

Federal/State Partnership Meeting
Making a Paradigm Shift in MCH:
Integrating Health Equity, Social Determinants of Health and the Life
Course Perspective
October 25-27, 2009

MICHAEL KOGAN: Inequities at my household level, and we're going to talk about why my son has his phone taken away more than my daughter. (Laughter).

So our first speaker is Lorraine Lathen. Lorraine is a health advocate with the bulk of her career centered on public health and social marketing. She spent nearly 20 years providing technical direction to family planning, HIV/AIDS education and child health initiatives in developing countries and the United States. She holds a BA in political science and French from Marquette University, a master's degree in international affairs from American University here in DC.

Lorraine.

(Applause)

LORRAINE LATHEN: Thank you very much for having me. I guess what I'd like to do is first really start to say that I'm speaking today, and I'm really trying to represent the voices of the communities that we're working with. So it's with a great deal of humility that I share this presentation with you.

So we're going to talk about ABCs for healthy families. It's funded by HRSA. The first time motherhood initiative and new parents initiative.

So I'd like to begin with a quote. And it starts by saying: Life begins to end the moment we become silent about the things that matter.

And I mean today, yesterday, certainly has been just for me to look at all the people that are speaking out and working on this issue of maternal and child health certainly means that people are not silent on the issue.

So basically the goals of our project were to develop a social marketing program that really focused on trying to reduce racial and ethnic disparities in birth outcomes.

And again my background is social marketing so I was contracted out by the state to work on this initiative.

And when you look at the state of Wisconsin, we realize that infants being born too soon and too small are the leading causes of infant death along with SIDS. We've had a number of cases of co-sleeping that has really brought to light the issue.

And also the issue as it relates to cultural issues around co-sleeping. So if you look at African-American infant mortality in the state of Wisconsin, our rates are about three times higher than white infants.

And basically there's been some research that basically says that if we were able to eliminate the disparity at least one African-American infant would be saved each week in the state of Wisconsin. So that's really what's motivated us to do the work that we do.

Looking a little bit at the stats, actually, I want to focus more so on Milwaukee and Racine. This is where this project, our social marketing initiative, is focused on.

So if you look at those rates, you're looking at 23.4 deaths per 1,000 live births in Racine and also looking at Milwaukee. The reason Dane County is highlighted is because all the disparity the black/white ratio is much smaller. And actually research has been put into place to look at what makes Dane County so different than the rest of the state of Wisconsin, and are there lessons learned that could be replicated.

So when we think about infant mortality, we also know that 90 percent of those infant deaths are occurring in south eastern Wisconsin. That's mainly Milwaukee, Racine and Kenosha and also southern in Beloit but the bulk of the deaths are

occurring in Milwaukee. We can focus on a number of zip codes. That's how we've been able to look at the issue and start to engage those communities that live in those zip codes.

What I wanted to share with you is our journey actually started a year ago. I was hired as a contractor to do focus group research with low income African-American mothers and grandmothers. And soon we realized we needed to also speak to the fathers.

And we really wanted to look at from their perception what were the barriers that were preventing them from engaging in activities that would support them in having healthier birth outcomes. And there was so much that came out of the data.

But one thing that I'm going to share with you today really focuses on the issue of stress and depression. So I would like for you to hear from a few of the women.

UNKNOWN SPEAKER: And I had a lot of depression could be harmful to the baby.

LORRAINE LATHEN: You guys can hear it? I don't know where the --. Okay let's go to the next one. I'm not sure about this. Whoops. Okay. Sorry. Okay. So anyway the whole issue was that what we were hearing from the mothers really

related to the fact that they were feeling as if they were isolated. And what we were hearing from the fathers is that they wanted to be involved. We were actually seeing fathers that were going to the prenatal care visits with the women and for one reason or another, after the infant was born, that's where they were dropping out. And we tried to focus on why were they dropping out? And we looked at kind of from an African-American's perspective, their ideal of what it meant to be a man in a relationship really we talked about the three Ps, African-American men professing their love for the women in in their life but also for them to be a provider and a protector.

When we start talking about health inequities, talking about social determinates of health and put African-American men in environments where they can no longer serve as protector and provider, they're dropping out of relationships.

So that really made us think, well, what do we need to do differently in terms of looking at maternal and child health. And part of it was engaging the fathers and really taking a life course perspective.

So we moved into the whole issue of integrating the life course perspective into the work that we do. And you know we really focused on how to increase the protective factors and reduce the risk factors in order to help families promote healthier birth outcomes.

And what I'd like to do, and I'm going to try to speak loudly because I'm not going to use this mic for one second. What I'd like to do is share with you kind of an exercise that we use in our community, because right now you know we use -- we quite often use a lot of jargon and terminology that really excludes communities. And we wanted to make sure that they felt engaged and involved in the process and that they were not researched on.

So basically we invited them a year ago to help us with the focus group research. We brought them along, put them in contact with experts in the community so when we started talking about life course perspective and aloe static load whatever and brought Mario and Dr. Drummond or others or Dr. Liu to the community, that they understood. They didn't feel as if they were out of the environment with these people, that they could really understand.

So I'm going to role play for just one second, if you will bear with me. And just imagine that I'm going to be, hmm, 21 years old. Okay.

So the whole purpose is just to explain the whole early programming and aloe static load. So I'm really going to try to talk loudly. Is that all right?

So basically what I would do out in the community, what I would say is, okay, I want to explain to you that there are factors that impact whether or not you're

going to have a healthy baby. And some of those factors, they happen long before you can even think about becoming pregnant.

And it's related to that early programming. So there's things that you do, things that happen in your life, it may be related to even where you live.

We call those social determinants of health. Okay? But those are the things that can impact whether or not you have a healthy baby. And they cause this burden on you. But they lay dormant for a number of years.

And then something happens. Something triggers these things that have been laying inside you that wake up. And so one of the things that trigger it is the fact that you become pregnant. So you become pregnant. You're already carrying this load. You're carrying a boulder, a big huge boulder, and you come in over here and you're saying, please, please help me relieve me of this boulder. Give me affordable safe housing. Take this boulder from me.

Then you keep walking along and it's relief for a certain amount of time now you have this apartment and it's in a safe neighborhood. But then something happens in your life, my God, you got it again, and you're walking, look I'm all the way down here. It's the withering effect that you're walking like this. The weathering effect that you're walking like this with this boulder.

So you continue and other populations, they're not hearing this big Boulder, because they have social support systems. They have other things that allows them to relieve them of this Boulder. But you don't.

In your community you don't have that. So how are we going to work together to allow you to relieve yourself of what they call the aloe static load? And so anyway, we go on and on. But my point is we really try to break this down so that the community understands that we want to involve them in the research. We don't want to feel that you're research science and we don't want you to think you don't bring something to the table.

That's just one quick example. Let me get back over here. So that's the life course perspective kind of defined or translated for the community. Does that make sense?

So this is our community advisory board, and we have people who are retired nurses. We have fathers. We have one father, he's the father of 11 kids from different women. But he's at the table. He's trying to go out and educate others about the whole issue of being an engaged father.

We have Social Service agencies. Just concerned citizens. And they meet -- originally we met once a month. Now we're meeting every other month. So this

was my dream team. We talk about them as being our community advisory board.

Then we have our technical advisory board that includes Dr. Liu, Mario Drummond, Dr. Collins, and Dr. Shorter-Gooden, who actually she wrote a book it's called "Shifting the Double Lives of African-American Women." And she really looks at the impact of gender and race on women on the well-being of women.

We call both of them the technical and advisory team. They now all meet together. Before we had them meeting separately. And we also have Dr. Felda Jackson who just joined the team as well. So we really are serious about this. We're serious about working in communities.

So as a result, just real quickly some accomplishments in Milwaukee. Milwaukee we trained 14 community members. They were trained to collect data in our communities, and they also received NIH Human Subject Certification. So some of them had GEDs. Some of them did not have high school degrees. But guess what, we didn't make any assumptions about them. We met them where they were. We took time. We took them through the whole process.

When they got their certificates that you print out, they were so excited about these certificates. So we trained them and then they went into the community and they collected research for us.

The data that they collected had to deal with kind of the community's understanding of the life course perspective. Of course we didn't use that word. But the understanding of how your life throughout the life span impacts whether or not -- impacts a number of health outcomes including birth outcomes.

And then they also collect the data to help us develop our marketing campaign. And that data was related to best ways to reach our target audience, which we figured out had to do with text messaging, radio and whatever. So they collected in Milwaukee 299 surveys. They were very proud that they were able to do that.

They were paid to do it. We feel as if we have a cadre of community members that can engage in participatory research. They also showed the screening of "Unnatural Causes." They saw the screenings they helped facilitate those workshops then when they got to meet people like Dr. Liu and Dr. Collins, I wish you could have seen their reaction they're like: That's Dr. Liu. Because they had seen on "Unnatural Causes." And then Dr. Collins. And I really think it made them aware of how serious we are about working with them.

And so then also we moved into developing support circles for mothers and fathers. And I think you might -- let me just -- some of you might have been able to pick up the handouts on the support circles. And it really summarizes the type of work that we did.

We developed eight sessions for mothers and originally we had four sessions for fathers. But the fathers kept coming. So they stayed long. But this summarizes those sessions that developed.

And I guess when you read it, I hope you read it from the standpoint that we really did look at issues related to social determinants of health. And we wanted to help mothers and fathers have healthy babies and keep them healthy, but we also had to deal with the issues of unemployment. We did mock job interviews. We did issues of trying to in terms of saving, opening a savings account, saving money for the future.

So anyway, you can kind of read through those pieces. And we accomplished the same thing in Racine as well with 16 community members and they also collected 452 surveys.

I'm going to take my last five minutes to share with you our campaign. It's called Journey of a Lifetime. And I think it really embraces the essence of the life course, in terms of looking at health throughout the life span with the acorn. It was launched on October 14th.

It basically says: Idea will stress in ways that don't stress out my baby. And that's kind of our tag line. We have posters, billboards. This is a copy of a billboard.

And we have print ads in all of the local papers.

And then we also have a MySpace page. So this is a MySpace that you can go to and get more information. And the text messaging, you can text "no stress" and you write in what's stressing you out. Is it housing? Is it unemployment? Is it whatever, and you'll get a text message back that refers you to our partners.

And I hope I have time to -- can I just have time for this? So this is a radio spot.

We did three. We did radio spot for preconception and then during pregnancy and interconception. So this is one of the spots.

Well, I guess I won't be opening it up. He just fixed it. Sorry. I won't be opening it up. Maybe we'll figure it out after the presentation.

So these are more of the brochures which you have, and, again, it gives messages before, during and after pregnancy. And I guess I'd like to end with a quote by Dr. Ralph Albernathy who said: "I don't know what the future may hold but I know who holds the future." So thank you.

(Applause)

MICHAEL KOGAN: Thank you very much, Lorraine. We're going to take questions at the end. In fact, we're limiting the presentations to 15 to 18 minutes to leave sufficient time at the end of the session for discussion, because I think all the presenters would like to hear your ideas on what more can be done.

So our next speaker is Anita Siegel. She's the Acting Director of the Alameda County Public Health Department, was appointed on October 21st, 2009.

Previous to that she served as the Deputy Director of Operations. She has oversight for family health services, emergency medical services, community health services, public health nursing, the Division of Communicable Disease Control and Prevention and the Health Equity Division. And so with that, Anita.
(Applause)

ANITA SIEGEL: Just a minute. Let me bring up my slide show. Great. Good afternoon. I'm very thrilled that I was invited to be part of this panel. I always take great pleasure in talking about the work that we're doing in Alameda County. And so I'm very happy to be with you all of you today. So I want to talk about the work we've done in Alameda County and how our public health department really set the way and the path for us to embark on a life course model and a life course initiative. Because there's a lot of prework that we've done around this.

I'm going to show you a few stats about Alameda County and some pictures and I'm going to tell you how we brought together partners outside the public health department to help us work on the social determinants of health.

So this is our mission, which is to work in partnership with a community to ensure optimal health and well being of all people. We take this very seriously. We involve our community residents and our community CBOs in all of our work.

And these are two of our health reports. And we know that overall, in Alameda County, we have improvements in health but we also know that health does not equal healthcare and that health inequities are greater than healthcare inequities. So a look at Alameda County. This is Piedmont, a nice part of Alameda County. This is the southern part of the county, Fremont, and this is Pleasanton, where it's very bikable around there.

This is also Alameda County. So this is Oakland and some parts of Hayward. So we see blight there. We see stores, like an overabundance of liquor stores and also fast food chains. And not a lot of healthy stores where you can buy healthful food. So how much does place matter? Let me show you some community trajectories.

This is a map of Alameda County. On this side is the San Francisco bay. And we have a lot of green. So like I said earlier, we've had great improvements in health outcomes.

So if you live in one of the green areas, we know that high school graduation rates there are about 90 percent. Unemployment is low. Around four percent. Poverty is pretty low. Seven percent. And there's home ownership of about 64 percent. And the non-white population is 49 percent.

Then if we go to the -- and there's a picture of that. You can see a lot of green. Many places to walk. And swimming pools in some of the backyards. This is a yellow part. And this is an area around San Leandro. So you don't see as much green but you still see pretty nice houses, some swimming pools. High school graduation rates in this area about 81 percent. Unemployment is six percent. Poverty is 10 percent. Home ownership is 52 percent, and the non-white population goes up to 59 percent.

And this is where we're concentrating our efforts in the red zone. So high school graduation rates go down to 65. Unemployment is 12 percent. Poverty has gone up to 25 percent. Home ownership is down to 38 percent. And the non-white population is 89 percent.

These areas also, if I were showing you some statistic on asthma, we have very high rates of asthma here, and a lot of early death and chronic disease. And as you can see, this is near the Port of Oakland. It's very industrial. Mixed use, a lot of apartment houses, and not a lot of places to buy fresh fruits and vegetables.

So these are the trajectories that we have. The green, very good life expectancy. The red total difference. And these are the things that we know affect this. Good schools. Whether you have a job or not. Crime. High rates of crime in the red area.

Segregation, as I mentioned the red area has almost 89 percent. Non-white population. Housing. And toxins. So what are the risks and protective factors that shape neighborhood conditions? These are the health inequities that we see as the root causes, are the social inequities that we know are the root causes of health inequities.

Late last year we published this report called Life and Death From Unnatural Causes. And we talked about segregation, income and employment, education, housing, transportation, air quality, food access and liquor stores, physical activity and neighborhood conditions. The criminal justice center -- the criminal justice. Access to healthcare and social relationships and community capacity building.

And here I'm going to go quickly through some slides. This is life expectancy at birth by neighborhood, and poverty in Alameda County. So you see if you live in a neighborhood where poverty is greater than 30 percent you have a much lower life expectancy than if you live in a neighborhood where poverty is less than 10 percent. And we break this out by race.

And this slide shows our race from or the differences in life expectancy from 1960 to 2005. In 1960, there was only 2.3 years' difference between African-Americans and whites. And in 1960 we only categorized deaths by that.

So someone that looked like me was categorized in the white and now we've refined that much better because we collect better data. In 1980, the difference was almost five years. And today it's almost eight years' difference.

So compared to a white child in the affluent Oakland Hills, an African-American born in West Oakland is one and a half times more likely to be born premature or low birth weight and seven times more likely to be born into poverty.

So going through the life course, a child born here will be two and a half times more likely to be behind in vaccination and four times less likely to read at grade level.

And then as an adult, five times more likely to be hospitalized for diabetes and two times more likely to die of heart disease. So that's the cumulative effect of race, income and place. There's 15 years' difference in life expectancy. And we're all going to die, but those 15 years means that people who die early quit contributing to their community, to their family, to their church, and it's unfair and it's preventable.

So in Alameda County, the Bay Area health officers and epidemiologists got together and developed this framework. We call this the Bar High Framework. I'm going to go through it quickly.

There's six boxes in this framework for health equity. And starting at the right we have mortality. We have disease and injury. And we have risk factors and behavior.

So we know that in the medical model we deal with mortality, with hospitalizations and clinics, disease and injury also with the emergency rooms and healthcare and then risk behavior and -- risk factors and behavior with health education.

And then we have social inequities, and we know that one of the ways to get to social inequities in community is to work with community and do community capacity building. We know that institutions, the way that they deal with their

power affects people's health. And we also know that there is discriminatory beliefs, mainly racism, that affects the health outcomes.

So this is what we're doing to deal with health equity. We've started some neighborhood initiatives that we call community capacity building, because health is not about access to resources and power -- or health is about access to resources and power. We're also working on a local policy agenda. And we're working to change ourselves as an institution.

So I want to tell you about two areas that we're working in Oakland. We've picked two areas because they are characterized by high rates of violence, poor health outcomes, low rates of unemployment and not very good school performances.

So we're working to build social, economic and political power in the communities to advocate for equal distribution of resources. As I said, they're West Oakland and Savani Park. We started our work in both of these communities by going door to door, doing a survey and finding out from the residents what it was that they wanted to change in their community, one, and what it was they wanted to, that they were willing to work on.

So in Savani Park, they wanted to improve Tyrone Carney Park. They wanted to reduce drug dealing and violence. They wanted to create more positive activities for youth, and they also wanted to prepare neighborhoods for disaster.

And this one came out -- we had our first community forum right after Katrina.

And because Savani, most of the residents in Savani Park looked like the people in New Orleans that were affected by Katrina. So preparing for a disaster was really important to them.

So we worked with them on that. In West Oakland, they wanted to renovate Durante Park and reduce blight and create a continuum of improved and connected youth services for employment.

We're also working on a local place, a local policy agenda. And we are one of the NACHO place matter sites. I don't know how many of you are part of that. So we've chosen five areas to concentrate in that focus on education, economics, criminal justice, housing, land use and transportation.

So here's some examples of policy interventions that we're working on affordable housing, transportation and land use. As an institution, one of the things that we've done is we went through a year and a half strategic planning process that was participatory. We actually went to every community in Alameda County represented by one of our board of supervisors and had a session with community members.

So we had six and then we had one in Spanish. And heard the voice of our community in order to come up with a strategic plan that works on reducing or helping to achieve health equity and reducing disparities.

We've also developed an all-staff Public Health 101 training. It's five modules. And everyone that works in the public health department has to go through these five modules. The modules are learning about the public health system, cultural competency and humility, racism, community capacity building and health inequities. We developed an internal leadership program to prepare future leaders to take on our work since many of our senior staff are either my age or older and about to retire. So we want to make sure that we're ready for that.

And then we've done a really good job of sharing our vision not only with our staff but also with our community residents and our community-based organization.

And we continue to have discussions on institutional racism. We've had two national speakers come to us. Most recently Kamara Jones spent a day training not only us but many of our partners.

So this is our strategic plan. And I don't want you to have to read all of this. Let me just tell you how the work that we're doing with our life course work is part of this. So we want to design a comprehensive and organizational approaches to improve departmental outcomes in this case it would be birth outcomes.

We want to facilitate creative collaborative strategy development to address the root causes of health inequities and we want to share these solutions. We also want to standardize the process for planning and measuring performance and we want to build sustainable partnerships with the community.

We want to advance systems that change policies and we want to cultivate nontraditional partners. So we organized a perinatal system design committee. We have every year we have 7,000 infants born into poverty in Alameda County. That's one third of our total births. Whoops.

We have many of our programs interface with maternal and child health population. I showed you that we have birth outcomes that persist by race. And we know that intervening during pregnancy is not enough to level the differences.

And we want to have a system that supports good health during prenatal and early childhood can lay the ground work for a lifetime of health and healthy development.

So we needed a unified approach. So this is how we started in the summer of 2008 we had a call to action and organized internally to get people interested in working on a life course initiative. In December we invited my neighbor from Contra Costa County to come and speak to us.

And Cheri has been very inspirational to our work. In fact, she continues to be a consultant to us. From March to June we engaged in a learning community where we learned about best practices throughout the country. Probably read about some of the work that many of you in the audience are doing. And learned about many different approaches. Not only in health but also in education.

And I must say one of the things that we read about that was truly inspirational was the Children's Harlem Zone and a book by Paul Tuft called "Whatever It Takes" and that was very inspirational.

In July of 2009 we got agreement on some guiding principles. And in September we had a symposium where we invited a lot of health professionals, but a lot of nontraditional partners. And we were extremely fortunate to have both Michael Liu and Mario Drummond be panelists for our symposium.

So these are the guiding principles we came up with; that the system must be comprehensive and integrated across the life course, has to be multi-level to address root causes. It has to be resident-driven. It has to be collaborative. And it has to be evidence-based and accountable, and we have to be committed to long-term solutions. So a lot of these problems weren't created overnight. We need to be committed over the long haul.

So here's our building blocks symposium poster. It was incredibly successful. We had our former director, Anthony Eaton for those who have had an opportunity to hear him, you know how inspirational he is.

So he laid the framework for Alameda County. He was followed by Dr. Liu who really gave the research and the academic model. And then the morning session ended with Mario Drummond talking about the practicality of how you go about making these changes.

So we had all these different partners from housing, child care, parks and rec, education, transportation. And we realized that we need all of them to do this work. Our challenge is how do we keep them all engaged? We know that people in healthcare, we can keep them in engaged with this work, but how do we get someone from parks and rec or education. They can't go back to their boss and say I'm going to work on this life course model. So that's one of the challenges we're dealing with right now.

So I want to thank my colleague who helped prepare this. And I'm done.

(Applause)

MICHAEL KOGAN: Thank you very much, Anita.

Our last speaker is Dr. Cheri Pies. She's the Director of the family Maternal and Child Health Programs for Contra Costa Health Services and she's on the faculty of the School of Public Health at U.C. Berkeley as a lecturer in the MCH program, the MSW/MPH current and dual degree programs, and the DRPH program.

And today she's going to talk to us about the life course model in the MCH department in Contra Costa County. Cheri.

(Applause)

CHERI PIES: Thanks, Michael. And thanks to my co-panelists. I wanted to say that this is a very exciting moment in time. Many of us have been working very hard over the past several years to bring the concept of the life course perspective health, equity social determinants of health to the attention of all of us in the field. So I'm delighted to be here.

And I really want to extend a special thanks to Milt Kotelchuck, and Michael Liu, Mario Drummond, because these three Ms in my life have been very influential in guiding my thinking, helping me to know what I'm trying to do and give me some reality checks as I go along.

So as Michael Kogan said, today we wanted to have a broader state perspective from Lorraine in Wisconsin, a more public health department perspective from

Anita in Alameda County. And I'm going to give an MCH program perspective on implementing and integrating the life course perspective.

Some of my slides you're going to see will be similar to the ones you've already seen. Balls we didn't compare our slides ahead of time. So first I just want to start with this picture of a beautiful blue sky. A couple of clouds up there, and I want you to just think for a minute as we go through time and as I go through my presentation what that blue sky says to you.

Because I'm going to come back to that. I promise not to sing Blue Skies.

Although Michael Kogan said he might join me. But I'm going to pass. But for now just be thinking about this blue sky.

So what I'm going to do is I'm going to tell you a little bit about Contra Costa County which is where I'm from. And I'll tell you about our life course initiative, talk about our road map. And I'm really going to focus the bulk of my time talking about a project that we are just implementing now called BEST, Building Economic Security Today and touch on the challenges and lessons learned.

So Contra Costa County is one of 58 counties and one of 61 health jurisdictions in California, northeast of San Francisco, and right next door to Alameda County. So you can see where we are there.

We're a county that's about a million people. We have about 13,500 births a year. The demographic breakdown is about 54 percent white. 22 percent Hispanic. 13 percent Asian, and eight percent African-American. But that's shifting and changing over time. And we're seeing an increasing number of Hispanic folks who are moving into our county now.

And we have about almost 20 percent of our residents live below the 200 percent of the poverty level. So what got me started on this life course initiative was, first, I heard Michael Liu speak in about 2003 and I had an aha experience. For those who haven't heard him speak I'd encourage you to watch "Unnatural Causes" or get an opportunity to see him, because it's like all the things I've been thinking about for decades in Maternal Child Health brought together in an hour talk. I said wow that's it. What got me started after I heard him speak was I looked at our data and I looked at the percentage of women who were getting into early prenatal care in our county and frankly we were doing pretty well. We weren't doing fabulous, but we were actually in 1999 we were number one in the state for early entry into prenatal care, and we've done fairly well with that. But you can see the breakdown across ethnic groups isn't exactly equal. But it's not bad.

But then I looked at our low birth weight rates. And as you can see even though we had African-American women who get into prenatal care fairly early, well 82 percent of them did, we had a high low birth weight rate for that population in

particular. And then we looked at our infant mortality rate and we were looking at 9.3. And you know frankly this was unacceptable.

The board of supervisors was asking me, you know, if you're getting women into prenatal care how come the outcomes aren't better? And frankly I was asking myself those questions. And Michael Liu's work helped me put it together.

So in 2005, with my staff, the MCH program in Contra Costa County, we launched a life course initiative. It was based on the work of Michael Liu and Neal Halfon in an article they published in 2003 in the MCH Journal, and the work that Michael Liu had done with Milt Kotelchuck on developing a 12-point plan to close the black/white gap in birth outcomes. We used those theoretical pieces to guide us.

We identified four goals for ourselves. We wanted to -- and as you'll see, you know they're really similar to the work that Lorraine and Anita are doing as well. We wanted to reduce health disparities and health inequities. We wanted to optimize reproductive potential.

We really wanted to create a paradigm shift in maternal child health. We wanted to move away from prenatal care and the medical model of being the panacea for improving health and birth outcomes. Above all, what we were aiming for was to

change the health of a generation. I will say that alone was what was inspirational to the staff that I gathered around to make this happen.

You saw the slide this morning. Dr. Van Dyck showed it. This is a schematic of the life course perspective. I won't go through it again. But just as a reminder, what it points to is increasing protective factors, reducing risk factors in an effort to raise up the line of African-American women to where the Caucasian women are.

And you know, African-American and Caucasian are the two population groups that you're seeing in a lot of this data, but that's because that's where we have a lot of numbers over a long period of time.

But you could be putting in Hispanic or Latinas in here too and you would see although a little higher than the African-Americans, especially second generation Latinas, they will be closer to the African-American lines.

So I just wanted to point that out. So for our life course initiative, we did a lot of staff education. We didn't really go out into the community so much. I had felt like I had to work with my staff internally and help them understand what was this about. And help them know it wasn't going to be more work but it was a different way of thinking about the work they were already doing.

We laid ground work with higher level managers, my boss, my boss's boss, the state; we really needed to bring people on board to let us do this work, because we're MCH. And we have particular performance measures that we're aiming to complete.

We focused on strict conception care. We designed some evaluation outcomes which I'll talk about, and really what we did was we developed a new intervention. And I'm not going to do this right now, but I will later. We have a website, this Life Course Initiative Web site. I have it at the end, a hyperlink. I'll click on it. You'll see we have a ton of materials. One thing I want to say is that anything that's on there that you are interested in and you want to use, go ahead and use it.

Take it, use it, make it your own, whatever it takes, because that's what it's there for.

With our staff, education, we talked about the theory of life course. We have a life course game that some students of mine developed based on Chutes and Ladders. And it's a lot of fun, and we can't produce it because it's a Hasbro product. But if you're interested in it, you can e-mail me and we'll send you a copy of it.

Also, City Match has developed their own life course game, which is another excellent game based on a variety of other things that they had seen and they had pulled it together and it's also quite good.

The reason I mention these games is that they are interactive and fun ways for people to learn about the life course perspective without having to hear a lecture, which especially after lunch I can see some of your eyes are still open so I'm happy. (Laughter).

We identified some life course activities that our staff were already doing. We talked about the 12 point plan, and most important with our staff what we did was we asked about how they could integrate the life course perspective into the work they're already doing. So what are you currently doing that lives with the life course perspective because we didn't want them to think that it was a brand new thing. We weren't reinventing the wheel and how could they integrate this into their future activities.

We were doing evaluation. We have a life course initiative data team. We conducted a survey of our staff to make sure they understood what we were talking about, and we've developed a logic model and an evaluation plan.

For our road map, we're using the 12 point plan. The purpose of the 12-point plan is to close the black/white gap in birth outcomes, move us beyond prenatal care

as the model, look further than individual level intervention. So really looking at more population-based interventions, and again moving beyond that medical model.

So we're moving more towards what health is and not what healthcare is.

And we've developed a little graphic here in Contra Costa. Well, not here. But, you know, here. Traveling many paths to help equity in Contra Costa County. Kind of reminded me of Dr. Hogan's graphic yesterday when she had the freeway intersections. We're looking at this intersection of all these possible paths. And many of these paths come from the 12-point plan. So undoing racism, increasing wealth to improve health. Creating reproductive life plans. Ensuring access to healthcare for all across the life course.

And we're using this as a way of saying: Here are all the different elements that we're using to get us closer to health equity. But the project that we've just launched best is an aim at reducing disparities and inequities in health outcomes by improving financial security and stability. This has been a big step for us because working with money and doing financial education of clients is not something that you typically do in maternal and child health. So it's meant we've had to develop a whole new set of partners.

I've had to learn a whole new language asset development. I always knew what financial planning was but there's a language out there connected to finance that I didn't know the first thing about.

So this has been actually an enormous amount of fun. Why do we pick financial stability? We watched "Unnatural Causes." I'm assuming almost everybody in this room has seen it. If you haven't, you must take a look at this exceptional series.

The first segment of the series is called in Sickness and in Wealth. And it focuses in on financial issues. And I think it's really what stimulated us to think we have to put health and wealth together.

And then we looked at the health/wealth connection. And even as Dr. Hogan said yesterday, we know that people who are higher up on the wealth gradient are or the social gradient are healthier. So, well, it doesn't take a lot of wealth. You don't have to be a Bill Gates. You just have to be a little wealthier to be a little healthier. So that was something that got us interested and engaged.

And from the 12-point plan we were looking at reducing poverty. These are points on the 12-point plan that I didn't go over because it's a lot of time. And supporting working mothers and families.

And then we wanted to pick something that we thought was feasible. And what I mean by feasible is something that I thought we could do that was measurable that would give us an opportunity to work with our community of families and say, okay, you know, did this work? Are we going to see any improvements in your health by increasing your wealth?

So these are just some quick slides. I want just to include -- there's a great Robert Wood Johnson report that looks at the intersection of health and wealth. This basically says the higher income you have, the longer life you're going to live.

I think for most of us that makes sense. Adult expectancy increases with increasing income and men and women in the highest income groups can expect to live at least six and a half years longer than poorer men and women. That's in contrast to 15 years in Alameda County but this is looking at it at a national level.

And this is a piece that's basically saying, you know, parents' income contributes to a child's chances for health. So I think that we really need to look at childhood poverty and figure out ways to lift children out of poverty, because as we lift their parents out of poverty, we lift the children out of poverty and we lift them closer to better health, longer lives, more productivity, increased contribution to themselves, to their families and society.

And income is linked with health regardless of race and ethnic group. And now I'm just going to share those with you. And this is a schematic that we have found to be interesting and useful to us, where you look at living and working conditions. Social and economic opportunities. All those contribute to better health across and around the life course. Across generations.

So here's a little something for you to ponder. Find a way to keep your stress level down. What works for me is making a ton of money and having practically free healthcare. (Laughter).

So it would work for me, too. So here's what we've been doing with BEST. We have developed a lodge tick model and here's what it looks like. We are looking to maximize family income for daily living. We're trying to help our clients preserve and increase their financial assets.

Now, financial assets, we're not talking about big 401(k)s and things like that. We're talking about a car, maybe a house. Maybe education savings for their kids. We're tracking -- we're not thinking pie in the sky. We're thinking on the ground.

We're trying to increase our financial stability and security and improve their financial status even a little bit with all of that we hope to increase their access to care, improve their housing, maybe help them live in a better neighborhood, and

help increase their food security and help them live in a place where there's less violence.

So this is where we're aiming. And overall we're looking at improved health outcomes and financial status for future generations. One thing we know children learn about money from their parents. I think we can all remember how our parents did or did not manage money very well or who taught you how to use a checkbook or make a savings account.

So we want to help parents do that, too. Our project activities have included staff trainings, developing interventions, working with partnerships and managing an evaluation plan, developing an evaluation plan, which we did in conjunction with some folks from CDC. But I just want to say one thing about our staff trainings. When we did the staff training on financial security and economic development, our staff were more engaged in those trainings than I think we realized they would want to be or need to be.

They wanted all the classes themselves. So that was actually a really good first step for us because we're now helping our staff figure some of these things out and they're dealing their own issues around money and sensitivity. So I think it's going to make a difference with our clients.

Our partnerships: We are partnering with the Federal Reserve Bank in our area, with the IRS, with banks, with our family economic security membership. We have these new partners. And they're excited to see health interested in money. So that's been exciting.

We have a home visiting intervention. We have two interventions, home visiting and WIC. Home visiting intervention we have our home visitors who are para professionals working one-on-one with clients doing an assessment of their financial concerns, giving information, making referrals and doing follow-up. They're not doing financial counseling.

We have an assessment form that the clients are filling out with the home visitor and we're talking through with them after we've visited them for a while. This isn't on the first visit, to get a sense of what they need.

And we're talking about things like opening a bank account, being able to talk to their partner about money. Some of the women can't even talk to their partners about money.

Reducing their debt. Cleaning up, cleaning up their credit. I mean, maximizing benefits. Some don't know about all the benefits they could possibly use.

In WIC, we're doing a series of educational classes. It's a six-week series. We're partnering with Operation Front Line. They have already a developed curriculum, and we're going to be using that with our WIC clients. We did focus groups this summer and asked our WIC clients what they needed to know. And they were more than happy to tell us what they wanted to learn about financial stability.

And they were able to make that connection between feeling good when you have enough money and feeling depressed and tired and not wanting to get out of bed when you didn't have enough money.

So they made that health/wealth connection at the level that they were experiencing it. The focus of our projects are really going to be on training staff, educating the clients, giving them the tools they need and making referrals to our partners who actually do the work.

I just want to be clear. In our MCH program we are not doing the financial work, per se. We're actually providing them with the referrals and we're doing a warm hand-off. So we have student interns working with us, and they've been calling all the places in our county where we could possibly send a client, getting the name of a person.

When I say, okay, Anita, I think you're going to call Opportunity Junction. This is Lorraine, here's her number, she's going to know you tell her I told you to call she'll be right there for you. So we're developing those relationships.

Our intermediate outcomes, because that's what we have to go to first, are increased knowledge and skills of our staff and clients. New practices for staff. We decided we were going to measure that, because that seemed important.

We want to look at increased confidence or readiness of our clients to adopt at least one asset along the strategy and we're looking at systems change.

Our challenges have been making a paradigm shift in gaining staff buy-in. It's slow. I started in 2005. Here we are 2009. We're going to 2010. It's a slow process. But we're getting there, and I'm excited.

Addressing financial status, financial issues, sensitive. Very sensitive. You've got to approach it very carefully. Learning and integrating new concepts takes time. People don't always want to do it. So we have the game, it really helps.

Who is paying for this? How much time does it take? How do you support this kind of effort? We've had to do it on county funds. How do you measure success? I would say that along has been our hardest question.

The lessons we've learned is you have to be -- we have to have a flexible time line. We need find new partners in order to be able to collaborate. Developing an evaluation plan. I would say any new project, evaluation plan ahead of time.

People are always going to ask how are you going to measure success?

And engaging the CDC with us in this has been really very helpful. And you know I would say that one of the lessons learned, and I will encourage all of you to think about this, is that this unique approach has really energized our staff and community partners.

People are excited, excuse me, people are excited to be at work and doing this work. They want to see, is it going to make a difference. So what am I doing here? Here we have these two publications in the back of the room. A report on the national MCH life course meeting that was held in June of 2008 and a policy brief, both are available on our website. Ah, here's our blue sky again. So for me when I look at that blue sky I'm thinking the sky's the limit. And that's where I'm going with this. You know, there's everything's possible. And it's not only possible for us but it's possible for our clients.

And I want to leave you with that image. And whatever it means to you, because this is an exciting time in maternal and child health. And the more that each us brings our ideas to the table, the more we're going to be reducing disparities and improving health equity for all the people we work with and our staff. So thanks.

(Applause)

Here's our information. My colleague in crime is Pam [indiscernible], and she's our life course coordinator. No time for the hyperlink. But that's our website and go to it. You can find whatever you'd like.

MICHAEL KOGAN: Well, thank you. Those are three really great presentations. I'd like to give you one round of applause for all of you. That was great.

(Applause)

I just want to say two things: I think they were so great that probably even after lunch nobody here felt like falling asleep. Raise your hand, actually, if you felt like falling asleep. (Laughter)

Okay. That's my point. So nobody did. My second point, and then I'm going to open the floor up for questions, is how we keep coming back to the theme of how things have changed in 15, 20 years, where 15 or 20 years ago we said let's measure prenatal care, it's got to be the reason that there are all these disparities.

If we can just somehow get women into care for the six to nine months it's going to change your whole lives, and it didn't. The point is you had to change your whole lives. And just looking, I started writing down all the different things that

were brought up in this session, whether it's place, crime, poverty, support circles for mothers and fathers, stress. Economic power, transportation, land use. All the different ways that we can partner with other organizations to try to make a difference, and, of course, share as an epidemiologist, Cheri hit on a key point: Our next challenge is how do we measure what this is going to bring.

So it leaves a lot of exciting possibilities and a lot of challenges. So thank you. And now I'd like to take questions from the audience for our speakers.

UNKNOWN SPEAKER: Did any of you all use experiences in Western Europe to model your programs?

MICHAEL KOGAN: Can you hear in the back?

UNKNOWN SPEAKER: No.

MICHAEL KOGAN: Okay. The question was:

UNKNOWN SPEAKER: Policies that --

MICHAEL KOGAN: Did you model your policies after places in Western Europe? Or places that have more integrated approaches?

UNKNOWN SPEAKER: So I wouldn't say that we modeled it after Western Europe, but if you look at the European countries, many people think that because they have universal health that their health outcomes are better. But I would challenge that to say that they have social policies that support populations. And actually in Unnatural Causes there's -- one of the segments is about a plant that closed in I think it was Wisconsin, and one that closed in Norway. And it was devastating to the community and the U.S. once that plant closed. But in Norway, because there were social policies to support those families, the effect was totally different. So I wouldn't say we modeled it, but I think there's experience that addresses that.

MICHAEL KOGAN: Yes, next question.

UNKNOWN SPEAKER: How can your state [indiscernible].

MICHAEL KOGAN: And the question was how can your state health departments help you?

CHERI PIES: Well, one thing I'll say is that our state department is already trying to help us. But I think they could bring together people to talk about these issues, to help talk about, make sure all the locals are educated about what health equity means, what life course could offer, what social determinants are, and then they could, we could really use some assistance in redefining our MCH objectives so

that they fit more compactly under a new direction, because the way the objectives are now it's kind of hard to shape what we're doing in that way, without being dishonest. And I think that the more the state can step up themselves to understanding these issues, to recognizing that it's the structural changes that have to take place, we have to look more broadly at social policy and public policy around poverty, racism, those big issues, and having been able to have real dialogue with them. I think it would be tremendous for people at the local level to have those conversations because we see it every day.

So I didn't read all the notes but I do have it in my notes one of the ways that I think would be useful is if our MCH scopes of work could incorporate course perspective work. That would be incredibly beneficial to us.

MICHAEL KOGAN: That question right there.

UNKNOWN SPEAKER: I am from the state of Wisconsin. The only thing I would like to add is we are spent for resources. So we happen to have this HRSA grant, but we have not a lot of state resources so we look to the federal government too. So we just need those resources.

UNKNOWN SPEAKER: That comment is a perfect introduction to my question. In Delaware, we're very interested in starting this. We've been working for about a year and a half. I cannot seem to get members of the general assembly and

other stakeholders to agree to shift funds in order to be able to do this. And given that we don't have the influx of new funds, how have you been able to get leaders and decision-makers to agree that it might be a pool of money from here in order to start shaping their work based on that?

LORRAINE LATHEN: We're all going to respond to that. I think people who control money, they want to see outcomes. They want to see things change. And I basically have come forward and said we're not seeing any change doing this. I want to try something different.

And I've been around a while in my county, and they have enough faith in me. I said I want to try this. I don't know if it's going to work but I know it's not going to hurt. And I want you to be willing to invest with me in this because I think that what we know about poverty, the issues that we're dealing with, we know that poverty keeps people down and is a risk factor for any number of social determinants.

So I basically went and talked with people individually and made the case and got my boss on board. And I think having people, other people who are doing this work like Michael Lu and Mario Drumand and now Anita, partner in Alameda County, has helped tremendously. It's taken persuasion and time. It didn't happen overnight. I worked a couple of years to get to this point. So I have a long view.

CHERI PIES: One thing that really helped us was the data. I presented some of the data. But our previous director, Dr. Riden, did a lot of work in educating our board of supervisors and telling them how important it was to address health inequities. And we've been fortunate in that we had some -- we had both tobacco settlement money and a measure that was passed in our county. We've been able to direct some of that money to this work.

And then Michael Lu introduced us to Mario and he's given us a lot of great ideas. So if you haven't talked to Mario Drumand, you must.

UNKNOWN PERSON: I'd just like to add, actually there's another project that I'm working on, and again it's with UW Madison, the School of Medicine and Public Health. And I actually sat -- they have a number of dollars through the Blue Cross/Blue Shield conversion. And I sat on a committee for almost two years and this is before the market, you know, tumbled. And we were really trying to focus on what can we do, where can we put our dollars to have impact?

And to really do targeted grant making. And I was able, with another colleague, there were only two community members that sat on this board, and we were able to make the argument to invest in improving birth outcomes for African-Americans in the state of Wisconsin. And if you can imagine, we actually got them to the point where they agreed to earmark \$10 million over a five-year

period to focus on African-Americans. And to get a school of medicine and public health to listen to us to say we want you to just consider taking a non-medical approach to look at social determinants of health and health equity and to realize if we improve the health of women or infants, we're also having an impact on women and community.

So it's really -- I keep talking about the importance of involving communities at the very beginning. So we have them. We were at the table. We pushed for that. We're proud of that. We're working with the state as well in terms of how to use those dollars.

So one quick point about that we're now funding four communities to take that 12-point plan to closing the black/white gap and they have to select one or two things out of the 12-point plan that they're going to focus on over a period of time. So I think having the voices of the community, it creates the political will. It puts pressure on the powers to be to allocate the money in a way that makes sense.

UNKNOWN SPEAKER: Something that Lorraine said made me remember something I wanted to say we have to do a better job educating our legislators and people who give us money about what maternal and child health is. I think that's what I learned from this. They don't really know what we do. If we're going to be doing something that's really going to affect the help of many generations

and whole communities, we need to help them understand it from their perspective.

So that also I think would make a difference.

MICHAEL KOGAN: In the interests of time let's take one more question if you have further questions for the speaker feel free to come on up unless you have to go.

UNKNOWN SPEAKER: How have you folks found the other sectors [indiscernible] do they buy in, is that what they do? [Indiscernible].

MICHAEL KOGAN: Do you want to repeat the question?

UNKNOWN PERSON: So your question was: How receptive have we found other folks in other sectors to work on this work? In Alameda County we've found them incredibly receptive. We had people from education, parks and rec, transportation, and, again, because our county, our public health department had worked with these other sectors before and actually brought them in and presented some data, they were primed to work on something. So we have total support. And the one child we have is how can they carry a message to their sector about what they're doing that isn't, that works on a life course but is less medical in terms and so that's one of the things we're doing.

But there's a couple of them that want to start baby college right now and we're totally willing to do that to work with them. The housing, the person from the Oakland Housing Authority and a couple of other sectors want to start a baby college. So there's a lot of support for this.

Oh, baby college. So baby college is part of the children's Harlem zone. It's one of the initiatives that Jeffrey Canada has started. He engages. It's totally in line with maternal and child health. He engages families, pregnant women and their partners to participate in this nine-week course where the moms and the dads learn how a baby develops and how to take care of that baby and how to prepare their infants and their children to be ready to learn. And it's part of a conveyor belt. So the baby college is first and then these kids from the neighborhood are gotten ready to participate in preschool and then to be part of these charter schools.

And for some men participating in baby college and learning about what's going on in the mom's uterus is transformational. Anyway, it's a great idea and several people in our community have read about it and want to start a baby college.

Mario, does that --

UNKNOWN PERSON: I was just going to add again also we've had success in bringing others to the table. When we did our research we asked the question in terms of what's the most important thing that you think needs to occur to help women have healthy babies and, again, mothers and fathers both said the mother said give our men jobs and the men said the same thing, to be engaged.

So my whole point is that we do have others at the table. We look at housing. We look at the issue of violence, preventing violence in the neighborhood, affordable safe housing. Just recently there was an issue where, food chains, Church's, they wanted to come in the neighbor and the neighbors, the neighborhood, they just protested against that. They said we want healthy food. And so even working with zoning to determine the liquor stores and everyone else that's coming into the neighborhood, when you have communities saying no we don't want that, we want whole foods instead.

So, again, we're working with a number of partners.

MICHAEL KOGAN: All right. Thank you very much for attending. We really appreciate your time and coming to hear about this.

(Applause)