If local, state, and national MCH priorities were more fully aligned, would it make a difference for women, children and families? My answer is a simple, “Yes.”

A growing body of disturbing health data surrounds us – just recently a Commonwealth Fund supported study reported that the US fell to the bottom of 19 industrialized nations in amenable mortality. 1 “Amenable mortality” describes deaths that are potentially preventable with timely and effective health care. Previous rankings had placed the United States in fifteenth place. Now that we find ourselves in last place, what will we do?

The responsibility for improving health in our community requires a new course of action, solidarity, united focus and renewed determination. Let’s examine and combine ways to increase our ability to make a difference. This will require recommitment at all levels to build relationships of trust with colleagues, and extend communication pathways that maximize our ability to define a critical set of maternal and child health population priorities.

The social, environmental, and behavioral complexities of many health problems call for a collective, systems-based response. This response requires all levels of government and community agencies (health care, hospitals, schools, urban planners, justice systems, etc.) to act as coalitions for positive change. Many Federal grants and agreements require documentation of collaboration and partnership, a strategy which should be practiced at all levels.

A major source of frustration, stress, and undue local competition can unwittingly stem from our own state and national partners, due to dependence upon their fiscal resources and support. Since funding opportunities are not always aligned with local needs, locals can be forced into difficult positions. A congruent local, state and national MCH agenda could lead to targeted efforts that strengthen overall responses.

CityMatCH as an organization biennially asks the member health departments to describe their MCH priorities. The 2007 membership assessment responded with the following identified critical health priority areas: preconception health, infant health – including breast-feeding, public health infrastructure, access to care/health equity and child health and well-being. Knowing these are the combined local priorities, one could ask how they relate to State and National priorities for MCH?

As MCH Director at the Duval County Health Department in Jacksonville (FL), I am thrilled to say that we perform strategic planning and priority alignment at the county and state levels. We stay involved and knowledgeable about national data and initiatives, to better respond when they match our local needs.

In Florida, the County Health Departments prepare business plans yearly and strategic plans every three years. With local input, the state has designed an electronic snapshot of key health indicators with some populated data to assist in tracking county specific priority indicators. Counties can add their unique priorities to the “snapshot” to determine progress in locally selected areas. As a total health system, we are working toward assuring

(Continued on page two)
"Let's Form a New MCH Alliance"

Local, state and national MCH priorities should be congruent and more formally aligned.

(Continued from page one)

this alignment of key priorities as well as community specific measurements to improve less-than-acceptable health outcomes.

In Florida, and probably in other communities across the nation, MCH priorities are determined with input from regional Healthy Start Coalitions. Florida’s 32 coalitions are partnerships made up of local public and private medical professionals, hospitals, schools, charities, social services agencies, and individuals Coalition members work together to identify and resolve local health problems affecting women and families. Health departments are represented with other community stakeholders.

The Coalition formulates a community health plan with designated priorities, developed with input from all members, utilizing the previously mentioned strategies, and shared with the State Department of Health. Coalition members design and implement education and advocacy strategies directed toward the legislature to encourage budgetary alignment with these priorities.

Although Florida, like many states, is currently in a revenue shortfall, the Governor has made key health recommendations to the Legislature which are similar to those lifted up via the CityMatCH Membership assessment. For example: access, child well-being and women’s health.

Based upon my years of experience in public health, and speaking from the heart rather than the pocketbook, the best place to “be” is at the local MCH level. We listen to and understand individual, family and community needs, pressures and strengths. We keep a pulse on what works and what doesn’t within programs and services. We teach, learn, motivate, and hopefully inspire the next generation of MCH leaders. Because we are closest to the action, our influence in setting realistic priorities at higher levels should be of great value.

How can we find balance between differing interests and achieve cohesion of purpose in order to reverse these poor health trends?

First, let’s remove the system barriers imposed on each other: poor communication, bureaucracy, politics, and competition, to name a few.

Why not develop a common set of principles that govern priority-setting and then choose selected priorities to be advanced at every level of public health? This could be achieved without minimizing issues specific to individual communities.

With commitment, we can make our differences become our strength and work to build consensus of action. A new local, state, and national alliance could assure targeted resources that will shape our progress.

Let’s move to first place as a Nation, and achieve health for all.

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Editor’s Note: Synkewecz developed the following list of strategies she has used to help identify local MCH Priorities. Use these strategies to move from an exhaustive, un-ranked “laundry list” of MCH issues to a short set of thoughtfully selected MCH priorities.

Determine Overall MCH Issues:
1. Seek accurate information on current health status.
2. Measure local data compared to other similar communities, state and national data.
3. Utilize available evidence-based strategies, recent studies, science and successful practice models.
4. Garner community involvement through the voices of the public, customers, and leaders.
5. Consider employee opinions, insights and recommendations.

Hone & Rank Selected MCH Priorities:
1. Analyze data elements.
2. Assess service needs and gaps.
3. Ask consumer perspectives.
4. Anticipate and listen to providers, staff, and community expectations.
5. Attribute costs.
6. Align resources.

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Webster’s definition of alignment includes, “A state of agreement or cooperation among persons, groups, nations, etc., with a common cause or viewpoint.”

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Additional information on the CityMatCH project can be found at http://dictionary.reference.com/browse/alignment

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CityMatCH wants to hear from YOU: Do you have additional ideas and strategies to share? Please send your ideas, questions and concerns about better aligning MCH priorities, to Maureen Fitzgerald at: mfitzger@unmc.edu.
How to Identify MCH Priorities across Levels

The cover story: "Let's form a New MCH Alliance," suggests that greater alignment of local, state and national MCH priorities would make a difference for women, children and families.

However, no formal mechanism currently exists to assure that local priorities are represented to the State and National Levels. In fact, simply identifying MCH priorities and seeking opportunities for greater alignment can be challenging for local MCH leaders with limited time and resources. Knowing where to find State and National MCH priorities and how to engage in the priority-setting process would be of great help.

Earlier this year, CityMatCH conducted key informant interviews to understand how local, state and national level organizations identify MCH/public health priorities and where greater alignment could be realized. CityMatCH also participated in the National MCH Summit. The Summit was sponsored by the Association of Teachers of Maternal and Child Health and brought together representatives from AMCHP, the MCH section of APHA, CityMatCH, the MCH Council of ASPH, HRSA/MCHB, and CDC. The interviews and the Summit helped inform this article.

To Identify State and National MCH Priorities

State MCH priorities are fairly easy to locate. Title V legislation requires States to conduct an MCH Needs Assessment every five years and select seven to ten key priorities for focused programming effort. These assessments inform strategic planning and National MCH priority-setting for the Health Resources and Services Administration’s Maternal and Child Health Bureau (HRSA/MCHB).

States take various approaches to gathering input and some states post information about their process on the Internet. (For example, see Oregon at: http://www.dhs.state.or.us/dhs/publichealth/newsletter/ph0207.cfm?q=2) Each state’s priorities can be found and compared at the HRSA/MCHB website, which also features state ‘snapshots’ with more detailed information.

Updating priorities for the Title V needs assessment is an ongoing process in many states. As described in the cover story, Florida, for example, utilizes local input strategically (See page one). “We use data to help drive decisions: we look at the frequency of mention plus impact and outcome data and incorporate these into a listing for further prioritization. We look to our regional offices, contract providers, and families to prioritize our agenda,” said Phyllis Sloyer, PhD Division Director for Children’s Medical Services at the Florida Department of Health, during her key informant interview with CityMatCH. Florida’s new Children’s Cabinet and the Governor’s Council on Physical Fitness offer recommendations; working groups. University partners in schools of public health and MCH centers all offer information from studies and also partner on work groups. Florida has used a variety of key informants representing local, community and regional levels. CAST V group process tools and affinity voting have been used to reach consensus.

At the National Level, MCHB’s programmatic website (http://mchb.hrsa.gov/programs/default.htm) identifies one key objective for these areas: Women and Infants, Child Health and Safety, Oral Health, Children with Special Health Care Needs, Adolescents, Data, Evaluation & Epidemiology, Health Promotion and Disease Prevention, Genetics, Research, Training, Traumatic Brain Injury and Women’s Health. (For example: Adolescents — MCHB Objective: Support development, expansion and enhancement of comprehensive, community-based, family-centered care.)

One model for how Divisions within the Centers for Disease Control and Prevention (CDC) sets MCH priorities came from a key informant interview with John Lehnherr, Acting Director for the Division of Reproductive Health (DRH) in CDC’s National Center for Chronic Disease Prevention and Health Promotion. He described the DRH/CDC priority-setting process as combining external peer reviews with the scientific community and key partners, including Division Director and Center staff input. They rely on public and private partners, Congress, the agency and staff for input on priorities. Some priorities are set through congressionally-directed authorization and budget guidance. Other priorities are choices – made by the leadership – and take into account external and internal input.

To Advance Local MCH Priorities

Find out how your particular state gathers input for their Title V Needs Assessment. Build connections with decisionmakers and offer to provide assistance and input. Above all, be persistent and get to the table.

Seek out and take advantage of opportunities to place your priorities in the hands of State and National level policymakers. Healthy People 3 is a great example of this. Every ten years, the U.S. Department of Health and Human Services revisits and modifies the Healthy People goals and objectives to produce a revised national agenda. Opportunities for local input into Healthy People 2020 have included regional meetings, public comment, and participating on the Secretary’s Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020.

First and foremost, local MCH leaders must advocate for the MCH priorities in their jurisdictions. While striving for greater alignment, we must retain flexibility. After all, the heart of MCH beats at the local level; every jurisdiction has a unique set of problems, areas of interest and opportunities.

Footnotes:
The 2007 CityMatCH Membership Assessment

**Methodology:** Between February and June 2007, CityMatCH conducted an extensive, on-line assessment of the membership *(see box below for membership definitions)*. Member representatives who did not respond initially were contacted by telephone and E-mail, given technical support, and if necessary, sent paper copies of the survey. The 2007 Membership Assessment comprised the following eight sections:

1. Demographic characteristics of member representatives
2. Health department infrastructure
3. Health department and member representative current priorities
4. Training received by members
5. Health department budget
6. Undoing institutional racism
7. Racial/ethnic health disparities
8. Preconception and women’s health

**Response:** Out of the 150 Local Health Department Members at that time, 92 (61%) responded at least partially to the on-line survey. Responses were not counted in this number unless they completed the first section, which addressed health department role, seniority, and retirement plans. Respondents represented 39 states across the United States, and all ten Federal Regions were represented within the responses. Federal Region 5 was the most strongly represented, with a total of six surveys returned, whereas Federal Region 2 returned two surveys. Twelve states AL, IA, MS, SD, MD, NH, NM, SC, TN, WV, WY (and Washington DC) were not represented in responses.

**Overview:** In this issue, we review health department and member representative’s MCH priorities. We look closely at our membership’s demographic characteristics, infrastructure and training, and offer a discussion of the implications for public health. Finally, responses to the sections on racial and ethnic health disparities and undoing institutional racism efforts are discussed and provide the basis for an E-Roundtable discussion (see page 11).

(Continued on next page)
**Methodology:** Members were asked, “As described by your health department, what are the top-three maternal and child health priorities in the next three years (2007-2010)?” No list of possible priorities was provided; the question was left open-ended.

Members were also asked, “According to your personal level of interest, what are your top-three maternal and child health priorities?” This was also an open-ended question.

Responses given were then categorized independently by two members of the CityMatCH staff. One response could be put in more than one category, which means that the counts given cannot be interpreted as the number of respondents, but only as a general indicator of the importance of the category to those members who responded.

**Top-ranked Health Department MCH Priorities**

As in previous assessments, the broader categories contain more topics and so are ranked higher. This partially explains why preconception health and infant health were the top-ranked priorities.

The preconception health category included access to adequate interconception care (with substance abuse and mental health care.) It included improving birth outcomes and reducing disparities in birth outcomes, as well as family planning and reducing adolescent pregnancy rates. Infant health, the second-highest priority category, included some of the same specific topics such as improving birth outcomes, and reducing disparities in birth outcomes. It also included improving access to MCH services, and increasing rates of immunization and breastfeeding.

The third-ranked priority – public health infrastructure – included access to care, insurance coverage, and MCH services such as WIC. The fourth was access to health care, and the fifth was child health and well-being.

Though this year’s open-ended question format precludes direct comparison to past years, the 2004 top priorities are provided as background. They were: adverse perinatal outcomes, access to care, racial and ethnic disparities, public health infrastructure, women’s health, under-immunization of children, and communicable disease prevention.

**Comparison to Personal Priorities**

The top-five ranked “personal” priorities of our respondents were preconception health, access to care/health equity, adolescent health/well-being, child health/well-being, and women’s health. It is interesting to note that most of the top-ranked health department priorities were actually cited less often as personal priorities. In particular, Infant Health and Public Health Infrastructure, the second and third-highest ranked department priorities, were only ranked sixth and eighth as personal priorities. The categories that were cited much more often as personal priorities than as department priorities were: adolescent health (ranked third as personal and eighth for health department priorities), behavioral/mental health (ranked ninth for personal but only seventeenth for organizational, and cultural competence (ranked fourteenth for personal but only twenty-fourth for health department.)

It is possible that these three are examples of emerging issues that our MCH leaders have identified as crucial, but that have not yet been adopted as priorities at the institutional level.

**Top Health Department Priorities in MCH**

(scores are counts of categorized responses of n=74 respondents)

- Preconception Health
- Infant Health (including Breastfeeding)
- Public Health Infrastructure
- Access to Care / Health Equity
- Child Health / Well-being
- Adverse Perinatal Outcomes
- Women's Health
- Adolescent Health / Well-being
- Healthy Weight / Obesity
- Family Planning / Pregnancy
- Membership Assessment 2007
Member Representatives

In this section of the 2007 Membership Assessment report, we share member representative demographic and professional trends, infrastructure and training experiences. We provide related discussions on workforce and leadership development, the MCH leadership competencies, and succession planning as key strategies for addressing selected concerns.

Demographics: No significant changes were noted in the racial/ethnic distribution of our respondents since 1998. Figure 1 highlights that, as in past surveys, the majority of the respondents (about three-fourths) self-identify as White, non-Hispanic.

Figure 2, “Trends in the Age of CityMatCH Member Representatives,” demonstrates a shifting of the age distribution of respondents to the right. In simple terms, member representatives are becoming overall more advanced in age. The percentage of respondents who were younger than age 50 decreased from 52 percent in 1998, to 33 percent in 2004, and to 21 percent in 2007.

Urban MCH Position-Related Trends

In one sense, Figure 3, “Years in Public Health” and Figure 4, “Years in Current Health Department” demonstrate positive aspects of the CityMatCH membership: member representatives overall have a long-term commitment to public health and to their health departments. They are an experienced group. Unfortunately, as they edge closer toward retirement, the cohort of younger people who will replace them is actually shrinking.

- The youngest seniority group (0 to 11 years in public health) makes up about one if five member representatives (see Figure 3) This number has decreased over the years, while the percentage of respondents who are more senior (24 or more years in public health) has increased from one in three (32%) to nearly one in two members (47%). This trend raises concerns about the level of experience of future MCH leaders.

- The percentage of respondents who have been in their current health department for less than 24 years has declined (see Figure 4), while the percentage that has been employed in their current health department the longest (24 years or more) has increased from one in three (32%) to nearly one in two members (47%).

- 42 percent had been in their current position for eight or more years and about one in three respondents had been in their current position for less than four years.

- The assessment also reviewed the number of years member representatives had been in their current position, and the number of years they had served as the CityMatCH member representative. Forty-two percent had been in their current position for eight or more years, and about one in three had been in their current position for less than four years. Thirty-five percent had been the CityMatCH representative for eight or more years, and about one in three had been the representative for less than four years.

- Level of management was assessed both directly and in terms of the number of employees reporting to the respondent. Over half (53.8%) of respondents were at executive level or higher, compared with 52 percent in 2004 and 48% in 1998. This was a small but steady increase in seniority. Two out of three (66%) of respondents had more than 50 employees reporting to them in 2007, compared to 50 percent in 2004 and 57 percent in 1998.

- Responses to the new question, shown in Figure 5, “Years until Retirement,” indicate that only 28 percent of respondents are more than ten years from retirement. In other words, nearly three-fourths of respondents will be retiring within the next ten years. This emphasizes the urgent need to replenish, strengthen and enhance the MCH workforce.

(Continued on next page)
An Aging Workforce Demands Creative Leadership Solutions

The graying of the public health workforce has been well-documented. For example, the Association of Schools of Public Health estimates that the public health workforce is diminishing over time (there were 50,000 fewer public health workers in 2000 than in 1980), forcing public health workers to do more for more people with fewer resources. This challenge is compounded by the fact that 23% of the current workforce – almost 110,000 workers – are eligible to retire by 2012.¹

This situation has resulted in shortages of public health physicians, nurses, epidemiologists, health care educators, and administrators, leaving the nation at risk. MCH is no exception to this trend.

Over the coming years, it will be critical to assure that MCH leaders are positioned to carry the torch by possessing the knowledge, skills and sense of purpose essential to meeting the unique needs of urban populations. This will require thoughtful succession planning and effective, innovative leadership training to assure the void left by retiring MCH leaders is filled.

An additional concern raised by the trend in age/seniority in MCH is discussed in the Training section (See page eight) where it is noted that member representatives who are closer to retirement were more likely to participate in training activities like state and national conferences.

CityLeaders: CityMatCH has developed a six-month training program for emerging MCH leaders, as a response to this critical need. CityLeaders has been developed by CityMatCH and is funded by HRSA/MCHB. The training program’s curriculum is anchored in the MCH Leadership Competencies (v 2.0, released February 2007, see http://leadership.mchtraining.net/). These competencies have been showcased previously both in CityLights and through the E-MCH Webcast Series (See the CityMatCH website for archived documents and recordings). For a more thorough description of CityLeaders, see related story on page 14.

MCH Leadership Competencies: At the CityMatCH 2008 Annual Urban MCH Leadership Conference, participants will have an opportunity to hear about The Johns Hopkins University School of Public Health on-line course targeted for MCH Leaders, “The Maternal and Child Health Leadership Skills Development Series” (See http://www.jhsph.edu/wchpc/MCHLDS). Skills development opportunities such as this are vitally important to assuring a competent MCH workforce over time. The series “brings leadership concepts to life in an MCH context, allowing anyone to conduct their own training sessions, within your time frames and settings.”² For more information on the Annual Conference, see the announcement on page 16.

Programs targeted toward building and enhancing new and emerging leaders in MCH must be a key strategy for addressing shifts in the MCH workforce. As the nation continues to shift emphasis toward chronic disease approaches, health equity and environmental health, schools of public health must target college students and build interest in public health professions.

While these concerns are not new, creating a sense of energy and importance around them for students actively choosing a career path is a strategy being promoted and pursued by schools of public health and the associations that support them.

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To assess the extent to which members were able to take advantage of training opportunities, they were asked how many trainings, workshops or conferences they had attended in the past twelve months for professional development. This question was asked in three parts: local trainings which required no travel, state or regional trainings for which some travel was required, and national or international trainings which required extensive travel.

**Results:** Among the 73 respondents, the average number of local trainings attended was 6.0, the average number of state/regional trainings was 2.6, and the average number of national/international trainings was 1.3. (See Figure 6). Forty-eight (66%) indicated that they attended three or more local trainings, while only 32 (44%) attended three or more state/regional trainings, and 11 (15%) attended national/international trainings.

**Factors Affecting Training:**

The results described above indicate that time and travel cost are factors in deciding what training events to attend, which is to be expected. It is interesting to note that those who attended local trainings were more likely to attend state/regional trainings. Among those who attended at least three local trainings, 75 percent attended at least two state/regional trainings, while among those who attended fewer local trainings, only 56 percent attended at least two state/regional trainings. No such relationship existed between attending local or state trainings and attending national/international trainings. This may reflect different sources of funding for national/international trainings.

Seniority and years to retirement are associated with attendance at training events, but not in the direction we might hope. Among our respondents, the less experienced, lower-level member representatives were less likely to attend training events at any travel distance than their older, more experienced colleagues. For example (See Figure 7), among respondents who were within ten years of retirement, 70 percent attended at least three local trainings, while among respondents who were at least ten years away from retirement, only 53 percent did so. The disparity persisted but was not as large for state and national trainings. The results were similar when seniority was indicated by years in public health.

Level of management was associated with national training attendance, but was not associated with attendance at local or state/regional trainings. Among higher-level member representatives (top/executive/upper middle) 75 percent attended a national/international training, while among lower-level representatives (middle/front line) only 46 percent did. The percentages attending state/regional and local were nearly equal for the two levels of management.

Those who reported attending no national trainings, were asked what factors prevented them from doing so and given three options (cost, travel restriction, and time). Cost was cited most often, by 20 respondents (71%). Time was second, with 12 respondents (42.9%) citing that factor. Ten (36%) cited travel restrictions, and three cited other reasons.

Members were also given an open-ended question: “What three factors most influence your decision to attend a particular national conference?” These responses were categorized and then counted. The most commonly cited factor, mentioned by 92 percent of the 73 respondents, was relevance of topics (to local practice, to individual job, or to personal interests). The second most often-mentioned factor was cost (69%). Time away from work/schedule conflicts was mentioned by 22 respondents (31%). Location was mentioned by 20 (28%). Quality of speakers was cited by 19 (27%). 17 (24%) indicated that they attended a conference because they had a special role or were presenting. Networking or developing relationships with colleagues was cited by 11 (16%). Five (7%) cited the availability of continuing education credits.

**Summary:** Our respondents are more likely to attend trainings, conferences, and workshops that require less travel, less cost, and less time. Relevance of topics was seen as the most important factor in deciding to attend a
Training Opportunities Shape Emerging Leaders

(Continued from previous page)

particular national conference. Respondents who are more senior and closer to retirement are more likely to attend trainings than younger ones. The fact that younger and less senior leaders report attending fewer trainings represents a lost opportunity to build the emerging workforce and prepare them for leadership roles.

(Membership Assessment results continue on next page)

The Time for Succession Planning is NOW

If we are truly committed to our mission: “improving the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities,” we must do everything in our power to assure the emerging MCH workforce is truly diverse, energized, trained in public health, and well-prepared for the challenges ahead.

Reports are popping up everywhere, including our own CityMatCH Membership Assessment, issuing dire warnings about baby-boomers retiring en-masse. I can tell you that for local urban MCH, this threat is already the reality. Just recently, we received word from another member who called to say she was retiring. The loss to her health department is palpable.

You might ask what CityMatCH is doing to build and support MCH leaders throughout their careers? Those of you who have attended our Annual Urban MCH Leadership Conference (taking place this year in Albuquerque, New Mexico, September 21-23), know that we work hard each year to provide cutting-edge opportunities for learning and networking. In the past two years, Conference trainings have included succession planning, the MCH leadership competencies, and plenty of leadership training. This year, we are featuring pre-conference sessions on Leadership: Negotiation and Conflict Resolution, Data Tools for MCH Professionals and Focused Conversation. Each year, we offer the Carol Douglas Scholarship which provides financial assistance to bring one CityMatCH Member Representative to Conference.

The responsibility for assuring that newer and emerging MCH leaders have sufficient opportunities to participate in learning experiences is a shared responsibility between CityMatCH and our Member Health Departments. We encourage MCH Leaders at ALL levels of experience to attend. Additionally, CityMatCH recognizes our member’s limited travel budgets by providing extensive training and learning opportunities, such as the Perinatal Periods of Risk Learning Network Conference calls, the Emerging Issues in MCH webcasts, and a multitude of offerings found on our website.

This edition of CityLights mentions several newer CityMatCH undertakings. For example, the CityLeaders training program, offers a way to engage both seasoned and emerging leaders. Rest assured that we are continually seeking out ways to build and enhance MCH Leadership skills among our members, both newer and those more senior. We urge you to visit our website frequently to find out about the latest opportunities.

What can our Member Representatives do back at in their own health departments? Foster a culture of caring and coaching, and offer mentoring experiences as a tool for succession planning. Senior leaders must develop succession plans featuring leadership development and embracing diversity.

Many health departments’ succession planning efforts are well underway; others are just beginning to develop strategies. They can look to organizations like The Center for Health Leadership and Practice – a Center of the Public Health Institute (see http://www.cfhl.org/) – a featured presenter at the 2007 CityMatCH Conference. The Center can help by providing succession planning and change management tools and strategies.

The most important thing is to get started. The time for succession planning is not somewhere down the road; the time is here – NOW.
Racial/Ethnic Health Disparities

Nearly a decade ago, through a strategic planning process, the CityMatCH membership identified racial/ethnic health disparities as a priority issue. The current membership assessment included a special section on this topic, asking members about priorities, partners, and challenges. Fifty-three member representatives responded to this section.

Priorities: The importance of racial/ethnic disparities at the institutional level was assessed by asking, “For the executive management team or leadership of your health department, how strong a priority overall is reducing racial and ethnic health disparities?” Out of the 53 respondents, 30 (57%) indicated that this is a “high” or “very high” priority, 13 (37%) rated it “medium,” and 10 (19%) rated it “low” or “not at all” a priority (See Figure 8).

Asking to select which specific health disparities were targeted by health departments to be addressed in their jurisdiction, the majority of respondents (35, or 30%) chose infant mortality. The next most frequently selected disparity was diabetes, followed by cardiovascular disease, HIV/AIDS, immunization, and cancer screening and management (See Figure 9). Other “write-in” top-priority health issues included obesity, asthma, and mental health.

Partners: Partnering across organizations is one way for local urban MCH leaders to more effectively address racial and ethnic health disparities. Members were asked to cite up to five “top” partners in their work on racial disparities. CityMatCH staff categorized the responses to the extent possible from the descriptions given. Some respondents listed two or more partners which were placed in the same category, so counts do not reflect the exact number of members, but are a general indication of the importance of that type of partner to the survey respondents.

Community-based organizations were by far the most frequently named as partners. In Figure 10, those with a specific minority focus and those with a specific infant mortality focus are counted separately; all together, 51 top partners were categorized as community based organizations. State government or state health departments were cited second most frequently, followed by hospitals and clinics. Local universities or university hospitals, health professionals, Healthy Start sites, FQHCs, churches, and businesses were cited five to 10 times each.

Challenges and Strategies: Members were asked, “After excluding funding and staffing concerns, what challenges most impact the ability of your health department to address racial and ethnic health disparities? What strategies does your health department use, or intend to use, to address these challenges? Responses to these open-ended questions were categorized and then counted. Counts do not reflect the exact number of communities facing this challenge.

Engaging community stakeholders, and bridging cultures/reaching disparate communities were the top-two categories (See Figure 11 on page 13). These included needing to serve many culture and language groups, negative perceptions of the health department, racism in the community or the health department, lack of minority health department employees, cultural beliefs of the community, and other challenges.

(Continued on page thirteen)
E-Roundtable: Undoing Institutional Racism in Local Public Health

The 2007 Membership Assessment asked questions about “Undoing Institutional Racism.” Seven of the 53 respondents to the section (13%) reported that their health departments had a definition of racism. Asked how high a priority is “undoing institutional racism” for your health department/agency, only five (9%) indicated that it was not at all a priority, but only nine (17%) indicated it was a high priority. The majority (74%) indicated that undoing racism was a medium or low priority (See Figure 10).

In reviewing the Assessment responses overall, CityMatCH observed frequent interchanging of the expressions: “undoing institutional racism,” and “eliminating health disparities” (See boxed text for helpful definitions).

The relationship between addressing institutional racism and reducing health disparities is described in CityMatCH’s “Undoing Racism in Public Health: A Blueprint for Action in Urban MCH.” According to the Blueprint, “institutional racism moves beyond beliefs and behaviors to the deeply ingrained structural and systemic factors affect individuals’ health… Organizational policies and attitudes that result in different levels of access and quality of service to different populations, or that assume that all clients have the same scope of needs, are major contributors to persistent health disparities.”

“Institutional racism must be addressed before health disparities can be reduced,” states Zenobia Harris, MPH, BSN, Central Region – Division of Health Arkansas Department of Health and Human Services, and cochair of the CityMatCH Undoing Racism Action Group. Harris suggests that urban health departments can “utilize existing structures/groups which address health disparities elimination and Undoing Racism. Health Disparity Elimination (HDE) as a proxy for Undoing Racism is a safe place to begin. Many do not perceive HDE to be as touchy or as inflammatory an area of discussion as ‘Undoing Racism.”

CityMatCH contacted a subset of assessment respondents in the “medium” or “high” priority categories to answer additional questions via an “E-Roundtable” query. Respondents were asked to describe events catalytic toward the prioritization of undoing racism, how their health departments responded, the impact on staff, advice for others and suggestions for how CityMatCH can support these efforts. Participants often answered questions by sharing their stories; selected summaries follow.

Controversy: Catalyst for Change
(Jane Bambace conducted an interview with Claude Dharamraj, MD, MPH, Director, and Ronalda Hobson, ARNP, Assistant Director in March 2008.)

The police shooting of a black motorist in October 1996 sparked civil unrest – a catalytic event for the Pinellas County Health Department. Seventeen neighborhoods in the heart of South St. Petersburg – an area where unemployment, poverty and crime run high – experienced rioting. Afterward, Federal, state, and local attention was drawn to this area, which was subsequently designated as an Enterprise Zone. Businesses received a variety of tax incentives to add new jobs, expand and make building improvements to rebuild, revitalize, and spur growth.

Pinellas County Health Department undertook numerous modifications in health care programs, including instituting an Office of Minority Health. They developed community interest in the Roundtable discussion, it was heartening to recognize how many positive changes the agency has been able to make, once the awareness of need was incorporated: consumer participation. Staffing changes were significant: they began hiring staff from within their jurisdiction, utilizing diverse interview panels for key positions to ensure their executive management team mirrored the community’s diversity.

Career advancement opportunities for African American staff were enhanced. Now, staff vacancies are advertised in local newspapers, contracts with minority vendors have increased, responses to consumer complaints have measurably improved, staff training in cultural diversity has been upgraded and mandated, and culturally-sensitive health literature is the norm.

Health Department leadership have effectively encouraged positive changes. Bambace concluded, “As we completed the roundtable discussion, it was heartening to recognize how many positive changes the agency has been able to make, once the awareness of need was incorporated: consumer participation. Staffing changes were significant: they began hiring staff from within their jurisdiction, utilizing diverse interview panels for key positions to ensure their executive management team mirrored the community’s diversity.

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Policy & Practice
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heightened.”

The strategic plan now identifies reducing health disparities through health programming. A balanced-scorecard approach is used to identify measurements as goals for health disparities. Survey tools quantify customer satisfaction and are evaluated as a performance measure.

Bambace said, “We encourage other local public health departments to remain optimistic that an agency can create a paradigm shift over time... It is important that 1) programs reflect the diversity of the population; 2) health indicators need to look at the diversity of the population; 3) strategic planning includes looking at data of diverse populations; and 4) the public needs to be educated by taking the data and making it useful for the public.”

“How Can CityMatCH Help?”

Ask tough questions and challenge health departments to confront difficult issues.

Bring experts to conferences/teleconferences who can turn data into public health action.

Identify best practices and promote a forum to share successes and failures.

Identify strong community partnerships working to assure the health of a community.

Model how the “Action Collaborative” approach can be an effective tool for local health departments and community partners.

Promote awareness of institutional racism, health disparities, their causes and effects on health status.

Serve as a conduit for connecting groups and organizations interested in learning new and more effective ways of addressing the key issues.

Share best practices and identified benchmarks.

Share information about successful models in other communities.

“Mind the Gap” – The Saint Paul Experience

(Deborah Hendricks met with Rob Fulton, Director, Saint Paul – Ramsey County Department of Public Health.)

The 1980s saw a vast resettlement of Hmong to Minnesota – particularly to St. Paul – now home to the largest single group of Hmong in the United States. This demographic shift catalyzed the need for an International team. More recently, large numbers of Mexican and other Spanish-speaking immigrants spurred the department to further prioritize undoing institutional racism. Participation in a Federal Healthy Start program highlighted the disparities in health outcomes experienced by African Americans and American Indians and encouraged the department to address systemic issues facing these diverse communities.

Also, Ramsey County has a Model Employer program that requires each department to have a plan to reduce racism. “Mind the Gap: Reducing Disparities to Improve Regional Competitiveness in the Twin Cities,” a report that tracks disparities in the region, argues that not only is reducing such disparities the right thing to do, it is also the smart thing to do. This report, developed by the Brookings Institution, and adopted by the Ramsey County Board of Commissioners, requires each department to develop activities to reduce disparities.

One result is a shifting from hiring Language Interpreters to the creation of a Health Education Program Assistant position. This has enabled staff to take a more active role in service delivery to diverse clients and families, particularly those who speak languages other than English. Additionally, funding and/or flexible time has been made available to these staff for job advancement and additional education. Several staff completed post-secondary educational programs (e.g. nursing, social work, and community health) as a result.

Overall, changes have been well received. Public Health Nurses and Health Educators have grown in their ability to work effectively with the program assistants by clarifying roles and responsibilities.

Says Hendricks, “Be patient; be inclusive of all. We have had some success with establishing staff-led groups to discuss issues related to diversity and institutional racism and have focused on creating welcoming environments as a first step in strategic action.”

Evolution of a Community

(Audrey M. Stevenson)

Several catalytic events led to the Salt Lake Valley Health Department’s (SLVHD) increased priority on undoing institutional racism. For twenty years, the area has seen a dramatic influx of diverse populations, a demographic shift that has significantly altered the community’s cultural and social fabric and sounded the call for culturally competent services.

SLVHD has sought to understand the needs of different ethnic groups based upon their expectations – not those determined ‘for’ them; to provide appropriate interpretation services for better communication and service provision and to equip staff in the provision of culturally sensitive services.

Dramatic changes have occurred as a result of the large influx of Hispanic families from Mexico, Guatemala, El Salvador, Cuba, Bolivia, Argentina, and others: Sudanese refugees, Somali-Bantu tribes, etc. As new groups arrive, the health department assesses programs needed and evaluates how best to serve each population. Providing culturally sensitive services at all clinics has been the leading edge of efforts to undo institutional racism. Programmatic changes are made based upon the evolving needs of the community.

SLVHD’s largest clinic serves as a “safety net” providing services to refugee populations and undocumented families. Hiring bilingual, bicultural staff and full time interpreters has helped to assure effective service provision at this clinic. Contracting

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(Continued from previous page) with an interpretative services company ensures clearer communication with those seeking services at clinics.

SLVHD regularly meets with community leaders and community members to establish their public health needs, leading to tailored public health programs and interventions.

An innovative collaboration with the University of Utah Department of Medicine provides primary care access for obstetric and women’s health services, pediatrics, midwifery, and a Teen Mother and Child Program. The genesis of this collaboration was the need for health care access for uninsured and refugee populations.

SLVHD has provided services targeted to refugee and immigrant populations for many years. Said Stevenson, “20 years ago, many different Asian cultures in our community critically needed public health services. SLVHD hired and employed interpreters to address language concerns. As the community and population has changed, the SLVHD has hired staff to provide culturally sensitive services.” For ten years, the Human Services Department has provided extensive training for employees in cultural awareness and sensitivity.

SLVHD continually evaluates programs and services to ensure they are provided to the entire community. Results are measured by the numbers served and by tracking service outcomes for each public health service. Two surveys of employees and clients regarding satisfaction of the services have been conducted.

“One of the best measures for determining our progress towards reducing institutional racism is the community meetings where we received feedback on how we are doing. We are committed to assure everyone has access to public health services regardless of race. We continually assess the access to our services by assessing the public transportation to our clinics, our hours of services and the availability of interpretative services,” concluded Stevenson.

Her advice to other communities is to “know your community” and ask members of the community what they need from your Health Department. SLVHD learned their assumptions were often very different than community-identified needs. She believes that most public health professionals are passionate about their work and desire to provide the best services. Improved understanding of new cultures within the community can help them fully achieve this goal.

Footnotes:

Racial/Ethnic Health Disparities (Continued from page ten)

analyze and interpret it, and data quality issues. Racism included negative attitudes in the community toward minority populations as well as community perceptions of the health department.

Working with different community groups was considered by many to be an effective strategy for reaching large numbers of people in different subpopulations. Getting messages out about the magnitude of health disparities, and also about successes, was often mentioned as a strategy for increasing community involvement. Strategies for reaching out to minority groups included training staff to be more culturally competent, and hiring more culturally and linguistically competent staff. Some strategies for improving data and evaluation were working with local universities, and with the state health department. Hiring of consultants was mentioned as a strategy for evaluation and for marketing. Other strategies included holding consumer workshops on economic self-sufficiency, using Nurse Family Partnership to encourage pregnant women to complete their education and set goals, and incorporating health impact assessments into city planning.

Membership Assessment Footnotes:
With demand for critical MCH leadership training higher than ever and the anticipated retirement of baby-boomers already upon us, assuring the next generation of leaders is well-prepared with knowledge, skills and a sense of MCH purpose, will become increasingly urgent.¹ Enter CityLeaders. This new leadership training program, developed by CityMatCH and funded by HRSA/MCHB, is designed with the needs of emerging and mid-level leaders in urban maternal and child health in mind.

Two major components of leadership training encompass this experience. First, the MCH Leadership Competencies version 2.0 (http://leadership.mchtraining.net/), provide the backdrop for the CityLeaders skills-building curriculum. Trainings are tailored to each cohort of CityLeaders and are provided through on-site conference workshops, teleconference calls, webinars, and self-instructional resource materials.

The second critical component of the CityLeaders program is the Mentor/Mentee relationship. Each CityLeader is paired with a seasoned, senior leader in urban maternal and child health. This Mentor shares their experiences, challenges the emerging or mid-level leaders to think differently, and provides an intergenerational exchange of ideas and strategies.

The first cohort of CityLeaders kicked off in August 2007 at the annual CityMatCH Conference. Their needs assessment indicated high training priority in the areas of Policy and Advocacy, Working with Communities and Systems, Critical Thinking, Interdisciplinary Team Building, Developing Others, and Negotiation and Conflict Resolution.

Year One CityLeaders were: D’Yuanna L. Allen (Nashville, TN), Rita Beam (Englewood, CO), Elisabeth Doot (Chicago, IL), Stephanie Freedman (Austin, TX), Jennifer Gross (San Mateo, CA), Amy Guccione (Lakewood, CO), Vivian Jackson, (Milwaukee, WI), Jennifer Jordan, (Eugene, OR), Terri Nikoletich (Long Beach, CA), Sara Paton (Dayton, OH), Lois Schipper (Seattle, WA), Judith Shlay (Denver, CO), Audrey Stevenson (Salt Lake City, UT). These future MCH Leaders completed the program and an intensive quantitative and qualitative evaluation in Spring 2008.

The first year of any new program represents a time for learning and growth. Key lessons learned from the first year of the CityLeaders program were the following:

- Urban maternal and child health professionals are busy. They appreciate the opportunity to learn new skills, but need a structured environment and “deadlines” to be successful.
- Even in an individual leadership training, facilitating a team atmosphere for trainees is still important.
- The Mentor/Mentee relationship is very important. It gives mentees an opportunity to seek advice and suggestion from someone outside of their own work environment.
- Qualities of a good mentor for urban maternal and child health professionals include: experience in urban maternal and child health, time availability, broad MCH knowledge base, supervisory experience, good listening skills, and the ability to ask important and challenging questions.

Applications to be a CityLeader or Mentor in Year 2 of the program are available on-line at: http://www.citymatch.org/cityleaders.php

For more information, contact Kathleen Brandert at kbrandert@unmc.edu or Brandon Grimm at blgrimm@unmc.edu.

Footnotes:
CityMatCH Preconception Health Collaborative Featured in the Journal of Women’s Health

“Integrating Preconception Health into Public Health Practice: A Tale of Three Cities,” by Brenda Thompson, MPH, CDC Public Health Prevention Specialist, assigned to CityMatCH, Magda Peck, ScD, Department of Pediatrics, College of Medicine, University of Nebraska Medical Center, Omaha, Nebraska, and Kathleen Brandert, MPH, CHES, CityMatCH, was published in the June edition of the Journal of Women's Health (JWH). (June 1, 2008, 17(5): 723-727.) JWH is a peer-reviewed journal which publishes the latest clinical and research papers on the medical health issues affecting women throughout their life-span, and is the official Journal of the American Women's Medical Association.

In 2006, the national Select Panel on Preconception Care published a set of 10 recommendations on how to improve preconception health and care in the United States. To help translate the national recommendations into action at the local level, CDC funded CityMatCH to coordinate a practice collaborative. Beginning in October of 2006, CityMatCH convened multidisciplinary teams from Hartford (CN), Nashville (TN), and Los Angeles County (CA) to engage in the CityMatCH Urban Practice Collaborative on Preconception Health.

The JWH article describes the CityMatCH practice collaborative process, which features team building and leadership development, community assessment, identification of strategies, and action planning around those strategies, and then highlights the three participating teams’ experiences in implementing the national recommendations at the local urban level.

To learn more about preconception health efforts at CityMatCH, contact Kathleen Brandert at kbrandert@unmc.edu. Readers can locate the Journal on the Internet at: http://www.liebertpub.com/publication.aspx?pub_id=42

2008-2009 CityMatCH Board Elections Held

A unique opportunity to support emerging public health leaders and help shape future MCH policy through leadership within CityMatCH awaits those who have been elected to the Board of Directors this summer. Ballots were sent to each member representative in Mid-May. According to the organization bylaws, the voting period remained open for a period of 30 days and closed on June 13. Winners of the election were announced to the membership June 29.

In 2008, the following seats were up for election:


**South East** (Virginia, Kentucky, Tennessee, North Carolina, Mississippi, Alabama, Georgia, South Carolina, Florida, Puerto Rico)

**North Central** (Colorado, Wyoming, North Dakota, South Dakota, Nebraska, Minnesota, Indiana, Iowa, Illinois, Wisconsin, Michigan)

**At-Large** (one seat, from any region)

Elected were Peter Simon, Providence (RI): North East and Mary Balluff, Omaha (NE): North Central. Kenneth Swann, who previously held the position of South East Board member, retired in early 2008. Sue Guptill from Durham (NC) was elected to fill this position. Marjorie Angert, who held the position of North East Board member, retired subsequent to the election process and Carolyn Slack, Columbus (OH), who had been elected to fill the At-Large position on the ballot, was appointed by the Executive Committee of the Board of Directors, to fill Angert’s position. Christine Englestad, Palm Beach (FL) was then appointed to the vacated At-Large position.

Best wishes from all at CityMatCH to Kenneth Swann and Marjorie Angert on their retirement.

For more information, contact Mark Law, Coordinator of Membership Services, at (402) 561-7500 or visit the website at www.citymatch.org.
Register NOW for the 18th Annual CityMatCH Urban MCH Leadership Conference in Albuquerque, New Mexico
September 21-23, 2008

New!!
Sign up for a Pre-Conference Workshop on Saturday, September 20:
- Focused Conversation
- Leadership: Negotiation and Conflict Resolution
- Data Tools for MCH Professionals

Find out more and register on-line at: www.citymatch.org/
Early bird registration deadline: Friday, August 1, 2008

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