm going to have to dance around it. Sorry about that, but otherwise, I have a habit of

moving my hands around and I click all sorts of buttons on the computer, so heaven knows what you'd be looking at two minutes from now. My point was -- that I was just making -- is that HRSA has, of course, a Title V with the resources available through it to serve women, infants and children across the country. But we also have other vehicles through the Health Resources and Services Administration that also provide -- not so directly or intensely perhaps in some circumstances -- but also provide support for the health and healthcare of the population about which you care deeply. For example, healthcare centers, our community health centers provide prenatal care to women across the nation.

And there are, of course, our nation's Poison Control Centers that are supported through HRSA. Over half of the calls made to those centers involve calls about children under the age of five years old, another program operated through HRSA. So while clearly the Maternal and Child Health Bureau is the standard bearer for the health of women and children, this population is touched by other HRSA programs and it behooves those of us inside of the agency to better understand what those touch points are, and for you to better understand them, too, and align them as effectively and throughout HRSA's programs as we possibly can, even across other HHS agencies, divisions and working in collaboration with other federal agencies. So Maternal and Child Health Bureau, extremely important within HRSA. But over time, we'll look at even more closely at how we can leverage some of our other portfolio programs within HRSA and then, of course, outside of HRSA to maximally benefit women, infants and children.

I mentioned a moment ago that the role of our regional office is changing. Going forward, our office of regional operations now has a maternal and child health point of contact in each of our 10 regional offices. And those individuals will be working closely with the staff of the Maternal and Child Health Bureau and, of course, with you. And I'll just point out that the table right here is the table -- you can put your hands up one more time for those folks who are looking at their notes -- they're the table of regional office staff -- yes. They are the folks who are across the nation, from Dallas to Seattle to New York, Philadelphia and so on, who will be working most closely with the Maternal and Child Health Bureau and also with you on these issues of concern.

Each regional office, by the way, also has a person who works closely with the Center for Medicaid & Medicare Services. Together, MCHB and CMS are implementing the children's health insurance program, outreach and enrolment grants to gain shift in Medicaid coverage for more children and women of childbearing age. So we're strengthening our resource capacity on behalf of the issues that are of concern to you internally. We're also looking at how we can align this focus even across our other programs.

Another resource, as an aside, for children through HRSA are our telehealth programs which use IT resources to forge partnerships and to leverage resources to reach vulnerable people, particularly -- or I should say including children in some of our most underserved areas. HRSA and the Department of Agriculture, for example, are funding

a school-based project in Kansas City that allows nurses at 13 inner city schools to screen children through telehealth consultations with clinicians at the University of Kansas Medical Center. You may already know about that particular initiative. It's called TeleKidcare and it's been running now for a decade, providing everything from drug counseling and mental health to dermatology and EENT services to kids who, otherwise, would have little or no access to care.

Speaking of leveraging resources, I also want to express my really sincere appreciation for -- and enthusiasm for the way that local and state partners have been able to not only match HRSA Title V grants but to exceed, really, all expectations in spite of the economic downturn. We all know that the recession is putting very heavy fiscal pressure on local and state governments which are increasingly hard pressed to find financial resources. Yet, in 2010, we expect state and local funds, program income, and other funding resources to add to our allocation of \$662 million and leverage a total of almost \$6 billion for Title V programs. Really, considering current economic conditions, this is quite an outstanding achievement.

Well, this brings me then to the crux of our issues at hand. Given that resources are unlikely to grow, at least to grow in any market sense, in the near future even as need continues to grow, as ably demonstrated by many of the graphs that Dr. van Dyck was sharing with us, we ask ourselves, "How can HRSA, in its part and its partners including you, work more efficiently and effectively to achieve better results, to reach more people, to provide more comprehensive services?" How can we do that? And this

leads to the reasons why I consider this meeting with you today to be so important for HRSA, just as Secretary Sebelius -- who will be here tomorrow -- also considers this gathering very important for this administration.

As the HRSA team knows well, I'm stressing a number of themes throughout the agency. They are themes that will position us to work collaboratively, more strongly with you in the healthcare environment that we face, one that has all of the features of economic downturn adversely impacting state governments, and also has the features associated with the research and interest in moving the dial forward on healthcare in this country through healthcare reform efforts underway here in Washington, D.C. So, as we look to see how we can reach more people -- more coffee, please -- how we can reach more people more effectively in spite of fewer resources and against the backdrop of healthcare reform. Some of what I'm looking at internally within HRSA is to focus like a laser on collaboration, to focus like a laser on performance improvement, and to focus like a laser on incorporating within the Health Resources and Services Administration a new and an even stronger focus on public health.

Let me make a comment about each of those priority areas of activity. Collaboration. It's one of my top priorities, and it involves both internal stakeholders inside the U.S. government and not even just inside the U.S. Department of Health and Human Services, and that collaboration, that focus on collaboration also involves our external stakeholders. Internally, I expect all of the different HRSA bureaus and offices to work collaboratively. We have silos in HRSA. Given where you come from, you know what

that's like. You probably do too, right, in the very agencies within which you're operating.

Well, we've got them and some of them are inherent because of our organizational structure, because of statutory requirements imposed on our programs. But to the extent we can, we are collectively now, within HRSA, focused on breaking down internal boundaries wherever they can be eliminated. I have instituted that expectation across all of the bureaus and offices of HRSA from our HIV/AIDS Bureau to our Office of Rural Health, to our Bureau of Health Professions, to our Bureau of Primary Healthcare, all with the expectation that they will and we will be cooperating and working very closely together. I think that matters. I think that matters for populations that you serve so that we're not just leveraging the resources strongly and powerfully that the Maternal and Child Health Bureau brings to the table, but we're looking across all of our programs to see how we can leverage activities, resources, expertise on behalf of, in this case, children, infants and mothers' health.

So all with the focus on cooperating and working more -- most closely together. Ideally then, we would find ways for activities seamlessly into the care provided by community health centers. So bottom line for me, the sum really is greater than the individual parts, from HRSA's vantage point. And from your vantage point, it means that you would hopefully, over time, even more easily know and be able to engage maternal, child issues articulated not just within the Maternal and Child Health Bureau but also articulated across HRSA.

And, of course, external collaboration. That collaboration is very important. It's as important as our internal efforts. This administration is very serious about it. I cannot begin to tell you how frequently in meetings that I am present in -- with Secretary Sebelius. She articulates that expectation that within HHS and with our partners, external HHS, we will be working more effectively together. That is her expectation.

So, along those lines, good news, some things are underway and you can look forward to more cooperative efforts going forward. Just to give you a little bit of a flavor of some of what's going on, for example, the substance abuse in Mental Health Services Administration has developed Project LAUNCH -- that acronym stands for Linking Actions for Unmet Needs in Children's Health -- together with HRSA and the Administration on Children and Families. The first phase of this project was launched last year in five states. The second phase was funded just last month and includes another 12 states and the District of Columbia. The project uses the existing network of Title V grantees to integrate mental health and social, emotional and behavioral planning in the delivery of care.

HRSA is also a part of a broader interagency effort to provide comprehensive services in early childhood. One such effort is the Federal Partners' Early Childhood Systems Workgroup, which supports deeper multi-agency efforts to build an integrated system of services focused on children and on their families. The group includes SAMSA, the CDC, the Departments of Education and Justice and other HHS offices.

Another effort that we're involved with is the State Early Childhood Comprehensive Systems Initiative, which is now on its third phase of helping states build and implement comprehensive service systems for the physical, social and emotional development of children. This one involves SAMSA, NDACF. In oral care, we co-sponsored an Institute of Medicine workshop, which found that, "The current oral healthcare workforce fails to meet the needs of many segments of the U.S. population." So we have just awarded contracts to the National Academy of Science to conduct a wide-ranging study of oral healthcare in the United States and to suggest ways that it could be improved.

And you're probably familiar with the five-year program that we started in 2007 with the USDA's Special Supplemental Nutrition Program for Women, Infants and Children called Building Collaboration for Oral Health. That collaboration enables WIC to serve as the entry point for dental care, to increase the number of at-risk one-year-olds who received preventive dental services, are able to access early dental care and have a relationship with the dental provider. I could provide many more examples. And even on the last point I would just say that it was only about a week ago that I was at USDA, meeting with about 10 of some of their senior staff, actually talking about WIC and the linkages between their efforts at USDA and our efforts at HRSA, very quickly attempting to find ways to even articulate more successfully a shared agenda between that agency and our own.

Bottom line, I hope that all of these though clearly underscores for you that this administration, this department and certainly HRSA are all very eager to expand and strengthen joint efforts wherever they can be found and wherever they can be shown to measurably improve results. For me, collaboration is also about working strategically and operationally with all important stakeholders. And I really want to underscore that HRSA is ready and very eager for a new phase in its partnership with AMCHP members and its partnership with each one of you. We are open to exploring new ways of working together, new ideas, new solutions to even better meet the needs of the population concerns about which we share.

If you have suggestions, we absolutely want to hear them. Frankly, we need to hear them. If you see avenues for breaking down silos, for eliminating redundancies, for improving efficiencies, we want to know about them. I encourage you to look very hard for opportunities that support broader healthcare improvement strategies and to share those ideas with us through our regional office staff and through our Maternal Child Health Bureau staff. Performance improvement is the second of the three areas that I mentioned are high priorities for me at the helm of HRSA. It's a theme that I plan to really hammer on as a HRSA administrator.

First, I want to recognize a very outstanding work that all of the grantees have done in collecting, analyzing and interpreting data. It may, for many of you, seem like a secondary task, but it is crucial. It's really crucial especially now. The next five-year needs assessment due next July will probably be shaped within the context of wide-

ranging, new healthcare reform legislation. It will require reliable, accurate, up-to-date and complete data. To know exactly what we can contribute to healthcare delivery for women and children including those with special healthcare needs and to know how we can best operate after healthcare reform legislation has passed, we need to know exactly what we do best. This means collecting the right data to determine performance, encouraging testing of the effectiveness of our work and tracking outcomes.

We need the very best data to more sharply define our impact on U.S. healthcare. That doesn't necessarily mean adding data. It may well mean being even smarter about what we are tracking and tracking it more effectively. In terms of performance, HRSA's bureau is more broadly -- are deeply involved in efforts to promote care quality. And some of the most interesting work in the area of quality performance measurement, quality assessment improvement, comes from this bureau, from the Maternal and Child Health Bureau.

As you well know, all of the 59 states and territories that get MCH Block Grants report annually on their progress for meeting targets on 18 National Performance Measures. We, as you also know, published those data on our Web site. When state officials apply for Block Grant funds each year, as they're required to do, MCH Bureau program staff meet onsite with them and engage in conversation about their performance and, if needed, about ways to improve it. I think that this linking of data to performance improvement is a model. It's a model, frankly, for all of the Health Resources and

Services Administration's programs. It's a model for what all of us should be doing: using data and applying it. Not just collecting data and putting it on an electronic shelf, but using it to drive quality improvement to drive performance improvement.

Since 2001, in another area of performance, the Maternal and Child Health Bureau has funded a smaller quality effort, not as widely known, but with an impact that touches the delivery of care to children virtually everywhere. It's called PECARN, an acronym for the Pediatric Emergency Care Applied Research Network. And it's the first federally funded pediatric emergency medicine network in the United States. Dr. van Dyck mentioned it earlier in his comments to his list of achievements. Let me just say one more word about it: with an investment of just over \$5 million, so small investment, big impact.

PECARN conducts research on the prevention and management of acute illness and injuries in children and youth of all ages through a network of 21 participating hospitals. PECARN research has already improved care for children with bronchiolitis and for those with head injuries. And it is a great example of how we are leveraging research and data to improve outcomes. Performance improvement also requires a closer collaboration at the regional level, which is why the duties of the HRSA's regional offices will now reach substantially beyond safe reviews and focus on core functions such as increasing access, reducing disparities and analyzing healthcare trends. The regional offices will focus more on strengthening links between states and communities and

coordinating technical assistance, and they will become more active in the recruitment and retention of the primary care workforce in their jurisdiction.

So in addition to collaboration, performance improvement, my third priority is a new approach at HRSA, a refreshed approach to public health. Joint efforts to improve performance in the coming years will take place within a rapidly changing economic and demographic landscape. This requires all of us, I think, to shift our focus from the treatment of acute conditions to incorporating a far more substantial and broader focus on prevention. This is why I recently appointed within the office of the administrator, Dr. Kyu Rhee as our chief public health officer. He is a primary care physician, and Dr. Rhee will oversee our HRSA-wide public health agenda. He is in the process of reviewing programs and policies from a public health perspective. And he's working more closely with all of our constituents and partners to promote disease prevention and healthier living.

He's already led efforts prior to joining HRSA to reduce health disparities through his work at the National Institutes of Health and through his work at the largest network of federally qualified health centers in Maryland. And Dr. Rhee has a special awareness of some of our programs at HRSA, having served for five years as one of our National Health Service Corps Scholars, and as a medical director of our HRSA-supported Upper Cardozo Health Center, one of the health centers here in Washington DC.

So collaboration, eye toward performance measurement and performance improvement, and all the strategies and science it takes to achieve that, and an eye toward threading a much stronger public health, population health focus through the work of the Health Resources and Services Administration. So, a bit of a snapshot of the directions we're moving even as we work in close collaboration with you.

In conclusion, let me just say that -- and it's perhaps not lost on any of you -- we are clearly passing through, I think, very historic times. There is palpable excitement, expectation and appreciation that accompanies our work. And I really think that for all of our portfolios, programs and so for the people that we serve -- for our portfolio of programs and for the people that we serve, these can be decisive days. Our ability to prove the value of your programs and to improve their performance even further will influence the course of healthcare. And, in fact, I think it already has begun.

So, looking forward, I ask you to join us to renew your commitment to our common shared goals, and know that at HRSA, we are an active and passionate partner in the mission that we share with you. Thank you very much for the opportunity to spend some minutes with you here this morning. And if you have any questions or comments, I'd be happy to try and address them. And most importantly, thank you for the very important work that each of you do on behalf of the American public. We're very proud at HRSA to be a partner with you in that work. Thank you. Thank you.

Any quick comments, questions, observations for me? Yes, sir?

PETER SIMON: Thank you very much. I'm Peter Simon from Rhode Island. We're having a problem getting our agencies paid. And the stimulus money is going to make it worse.

MARY WAKEFIELD: Okay.

PETER SIMON: We have a cash flow problem. The states -- many of the states are seeing really decreasing revenue streams. And because the federal government has a policy of reimbursement once states have actually spent money on federal contracts, we can't pay our bills, we can't draw down federal money. If there's one thing that you could do for us, it would be to figure out some way to change that system.

MARY WAKEFIELD: 'Cause you've given me a harder task. Actually, this is coming as news to me. And so, in terms of -- it sounds like delayed payment for -- as a reimbursement for expenditures that have already been incurred by your state and no doubt probably other states that are in the room. I don't -- what I can promise you is that I'll take a look at that and, at the very least, do two things. One, share it with my supervisors, who is, of course, the deputy secretary and the secretary. So I'll share it there. And I'll also take a look at what we are doing internally to make sure that we are as efficient as we can be within the Health Resources and Services Administration. So thank you for flagging that. Let me just -- and let me guarantee you that, at the very least, I'll take a look at it and see what we can do. I can envision that would be an

extremely serious challenge for you particularly given the economic constraints that states are operating under right now. So thanks for sharing that. Yes.

TRISH THOMAS: Hi, good morning, Dr. Wakefield. I'm Trish Thomas from the Pueblo of Laguna and I was very happy to hear that you're looking at broader collaboration. And I want to know how the collaboration is working with the Tribal Nations and the Indian Health Service.

MARY WAKEFIELD: Well, I'll say two things to you. I have a meeting with Dr. Yvette Roubideaux either today or tomorrow with exactly that aim in mind, to look at where our shared agenda overlaps and to explore avenues for aligning our resources even more effectively between IHS and HRSA. I participated, shortly after I arrived March 10th in this position, in a meeting with HHS leadership and Tribal Nation leadership. And at the very end of the meeting, one of the tribal leaders said -- there were probably about a hundred people in the room -- "And so, what will happen between this year and next year?" And there's just a bit of a pause because it was an important question. And I stepped in and said, "Well, what I can promise you from HRSA," because this is of course all of HHS there, "What I can promise you from HRSA is that we'll do a drill down and take a look at where our programs are currently operating on behalf of Tribal Nations and where they're not but could be."

Well, since about April when that meeting occurred and now we've conducted that assessment of where we've got opportunities to leverage our resources even more than

we have, perhaps historically. And that will be part of the agenda in my conversation that I bring to Dr. Roubideaux -- it's either today or tomorrow. I can't remember. So, we're working on that, and look forward to more opportunities.

HRSA's mission is focused, of course, on insuring access to high quality health and health services for underserved populations primarily, not just, but primarily across many of our programs. And of course, the population's healthcare needs across our tribal nations are often compromised in terms of health status. I know that having grown up just 13 miles from a reservation in the state of North Dakota and seeing it firsthand. I can appreciate the challenges, but we're going to do everything we can to leverage resources going forward.

TRISH THOMAS: Thank you.

MARY WAKEFIELD: You bet.

Anything else? Okay. Two great questions or comments, then. And I'll just say thank you again for the privilege of being with you here this morning. And do share all of your great ideas, concerns, problems that you have with us. We will do everything we can to address challenges as expeditiously as possible and to incorporate your ideas so that we can serve you even better as you extend the reach of HRSA in your states across the country. So thank you again. And I think I'll be seeing you again tomorrow when the secretary is here. Thank you. And thank you, both of you.

Thanks, Cassie.

CASSIE LAUVER: Thank you. And I think you can feel the enthusiasm that the room has with your vision for HRSA for Public Health and how Maternal and Child Health fits into that. And I think when you talk about the three areas that are key to you, looking at partnerships, looking at quality measures, these are people that are on your team and exhibit that every day in terms of their partnership, historically and forward. So thank you very much.

Just a couple of quick notes -- and thanks to Peter, too, because I think he really carried on from yesterday's...

So the old dog can learn a new trick, it seems. We are not done now. We are carrying forward. And I think, this afternoon, in terms of the breakout sessions, they are very -- they are very meaty. I think people are going to have a difficult time selecting which session that you are going to. So we're very pleased. It's a good problem to have.

Now, I will say that three of the sessions in each of the breakout sessions will be recorded and archived. That will make your job a little easier. And I think either at the registration table and on the doors for the breakout sessions, there will be an identification tag indicating whether that session is going to be video recorded. So hopefully that will help make your decisions and look forward now to going to our regional breakouts. And again, we're very pleased to have our colleagues from the field

offices here. And it will be a great opportunity for them to debut in their new roles in the regional breakouts. So thank you very much.