Activating MCH Leaders for Impact: Reflecting on our Past, Preparing for our Future

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Learning Objectives

By the end of this training, participants will:

• Explore the roots of Title V and MCH

• Discuss the structure of Title V, including flexibilities and constraints

• Examine the future of Title V, and opportunities for MCH practice and leadership

MCH Leadership Competencies:

• MCH Knowledge Base/Context

• Working with Communities and Systems

AMCHP
Key Questions to Guide Us

• Who is AMCHP? How do I get involved?
• How did Title V and MCH in America Start?
• Why a Block Grant? Why needs assessment?
• What are the flexibilities and constraints of the Title V program?
• Why so much emphasis on data?
• What / where are the levers you have as an MCH leader?
• Where does change come from?
• What does partnership and collaboration mean as we look towards the future of Title V?
• What does a Title V leader look like?

AMCHP
Who is AMCHP? Mission and Vision:

AMCHP leads and supports programs nationally to protect and promote the optimal health of women, children, youth, families, and communities.

AMCHP envisions a nation that values and invests in the health and wellbeing of all women, children, youth, families, and communities so that they may thrive.
AMCHP Strategic Plan

OUR CHALLENGES

LACK OF EVIDENCE
56% of persons working in maternal and child health-related programs areas (excluding MCH) indicated awareness of evidence-based public health practice.

CARE FOR CYSHCN
84% of children with special health care needs do not receive care in a health maintenance system.

SHRINKING WORKFORCE
54% of people plan to leave the state public health workforce in five years.

CHASING ZERO
0 deaths due to maternal and infant deaths.

INSUFFICIENT INVESTMENT
Our nation’s most emergent public health issues are particularly impacting MCH populations, yet federal funding for some core MCH public health programs remains lower than it was 20 years ago.

AMCHP Strategic Plan 2019-21

A Bridge for Action

AMCHP leads and supports programs nationally to protect and promote the optimal health of women, children, youth families, and communities. AMCHP envisions a nation that values and invests in the health and well-being of all women, children, youth, families, and communities so that they may thrive.
# How can I get involved?

## Board of Directors
- President
- Past President
- President Elect
- Treasurer
- Secretary
- 10 Regional directors
- 2 Family representatives
- 2 At-large members

[http://www.amchp.org/AboutAMCHP/About/board/Pages/default.aspx](http://www.amchp.org/AboutAMCHP/About/board/Pages/default.aspx)

## Committees
### Committees of the Board
- Executive
- Finance

### Committees of the Association
- Annual Conference Planning
- Best Practices
- Family Leadership, Education, and Development (LEAD)
- Governance
- Health Equity
- Legislative and Health Care Finance
- Workforce and Leadership Development

[http://www.amchp.org/AboutAMCHP/About/board/Pages/Committees.aspx](http://www.amchp.org/AboutAMCHP/About/board/Pages/Committees.aspx)
How did Title V and MCH in America Start?

Child labor
Social Justice

Florence Kelly
Speech on Child Labor in America

Children’s Bureau
Est. 1912

AMCHP
“To investigate and report upon matters pertaining to the welfare of children and child life among all classes of our people and especially investigate the questions of infant mortality, the birth rate, orphanages, juvenile courts, desertion, accidents and diseases of children, employment, (and) legislation affecting children in the several states and territories.”

**Directors of the Children’s Bureau:**
- Julia Lathrop, Chief, 1912-1921
- Grace Abbott, Chief, 1921-1934
- Katharine Lenroot, Chief, 1934-1951
- Martha Eliot, Chief, 1951-1956
- Katherine Oettinger, Chief, 1957-1968
The MCH Workforce

The Children’s Bureau sought to professionalize the workforce – these are child welfare workers in Minnesota, circa 1920.

They developed a variety of training programs that continue to this day in pediatrics, obstetrics, adolescent health, nurse-midwifery, nursing, social work, nutrition and public health.
MCH Chronology Highlights

1909: First White House Conference on Children and Youth
1912: The creation of the U.S. Children’s Bureau
1921-1929: The Maternity and Infancy Care Act / Sheppard Towner Act
1935: Title V of the Social Security Act
1981: Block Grant (OBRA 1981)
1989: OBRA 1989
2015: Block Grant Transformation
2020: 85th Anniversary of Title V

http://www.amchp.org/AboutTitleV/Documents/Celebrating-the-Legacy.pdf
Global Meets Local

LOUISVILLE METRO’S HISTORY

This historical timeline provides brief information on events that shaped Louisville Metro and created the social, political and economic landscape that we see today.

Slavery and Statehood:
Enslaved Africans trafficked by the earliest colonists were forced into unpaid labor on a large scale to clear and settle central Kentucky. When Kentucky attained statehood in 1792, it did so as the first state to sanction slavery in its Constitution.

19th-Century Immigration:
After its canal was completed in 1830, Louisville attracted a huge influx of German and Irish immigrants, triggering a wave of anti-immigrant, anti-Catholic protest that culminated on August 6, 1855—a day known as “Bloody Monday” with riots, arson, and murder that left at least 23 dead.

Colonization:
Indigenous peoples lived, hunted, and developed complex societies for thousands of years in what would later become Louisville. After European colonizers who came to North America in search of economic opportunity began to settle here in the early 1770s, they laid claim to all lands that belonged to native peoples.

Steamboats and the Slave Trade:
The invention of the steamboat in 1811 helped Louisville rise to regional prominence as a shipping hub along the Ohio River and as a regional center for the slave trade, with many Africans sent “down the river” from here to points farther south.

Struggles over Slavery:
As conflicts over slavery led to Civil War in 1861, Kentucky remained officially neutral. In reality, White people fought bitterly for both sides while some Black-free bondsmen to serve as Union troops. Kentucky Whits were so divided, and the state was of such strategic importance to the war that President Abraham Lincoln’s 1863 Emancipation Proclamation exempted Kentucky. Sayrey ended here only in 1865 with the postwar passage of the Thirteenth Amendment—an amendment that Kentucky refused to approve.

Buchanan v. Warley, 1917:
When Louisville passed a housing segregation ordinance in 1914 that restricted residents to moving only onto blocks containing a majority of their own race, a new local NAACP branch challenged the ordinance all the way to the U.S. Supreme Court with the help of local Black journalist William Warley and a White realtor named Charles Buchanan. In 1917, the Supreme Court upheld property rights for both races and outlawed residential segregation ordinances, a major first step in stopping the advance of racial segregation laws.

The Future is NOW: Integrating MCH Transformations

Early Nashvile
- 1779 Settlers arrived from North Carolina
- 1780 Twenty % of the Black population were free persons
- Early white settlers or heirs were guaranteed 640 acres
- 1840’s Nashville was labeled one of the deadliest places to live
- 1862 Nashville became the first Southern Capital to fall to the Union soldiers

History shapes us

Reflection Questions

What resonates with you from the history of MCH? What do you want to learn more about?

Who has inspired you in your leadership journey?

How are they in touch with the history of MCH, the place they live and work, the institution / organization?
What is Title V?

The MCH Services Block Grant (Title V of the Social Security Act of 1935):
The nation’s longest standing public health legislation focused solely on improving the health of all mothers and children, including children with special health care needs (CSHCN)

Appropriates funds to states to:

- Ensure access to quality health services
- Promote the health of children by providing preventive and primary care services
- Provide and promote family-centered, community-based, coordinated care for children with special health care needs

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Why a Block Grant? What does that mean?

- **Title V became a Block Grant in 1981 under President Ronald Reagan**
- **Returned power back to states**: Role of states enhanced; role of federal government diminished
- **Provides flexibility, reduces administrative costs and burden**

- **Consolidated seven programs**: Crippled Children’s Services/ Title V; Prevention of Lead-Based Paint Poisoning; Genetic Diseases; SIDS; Adolescent Health Services; Hemophilia Treatment Centers; Supplemental Security Income (SSI) Disabled Children’s Services
- **Required that the State Health Agency administer the MCH Block Grant**
- **SPRANS**: Provided that the MCH Block Grant have a 10-15% federal set-aside for Special Projects of Regional and National Significance
Every 5 years, states conduct a needs assessment to prioritize MCH needs.

Each year, states submit a block grant application outlining their strategic priorities for the year.

States select National Performance Measures that align with their strategic priorities.

States may create one or more state performance measures and one or more state outcome measures.

Annually, states report on these measures.

Next stop: 2020!
Why a 5 Year Needs Assessment?

- Accurate and complete picture of the strengths and weaknesses of a state’s public health system
- Inform priorities, understand gaps, and set the agenda
- Understand, allocate, and develop available resources to meet needs
- Improve maternal, child, family, and community health outcomes

*If you don't know where you are, you won't know where to go next...a needs assessment is a great starting point.* - Joan Wightkin, former administrator, MCH Program, Louisiana
Steps 1-4: Most of the Needs Assessment Process

1. Engage Stakeholders
2. Assess Needs and Identify Desired Outcome and Mandates
3. Examine Strengths and Capacity
4. Select Priorities

Steps 5-9: State Action Plan

- 9. Report Back to Stakeholders
- 8. Monitor Progress for Impact on Outcomes
- 7. Seek and Allocate Resources
- 6. Develop Action Plan
- 5. Set Performance Objectives
- 4. Select Priorities
- 3. Examine Strengths and Capacity
- 2. Assess Needs and Identify Desired Outcome and Mandates
- 1. Engage Stakeholders

Enabling Services

Health Domains
- Maternal
- Infant Health
- Child Health
- Adolescent Health
- CSHCN
- Cross-cutting/Building
- Public Health and Systems

Strengthen Partnerships

Improved Outcomes

Direct Services

Steps 1-4: Most of the Needs Assessment Process

Steps 5-9: State Action Plan
Flexibilities and Constraints

- **Match:** State must match every $4 of federal Title V money that they receive by at least $3 of non-federal dollars.

- **30-30-10:** At least 30% of the funds are to be used for primary and preventive care services for children; At least 30% of funds are to be used for Children with Special Health Care Needs (CSHCN); No more than 10% towards administration.

- **Systems:** Children with Special Health Care Needs (CHSCN) programs must assume leadership role in the development of family centered, community-based, coordinated systems of care.

- **Coordination:** Title V activities with the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) of Medicaid, supplemental food programs (e.g., WIC) and other related education and health programs; MOU with Medicaid required.

- **Reporting:** Reporting requirements reflect the health of the entire MCH population. Must include data in their plans on the number of pregnant women and infants covered by Medicaid.

AMCHP
Reflection Questions

How do you react to constraints in your work?

Are you the type of person who looks for opportunities within the constraints? Do you feel your creativity is limited by rules and restrictions?

What are ways you can explore and create possibilities within the constraints?

How will you build your skills and your bench of team mates to take collective action?

How will you use the power you have within structures to remove or remake the constraints?

AMCHP
Why so much emphasis on data?

Historical: Children’s Bureau studied infant mortality, child malnutrition, and published pamphlets on infant and child care, reaching over half the population; created the US Birth Registration System; weighed and measured millions of children to create pediatric growth charts.
Measurement Framework for Title V

STATE PRIORITIES

ESMs

Evidence-based strategies/practices

NPMs

SPMs

Improved performance leads to improved outcomes

NOMs
What the heck is an ESM anyway?

- Evidence-based or informed measures that each State Title V program develops to affect the National Performance Measures
- Assess impact of State Title V strategies and activities contained in the State Action Plan
- Criteria for ESMs:
  - activities had to be measurable
  - evidence that the activity was related to the national performance measure chosen

Accountability & Impact

HIGHLIGHTS OF THE FY 2017 TVIS DATA RELEASE

INVESTMENT

- The Title V MCH federal-state partnership investment was MORE THAN $6 BILLION.
- 86% pregnant women, 99% of infants, and 55% of children nationally benefited from a Title V-supported service.
- MORE THAN 69% of the total federal and state/local Title V funds expended supported services for children with special health care needs.
- Included in the over 48 MILLION children served, Title V supported direct and/or enabling services for almost 2 MILLION children with special health care needs.

ACCOUNTABILITY

- NPMs that addressed well-woman visit, breastfeeding, developmental screening and medical home were selected by forty or MORE OF THE 59 states and jurisdictions.
- The number of performance measures selected by an individual state RANGED FROM 5-11 NPMs in the FY 2019 Application/FY 2017 Annual Report.
What / where are the levers you have as an MCH leader?

- Health equity and social justice
- Addressing systemic racism
What got us “here”

- Studying disparities
- Talking about equity
- Awareness

What will get us “there”

- Learning and unlearning (necessary but not sufficient)
- Individual / collective accountability
- Policy change
- Systems change

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Where does change come from?

- Policy (big P, little p)
- Systems
- Environment
- Population needs
- Community-engaged work
- Change agents
- Activation of leaders across all levels – not just “directors”

In every state since 1935, MCH has existed at the nexus of community-based prevention and clinically-based intervention with responsibility for the entire population of mothers and children.
What does partnership and collaboration mean as we look to the future?

Who?
• Health care / clinical partners, housing, transport, environmental health, corporate partners, the health marketplace, and community-based work

How?
• Avoiding the scarcity mindset in leadership
• Title V programs have a history of being asked to do more and more with less and less
• What if we focused partnership and collaboration efforts on doing more with more?
What does a Title V leader look like?

- Cultivating vision
- Thinking upstream
- Inclusive

- Centering in equity
- Being actively antiracist
- Asking questions
- Steadfast
- Building partnerships
- Knowing constraints & flexibilities
- Bridging generational-style-culture gaps
- Steadfast
What does a Title V leader look like?
Reflection Questions

How will you be an agent for change?

What opportunities do you have to lead from where you are?

What skills will you need?

What strengths can you build on?
Need more?

AMCHP Website: www.amchp.org

Resource library: http://www.amchp.org/Pages/Resources.aspx

Guide for Senior Managers: http://www.amchp.org/AboutTitleV/Resources/GuideforSeniorManagers/Pages/default.aspx

75th Anniversary of Title V Booklet: http://www.amchp.org/AboutTitleV/Documents/Celebrating-the-Legacy.pdf


MCH Digital Library: www.mchlibrary.org

MCH Navigator Training Portal for MCH Professionals: www.mchnavigator.org


Needs Assessment Toolkit: www.mchneeds.net
Glossary of Key Terms

Public Health: What we do as societies to create conditions in which we can all be healthy (IOM 1988)

MCH: Maternal and child health

CYSHCN or CSHCN: Children and Youth with Special Health Care Needs

Title V: MCH Services Block Grant, which is authorized under Title V of the Social Security Act, AKA “the Block Grant”

OBRA: Omnibus Budget Reconciliation Act

SPRANS: Special Projects of Regional and National Significance

NPM: National Performance Measure

NOM: National Outcome Measure

ESM: Evidence-based or evidence-informed Strategy Measure

SPM: State Performance Measure

ACA: Patient Protection and Affordable Care Act