



CityLights

Promoting communication and collaboration to improve the health of urban children and families

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Urban MCH Update: Medicaid Managed Care in U.S. Cities

by Magda G. Peck, ScD
CityMatCH CEO/Executive Director

Managed care has become a permanent part of nearly every major urban community. America's inner cities will continue to be the bellwether of consequences and opportunities under Medicaid managed care.

In the past decade, state Medicaid agencies have embraced managed care as a mechanism to control costs and assure access.

Women, children and youth are the populations most quickly moving into managed care, especially through public sector managed care arrangements.

Nowhere is this more apparent than in America's central cities, which are prime targets for the growth of Medicaid managed care, given their high concentrations of low income women and children. In the 1993 CityMatCH national survey of major urban health departments, 61 percent of city and county health departments serving one or more central cities with at least 100,000 population reported that Medicaid managed care was in place or would be implemented within one year. A follow-up survey, conducted in 1997 by CityMatCH, showed that proportion increased to 84 percent, with most urban localities reporting state mandated programs in their cities for Medicaid enrolled women and children. (see page 3)

Principal concerns about Medicaid managed care for urban women, children and adolescents include assuring access to care in a changed provider landscape, assuring appropriate utilization of primary and preventive

services, maintaining quality care given the pressure to control cost, securing the participation of quality providers, helping consumers achieve satisfaction, and managing enrollment and disenrollment as clients move across systems and in and out of eligibility. Urban health departments in jurisdictions where Medicaid managed care is being implemented have reported

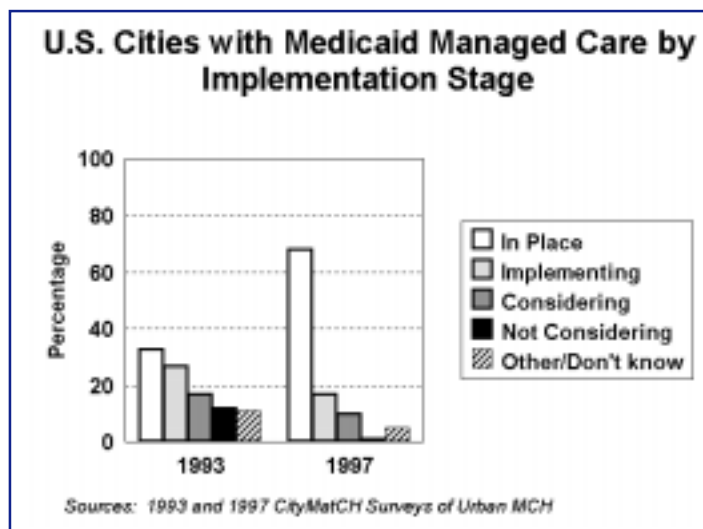
premiums than those paid by commercial insurers, hence lower enrollment or more stringent utilization standards to compensate for an insufficient provider base; (3) special population needs limiting optimal adaptation to a new complex system, including literacy and language barriers; and (4) unstable eligibility and short enrollment periods, limiting the return on managed care plan investments in prevention and primary care.

As was true a century ago, all that is right and wrong in new health and welfare policy will manifest on the stage of urban America. Public health must play an essential advocacy role for systems change which safeguards the health of women, children, and families along the way, for as Ehlinger has noted wisely, "the fate of our cities eventually will become the fate of us all."

Editor's note: This article is excerpted from the forthcoming book:

"Family Health and Welfare Reform for the 21st Century," Jones and Bartlett Publishers, Sudbury, Massachusetts.

References have been deleted for space purposes only. Citations and references are available from the author.



problems in each of these dimensions in the early implementation stages.

The complexities of transition to Medicaid managed care for local health departments and other essential community providers pose even greater challenges to the urban safety net. They often have less revenue to work with, less access to investment capital, and feel the brunt of uncompensated care of uninsured patients with short enrollment periods.

Several key factors further complicate Medicaid managed care in the inner city, including: (1) sicker inner city populations, requiring more costly care; (2) lower Medicaid managed care

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CityViews

When the Story's Over

by Magda G. Peck, ScD
CityMatCH CEO/Executive Director



Peck

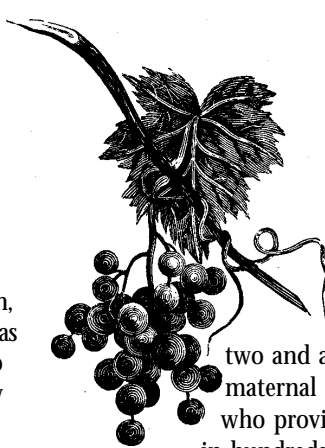
Her name tag said "Helen, Sussex County." She was the last of the folks who came up to me after my opening keynote at the Governor's Summit on Infant Mortality. It had been a good talk; the storytelling about Sam and Dave had hit home. After thanking her for kind words of praise, I asked, "Have you lived in Sussex County long?" We looked to be of similar vintage. "My whole life," she replied.

I hesitated, then asked her if she had ever heard of the Peck-Sussex Corporation which had built a carpet manufacturing plant in her county in the late 1960's. The question triggered a flood of old memories: The Governor standing next to my father at the opening, praising his endeavor to bring jobs to one of the hardest hit areas of the state. Daddy's look of tired satisfaction for having made it happen. Rows of forklifts parked on the yet-to-be-used, shiny plant floor. All that work, hope, anticipation. And then how it all fell apart.

The 1970's was my family's decade of darkness. It began suddenly one morning with the car crash that claimed the life of a homeward bound older sister and ended ten years later with my father's suicide. In between, a whirlwind of events, including the bankruptcy of Peck-Sussex Corporation. The plant had shut down, taking all those jobs with it. Daddy didn't mention Sussex County again that I recall; nor did we.

Helen was a child like me when the plant opened, and she said she didn't remember much. I told her our story, how he had felt about letting the people of Sussex County down. She took my hand and looked me straight in the eye. "Now you tell those boys of yours, Sam and Dave, that they should be proud of their grandfather." And she told me how the County had converted the factory into a workshop for disabled adults. "If that plant had never been built, we'd never have the workshop today." I had ended our story nearly three decades earlier. In Sussex County, the local story wasn't over yet.

As we mount new projects, programs, and policies, when should we measure their impact? My father's



Wither MCH?

by Peter J. Morris, MD, MPH
CityMatCH Board Chair

It has been my honor to serve as Chair of CityMatCH these past two and a half years, representing local public health generally, and local maternal and child health specifically in state and national forums. For us, who provide not just the services, but present a human face to those services in hundreds of cities and communities across the country, it has been a rough two years.

Paradoxically, we have achieved more success and met more outcomes at a time of more confusion and diffused attention to our passion: the fate and future success of mothers, infants, and children in our communities. Despite- or perhaps because of- improved immunization rates, decreased infant mortality, decreased teen pregnancy, and the prospect of improved access to health care through CHIP, the debate has shifted to improving economic self sufficiency and enhancing responsible participation in community. Citizenship dominates the public debate: literally, in the case of undocumented aliens, and figuratively, in a society rightfully and sometimes righteously exacting responsibilities in exchange for privileges. This, at a time where application of our immense wealth and burgeoning knowledge might be closing historical gaps in income, education, nutrition and health.

What gives? Is it El Nino? Will our progress stall just like the high and low pressure systems that have brought heat and drought to our heartland? Will MCH wither on the vine?

I think not, but tough times call not only for renewed effort, but for new efforts, new strategies, and a new way of viewing our passion. Health indicators must be better translated into public indicators, where better health and nutrition is related to better education and income. Perhaps the best illustration I can think of is a recent debate among academics as to the existence of a science of MCH. Are we grounded solely in epidemiology, biostatistics, public policy and programs? Or, should these basic sciences include or be replaced by the science of 'human development? Is maternal and child health' expressive and expansive 'enough,' or should we consider 'women and child health' our mission? As one pundit suggested, should 'MCH' give way to 'FWB': *Family Well Being?*

I think so. In this time of drought, it is not sufficient to plant what we have always grown and expect to yield the same crop. Nor, in a time of scarce resources, can we afford merely to fertilize and irrigate more. The climate has changed. We must plant improved seeds, weed, prune, and cultivate our crops, even as we seek new crops and identify new markets- if we are to thrive.

And thrive we must, for the science of human development assures us that the care and feeding of mothers, infants, and children is as important now as ever. Our times suggest the effort required is more collaborative than ever. MCH never could or did do it on its own. Our advocacy for and the engagement of parents, neighbors, and communities can only result in improved outcomes for our clients, ourselves, our communities, and our nation.

Let's not let MCH wither on the vine.

business failure literally laid the foundation for a subsequent local success. What of Medicaid managed care or welfare reform or CHIP -what are the best indicators of their success or failure, and when should they be measured? We must be thoughtful, robust, and vigilant in our current surveillance, for real lives

are at stake. Let us also remember for managed care and other changes in the foundation of health policy, it may well be equally important to anticipate and assess longer term change. Dark as things may seem now to some, those stories aren't over yet either. *Give it time; give it time.*



Morris

A Second Look: Medicaid Managed Care and Urban MCH



In 1993, CityMatCH conducted research on the impact of Medicaid managed care on health services delivery in urban health

departments. The results of this earlier work, *“Changing the Rules: Medicaid Managed Care and MCH in U.S. Cities”* published in 1994, produced a wealth of new information on how urban health departments were responding to the demands of Medicaid managed care implementation in their jurisdictions. In 1997, the national debate continued with an appreciation that system changes are a slow and difficult process. It also was acknowledged that the impact of system changes is not measured overnight. Based upon input from urban leaders, CityMatCH initiated a second survey in the summer of 1997 to help fill the gaps in information about the perceived impact of Medicaid managed care on local health departments that serve vulnerable MCH populations. In this report, we present updated information on the implementation status and configuration of Medicaid managed care in urban areas.

Medicaid Managed Care in Cities

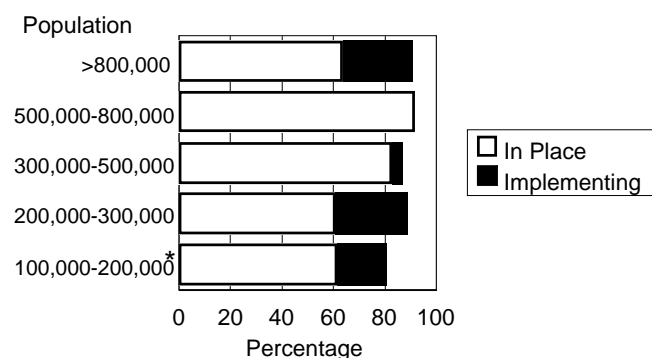
The results of the 1997 CityMatCH survey confirmed that there continues to be rapid growth in Medicaid managed care efforts since 1993. Of the 177 urban health departments surveyed, 133 completed surveys were returned for a response rate of 75%. These health department jurisdictions generally include one city greater than 100,000, and are referred to as U.S. Cities. Of the responding health departments, 84% reported that Medicaid managed care was currently in place or implementing—either currently implementing or implementing within the year. This percentage increased from 61% in 1993.

The 1997 survey results indicate there is greater experience about the health department’s role and status of Medicaid managed care than in 1993. With more urban health departments reporting Medicaid managed care in place, a lower percentage of cities were in the implementation and consideration phase in 1997 than in 1993. 68% reported that Medicaid managed care was currently in place within their jurisdiction, a twofold increase since 1993 when 33% of urban health departments reported Medicaid managed care in place. 10% of responding urban health departments were considering Medicaid managed care in 1997—either considering or were planning to implement in more than a year—down from 17% in 1993. In only 1% was Medicaid managed care not being considered, a substantial change from 1993 when 12% reported that they were not considering a Medicaid managed care system.

Implementation by City Size

In 1997, Medicaid managed care has been implemented or is being implemented in most urban areas regardless of the

U.S. Cities With Medicaid Managed Care by Implementation Stage and City Size, 1997



Source: 1997 CityMatCH Survey of Urban MCH

*Includes eight CityMatCH cities with less than 100,000.

Figure 1

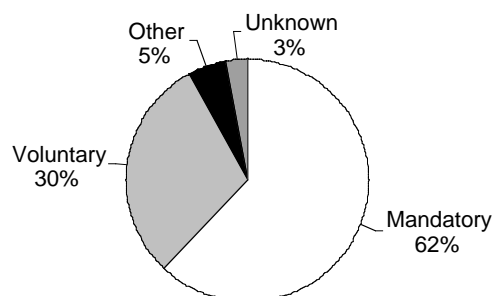
population size. Although a substantially larger percentage of the moderate to large U.S. cities—cities with populations between 300,00 and 800,000 people—have Medicaid managed care plans in place, this difference will not remain for long based on the percentage of cities currently in the implementation phase. Only 64% of cities with populations greater than 800,000 people have plans in place compared with 92% of cities with populations between 500,000 to 800,000 people. (See Figure 1). However, the percentage with plans in place for the largest cities will increase to 91% in the next few years when 27% of these cities complete their implementation phase. The same pattern holds true for cities with populations less than 300,000 people.

Managed Care Configurations

The 1997 CityMatCH survey also asked each health department to describe the configurations of the Medicaid

(continued on page 4)

US Cities With or Implementing Managed Care for All Medicaid Eligible Clients by Enrollment Type, 1997



Source: 1997 CityMatCH Survey of Urban MCH

Figure 2

CityResources

(continued from page 3)

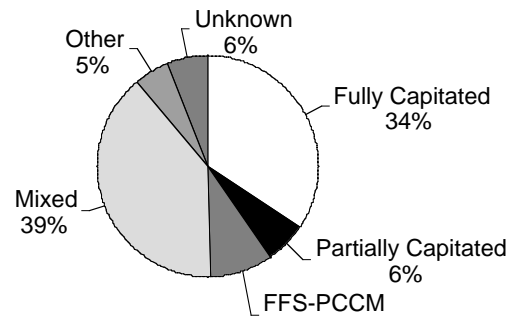
managed care systems. Information was collected on: 1) the length of time Medicaid managed care had been implemented; 2) the type of client enrollment; and 3) the type of provider reimbursement.

Of the 88 local health departments with Medicaid managed care systems in place in their jurisdiction, most systems were relatively new: 52% for less than two years, 31% for three to five years, and only 17% for more than five years. Of the 113 urban health departments who reported that Medicaid managed care was either in place or being implemented within the year, almost two-thirds had mandatory enrollment for Medicaid clients (See Figure 2).

Almost three-fourths indicated that the provider reimbursement mechanism was either fully capitated or mixed (See

Figure 3). Although the client enrollment mechanism has changed little since 1993, fewer Medicaid managed care systems are using "fee for service" with primary care case management as the only reimbursement mechanism.

US Cities With or Implementing Managed Care for All Medicaid Eligible Clients by Reimbursement Type, 1997



Source: 1997 CityMatCH Survey of Urban MCH

Figure 3

Editor's note: This report is excerpted from the 1998 CityMatCH publication to be released this Fall, "A Second Look at Medicaid Managed Care, MCH and

Urban Health Departments: Changing the Rules II." For more information, or to obtain a copy, contact CityMatCH at (402) 559-8323.

Managed Care Materials at Your Fingertips...

"Medicaid Managed Care: A Handbook for Public Health Agencies" (\$15) and "Promoting Quality Care for Communities: The Role of Health Departments in an Era of Managed Care" (free) are available from NACCHO. Both publications can be ordered from NACCHO on the Internet at http://www.naccho.org/resc/pub_list.html under the section of Personal Health.

"Right Time, Right Place: Managed Care & Early Childhood Development,"

Children Now's report on promising strategies for delivering early childhood development services in managed care settings. For more information, 510-763-2444.

"Meeting the Challenge: HRSA & Managed Care" is a report published by the Health Resources & Services Administration. This report summarizes HRSA's actions in the managed care arena over the last several years, as well as managed care contacts within HRSA and information on ordering HRSA publications about managed care. To

obtain additional copies, please contact the National Clearinghouse for Primary Care Information, 2070 Chain Bridge Road, Suite 450, Vienna VA 22183. Phone: (800) 400-2742, fax: (703) 821-2098 or e-mail:

primarycare@circ.sol.com/
"Medicaid Managed Care and FQHCs: Experiences of Plans, Networks and Individual Health Centers" is a report published by Mathematica Policy Research, Inc. examining the response of Federally

Qualified Health Centers to Medicaid Managed Care and local health plans. For more information, please contact Jan Watterworth, Librarian, Mathematica Policy Research, Inc., P.O. Box 2393, Princeton, NJ 08543-2393. Phone: (609) 275-2350 or (609) 275-2334.

"Improving Child Health in a Managed Care Environment" is a roundtable report made available by the Ross Products Division of Abbot Laboratories. For more information, please contact Ross Products Division, 625 Cleveland Ave., Columbus, OH 43215. Phone: (614) 624-7677.



WEBSITES:

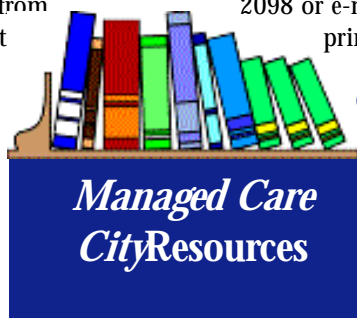
www.ahcpr.gov offers links to current research at the Agency for Health Care Policy & Research website. Included on the site is data

from the Medical Expenditure Panel Survey (MEPS), clinical and consumer information, research findings and funding opportunities.

www.yahoo.com/Health/Health_Care/Managed_Care/ is a site on Yahoo! offering general resources of a variety of viewpoints on managed care.

www.healthfinder.gov, the Federal government website, has links to general health resources. This site, intended to be a gateway for health information, includes resources available from both governmental and private sources, on topics including but not limited to Medicare and Medicaid, clinical information on specific conditions and professional development.

www.hcfa.gov, the website of the Health Care Financing Administration, can be accessed for additional information on the financing of Medicaid Managed Care as well as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).



In this issue of *CityLights*, we profile the American Association of Health Plans (AAHP), and the National Institute for Health Care Management (NIHCM), new *CityFriends*. Like *CityMatCH*, AAHP and NIHCM have entered into a Cooperative Agreement with the Federal Maternal and Child Health Bureau under the MCH Partnership for Information and Communication (PIC). Additional information about PIC can be found on the website: <http://www.ncemch.georgetown.edu/pic/default.html>

NIHCM Brings Public and Private Sectors Together

The National Institute for Health Care Management (NIHCM) is a nonpartisan research and educational organization established to bring together the public and private sectors to build expertise in managed care and related health care topics. NIHCM supports fact-based research and dissemination of effective and innovative practices in health care, especially those involving management, financing and delivery. NIHCM also serves as a clearinghouse for health care information.

Through a cooperative agreement with the U.S. Maternal and Child Health Bureau, NIHCM joined the Partnership for Information and Communication (PIC) in August, 1997. The central goal of NIHCM's PIC project is to bring together key stakeholders in maternal and child health with managed care executives to exchange information, insights and expertise and to promote the Bright Futures approach to comprehensive care of children. As a means of fostering this interchange, NIHCM is conducting a series of forums on key issues affecting maternal and child health and Bright Futures and preparing Action Briefs that summarize the meetings.

There are two Action Briefs from the first forum "Managed Care and Child Health: Opportunities and Challenges" held December 9, 1997. The two briefs, "Bright Futures and Managed Care" and "Practitioners Discuss the New Children's Health Insurance Program," have been sent to all *CityMatCH* members. (If you did not receive a copy, please see NIHCM's web site, or call Therese Finan at 202-296-4196). The Action Brief from the second forum held March 31, 1998, "Outreach: Private and Public Sector Efforts That Work," will be available shortly.

Other activities include preparing Child Health Updates to keep managed care executives informed of developments

with Bright Futures and maternal and child health issues, sponsoring journalism and research awards to encourage reporting and research on maternal and child health issues and disseminating information through our web site. The 1998 Research Award is in process, and the submission deadline for entries is September 30, 1998.

For more information about the awards, please call Anne Mahoney at 202-296-4426 or visit NIHCM's web site: www.nihcm.org.



AAHP: Facilitating Public-Private Partnerships in MCH

Currently about 80% of commercial health insurance enrollees, and nearly 50% of Medicaid recipients are enrolled in the coordinated care delivery systems of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Independent Practitioner Associations (IPAs). Representing the vast majority of these health plans is the American Association of Health Plans (AAHP) - one of the Maternal and Child Health Bureau's newest PIC members.

Health topics currently addressed through public-private partnerships include: expanding immunization coverage; tobacco and smoking prevention and cessation; promotion of improved nutrition and physical activity; asthma; prevention and capacity-building with support from CDC, that engages our member health plans in health care research on a range of topics, including prevention and public health. AAHP promote community-based health initiatives through our annual Community Leadership Awards Program.

AAHP recently began a five-year initiative supported by the Maternal and

Child Health Bureau of HRSA. Our role is threefold: 1) to serve as a bridge between public sector health organizations and our own private sector member health plans to encourage the sharing of expertise on MCH care; 2) to identify and promote improved practices of MCH care; and 3) to help introduce and disseminate the "Bright Futures" model of health promotion among our membership. AAHP began a comprehensive literature review to identify current delivery issues among health plans, a survey and analysis of members' current MCH practices, and an in-depth review of members' experiences with Medicaid health promotion requirements in order to gain insights on how other comprehensive health promotion models like "Bright Futures" might be received. AAHP will hold workshops in the future to share these findings.

As a national membership organization, AAHP offers many typical services: providing training and professional education, and monitoring and reporting on relevant policy and legislative issues. AAHP also supports a wide array of initiatives on quality and accreditation, health services research, work force training and development, medical care delivery, and on public health and prevention. Primary care providers, provide public health and prevention services that contribute to larger public health and prevention initiatives. AAHP builds and expands on this strong foundation of preventive care, and helps link private health plan members with public health organizations to further improve clinical preventive care and achieve more optimal public-private partnerships.

Though not a complete list, these examples illustrate ways AAHP is facilitating improved quality of care and expanded public-private collaboration. Many more examples exist at the local level where individual health plans are linking with community and public health organizations to address community health needs. For more examples and additional information, please refer to AAHP's web site at www.aahp.org.



1997 SpotLights: Syracuse, NY and San Diego, CA

Managed Care Initiative Serves Underserved in Onondaga County

Llamara Padro Milano, BSN, RN, accepted a **SpotLight** award at the 1997 CityMatCH conference in Atlanta, Georgia on behalf of the Onondaga County Health Department (OCHD) in Syracuse, NY. OCHD, a local public health agency serving a population of about 500,000, has developed a comprehensive system to integrate public health with managed care. This system linked them with four different Managed Care Organizations (MCO's).

Managed Care offered an opportunity to integrate a system of fragmented care in which families saw multiple providers to receive preventive and curative services. The lack of experience of MCO's in working with high risk/disadvantaged populations would be augmented by the expertise of the Health Department. The Health Department's strength lay in the expertise of staff in understanding and meeting the needs of the population.

Milano detailed some of the aims of

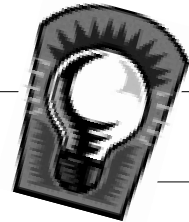
the joint venture: *"to monitor the provision of preventive services among enrolled populations; to work with managed care to address the needs of high risk/disadvantaged populations through outreach and home visitations by public health teams (nursing, social work, community health workers, and outreach workers); to link managed care to Health Department preventive activities and services; to create a quality assurance program; and to identify and report access barriers to Health Department programs and staff, primary care providers and respective Managed Care Operations."*

Accomplishments have been many. First, all MCO's agreed to exchange written letters of intent to develop an agreement with the Health Department. The MCO's enrolling Medicaid clients signed the partnership agreements. Second, an information package for health care providers and other community entities was developed and distributed. Milano was pleased that the contracted MCO's developed trust in the

expertise and services of OCHD's Health Team. As well, the Health Department's staff saw the need for MCO's to decrease the language barrier for their non-English speaking members trying to access member services.

OCHD learned the importance of ensuring open lines of communication, both externally and internally, even when it seemed that every detail has been addressed. Milano recommends that communications occur on a regular basis, from daily written and verbal communications about the referral and authorization process to bi-weekly meetings with key stakeholders. She also said that documentation is essential in order to ensure the delivery of quality services and in receiving prompt reimbursement for services rendered.

For more information about this project, contact Llamara Padro Milano, Onondaga Country Health Department, Syracuse, NY, 315-435-3287.



Healthy San Diego: Striking a Balance in Care

The County of San Diego Department of Health Services (DHS) received a **SpotLight** award at the 1997 CityMatCH conference in Atlanta for its role in the development of a unique pilot program called "Healthy San Diego" (HSD).

The program is the result of a three year collaborative process involving key local stakeholders. In this plan, the County Department of Health Services (DHS) is not a direct service provider, nor part of any managed care plan. It acts as a neutral facilitator, balancing the priorities of the stakeholders and negotiating with the State DHS, legislature, and the State lobbying organizations of local stakeholders. The County DHS has done this by staffing all meetings and performing necessary follow-up. County DHS has acted as a spokesperson to the media and other interested parties, and worked "behind

the scenes" to develop consensus and to "troubleshoot."

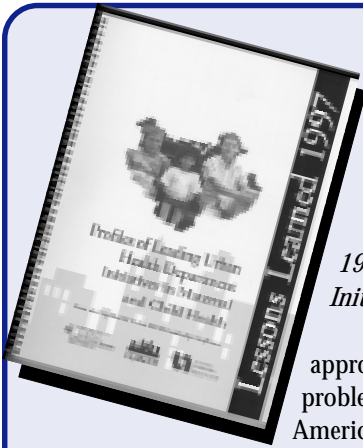
By ensuring that a good referral and communication system is in place between Plan providers, "carved out" Medi-Cal programs and public health programs, consumers should be better able to use managed care and make appropriate plan selections.

Healthy San Diego developed "local standards," specific to plan contracts with HSD, which have been agreed to by both local stakeholders and by the state. These standards include the protection of traditional providers. Enrollment counseling is now performed by County DHS staff. A Local Quality Improvement (QI) Subcommittee was created which is working on the development of a consumer-friendly Plan Report Card on mutual QI studies and indicators to be monitored across all Plans. This will ensure mechanisms for

cooperation of Plans with Public Health programs, and for facilitating miscellaneous cooperative projects among Plans.

During this three-year process, DHS learned that it is not necessary to be a direct service provider and to compete for funds with providers to carry out core public health functions. They also now realize that the political process piece is as important as the project content pieces. They recommend that others stay "ahead of the curve" and that Public health partner to produce report cards, locally monitor systems performance and outcomes and to participate in community level interventions.

For more information about this project, contact Nancy Bowen, San Diego, CA, Department of Health Services, at 619-692-8809.



New CityMatCH Publication Available

CityMatCH announces the release of its most recent publication, "*Lessons Learned 1997: Profiles of Leading Urban Health Departments Initiatives in Maternal and Child Health.*"

There continues to be a call for innovative approaches and "best practices" to solve the public health problems facing women, children and adolescents in America's cities. Urban communities want to know how to overcome barriers to implementation, how to go from "project" to scale, and how to sustain resources and commitment for long-term change. *Lessons Learned 1997* provides information from many of your own health departments about promising program and policy initiatives in urban maternal and child health to address the demand for replicable solutions.

An evaluation form is included with each copy of the publication. CityMatCH asks readers to take just a few minutes and fill it out. The feedback will enable us to better serve you.

One copy of this publication will be mailed to each CityMatCH member. Additional copies may be obtained for \$15 directly from the CityMatCH Central Office at 402/559-8323.

Farewells and Congratulations: Changes on the CityMatCH Board

Please join CityMatCH Board of Directors, staff, and membership in offering special thanks to our outgoing Board members. Over the past two years, they have provided invaluable service and leadership.

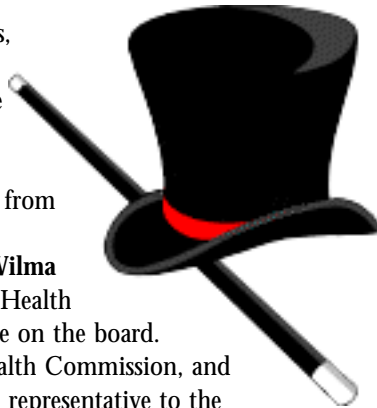
Region IV representative **Claude Dharamraj** from the Pinellas County Health Department in St. Petersburg, Florida and At-Large representative **Wilma Brakefield-Caldwell** from the Detroit, Michigan Health Department are both ending their terms of service on the board.

Lillian Shirley has left the Boston Public Health Commission, and therefore is no longer eligible to serve as Region I representative to the CityMatCH Board of Directors. A special call for nominations and election will be held to fill the vacancy. Lisa Belanger of Portland, Maine was appointed by the Executive Board in August to serve on an interim capacity until the results of the election are determined.

Our hats off to Claude, Wilma and Lillian for their efforts these past years.

Congratulations are also in order for the following new Board members selected for a three-year term September 1998- September 2001: Llamara Padro Milano (Syracuse, NY) in Region II, Betty Thompson (Nashville, TN) in Region IV, Carole Douglas (Lincoln, NE) in Region VII, Gary Oxman (Portland, OR) and Zenobia Harris (Little Rock, AR) as At-Large Representatives.

Welcome to the Board!



Leadership Changes at the Maternal & Child Health Bureau



Audrey Nora

Dr. Audrey Nora, Assistant Surgeon General and Associate Administrator for MCH, Health Resources Services Administration, recently announced her retirement as Director of the Maternal and

Child Health Bureau (MCHB), an \$842 million program designed to promote the health of mothers, children and families, particularly those who are poor or lack access to care. MCHB is in charge of the Maternal and Child Health Services Block Grants (Title V) to the States, the Healthy Start Initiative, the Emergency Medical Services for Children Program and the Abstinence Education Program. Dr. Nora provided outstanding leadership and will be missed.

Health Resources and Services Administrator Dr. Claude Earl Fox has appointed Dr. Peter van Dyck as Acting Associate Administrator of MCHB. Former positions held by van Dyck include director of the MCHB's Office of State and Community Health, senior medical advisor to MCHB, director of the Utah Department of Health's Family Health Services Division and pediatrics professor at the University of Utah Medical Center.

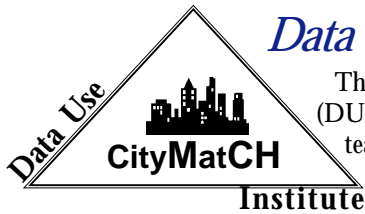


Peter van Dyck

In addition, van Dyck is past president of the Association of Maternal and Child Health Programs and past chair of the maternal and child health section of the American Public Health Association.

Since the creation of CityMatCH, the Maternal and Child Health Bureau has been one of our primary funders and strongest supporters. We wish both Dr. Nora, and Dr. van Dyck the best.





Data Use Institute Leverages Local Support

The 1998-99 CityMatCH-CDC Urban Data Use Institute (DUI) has exciting developments to report about this year's teams. The last *CityLights* edition mentioned that several applicants to the Institute were accepted, but were not funded due to limited resources. Three cities

took the initiative to seek out local funding in order to participate, and were successful in this quest. We welcome these cities to the 1998-99 Data Use Institute: Honolulu, HI; Spokane, WA; and Washington D.C.

When asked what influenced their decision to pursue local funding in order to participate, Spokane's team leader, Barbara Feyh stated, *"We believed that this (DUI) was a wonderful training opportunity, utilizing the highest caliber of people, whom we would not be able to get in Spokane, and we really wanted to be a part of this learning process."* Another locally funded team, Honolulu, HI shared this ambition. Nancy Kuntz, Honolulu's CityMatCH representative, said *"The process of pulling together as a team to develop the Data Use Institute Project proposal was energizing. While we waited to hear about the CityMatCH grant, we were already mentally moving forward...When our proposal was approved but not funded, it seemed imperative to move forward and...put that vision into place."*

Several 1998-99 DUI Teams also added members and secured local funding to sponsor those team members. The following teams are independently funding one additional member: Greensboro, NC; St. Petersburg, FL; and Orange County, CA. The teams from Phoenix, AZ and Hartford, CT were able to secure funding for two additional members, five traveling team members per city! One innovative way teams maximize project resources is by having nontraveling team members participate as project consultants. These people commit expertise and time towards the team's project but do not travel or participate in the structured DUI activities.

Orange County, CA has three consulting members from the University of California at Irvine, Injury Prevention Research Center for its project. Hartford, CT has one consulting member from its health department. When asked what influenced his team to include additional members and secure local funding for these members, Team Leader Len Foster, replied, *"Orange County's DUI team organizers and application writers were determined to use the DUI opportunity to enhance capacity building within our community and enhance collaborative relationships...Evidence of significant interest in the area of injury prevention and risk assessment was present among multiple agencies. To limit participation on the team would have eliminated a key player. The Children's Hospital contact approached the CEO with the proposal to participate in DUI and fund a slot. Children's Hospital of Orange County (CHOC) was supportive on both counts, an opportunity we could not pass up."*

Stay tuned for more ground breaking developments with the Urban MCH Urban Data Use Institute! For more information, contact Donadea Rasmussen at 402-559-5642 or via email: drasmuss@mail.unmc.edu.

Leadership into Action Through Effective MCH Data Use



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