A note about this month’s AMCHP Pulse from Michael Fraser, PhD, Chief Executive Officer, AMCHP

This issue of Pulse focuses on state and local collaboration, a topic that is of special interest to me. Having started my public health career at the National Association of County and City Health Officials (NACCHO) I was exposed to local public health at the city and county level and spent several years working to better understand and describe local and state public health infrastructure nationwide. I left NACCHO to work at the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) and was exposed to federal public health agencies and the way that these large agencies work with both states and local health departments. My current work with state health departments and their MCH and CYSHCN programs at AMCHP nicely compliments my journey across the various levels of governmental public health. Are there differences between these three levels of public health? Certainly. But having had a foot in these three important parts of public health, I can honestly say I believe there are many more similarities than differences among them.

This month’s From the President and From the CEO feature state and local collaboration in a unique manner. Instead of the regular columns from AMCHP’s President Phyllis Sloyer and myself, we decided to engage in conversations with CityMatCH, our urban MCH partner, about the topic. The themes of trust, collaboration, shared purpose and shared vision, and shared frustration with lack of resources, need for accountability, and more energy in building and connecting MCH systems at all levels of government are common themes. I hope you enjoy reading these conversations as much as we enjoyed having them. Let us know what you think!
From the Presidents

MCH Local and State Partnerships

Phyllis Sloyer, RN, PhD, PAHM, FAAP
AMCHP President
Division Director, Division of CMS, Florida Department of Health

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Chair, CityMatCH Board of Directors
Director, Family, Youth and Infant Health
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This month’s Pulse features the topic of state and local collaboration. We asked the leaders of AMCHP and CityMatCH to share their thoughts on a few questions related to partnership and collaboration between state and local MCH programs.

Q: From your vantage points, what works in promoting successful state and local collaboration?

Kim: Three things are critical if state and local public health agencies are going to collectively advance the health of women, children and families. First, and most critical, we must remind ourselves and explicitly state our shared aim of improving health and wellness. Regardless of turf wars, clashing personalities, population differences, budgetary conflicts, or divergent objectives, we all strive for the same thing: Mothers and children, fathers and families that live healthy and productive lives. We want our communities to thrive. Second, we must keep the lines of communication open. When communication ceases, too often assumptions, and one sided expectations begin to define relationships between state and local health departments. These assumptions and expectations draw lines in the sand, erroneously pitting local agendas against those of the state, and vice versa. When this happens, critical collaborations morph into defensive maneuvers that are not beneficial to either entity. Regular and open communication is the surest way to safeguard against this constant threat. Finally, we must be willing to see, and respect each others’ points of view. Differences should be expected, accepted, and used as opportunities. It’s our ability to find mutuality in our differences that yields creative solutions and innovative programs.

Phyllis: First, an understanding of the respective constraints and roles and responsibilities and second a recognition that local is where the heart of services are. I believe it is the behavioral competencies that make a difference here, over and above knowledge. Strong networking and consensus building skills are necessary. Often I use a team where one or two individual possess the behavioral competencies...
necessary to establish a collaborative environment and others who possess the technical and knowledge competencies needed to outline effective implementation of a strategy. This is hard work and takes a commitment to clear your calendar so that you have the time to work on collaboration. I also think the agency’s values set the tone for this as well as senior leadership’s commitment to a partnership model. I have also found low turnover and consistency has improved collaboration. The changes in workforce and shorter tenure in a position will create new challenges for us in the future.

Q: How can AMCHP and CityMatCH promote state and local partnerships?

Phyllis: We both have a national presence and have, in part, common members. We can and should develop a shared vision and implementation steps toward fulfillment of that vision. I believe we have begun this process and have a lot of work to do to keep each other informed and find common activities we can work on to advance maternal and child health, whether at a state or local level.

Kim: I believe AMCHP and CityMatCH have already created an effective approach for this. The State/Local Practice Collaborative model provides the opportunity for multidisciplinary teams to work within, and across states for improved effectiveness. Team members work as equal partners with shared goals and routine communication. The experiences and skills these team participants master stretch individuals to embrace new ideas and enhanced ways of “doing” public health. If you have not had the opportunity to participate, I highly recommend it.

Q: What are some sticking points that we have to work together to address as state and local MCH leaders?

Kim: Although the ultimate goal is the same for both state and local entities, the steps to get there can often be very different. Again, the solutions to this challenge are readily available: recognizing shared aims, communicating regularly, and seeing each other’s perspectives. We need only to be willing to use the tools we have available.

Phyllis: I think dwindling resources develops a perception of the state transferring risk and responsibility without sufficient resources being transferred to the local level, not unlike the states’ complaints about the new federalism. Furthermore, our governance structures may create competition for the same resources. Sticking points can also be created by changes in leadership in the executive and legislative branches and changes in perception about the value of our services.

Q: What have been past challenges in local and state collaboration from which we can learn?

Phyllis: We too often do not document the structural, policy, and other frameworks that led to success. It is important to catalogue the strategies used in creating success or in avoiding failure. I am also a firm believer in recruiting and molding successful leaders with the competencies necessary to create and sustain an effective environment. Never believe that function follows form! Question and listen to those who have been successful at building state and local partnerships and make a point of making it a top priority in our job! At the state level, our customers are as much the local health departments or local provider networks as are the women and children who are the foundation of our mission.

Kim: Two areas in particular come to mind, and I suspect these two issues are among the most daunting for most local maternal and child health workers. First, budget concerns. Often times we don’t understand why or how state resources are divided among locals. Urban areas often feel short changed due to far more clients needing service while at the same time, rural areas may feel that appropriations are uneven or unfair also. When dealing with an ever-shrinking resource pot, state, urban and rural health agencies far too often leave the table disillusioned, and this erodes the relationship dynamics. Come time to sit at the table the following year, expectations are low, and willingness to give, even
From the Presidents CONT.

MCH Local and State Partnerships

a little is even lower. The second challenge in state/local collaboration that is specific to maternal and child health has to do with the needs assessments conducted every five years. We as state and local representatives must do a better job of collaboratively completing this assessment. This kind of mutuality at this level can be the first step in assuring that what results from the assessment will potentially set the stage for positive partnerships.

From the CEOs

State and Local Collaborations

Michael R. Fraser, PhD
Chief Executive Officer, AMCHP

Patrick Simpson, MPH
Executive Director, CityMatCH

For almost 20 years, CityMatCH has supported urban maternal and child health programs nationwide. CityMatCH members are MCH directors and other public leaders in health departments serving jurisdictions with populations of 100,000 or more residents. I caught up with Patrick Simpson, MPH, CityMatCH’s Executive Director in Omaha, Nebraska, where CityMatCH is headquartered.

Mike: So, Patrick, this month’s issue of Pulse is all about state and local collaboration. What do you think are some of the big issues we need to address as we think about this really important topic?

Patrick: I have always liked the quote from Sir Isaac Newton, “if I have seen further than others, it is by standing upon the shoulders of giants.” It highlights that our greatest accomplishments are rarely individual achievements but collaborations with many players or at least giant ones. But what gets in our way of successful collaboration? As resources get tighter and tighter, it is human nature to protect those closest around us: our colleagues, our subordinates, ourselves. Collaboration outside our own agency requires a level of trust that isn’t easy. We have to set aside our self-preservation instincts competing for limited resources and keep the bigger goal in mind which is healthy women and children in our communities.

Mike: I totally agree, and there are certainly many giants in our field that have really helped pave the way for effective state and local collaboration. But Pat, I see us spending a lot of time and energy in conversations about how much money local health departments get from their states and a general sentiment from locals that states do not pass enough money to local agencies within their states. I think we can both agree many local agencies think that state programs “hold on” to resources that many would like to see invested locally. There are legitimate reasons for states to build capacity in their health department, especially as we look at statewide needs assessment activities, epidemiology capacity, and the state role in filling gaps and meeting needs across a state, including areas where there is no local health agency. Do you think we’ll ever be able to agree on what kinds of things states should do, and what kinds of things locals should do that would help us move beyond the conversation about how much money goes to whom?
State and Local Collaborations

Patrick: I wish I had an easy “yes” or “no” answer but unfortunately each state and locality is a politicized environment in which what is good for the population and backed by science doesn’t always align with the politics. I think there will continue to be efforts to set standards of practice and core competencies, and that dedicated public health people will continue to strive to do the best for those they serve. It will take strong leadership in state and local government to agree on how best to get the necessary work done. I am hopeful, and patient.

Mike: Yeah, it really does come back to leadership doesn’t it? If the leadership and vision are there, a program can do great things regardless of what level of government they are serving. But money helps!

Patrick: Exactly. Mike, you’ve worked with both local and state health departments. What do you see as some of the biggest challenges to effective collaboration?

Mike: Well, in both settings there is never enough money, nor enough people to do the work. I think chronic funding challenges and workforce recruitment and development issues will continue to create an environment where competition comes before collaboration. It makes sense to me to spend some time as AMCHP and CityMatCH, and probably engage NACCHO and other similar groups, in state specific conversations about what the MCH infrastructure looks like and what a state function versus a local function might be. I have travelled to many states, and honestly there are some areas of duplication and fragmentation at the local and state levels. We cannot afford that – we cannot continue to try to all do the same work without some real strategic conversations about who needs to do what, where, and when, and with whose money! Do you agree?

Patrick: It is a challenge to coordinate programs, especially in large population states where there is so much need. But yes, as we get less and less resources to do more and more work we certainly can’t afford to fragment or duplicate services. It makes sense to have a strategic conversation at the national level about where we want to go, together, and what we need to do to move forward.

Mike: I notice that we talk a lot about collaboration. What do you think true collaboration, not just “lip service” collaboration, is all about? To me it involves trust, a willingness to identify solutions that are bigger than any one agency or level of government, and a serious commitment to invest resources where the needs is and the work has to get done. Do you agree?

Patrick: I definitely agree with you on that. True collaboration is about trust and putting your resources – money, people, social capital - on the table for the greater good. How to get to the end point is the fun part! The creativity in the planning and the relationships built during implementation of a program are the end results of all the collaborators agreeing on the vision and pooling their resources, and trusting that the right people are there to get the important work done.

Mike: Well, it certainly has been fun starting this dialogue, but I get the sense this isn’t the last conversation we’ll have on the topic, is it?

Patrick: Certainly not! But let’s work together to move our shared agenda forward – I am glad that we have worked hard over the past two years to better align AMCHP and CityMatCH and state and local MCH practice. Let’s keep going!
State Budget Crisis

According to the Center on Budget and Policy Priorities, 48 states are facing fiscal stress in their fiscal year 2010 budgets with initial estimates of these shortfalls totaling $166 billion. Since the beginning of the current recession, states have begun making cuts and felt increased pressure as the economy has continued to weaken. Although fiscal relief from the American Recovery and Reinvestment Act has minimized the impact of some of these cuts, many states still face severe fiscal challenges. To help close budget gaps at least 39 states report making cuts that will impact services to vulnerable residents. ¹

Impact on State Public Health

According to a recent survey of health agencies conducted by the Association of State and Territorial Health Officials (ASTHO), shrinking state health department budgets brought on by the current economic downturn are forcing cuts in critical public health programs. ² According to the ASTHO survey, nearly 30% of states’ fiscal year 2008 health department budgets were cut below their fiscal year 2007 level and almost two thirds of state health departments expect this trend to continue in 2009. ³

Nearly half of all states implemented cuts to public health programs that will affect low-income children’s or families’ eligibility for health insurance or reduce their access to health services, including maternal and child health services. In addition to reducing services, eroded funding impacts state public health departments’ capacity to coordinate efforts across communities. If state funding continues to decline, communities may turn to categorical funding streams to fill gaps, resulting in divergence of priorities and possible duplication of effort among agencies and programs.

States have also been forced to cut back on their workforce to help balance fiscal pressures. Hiring freezes and furloughs place additional pressure on an already limited workforce to meet the increasing demands for public services during tough economic times. At least 27 states have instituted hiring freezes, 10 have announced lay-offs, 15 have reduced state worker wages, and several have delayed scheduled pay increases (including cost of living adjustments). Based on media reports, 21 states were either already implementing or considering furloughs.

MCH Impact

States have reported cuts or complete elimination for several key maternal and child health programs including home visiting, newborn screening, family planning, transition assistance for children with special needs, care coordination for underinsured women, vaccinations and school-based health. While the reality of each state and local agencies’ budget cuts vary, the impact on programs that keep mothers, children and families healthy is critical. Cuts mean less funding from states to support local government programs.
and services. In one state, for example, more than $20 million in cuts to the state’s maternal child and adolescent health program have been proposed, and a county health program for at-risk pregnant women and teenagers may be eliminated. The program, operated by county public health departments, provides services to women and teens to reduce incidences of low birth weight, premature delivery, maternal and infant mortality, preventable childhood diseases and disabling conditions. Yet another state will see cuts to a county immunization program and may have to limit vaccinations to high-risk populations. In addition, a community nutrition program in the same county that taught elementary school children about nutrition and healthy living has been eliminated. With a substantial cut to the tobacco use prevention program the county health department will no longer offer local smoking cessation classes. With less focus on tobacco prevention, states may see an increase in poor outcomes among women who might have been reached by these programs.

Looking Ahead

In addition to cutting programs and services and reducing their workforce, states are exploring ways to raise revenue. To help balance the severe budget cuts, over half of all states are raising taxes or considering doing so. Increases in personal income, business, sales, and excise taxes have been enacted or are under consideration. Unfortunately, future projections of the state fiscal crisis reveal a continued crunch looking forward to 2011, when total gaps are expected to exceed $350 billion.

As health reform continues to be debated in Washington D.C., state fiscal restraints will certainly have an impact on what health reform proposals states will be able to support. A bipartisan group of governors met recently with the President to voice their concern over increasing the burden on states to deliver health services. The President shared his urgent desire to restructure the nation’s health-care system but warned that any changes should not place more burdens on strained state budgets or eliminate innovative programs they already have in place.

AMCHP continues to closely monitor the fiscal crisis faced by states and MCH departments in particular. We will continue to advocate for an increased investment in public health both through the appropriations process and in health reform. Most importantly, we consistently urge Congress to increase funding for the Title V MCH Block Grant so that states can continue to provide essential preventive services that reduce health care costs and promote wellness.

Endnotes

1  http://www.cbpp.org/cms/?fa=view&id=1214
2  http://www.astho.org/pubs/Impact_Budget_Cuts.pdf
4  http://www.cbpp.org/cms/index.cfm?fa=view&id=1214
5  http://www.cbpp.org/cms/index.cfm?fa=view&id=2853
6  States Assert Place in Health-Care Debate Governors Fear Shifting of Costs By Michael A. Fletcher Washington Post Staff Writer Thursday, June 25, 2009
health agency. The remaining states have autonomous, independent health departments working at the local level coordinating their efforts with the work of the state health agency.

A cross-section of four very different states – Maine, Florida, Alabama and Hawaii – provides a look at what MCH and CYSHCN programs look like in “centralized” states where most local public health services are directly provided by a unit of the state health agency. These states have unique models for providing public health services at the local level because the distinction between “local” and “state” is blurred. These cases illustrate the complexity of state-local collaboration required to improve maternal and child health outcomes even when the state is the “local” agency. As in public health overall collaboration and partnership are required to provide effective and efficient MCH services to all residents of a jurisdiction.

Maine: An Evolving State/Local System

Unlike many New England states, Maine has just two local health departments: Portland and Bangor. The state health department has traditionally responded to public needs in the other parts of the state and provided public health services directly through contracts with local service providers in towns and regions across the state. As a result of Turning Point, an initiative to examine the state/local public health infrastructure in Maine, and Governor Baldacci’s Dirigo Health Reform legislation, public health leaders engaged in a dialogue about the various roles of state and local public health authorities. Using the Ten Essential Services of Public Health as a framework, the conversation focused on which services would most effectively be provided at the local level and which would be most effectively provided at the state level.

The dialogue resulted in a shared recognition of the need for a “mid-level” district or regional entity for the purpose of coordinating services. The boundaries of the eight districts take into account population, geographic spread, hospital services areas and county borders.

The establishment of the districts was designed to enhance effectiveness and efficiency of public health services by creating the geographic framework for greater consistency and equity in statewide delivery of the 10 essential public health services, providing a consistent basis for regional planning and coordinating across the public, nonprofit, and business sectors, and building sustainable infrastructure through regional co-location of Maine CDC and DHHS staff, “braided” funds, and the establishment of regional coordinating councils. To make this happen, Maine revamped its district infrastructure so that state government programs now all use the same district boundaries for all programs including EMS, Child Welfare, Food stamps, WIC, and TANF – a major feat when one considers all the players involved. Now when the Maine CDC has competitive funding the available funds are structured by districts. The Maine CDC is also working on braiding funding from more than one source into one contract when appropriate. The District Coordinating Councils are emerging as regional organizations by which to implement state programs at the local level, and proving to be an effective and efficient mechanism to build sustainable public health capacity throughout the state. As Maine moves forward with this new infrastructure, the state MCH program anticipates building upon these district organizations to implement programs, coordinate efforts, and reduce duplication and overlap in services at the local level.

Alabama: A Centralized System with Different MCH and CSHCN Agencies

In Alabama public health, including Title V services, is centralized under the authority of the State Health Officer for 65 of the 67 counties in the state. The CSHCN program is subcontracted out to a separate department that has its own Commissioner. The Alabama Department of Public Health (ADPH) is the Title V agency for the state, while Children’s Rehabilitation Service (CRS), a division of the Alabama Department of Rehabilitation Services, is the state’s CSHCN program. The state is divided into Public Health Areas with administrators who are organized under and
supervised by the State Health Officer. For CSHCN, the state is divided into Districts with district supervisors who are supervised by the CSHCN Director.

The centralized structure makes it easier for the State Health Officer and CSHCN Director to directly influence what is happening in MCH operations for the state. This structure allows for alignment of state priorities, values, and the mission of each program at the local level in an efficient manner. It also improves consistency in service delivery and policy setting, and allows for easier data collection at the local office level. The centralized structure with local offices allows for community-based service delivery and a strong local presence. Having CSHCN in a separate agency that is entirely devoted to serving people with disabilities is helpful in that administration and service delivery is provided by experts in disability and special health care needs that are coordinated by one state entity. This expands the reach of MCH and the presence of public health in local communities. There is less of a sense of “crossing lines” as Alabamians receive services through the public health system, including CSHCN. For example, families with CSHCN can receive services at their local office, but can also choose another site if they prefer. External to the agency (ADPH and CRS), the MCH structure and organization makes it easier for the respective Directors to assume a leadership role in engaging in partnerships with other stakeholders and with other members of the system of care in the state.

**Florida: A Statewide System with Local Roots**

In Florida, the state Department of Health administers 67 County Health Departments (CHDs) which act as the foundation of the state’s public health care system, providing critical detection, treatment and prevention services that protect Floridians from disease and injury. Every person, living in every community in Florida, benefits from the public health services provided by the local county health departments. As the implementation arm of Florida’s public health care system, the CHDs have the responsibility to prevent and treat infectious diseases of public health significance; monitor and regulate activities to prevent disease of environmental origin including rabies, West Nile virus, food and waterborne diseases; partner with other community organizations to ensure access to basic primary care medical services and serve as one of Florida’s largest safety net providers for the uninsured and Medicaid populations; promote healthy lifestyles by focusing on wellness and prevention services such as smoking cessation, school health services, and encouraging healthy behaviors to reduce the incidence of chronic diseases; prepare for and respond to natural and man-made disasters, and other modern public health emergencies. CHDs are among the largest providers of clinical care in the state providing over 3.3 million visits to over 1.0 million patients annually.

FDOH also encompasses Children’s Medical Services (CMS) which is an integrated statewide network of providers who deliver care to children with special health care needs. The foundation of CMS was to form partnerships at the local, regional and state level to assure quality health care for children with special health care needs. In 1996, CMS became a Medicaid plan and in 1998 a state children’s health insurance plan for CSHCN. In addition to its service delivery responsibilities it is also responsible for the tracking and follow-up component of newborn screening, high risk perinatal care through regional centers, early intervention for infants and toddlers, medical services to confirm child abuse, a statewide poison control network, and child abuse death reviews. Children’s Medical Services has line authority over its 22 area offices arranged in regions. The central office has responsibility for certain functions such as policy development, standards setting, financial and contract management, as well as quality assurance, provider management and credentialing, enrollment processing and tracking, and training.

Some benefits of the Florida model include a seamless integration of state and local policy development, with CHDs acting as the implementation arm of the department. The state also has a statewide performance improvement process that uses shared measures...
Unique Collaborations in Four States

across the state. Florida’s Healthy Start Coalitions (single county and regional organizations) work as the statutorily designated entities responsible for needs assessment, planning, and purchasing the delivery of MCH services at the local level—these are contracted entities from the state health office that work with the local county health departments and other providers to leverage resources and assure services.

Partnership in Paradise: State and Local Public Health in Hawaii

Hawaii has a centralized public health system and there are no county funded or local health departments within the state. District Health Offices are managed by a District Health Officer within each county and all personnel are state Department of Health employees. Except for the Office of Rural Health which is located on the “Big Island” (the Island of Hawaii), all division and administrative heads are housed on Oahu as 70% of the state’s population resides there.

The majority of direct and enabling services are delivered through contracts with private sector health and human services organizations on each of the Hawaiian islands. Clinic based services are contracted with Community Health Centers. Placement of community resources at the “grass roots” level is an essential component in linking successful partnerships among policymakers, health care providers, families, the general public and others to identify and solve maternal and child health issues and concerns in the state. MCH infrastructure building and population based services are managed through the strategic placement of MCH and Family Health Services Division (FHSD) Coordinators and CSHCN staff on the neighbor islands and this allows for collaborative partnerships and mobilizations of Title V/FHSD initiatives and programs. Neighbor island coordinators and staff actively participate in both local and statewide coalitions and advisory groups which provides for open communication and recognition of varied cultural values and practices. Provision of MCH services to culturally and linguistically diverse populations and addressing racial and ethnic disparities in the health of women of reproductive age is a challenge for many states, including Hawaii. To address these issues, programs and community health centers actively recruit and retain staff that are culturally competent and linguistically capable of interpreting various languages. Hawaii’s centralized structure allows for a focus on priority MCH needs statewide and activation of a unified approach in provision of MCH/CSHCN services. Local area MCH/CSHCN, FHSD representation acts as a catalyst on each neighbor islands to assure quality preventative and protective health care. The procurement of direct and enabling services through contracting also assures that there is a continuity of service delivery throughout the entire state and allows the division to implement a standard of care.

Hawaii’s Title V Director, Loretta Fuddy, believes the major difference between centralized and other public health systems is that the centralized system limits the number of competing agendas and priorities. State and counties alike have a common goal and purpose “to protect and improve the health and environment for all people in Hawai’i.”

All four of these states demonstrate that even when the state is the local, and the local is the state, collaboration with partners at the community level is required to carry out critical MCH services. As states look to address MCH challenges an examination of how the state health agency is organized, and what services are provided by which level of government, may provide an opportunity to improve program performance and more efficiently provide services within our diverse states and territories.

Thanks to the following individuals for their input in this article: Valerie Ricker (Maine), Julie Preskitt, Chris Haag, and Melinda Davis (Alabama), Annette Phelps and Phyllis Sloyer (Florida), and Loretta Fuddy (Hawaii).
Thoughts on Working at the Local and State Level

By Larry D. Jones, MPH
Health Director
Independence Health Department
Independence, Missouri

Larry Jones has been working in public health since 1970 when he began his career with the Kirksville College of Osteopathic Medicine in their federally funded Children and Youth Project, a program that is dedicated to providing primary care services, dental services and hospital services to children of low income families from birth to 18 years of age. While Larry was at the Kirksville College of Osteopathic Medicine, he applied for and received one of the first 19 Women, Infants and Children (WIC) Supplemental Food Program grants in the nation.

In 1974, Larry joined the staff at the Missouri Department of Health and Senior Services as the Deputy Division Director for Maternal and Child Health. During that time he started a High Risk Maternity and Infant Care program funded by state funds that later became a Medicaid expansion program. He helped start the First Steps Program, a federally funded program for newborn through three year olds with developmental delays. He also administered the MCH Block Grant. Larry then spent the next seven years helping to strengthen local public health agencies while working for the Center for Local Public Health Services. He has been the Health Director for the City of Independence since December 2001. In this role, he provides leadership for the health department, the Kansas City metropolitan region and the state.

We asked Larry to answer some questions about his experience working at the state and then at the local level. He shares his thoughts below.

Q: Is there a major difference between being an employee at the state vs. the local level?

Over the past nearly 40 years in public health, I have had the privilege to work in both. After both, I would say yes. Working at the state level allows you to see the overall picture of your state; however, it often means the design of one-size fits all program. Just like in clothing putting a one-size-fits-all garment on a 3X or petite person doesn’t work, it doesn’t work in MCH either. Working at the local level lets you see what the real needs are in your area and develop and evaluate programs that impact those needs. You know who really works well with you to impact these needs in your community. Since it works so well for you, you wonder why the state doesn't just have everyone do it your way. You also wonder why in the world the state is giving money to the only community-based organization in your area that does not cooperate with the rest of the community and always wants to do it their way or not at all.

Q: What are the key components to building partnerships?

What really works is a partnership between state, local and community partners. There will never be enough money to fund everyone or everything to the level each feels is necessary. When you are working at the state or local level, it is helpful to have an advisory committee. At the state level, a committee of local public health departments that represent all sizes of health departments; and at the local level, partners that are both willing and unwilling to work with you. You do not need everyone to agree with you -- you will develop some of your best work by seeing the problem from all levels and the pros and cons of your recommended solutions.

Q: What is the value of sharing best practices?

We are all working to provide our citizens with the best practice possible. However, we sometimes need to
Feature cont.
Thoughts on Working at the Local and State Level

remember that we cannot let recognized best practices stand in the way of development of best practices. All best practices of today were once someone’s dreams. They had the fortitude to try something that hadn’t been done, to evaluate their idea, and to share it with others. If we do not do this as well, we will be in a rut where we only do what we have always done, and we will continue to wonder why we are not making more progress. We also need to share what we are doing that works well with each other. Model Practices at the local and state level need to be shared. State MCH programs could develop web sites that allow the sharing of what is working in your local health departments. Maybe a local agency has adopted an ordinance that restates the state statute on immunizations requirements for attendance at daycare centers so that they can enforce this monthly instead of the once or twice a year that the state might conduct inspections.

Public Health Accreditation and MCH Programs: A Natural Partnership for Health Improvement

By Kaye Bender, PhD, RN, FAAN
President and CEO, PHAB

The Public Health Accreditation Board (PHAB) was established in 2007 to establish a national voluntary public health accreditation program for state, local and tribal health departments. The idea came about as a result of a previous study, Exploring Accreditation, in which it was determined that it is both desirable and feasible to embark on this effort. PHAB has recently been busy developing and vetting the proposed standards for accreditation, in which we received almost 4,000 individual comments. Approximately 123 online surveys were completed. Many of the responses represented a group process, so a significantly larger number of public health stakeholders contributed this input. About 35 paper surveys were received. Twenty-nine feedback forms were received from groups who held vetting discussions. We also received more than a dozen narrative comments submitted in emails or letters. The Board will receive the analysis of this feedback, edit the standards and begin the beta test later in the fall. This next process will test the standards, measures, assessment process, and written support documents in order to identify areas for improvement. Revisions can then be adopted prior to the official launch of the program, in 2011. The letters of invitation will be released in July for health departments to apply to participate in the beta test. PHAB will ensure that the health departments selected for the beta test represent the broad array of health departments that exist across the country. PHAB is seeking to identify a variety of health departments relative to size, structure, population served, governance, geographic region, and degree of preparedness for accreditation. Beta test sites will be announced in October 2009 and training will begin shortly thereafter.

We hope that MCH program staff will support their health departments in submitting applications to be a beta test site. MCH information, such as the needs assessment, strategic planning documents, population focused health education materials, policies, plans, and other similar work products associated with maintaining a solid MCH program can be used as some of the documentation for meeting the standards. The beta test is a great opportunity to see how that will work when the accreditation program officially begins. Accreditation goals are consistent with those of MCH programs: to support quality and performance improvement in the public health services provided by the health departments. For more information or to see how to get involved, please visit here.
Member to Member

How are you involving local health departments in your state needs assessment?

Colorado

Karen Trierweiler, MS, CNM
Director, Center for Healthy Families & Communities
Colorado Department of Public Health and Environment

Colorado has local health department representation on both the Needs Assessment Steering Committee (responsible for day-to-day management of the needs assessment process) and the Needs Assessment Advisory Committee (a larger stakeholder group responsible for overall direction and feedback.) A list of potential priority areas for each MCH population will be identified from an online survey of stakeholders, including local public health, and a review of quantitative MCH health status measures for Colorado. Local public health staff will subsequently be involved in an online prioritization process to further hone this list to a set of issues for final consideration.

Montana

Dianna Frick
MCH Epidemiologist
Montana Department of Public Health and Human Services (Pictured, left)

Ann Marie Buss
Supervisor/MCHC Family and Community Health Bureau (Pictured, right)

In the summer of 2008, maternal and child health (MCH) contacts in Montana’s local health departments (LHDs) participated in teleconferences and a survey about priority health needs and emerging health needs in Montana. LHDs also provided input on the best way to collect population-based information on MCH needs and priorities, especially given the size of the state (145,552 square miles) and the distribution of the population (almost 50% living in rural or frontier areas).

In 2009, LHDs participated in a conference call about MCH data usage and planning and the administration of a capacity survey to community-based MCH organizations. LHDs provided comments and suggestions on the survey and sent lists of contacts in their communities and counties.

Several LHD representatives serve on the Family Health Advisory Council and provide feedback throughout the needs assessment process. In the future, MCH plans to invite the LHDs to participate in focus groups to be held across Montana.

Success Story

The Three C’s of Successful State and Local Partnerships in West Virginia: Communicate, Collaborate and Coordinate

By Pat Moss
Director, Office of Maternal, Child and Family Health, West Virginia Bureau for Public Health

“Communicate – Collaborate – Coordinate” has always been the MCH (public health) mantra. Clearly, working in partnership toward a shared vision has been critical to successful maternal and child health system development across the country.

The details of how this is achieved are sometimes elusive, and each state has its many stories. West Virginia is no exception.

In the early 2000’s, the West Virginia Bureau for Public Health and local health departments acknowledged the need for an improved working relationship to advance
Success Story cont.
The Three C’s of Successful Partnerships

Public health efforts. A written working relationship charter was developed that specified how issues would be advanced, problems studied and plans executed; teaming principles and practices were agreed upon; and communication and decision making processes were formalized.

A basis for collaborative work involving the state and local health departments required the following agreed upon process:

1. Workgroups must have a defined purpose;
2. The number of people, areas of expertise, skills and resources needed must be identified;
3. Communication of information about the expected time commitment, travel, etc. must be delineated;
4. A proposed roster of workgroup members may be suggested; and
5. Ultimately, an oversight committee representing an equal number of local health department and the State Bureau for Public Health, select workgroup members and draft charters.

This is an ongoing process that exists today and has resulted in a strengthened relationship among local health departments, boards of health and the Bureau for Public Health (state). The formalization of processes has also resulted in increased opportunity for public health to improve collaborative planning, teaming and decision making. The most lasting benefit has been one vision shared that has resulted in increased legislative appropriations to support local health department core functions.

The West Virginia team said it best: Success will be when we recognize that the success of the whole is greater than any one issue.

For further information, please contact Pat Moss, Director, Office of Maternal, Child and Family Health via phone at (304) 558-7261 or Kay Shamblin, Director, Division of Local Health via phone at (304) 558-887.

View from Washington

By Brent Ewig, MHS
Director of Public Policy & Government Affairs, AMCHP

Greetings once again from our nation’s capital! A historic debate over health reform is well under way and while battle lines are being drawn there remains significant optimism that this might be the year that health reform finally happens. I am writing this column the day after the Senate HELP Committee passed the first major Congressional health reform proposal, and the House is beginning to mark up their reform legislation today. The Senate Finance Committee legislation is also expected any day.

House leaders are continuing to pledge action on a bill by the full House of Representatives prior to the scheduled August recess, while timing of action by the full Senate is much harder to predict. What is clear is that the next few weeks and months will be critical in determining whether a health reform bill can garner enough votes to pass both chambers and be signed into law this year.

We are scrambling to analyze and summarize what each leading proposal means for MCH populations and state public health programs. We will soon circulate summaries of key MCH provisions, and please check the AMCHP Health Reform Resources Hub regularly for new information. We are also continuing to advocate for health reform that incorporates AMCHP’s three principles that 1) promote affordable coverage for all Americans; 2) includes a benefits package that addresses the unique needs of women, children, adolescents, and children with special health care needs; and 3) recognizes that health care is essential but insufficient to improve health and therefore invest in state public health and MCH programs.

Consistent with the theme of state and local collaboration, I do want to highlight one of the key
provisions in both the Senate HELP and House health reform proposals that we think could directly improve this relationship. Both the Senate HELP and House tri-committee bill propose dramatic investment of new public health funding to make sure there are more adequate resources to support public health at the federal, state and local level. Specifically, each bill proposes the creation of a Public Health Investment Fund that at full implementation would provide roughly an additional $10 billion annually and above current funding levels to support public health programs.

Having a much bigger pie to split up among federal, state and local agencies should go a long way to reducing the all too familiar tension that impedes state/local collaboration – namely wrangling over limited resources. This tension is exacerbated in times like these when both state and locals are faced with dramatically eroding public health funding. The perceptions and arguments are familiar – the locals think that states horde all of the money and the states think that direct local investments without a state coordination role promotes fragmentation and duplication. I may be naïve, but having significantly more resources to support all three legs of the three-legged stool of our federal/state/local public health system should help ease this tension and allow us to refocus our energies on our shared goals to promote the health of all women and children in America.

Who’s New CONT.

Meet AMCHP’s New Associate Director for Women’s & Infant Health

AMCHP is pleased to announce that Vanessa White has joined the staff as the Associate Director for Women’s & Infant Health. Vanessa was most recently at the Association of Public Health Laboratories where she was a Senior Program Manager for the Laboratory Systems & Standards Program. Vanessa also has experience with the Montgomery County Department of Health and Human Services in Maryland, where she staffed the Fetal and Infant Mortality Review (FIMR) Board, led Montgomery County’s (CityMatCH) Data Use Institute Team, and developed provider and patient education campaigns to improve birth outcomes. Vanessa also has experience with the Association of Schools of Public Health where she managed a project to strengthen practice programs in accredited schools of public health. Vanessa earned her MPH from Boston University and her undergraduate degree in International Studies from Pepperdine University.

Data and Trends

National and State Resources from the Data Resource Center

Partnering to improve maternal and child health requires reliable, valid and easy to access data. Partnerships need data to both shape and advocate for improvement in policy and practice. Data forces partners to check assumptions and make good choices about what to focus on, about what is needed, what is working and what to focus on to improve policy and practice. The Data Resource Center (DRC) provides you and your partners with easy, point-and-click access to national and state level data on everything from children’s health status to services use and performance. Take advantage of this free resource to inform and stimulate health improvement partnerships and engage all partners.
STATE PUBLIC HEALTH is one part of a governmental public health system made up of local, state, and federal agencies working together to protect the health of the public.

In 13 states all local public health services are provided by the state health agency.

In another 17 states, one or more localities receive their local services through the state health agency.

In all 50 states, Americans benefit from basic public health services provided at the state level, including but not limited to:

- Running statewide prevention programs like tobacco quit lines and newborn screening
- Budgeting and tracking a basic level of public health services across the state
- Providing specialized professional services such as disease outbreak specialists
- Analyzing statewide data to target public health threats and diseases
- Investigating outbreaks, environmental hazards, and other threats across the state
- Verifying that resources are used effectively and equitably throughout the state
- Licensing and regulating health care, food service, and other facilities
- Laboratory services for infectious disease and biological and chemical agents

As shown above, **30 State Health Agencies** — representing **55% of the U.S. population** — directly provide all or some local public health services, including:

- Newborn screening
- Maternal and child healthcare
- Chronic disease prevention and control
- Screening for blood lead, tuberculosis, HIV/AIDS, and STDs
- Services for children with special health care needs
- Immunizations
- Minority health services
- Rural health services
- Food safety education
- Mosquito control
- Radiation and radon control
- Regulation of emergency medical services
- Regulation of indoor air quality and water supply safety
- Toxicology
- Bioterrorism and natural, chemical, and nuclear disaster response
- Trauma services
- Veterinarian public health services.
State Health Agencies
Provide Public Health Services to All Communities

30 State Health Agencies - Representing 55% of the U.S. Population
Directly Provide All or Some Public Health Services at Local and Community Levels

All 50 states Americans benefit from basic public health services provided at the state level
In another 17 states, one or more localities receive all its services through the state health agency
In 13 states, all local services are provided by the state health agency

*AL, NH & VA have one or two large metropolitan areas that are locally governed
ASTHO’s Request for Quotes on MCH Promising Practices
ASTHO’s MCH Project is looking for a contractor to see if the Title V Info System can be used to objectively or passively find short-term or intermediate indicators that could be linked to potential promising practices in states. The deadline for submissions is July 22. To download a copy of the request for quotes, visit here.

PHAB is seeking a Beta Test Evaluator
The Public Health Accreditation Board (PHAB) seeks a qualified evaluation contractor to: (1) design and conduct a process evaluation of the beta test and evaluate costs and time; (2) gather real time data; (3) analyze data and draw conclusions; and (4) submit interim and final reports of findings and recommendations for improvements on a phased basis to PHAB. PHAB has issued a request for proposals for the evaluation of the beta test. In order to be considered for this project, applicants must be able to demonstrate significant experience with the conduct of program evaluation in general, and beta testing and other formative evaluation techniques, specifically. Those with knowledge of accreditation are encouraged to apply. Knowledge of governmental public health departments is desired. Proposals for the evaluation of the beta test must be received by PHAB no later than 5 p.m. (EDT) on July 31. To learn more, visit here.

Call for Abstracts for the National Conference on Blood Disorders in Public Health
The Conference Planning Committee for the National Conference on Blood Disorders in Public Health is seeking abstracts to be considered for presentation at the conference. The committee encourages interested individuals or organizations to submit abstracts that address specific issues, approaches or strategies that contribute to the prevention of complications experienced by people with blood disorders. Priority preference will be given to abstracts that demonstrate the application of public health strategies to promote the health and/or improve outcomes of people with blood disorders. The deadline for all abstracts is August 9. For more information about submission guidelines or to submit an abstract, visit here.

Resources
Association of State and Territorial Health Officials (ASTHO) - Is a non-profit membership association representing the chiefs of state and territorial health agencies and the individuals who work for them. State health officials receive valuable, timely and accurate information, advice, and support on critically important public health concerns from ASTHO. These efforts, representing the interests of state/territorial health agencies and the people that health officials serve, have paid big dividends. Federal policymakers look to ASTHO for expertise when developing policy, drafting legislation, and disseminating regulations. ASTHO leaders frequently testify on Capitol Hill and have the opportunity to meet with top Administration and congressional officials.

CityMatCH - Is a freestanding national membership organization of city and county health departments'
maternal and child health programs and leaders representing urban communities in the United States. The mission of CityMatCH is to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities. CityMatCH is grounded in the philosophy that all children and families deserve to be healthy and achieve their optimal growth and development in the physical, intellectual, social, emotional, and spiritual aspects of their lives. The responsibility for assuring this is shared by each individual and his or her family, the community, and government at the federal, state, and local levels. Children and families in urban areas have unique needs and deserve special attention. These needs must be effectively addressed in order for all children, and ultimately our society, to achieve full potential. Local public health agencies are a critical component of the collaborative effort that is needed to improve the health of children and families in urban areas.

**National Association of Counties (NACo)** - Is the only national organization that represents county governments in the United States. NACo provides essential services to the nation’s 3,066 counties. NACo advances issues with a unified voice before the federal government, improves the public’s understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. NACo is a full-service organization that provides an extensive line of services including legislative, research, technical, and public affairs assistance, as well as enterprise services to its members. The association acts as a liaison with other levels of government, works to improve public understanding of counties, serves as a national advocate for counties and provides them with resources to help them find innovative methods to meet the challenges they face.

**National Association of County and City Health Officials (NACCHO)** - Is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

**National Governor’s Association (NGA)** - The bipartisan organization of the nation’s governors, promotes visionary state leadership, shares best practices and speaks with a unified voice on national policy. NGA is the collective voice of the nation’s governors and one of Washington, D.C.’s most respected public policy organizations. Its members are the governors of the 50 states, three territories and two commonwealths. NGA provides governors and their senior staff members with services that range from representing states on Capitol Hill and before the Administration on key federal issues to developing and implementing innovative solutions to public policy challenges through the NGA Center for Best Practices. NGA also provides management and technical assistance to both new and incumbent governors.

**Public Health Accreditation Board (PHAB)** - Is dedicated to raising the standard for public health. With support from the CDC and The Robert Wood Johnson Foundation, PHAB is working with leading public health experts from the field to develop a voluntary national accreditation program that will help public health departments assess their current capacity and guide them to become even better providers of quality service, thus promoting a healthier public. In an effort to align national standards with the needs of members and address a wide range of public health department structures and circumstances across the country, PHAB is working closely with NACCHO, ASTHO and NALBOH. PHAB has also created several committees and workgroups comprised primarily of state and local health officials to develop all aspects of the new accreditation program. These expert workgroups and committees are developing the features of the new accreditation program building on the excellent work of others who’ve addressed performance improvement and existing state-based performance standard programs.
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AMCHP’s CAREER CENTER

The Career Center is the premiere online job board for individuals seeking employment in Maternal and Child Health programs. Whether you are looking for an entry-level position or are a more seasoned professional looking for new opportunities, AMCHP’s Career Center has great openings for great people! Searching our database is free and open to all job-seekers. AMCHP members receive a discount on job-postings - so sign up today!

SAVE THE DATE!

AMCHP’S 2010 ANNUAL CONFERENCE - “Moving Ahead Together: Celebrating the Legacy, Shaping the Future of MCH”

March 6-10, 2010
Gaylord National Convention Center
National Harbor, MD

The 2010 AMCHP Conference will bring together leaders in maternal and child health, public health practitioners and family advocates. Join us for sessions led by researchers, federal officials, advocates, families, healthcare providers and directors of state programs.

Click here to view the slides, transcripts and videos from the 2009 conference. NOTE: You may need to download RealPlayer and/or PowerPoint 2007 Viewer to view the presentations.