The Proof Is In The Process

Nebraska's Path to a Life Course Framework for Adolescent Health and Development
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Today's Presentation Will:

- Focus
- Illustrate
- Describe
- Demonstrate
Nebraska’s Journey

- Prepare
- Augment
- Maintain
- Support
The Starting Point
Developing the 2005 Needs Assessment

- Informed by committee
- Refined through technical assistance
  - Adopting a model, implementing tools
- Driven by population-defined work groups
Navigation

• Systematic Approach
• Prioritizing
  • Criteria, Weight and Rate
• Uniformity and Equality
Needs Assessment Sets The Future Course
Summarizing the Process

1. Present overall objectives and the recommended process for prioritization to NAC.
2. NAC selects criteria for the ranking of problems.
3. NAC develops criteria rating scales.
4. NAC determines weights for each criterion.
5. NAC reviews preliminary draft of data.
6. Convene workgroups, assign tasks and provide orientation and experience in applying criteria.
7. Workgroups review all the available data for their population group and identify problems/needs.
8. Presentation of identified problems and data summary from all workgroups to the larger planning group.
9. Agree on the final problem list to be prioritized.
10. Use weighted criteria to score problems.
11. Sum participant’s scores / rank problems.
12. Discuss and confirm results
Nebraska's 2005 Ten Priorities

- Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.

- Reduce the percent of women of childbearing age, particularly pregnant and post-partum women, and adolescents who use tobacco and reduce the percent of infants, children and youth exposed to second hand smoke.

- Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.

- Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.

- Reduce the number and rates of child abuse, neglect, and intentional injuries of children.

- Reduce the rates of infant mortality, especially racial/ethnic disparities.

- **Reduce alcohol use among youth.**

- Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.

- Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.

- Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.
Next Steps
Strategy Development

- Methodology
- Problem Analysis
- Logic Models
Problem Analysis

Societal/Policy Level/Tertiary Precursors
- Socio-economic factors: Poverty, Racism
- Educational Policies: Class size, Standards, Dollars
- Health Care Policies (Medical & Dental): Insurance, Funding, Public health, Cost of care
- Environmental Factors: Walking trails, air water quality, pesticides
- Economic Factors: Affordable housing, food (fruits/vegetables)
- Sexism
- Public Policy on Immigration

Family/Institutional Level/Secondary Precursors
- Nuclear Family Factors: Family history, Parenting Support, Income, Not married (parent of pregnant woman), substance abuse
- Community Networks: Close friends, Significant others, Extended family, Religious community groups
- School/Workplace Factors: Safety issues, Stress, Relationships
- Health Care Provider Issues (Medical & Dental): Access to care, Transportation, Location, Ratio of providers, Quality care, Language access
- Violence: Physical and psychological
- Women enrolled in Medicaid/WIC
- Women with two or more children
- Lack of access to nutritional food
- Lack of access to physical activity/opportunities
- Cultural Beliefs and Traditions

Individual Level/Primary Precursors
- Genetic/Biological Risk Factors: Previous history of preterm birth
- Psychological Factors: Stress, Marital status
- Unintended pregnancy
- Age
- Health Status/Medical Condition: Chronic disease, Diabetes, Pre-pregnancy weight (obesity, poor weight gain), Birth spacing, Infections, Obstetrical history, previous SGA/Preterm outcome, Oral Health
- Cognitive Factors: Less than a HS education, Knowledge — ability to learn
- Health Behaviors: Smoking, Drug use, Late prenatal care, Nutritional intake, Physical Exercise

Targeted Indicator: Preterm and LBW among all women of child bearing age **

Consequences: Mortality, morbidity, high cost and lifelong consequences.

** Race/Ethnicity and Age: There is a higher incidence of preterm and LBW among teens and older moms as well as within racial/ethnic groups. (Highest among African American) This work group will have strategies targeting these specific populations.
Safety Factors:
Safe neighborhood, public safety, ER response, availability of city parks.

Community Networks:
Close friends, significant others, extended family, religious community groups

Nuclear Family Factors:
Family History, Parenting Support, Income, Not Married (parents of pregnant women) substance abuse

Consistent message among community networks, enhance existing networks, healthy relationships, broaden advocacy, identify other support.

Health Behaviors:
Smoking, Drug use, late prenatal care, Nutrition intake, Physical Exercise Stress, Unintended pregnancy
**Logic Model**

**Model 2**

**Theory:** Perceptions of safety/security affect the ability of community networks and nuclear families to influence health behaviors of women especially women at-risk for PT/LBW infants.

**Change:** Improvements and enhancements in community networks and social relationships will have an impact on birth outcomes specifically preterm and LBW infants of at risk mothers.

**Problem Statement:** Lack of social supports contributes to Preterm and Low Birth Weight

<table>
<thead>
<tr>
<th>INPUTS (Resources)</th>
<th>OUTPUTS</th>
<th>OUTCOMES – IMPACT</th>
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<tbody>
<tr>
<td>Stakeholder group</td>
<td>Environmental scan of community support systems. Inventory and Develop directory of mental health and peer support services Identify Best practices in safe and supportive networks and peer groups Develop campaign to educate lay health persons on identification/support of isolated women Promote Community collaboratives to include strong behavioral health representation Assessment of neighborhoods/communities with high rates of PT/LBW</td>
<td>Communities are aware of what safe and supported means and are providing a safe supported network to women Communities and Women understand the connection between stress and poor outcomes Increase KSA's toward providing culturally appropriate mental health care and reduce stigma of accessing care</td>
</tr>
<tr>
<td>Educational programs to build on Money Staff time Content experts National resources Policymakers Faith community Educators Public Health Government Minority Health Groups Workplace Service industry</td>
<td>Policy makers Community leaders And local communities Employers Faith based providers Beauticians, nail salons School counselors Pastors wives etc.</td>
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MCH Preterm/Low Birth Weight Strategic Planning Work Group
Following the Course for 2010

- Life Course Framework
- Socio-Ecological Model
- Comprehensive Systems Focus
Understanding the Life Course Approach

Graphic Concept Adapted from Neal Halfon, UCLA
Risk Reduction and Health Promotion Across the Lifespan

Graphic Concept Adapted from Neal Halfon, UCLA
The Social-Ecological Model
Life Course Framework
Guides Actions

- Funding of community-based projects – 2008
- Successful Grant Application
  - First Time Motherhood/New Parents Initiative
- Adolescent Comprehensive System Initiative
Adolescent Comprehensive System

- Physical, Mental and Oral Health Care
- Community Support
- Education and Career Development
- Social-Emotional Development
- Health Promotion
- Family Support and Education
Moving On
The MCH Needs Assessment for 2010

- Align the focus
- Streamline the process
- Coordinate efforts
- Cross-cut across multiple population groups
Applying Structure

For 2010:

- “Informed” approach
- Expanded measures
- Refined perspective
- Life Course framework
- Improved Indicators
Health Outcomes
- Premature Mortality (50% of outcomes) * years of potential life lost –YPLL
- General health status (50% of outcomes) *self-reported fair or poor health

Health Determinants
- Health behaviors (40% of determinants)
- Health Care (10% of determinants)

Health Care (10% of determinants)
- Access to Care
- Quality of Care

Health behaviors (40% of determinants)
- Tobacco
- Diet and Exercise
- Alcohol Use
- High risk sexual behavior
- Violence

Socioeconomic factors (40% of determinants)
- Education
- Income
- Social Disruption

Physical Environment (10% of determinants)
- Air Quality
- Water Quality
- Built Environment

Programs and Policies

Structural Framework for 2010
Framework - Continued

Health Determinants

Health Care

Access To Care

Medicaid/EPsDT Data

Health Behavior

ATOD

YRBS Data

Physical Environment

Injury

YRBS Data

SES/Demographics

Air Quality

Tobacco Survey Data

Age

Graduation Rates
What We Hope for 2010

1. Expanded NAC
2. Enhanced structure to the process
3. Richer, more complex analysis of needs
Conclusion
Making The Connection

- Foundational Process
- Guiding Framework
- Process + Framework = Enhanced focus on adolescents
Thank You!

Questions?

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Bibliography

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- Huffman, Sue, Karsting, Kathy; *Life Course Development: Thinking About Cause and Effect in 21st Century Populations*, Nebraska DHHS, Division of Public Health, Lifespan Health Services, October 2009


Resources


*What is the Life-Course Perspective?* NACCHO MCH Newsletter, October, 2008