From the CEO

“Show me the data!”

In a famous scene from the film Jerry Maguire, Rod Tidwell, an Arizona Cardinals wide receiver played by Cuba Gooding, Jr., is on the phone deal-making with sports agent Jerry Maguire (played by Tom Cruise) when he shouts the now oft-repeated phrase, “Show me the money! Show me the money!”

As I thought about data and assessment activities for this month’s issue of Pulse, I considered how we often shout “Show me the data!” in our maternal and child health work. MCH professionals have an insatiable appetite for data, which makes sense—evidence-based and science-based practices are core to our work. We use data to support our ideas and observations, and gather evidence on the effectiveness of our interventions. We use data to support our hunches, tell our stories, and even to argue for more funding (“Show me the money!”).

More importantly, we use data and assessment activities to identify priorities for local, state, and national maternal and child health programs and to focus limited program resources on the places where they are needed the most. Data are core to maternal and child health and assessment is indeed one of the core functions of public health practice.

AMCHP’s current program portfolio supports data and assessment capacity-building for state MCH programs in a number of ways. We have been engaged with AMCHP members and our national partners, including the MCHB and CDC, to determine how to best support state needs assessment activities as we move towards the next required five-year needs assessment in the MCH Block Grant. A result of this joint planning is AMCHP’s role in coordinating four data trainings at the December 2008 MCH Epidemiology Conference in Atlanta, Georgia, one of which is a course on how to conduct statewide needs assessments. AMCHP is also working with partners to support regionally-based needs assessment trainings, and is excited to be working with the Rocky Mountain Public Health Education Consortium, which will be conducting a day-long needs assessment program in Albuquerque.
From the CEO continued

on September 19th. We hope to continue developing programs that will support state and local efforts to conduct comprehensive statewide needs assessment for the upcoming five-year assessment, and for the years in between.

AMCHP also incorporates data and assessment activities in our other policy and program work. Our Best Practices program looks for the best evidence available before deeming a practice to be a “best practice” or model program. Our policy team uses the data you provide to us, MCHB and others to illustrate pressing MCH needs at the state and national level, and to make the case for increasing Title V funding. AMCHP staff use data to evaluate the impact of AMCHP’s programs, and we have developed a monthly “data dashboard” to monitor AMCHP’s fiscal health and membership goals.

With all the focus on data and assessment it is easy to say that we truly are “data-driven” in the work we do. But it is important to remember that data and assessment activities are a means to an ends, data collection should never be an ends of its own. Far too often data are collected only to sit on a shelf and never be analyzed. When we develop surveys, we try to make sure that we are not collecting extra data that “we may need someday.” That’s collecting data for data’s sake, and to me that’s a waste of time and money.

Another danger of data and assessment activities is relying too heavily on one piece of data or one type of analysis and failing to notice significant issues or trends that are important to a group, but do not show up “in the data.” I like to tell the story of a community who was told by their health department that septic systems and wastewater regulations should be their highest public health priority given all the development in their area and the challenges growth and new building imposed on their neighborhood. When some community members participated in a focus group and were asked about their priorities, instead of just looking at the environmental data used by the health department, wastewater issues never came up. Instead, residents said they wanted to be sure the new developments included sidewalks and playground in their neighborhoods since the developers were not including those features in their plans. If the health department used just their own survey data, their work would have missed the community’s pressing priority. I wonder what else we are missing when we focus too heavily on “what the data say” without also asking “whose data are these?,” and “what does the community say?” in our analyses.

Even more difficult to address is the issue of ignoring the data because the implications of the data are too controversial, or having to totally revamped a program because the data indicate that it is no longer needed. These cases are tough because they require asking difficult questions, negotiating win-win solutions, and engaging in crucial conversations. If we really are using data to inform our work, how can we be sure that we are also using those data to truly focus on the most pressing MCH problems? One example that comes to mind is health equity and health disparities. We know there are major differences in health status in different populations within our states, but how effectively are we addressing these issues even though we have the data to support increasing our efforts? Data alone cannot solve the problem—we know the problem all too well. Data-driven solutions are what we really need, and we need them soon.

AMCHP is committed to working with partners to strengthen states’ capacities to use data to improve maternal and child health outcomes. Recently, we have been engaged in conversations with a group of MCH epidemiologists looking to develop an organization to promote MCH epidemiology at the local, state, and national levels. Clearly, MCH epidemiologists are important resources in promoting effective MCH practice and AMCHP supports the development of MCH epidemiology capacity in all states and territories. We look forward to working with colleagues to improve the work we do in data and assessment, including our support for MCH epidemiology. Together, we can truly say that we are using data to improve our work, and improve the health of mothers and children nationwide.
Get Involved

AMCHP Data Training Workshops

AMCHP, in partnership with the CDC, DRH, and MCHB, will conduct four data training workshops on December 8-9, 2008, in Atlanta, Georgia. The trainings serve as pre-cursors to the 14th Annual CDC MCH EPI Conference scheduled for December 10-12, 2008 at the Crowne Plaza Hotel Atlanta-Ravinia. All four of the following courses will be two-day comprehensive and hands-on data trainings:

1. State Title V Program MCH Needs Assessment Practice
2. Scientific Writing: Communicating Research Investigation Effectively to Expedite Publication, Programmatic and Policy in Public Health
3. Time Trend Analysis for MCH Outcomes in Large and Small Populations
4. Using the Population Attributable Fraction (PAF) to Assess MCH Population Outcomes

Registration and course descriptions are now available online. Registration Closes on August 22. Space is limited. For more information, please contact Henry Maingi at hmaingi@amcho.org or Brynn Rubinstein at brubinstein@amchp.org.

Do you have a Request for Technical Assistance regarding your States’ Needs Assessment Activities?

AMCHP is planning technical assistance workshops to strengthen state Title V program staffs’ skills to implement state needs assessments occurring in 2009. So that we can be responsive to your technical assistance needs, please respond to the following open-ended question by clicking on the text below. Your responses will be transmitted electronically to us once you complete the question.

Q: What questions/concerns do you have regarding the needs assessment process in your state for which you would like to receive Technical Assistance?

Member Spotlight

Valerie Ricker, Director of Maine’s Family Health Division

AMCHP staff interviewed Valerie Ricker, Director of Maine’s Family Health Division. The purpose of the interview was to get a sense of how the use of data has impacted Maine’s MCH programs and policies. The MCH Director noted that the Maine Center for Disease Control and Prevention, Department of Health and Human Services hired its first formally trained epidemiologist about eight years ago, but things have improved over the years. Today, Maine has five epidemiologists working between the Division of Chronic Disease and the Division of Family Health.

Q: How has the use of data impacted Maine’s programs and policies?

The presence of epidemiologists has made data more accessible and allowed Maine to create more targeted programs and policies. For example, several years ago Maine used PRAMS data to pass tobacco legislation. The legislation led to increased Maine’s tobacco tax to one of the highest in the nation. The money earned from the tax went to build a tobacco free Maine. The data were obtained from the YRBS which had indicated Maine adolescents had very high smoking rates. The data led Maine program staff to examine data and directed the anti-tobacco campaign with a significant focus toward teenagers. As a result of our successful campaign, Maine’s adolescent smoking rates decreased. Consequently, declines were noted in adults.

Q: What challenges have you faced while integrating data and epidemiology into your program work?

First, finding resources to hire staff with formal education in epidemiology proved problematic. A combination of factors contributed to this tenderness: Maine being a rural state, a lower pay scale, and a lack of people interested in living in Maine brought difficulty in recruiting qualified data staff. We maintained our commitment to hire epidemiologists who met national educational standards required for epidemiology. It took 18 months to find and interview a viable candidate.

Q: How can AMCHP help your state enhance epidemiology capacity to communicate your research and data to state legislators to improve MCH public health policies?

AMCHP can help in many ways: promote the integration of evaluation and epidemiology; for evaluation is a critical part of improving the quality, capacity and effectiveness of our department programs and policies. AMCHP could assist in identifying more resources, particularly for states that have been unable to build their epidemiology capacity, would help; and identifying tools to educate legislators to understand the quality of MCH data, e.g., congenital birth defects data fact sheets. And AMCHP providing samples of how other states have utilized data in their states would also help.
Feature 1

GPS for Maternal and Child Health: Using State-Level Data to Improve Systems of Care for Children

By Michael D. Kogan, PhD, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services

In the not too distant past, many maternal and child health (MCH) programs were designed without data to guide them, and they did not collect data during the program to evaluate their effectiveness. In a way, it’s like driving a car blind-folded; while it may be thrilling at first, there’s a good chance that you will not wind up at your final destination.

At the beginning of the 21st century, many states did not have data on either the health status or health care experiences of children in their states, often because they lacked the resources to collect the data. To rectify this situation, the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration began an ambitious program to conduct nationally- and state-representative surveys every two years, alternating a survey on children with special health care needs (CSHCN), with a survey on the overall children’s population. The purposes were to provide data to help states respond to MCHB’s Title V Block Grant performance measures, and to be used as a tool for improving systems of care and outcomes for children.

Beginning with the 2001 National Survey of CSHCN and followed by the 2003 National Survey of Children’s Health, the MCHB has now conducted four of these surveys. The information from the 2007 National Survey of Children’s Health should be available in early 2009. The information from the 2005-2006 National Survey of CSHCN recently became available. This survey, with 40,000 CSHCN and at least 750 CSHCN in each state, illustrates the importance of being able to conduct state-specific analyses. The chart book on this survey, available at http://mchb.hrsa.gov/cshcn05/ shows, for example, that the percent of CSHCN who received coordinated, ongoing, comprehensive care in a medical home ranged from 39 – 57 percent across states, or the percent of CSHCN who had unmet needs for health services ranged from 10-23 percent. Moreover, since this is the second National Survey of CSHCN, changes over time periods can also be viewed when the measures are comparable. For example, from 2001 to 2005-2006, there was a dramatic change in how CSHCN are insured: in 2001, 21.7% of CSHCN were covered only by public insurance; by 2005-2006, that had increased to 28%.

It is not enough to simply conduct the surveys. Otherwise, the data would just sit there, collecting dust like a bad wedding gift (the Elvis Presley-shaped wine holder that my Great Aunt Selma gave me comes to mind). The data needs to be available and accessible in a form that even the most number-phobic individual can access. So the MCHB established the Data Resource Center, where anyone can simply type in a query and information for your state will be provided almost instantaneously. The website is http://www.childhealthdata.org.

Think of these surveys as GPS devices for your state MCH programs; they can help guide you to use your resources most efficiently to develop systems of care to improve children’s health. Hopefully, the days of driving blind-folded are now in the past.

Feature 2

Breastfeeding Increases, Duration Does Not: Recent Trends in Breastfeeding

The 17th annual World Breastfeeding Week (WBW), celebrated in more than 120 countries worldwide, will be August 1-7. To commemorate this year’s WBW theme, Mother Support: Going for the Gold, AMCHP will explore the most recent changes in breastfeeding trends in order to initiate a discussion about how to effectively encourage breastfeeding in your states, counties, or communities.

In April, the National Center for Health Statistics (NCHS) released a Data Brief with national data indicating that average national breastfeeding rates exceeded the Healthy People 2010 target goal. The Data Brief, Breastfeeding in the United States: Findings from the National Health and Nutrition Examination Surveys, 1999–2006, examines the changes in breastfeeding trends in the United States from 1999-2006 data from the National Health and Nutrition Examination Surveys (NHANES). In their analysis, NCHS found that from 1993 to 2006 the percentage of infants that had ever been breastfed increased by over 15 percent, from 60% to 77%, surpassing the 2010 Health People benchmark of 75%. Overall, improved breastfeeding rates were observed among all races and ethnicities studied, but the brief noted the most significant...
change among non-Hispanic blacks, where the breastfeeding rate increased from 36% in 1993-1994 to 65% in 2005-2006. To access the NCHS Data Brief with data sets and learn more about national breastfeeding trends, go to http://www.cdc.gov/nchs/data/databriefs/db05.pdf.

While the past decade reveals significant improvements in the number of infants ever breastfed, the percent of infants still breastfeeding at six months remains unchanged. Using birth year cohort data from the NHANES from 1999 to 2004, NCHS found that the total percentage of infants still breastfed at six months or later hovered around 30 percent. None of the race-ethnicity populations studied achieved the Healthy People 2010 goal for breastfeeding at six months: 50% of all infants ever breastfed. The substantial difference between the percentage of infants ever breastfeed (77%) and the percentage of infants still breastfed at six months (30%) suggests that despite the high initiation rates of breastfeeding, many mothers, for variety of reasons not specified in this data brief, stop breastfeeding by the time their child is six months.

So what can be done to promote and prolong the duration of breastfeeding?

As the theme for this year’s World Breastfeeding Week advocates, let’s go for the gold—the gold standard of breastfeeding. WBW demands greater support for mothers to help them attain the “gold standard of infant feeding: breastfeeding exclusively for the first six months, and continue breastfeeding together with feeding other appropriate complementary food for up to two years and beyond.” To learn more about World Breastfeeding Week and the Global Initiative for Mother Support for Breastfeeding go to www.worldbreastfeedingweek.org.

Also, let’s look to our members. Oregon is among the states that have made significant strides in breastfeeding policy. In order to make the work environment more conducive to new moms and to encourage mothers to continue breastfeeding after returning to work, Oregon Title V worked with advocates and legislator to develop and pass “Oregon House Bill 2372, the Return to Work and Breast feeding.” The bill requires employers to give mothers unpaid time and a private place to lactate every four hours during the work day. To learn more about Oregon’s bill visit the MCH Success Stories column in this issue of Pulse or go to http://www.oregon.gov/DHS/ph/bf/.

Feature 3
CDC’S First Annual Report from the National Violent Death Reporting System (NVDRS)

The Centers for Disease Control and Prevention (CDC)’s Division of Violence Prevention launched a national data and information gathering system referred to as the National Violent Death Reporting System (NVDRS) in 2003. The system was intended to improve the collection of violent death data in the United States, where an estimated 50,000 persons die annually as a result of violence-related injuries. Previous reporting systems were fragmented, sometimes voluntary, had no uniform data elements, and provided little information about the circumstances that precipitated violent deaths.

The NVDRS began with seven states: Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina and Virginia. Colorado, Georgia, North Carolina, Oklahoma, Rhode Island and Wisconsin joined in 2004, followed by California, Kentucky, New Mexico and Utah in 2005, for a total of 17 states.

On April 11, 2008 the CDC released its first NVDRS Surveillance Summary in the Morbidity and Mortality Weekly Report (MMWR, 57(SS03); 1-43, 45). The MMWR Surveillance Summary presents 2005 data. The results are reported by sex, age group, race/ethnicity, and marital status, location of injury, method of injury, circumstances of injury, and other selected characteristics. This report includes data from 16 states that implemented the system. Data from California are not included as the system has been implemented in only a limited number of cities and counties rather than statewide.

A goal of the system is to provide state public health agencies and interested officials, including policy planners and program directors, with a better understanding of the prevalence of homicide and suicide. NVDRS can be used to inform prevention and intervention strategies in states. Interested states and individuals are encouraged to access the NVDRS Report at: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5703a1.htm. For more information, contact Debra L. Karch, PhD, at dwv0@cdc.gov or (770) 488-1307, or contact Henry Maingi at hmaingi@amchp.org or (202) 775-0436, Ext. 133.
New State and Local MCH Epidemiologist Organization

A State and Local MCH Epidemiologist Organization (MCHEPI) is being developed by a group of seasoned state and local public health MCH EPI officials. The organization will support state and local MCH epidemiologist staff in the use of effective public health surveillance and epidemiologic practice through the following methods: training, capacity development, and peer consultation; the development of standards for practice; and advocacy for resources and scientifically-based policy. If you wish to know more details about the organization’s status or provide input, please contact Bill Sappenfield, State MCH Epidemiologist, Florida Department of Health (Bill_Sappenfield@doh.state.fl.us).

Proposed Mission, Objectives, and Activities of a State and Local MCH Epidemiologist Organization

MISSION:
The organization will promote the use of data to guide public health practice and improve maternal and child health. The organization will accomplish this by supporting the use of effective public health surveillance and epidemiologic practice through training, capacity development, and peer consultation; developing standards for practice; and advocating for resources and scientifically based policy.

GOALS AND PROPOSED ACTIVITIES:

1. To promote and improve communication among peers
   - Develop an effective strategy for communication about MCH-related issues.
     - Continue to use MCH listserv as a platform, use the AMCHP/CSTE listserv, or develop a new listserv.
     - Develop a website for posting contacts, announcements, materials, links, job announcements, computer programming code, and other useful information.
     - Develop a periodic update like the AMCHP pulse.
     - Establish web-based discussion board.
   - Conduct quarterly conference calls to discuss projects, collaborative efforts, and emerging issues; these could occur after CDC’s MCH EPI Grand Rounds.
   - Develop communication briefs and strategies for communicating MCH epidemiology’s roles to organizations and funding sources at a local, state, and national level.

2. To assist in strengthening the work force
   - Promote and develop mentorship strategies for new lead state MCH epidemiologists.
     - Establish a volunteer set of mentors for lead MCH epidemiologists.
     - Assist CDC to develop transition strategies of assignees and other fellows into MCH epidemiology leadership positions.
   - Promote career development strategies.
     - Develop/promote statements of work for MCH epidemiologists.
     - Develop recommendations for funding for MCH epidemiologists.
     - Explore possible recommendations for dedicated funding streams for MCH epidemiologists.
     - Develop recommendations to assure that programs and other funding sources (i.e. federal organizations) fund epidemiology-related functions.
   - Promote recruitment/retention efforts.
     - Develop a set of essentials duties and tasks for use in job descriptions.
     - Develop common mechanisms for distributing job announcements. (Note: MCH Listserv is the existing source.)
     - Support and attend the career mentoring session at the MCH EPI Conference. (Note: this would be more useful for us in the public health field if there were funding for MCH epidemiologists and thus positions available.)
     - Provide information on current and appropriate salary ranges for MCH epidemiologists including masters-level non-physicians, doctoral-level non-physicians, and physicians.
     - Offer assessments of capacity (something like a STIPDA STAT visit activity).
   - Develop, promote, and support efforts to train MCH epidemiologists.
     - Develop strategies to assure participation at pre-conference training and conferences such as MCH Epi Conference.
     - Request HRSA MCH Bureau and CDC Division of Reproductive Health write a joint letter to Title V Directors and others to request that MCH epidemiologists attend the MCH EPI Conference. (Note: This would work if there is funding for MCH EPI travel, and if the participation would be either required by a grant or mandatory somehow. Otherwise, the letter may not be as helpful.)
     - Confer with Juan Acuna and Michael Kogan on the best way to provide state and local input into current national training efforts.
• Work with CDC and CSTE to promote and support EIS and CSTE fellows interested in MCH and working on MCH-related projects.

• Promote the need for expanded graduate education to train MCH epidemiologists, for expanded placements of graduate students in state and local health agencies, for expanded fellowships post-graduation, and for the introduction of a public health service type program for students receiving funding for their graduate MCHEPI education that requires them to perform certain number of years of service in state and local health agencies in return for funding.

3. To develop and provide processes and materials that strengthens practice

• Develop a common set of goals and directions towards which all MCH leaders and MCH epidemiology leaders can work.

• Develop a process or mechanism for sharing and discussing best and new innovative practices: epidemiology methods, translation of epidemiology findings, epidemiologists’ roles in different initiatives that led to policy development, and collaboration of epidemiologists from different fields.

• Develop and promote opportunities to work collaboratively among the fields, such as MCH and Chronic Diseases.

• Develop practice-related efforts that strengthen the practice field.
  ▪ Currently there is a six-state effort to develop CORE Preconception Health Indicators.

• Share/promote effective university and public health organization collaborations.

• Work with HRSA MCH Bureau to promote the publication of state practice and research articles.

• Promote the role of translating or communicating epidemiologic studies into practical and applied knowledge for the practitioners who design and implement programs; the workforce exists to serve and inform the work and practice of MCH.

4. To advocate positions and recommendations that strengthens the field

• Support and provide input to CDC and HRSA/MCHB on MCH EPI related activities.

• Provide advice and support to AMCHP, CSTE, NAPHSIS, and the MCH Journal.

• Develop and promote national recommendations for the field.

• Develop new partnership with other national organizations, such as NIH/NICHD.

CURRENT ORGANIZATIONAL COMMITTEE MEMBERS:

Genet Burka
Brian Castrucci
Anita Cowden
Virolanda Grigorescu
Fife Hafsatu
Shaheen Hossain
Jennifer Hudson
Laurin Kasehagen
David Laflamme
Dick Lorenz
Bill Sappenfield
Sam Viner-Brown
Success Stories

From Data to Program and Policy: Michigan’s Success Story on Preventing Unintended Pregnancy

In Michigan, great strides have been made to address the reduction of unintended pregnancy in the state. However, the prevalence of unintended pregnancy remains stagnant, at approximately 40%, since 1988 (Pregnancy Risk Assessment Monitoring System—PRAMS—findings).

Michigan PRAMS, the only data source for this particular matter, has been extensively used. Different studies and analyses were conducted to better understand the determinants as well as the characteristics of women who experienced an unintended pregnancy. The findings were broadly disseminated and shared with different stakeholders and policy makers in an effort to develop program initiatives, to promote policies aimed at reducing unintended pregnancy, and attract additional funds to support such programs.

As a result, unintended pregnancy was identified as a priority public health concern and objectives of developing programs and policies capable of monitoring indicators associated with unintended pregnancy were set.

At the direction of the Governor and beginning in 2003, a workgroup created the Blueprint for Preventing Unintended Pregnancies. This blueprint includes the following goals:

1) **Plan First! Program**—Through this program, the Michigan Department of Community Health (MDCH) currently provides family planning services to women ages 19 to 44 who otherwise would not have medical coverage for these services.

2) **Talk Early & Talk Often**—This program helps parents of middle school children develop the necessary skills to talk to their children about abstinence and sexuality. Since it began in October 2005, more than 70 workshops have been held throughout Michigan in public and parochial schools, medical centers, worship centers, health departments, and libraries, reaching more than 800 parents. Survey results from parents who participated have been overwhelmingly positive. For more information, visit [http://www.michigan.gov/miparentresources/0,1607,7-107-37383---,00.html](http://www.michigan.gov/miparentresources/0,1607,7-107-37383---,00.html).

3) **Contraceptive Equity**—The Governor has called upon the Legislature to require that health plans that cover prescription drugs also cover birth control.

4) **Prevention of Unintended Pregnancy in Adults guidelines**—Michigan Quality Improvement Consortium (MQIC) 2007 Prevention of Unintended Pregnancy in Adults 18 Years and Older guideline was approved by the MQIC Medical Directors’ Committee and endorsed for distribution/publication effective June 20, 2007.

As a long term goal, the prevention of unintended pregnancies due to expanded family planning services would improve the birth outcomes.

Training to Increase Understanding of Micronesian People: Hawaii’s Use of an AMCHP Data Mini-Grant

In 2007, the Hawaii State Department of Health, Family Health Services Division was awarded a Data and Assessment Technical Assistance (DATA) Mini-Grant from AMCHP. The grant provided us the opportunity to address an emerging issue in the State of Hawaii, that of the migration of Micronesians into the state. The grant supported training in understanding of how Micronesian cultural practices influence health care practices, as well as the access and use of the health care system.

Department staff from throughout the state attended the training. The training created a tool, a matrix that summarizes the various Micronesian people and selected social/cultural characteristics such as: “what is illness,” non-verbal communication, willingness to divulge personal/ sensitive information, birth practices, and prenatal care. There was consensus by the participants that the training provided a better understanding of the Micronesian peoples and how we can better address their issues, whether it be through program development, policy development or services. Staff took home the lessons learned, and one county has replicated the training for their staff.
Translating MCH Data into Policy: An Integrated Approach to Improve Preconception Health and Birth Outcomes in Los Angeles County

How to use data to develop and fund MCH programs:

Antelope Valley (AV) is the largest of eight Service Planning Areas comprising Los Angeles County (LAC). Between 1999 and 2002, the infant mortality rate in this geographically isolated, sparsely populated region increased from 5.0 to 10.6 per 1,000 births (over double the county rate). Of most concern was a spike in the African American rate, rising from 11.0 per 1,000 live births (N=7) in 1999 to 32.7 per 1,000 live births (N=27) in 2002. The LAC Department of Public Health, Maternal, Child, and Adolescent Health (DPH MCAH) Programs partnered with Antelope Valley Partners for Health, a public-private collaborative that had been working to improve AV community health and services, to study the problem and form a strategic action plan.

LAC DPH MCAH used the Perinatal Periods of Risk (PPOR) approach to identify and quantify problem areas and mobilize community action. Analyses used multiple data sources to identify factors associated with poor birth outcomes and infant deaths and potential areas of intervention. Data included: 2002 Vital Statistics files from the California DPH to identify areas with the highest excess rates of fetal and infant mortality; case reviews of the 2002 infant deaths (N=53) following California’s approved FIMR protocol; and population-based survey data of AV mothers who recently delivered a live born infant (Los Angeles Mommy and Baby Project) to identify factors associated with poor birth outcomes. Analyses identified two key areas for continued research and intervention: maternal health/prematurity and infant health. Community stakeholders reviewed findings and developed targeted actions to address infant mortality. Key funders and policy makers invested additional funds to promote healthy births in AV. This work also prompted the launch of a major stakeholder effort focusing on preconception health promotion.

Oregon’s Use of Data to Create and Pass a State Policy

Oregon State PRAMS data and national research combined made for a successful policy change through legislative change. In Oregon, over 89 percent of women start out breast feeding – one of the highest rates in the nation. Unfortunately, less than 27 percent of Oregon infants are exclusively breast-fed for the six months as recommended by the American Academy of Pediatrics. The high initiation rates make it clear that Oregon mothers want to breast-feed. The majority of them are unable to continue for the recommended six months due to the many barriers they face – the primary obstacle being the lack of accommodations for breast feeding mothers upon returning to the workplace.

To address this issue, a public-private coalition worked through two legislative sessions to achieve the passage of landmark legislation on Employer requirements for accommodation. The advocates worked with legislators to create the “Oregon House Bill 2372, the Return to Work and Breast feeding”, which supported women who chose to breast-feed after they returned to work. The Oregon legislature passed the bill in May 2007. The bill requires employers of 25 or more employees to provide a mother unpaid time and a private place to express milk every four hours during the work day. For more information on the legislation or implementation tools go to http://www.oregon.gov/DHS/ph/bf/
March of Dimes recently released a report linking the increase of Cesarean deliveries in the past decade to the increase of late preterm births.

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Figures 1 and 5 highlight the changes in U.S. breastfeeding rates and practices over the past decade.

Figure 5. Percentage of infants who were still breastfed at 6 months of age by birth cohort and race-ethnicity group: United States, 1993–2004

NOTES: Mexican-American infants significantly higher than non-Hispanic black infants in all birth cohorts. Non-Hispanic white infants significantly higher than non-Hispanic black infants in all birth cohorts except the 2001–2002 cohort. SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey.
Resource Bank

Introducing the AMCHP MCH Data Resource Portal!

http://www.amchp.org/topics/a-g/data_resources.php

The data team at AMCHP is excited to offer a portal that brings together different data query resources developed by our partners for easy access by our members. The site includes information about and links to various MCH data systems. This portal is a work in progress, as we are always expanding and reorganizing to make this MCH resource comprehensive and user-friendly.

Title V Information System (TVIS)
https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp

This resource provides information on financial and program data for the most recent year, measurement and indicators, state narratives, data summary reports, and state needs assessments.

March of Dimes PeriStats
http://www.marchofdimes.com/peristats/

Developed by the March of Dimes Perinatal Data Center, the PeriStats Web site provides free access to U.S., state, county, and city maternal and infant health data. Create your own maps or graphs and access state summaries.

Data Resource Center (DRC) for Child and Adolescent Health
http://www.childhealthdata.org/content/Default.aspx

This resource includes national and state-based data on over 100 indicators from the National Survey of Children’s Health (NSCH) and the National Survey of Children with Special Health Care Needs (NS-CSHCN). The DRC’s easy-to-use interactive search feature allows users to select, view, compare, and download national survey data results for every state and HRSA region.
**View from Washington**

**Using Data and Assessment to Improve MCH Policy**

In public health school we are taught that epidemiology is the fundamental science of public health practice. Furthermore, the concept of assessment is so important that the Institute of Medicine declared it the first among three core functions of public health—followed by assurance and policy development. After all, if we do not have data to understand the causes and distribution of disease across the population, how can we even begin to develop the programs and policies needed to fight disease and promote health?

Unfortunately, Washington too often generates examples of where the science and data are clear, but the policy languishes. This is sometimes because of divergent ideology, and often complicated by a lack of political will and available resources. Perhaps no other issue so clearly represents the disconnect between science and policy than our national approach to injury prevention. While injury continues to be the leading preventable killer of children, the U.S. spends literally tens of billions of dollars every year to provide health insurance to children—in part to treat injuries. Meanwhile, last year the entire budget of the CDC’s National Center for Injury Prevention and Control was only $134 million. At this level the CDC is able to fund only 30 states for basic injury prevention programs. There are few better illustrations of where our public policy favors treatment over prevention.

Consider also our national approach to health insurance. Despite an abundance of research demonstrating how health insurance helps people get timely access to medical care and protects against the risk of expensive and unanticipated medical events, our nation continues to tolerate close to 47 million of our citizens going without coverage. Furthermore, the ongoing national debate over health coverage completely overshadows the growing body of research that argues for policies addressing the social determinants of health in areas such as poverty and income, education, unemployment, housing, transportation, the environment, and nutrition.

The problem is finding a way to make the leap from assessment to policy development. In other words, how can we navigate between what science shows and what politics will allow? I think part of the answer lies in improving our communication about how data and policy should interact. This issue is so important that Dr. Pat Nolan, a former Rhode Island State Health Official, often says communication should be the fundamental science of public health.

Our goal at AMCHP is to find better ways to communicate data and assessment results to policymakers, and to use compelling examples and stories to illustrate the connections. In the past year, we have been spreading the word on Capitol Hill that all state Title V programs conduct thoughtful and in-depth assessments every five years to identify their most pressing MCH needs and have data to demonstrate tremendous un-met needs, but have been hampered by limited and declining resources to implement proven programs and policies.

We are also asking Congress to consider how eroding funding in MCH programs is coinciding with alarming new data demonstrating our lack of national progress in infant and maternal mortality, teen birth rates, childhood obesity, and other important MCH indicators. We are trying to make sure that policymakers understand the impact of over $60 million in cuts to the Title V Maternal and Child Health (MCH) Services Block Grant over the past six years.

While the House Appropriations Committee recently proposed a modest increase ($9 million) for Title V in FY ’09, we must now carefully adapt our message to communicate how this modest investment will only begin to rebuild what has been lost in recent years. And although it is an uphill battle, we will continue to advocate that fully funding the Title V MCH Block Grant at $850 million is critically needed to enhance MCH.