



CityLights

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

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In this edition of CityLights, we hear from our members and key partners about the leadership, organization and financing of maternal and child health in America's cities. From their varied perspectives, we learn what are urban MCH priorities - current and emerging. We have drawn from the results of the 1998 CityMatCH Members Assessment and recent conversations with national leaders to provide this edition's public health profile of MCH in urban communities.

Assessing Urban Maternal and Child Health Leaders

Public health departments serving urban communities provide essential leadership to promote and sustain the health of children and families in America's cities. How then, are they organized, financed and led to safeguard urban maternal and child health? CityMatCH has been following this key question for the past decade through a series of surveys of its member health departments.

Local health departments whose jurisdictions include one or more cities with a population of 100,000 or greater (or the city with the largest population in smaller areas) are invited each year to become part of the CityMatCH urban MCH network. Each member health department appoints their lead individual for maternal and child health to be its representative to CityMatCH. These designated urban MCH leaders are asked to serve as the single point of entry for surveys, rapid assessments, and other requests for information, on behalf of their health departments.

To better target programs and activities, and to address important health issues facing women, children and families in America's cities, CityMatCH periodically surveys its member health departments.

The 1998 Members Assessment offers insights into the changing face of urban MCH leadership and organization. In August and September of 1998, CityMatCH conducted the 1998 Members Assessment. An 11 page survey of 38 questions

was mailed to the 142 member health departments who serve cities greater than 100,000 people or the largest city in the state. Follow up phone calls were made to non-responding members. Moreover, members were required to return a members assessment in order to receive a travel stipend for the Annual

Urban MCH Leadership Conference in September 1998. 123 members completed and returned the survey for an 87% response rate.

The assessment focused on a series of issues. First, the survey asked information about the CityMatCH representative--the designated agency leader for health issues related to women, children and families.

The CityMatCH representative was the primary person responsible for having the survey completed and returned. Next, the survey focused on the health department's MCH budget, the agency's current and emerging MCH priorities, potential training methodologies, and current agency technology. Selected results are featured in this edition (*See page four*).

The unique focus of this assessment, looking closely at CityMatCH members and their needs, has provided a clear picture of who our members are. It has also given insights into who the next leaders will be, what the pressing MCH concerns are, which issues are emerging, what changes are occurring in local urban health departments, and why.

as • sess to determine the importance, size, or value of . . .
(Merriam Webster's New Collegiate Dictionary, 10th Edition)



CityMatCH has moved its Central Office. Note new phone number 402-595-1700 & FAX 402-595-1693. Same regular and electronic mailing addresses.

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Firsts...

Magda Peck, ScD
CEO, Executive Director of CityMatCH

Sam did his first overnight camp this summer. We dutifully checked the lists of requisites and marked "S.A." on each size 14 Fruit of the Loom. We discovered the maximum volume of a standard duffel bag. I was the chosen parent to make the 500-mile-trek north to Wisconsin; all those stories of six long summers at Camp Greylock must have convinced Sam of my superior preparedness. So we set out one Sunday morning last June, trunk bursting with gear. With 11-year-old Sam in the back seat was Alex, a camp veteran returning for a second tour. The first leg to Rockford, Illinois was uneventful, until Alex called home one last time.

The cry of homesickness is a penetrating howl of grief and terror that comes from a dark place deep in the gut. It seems endless, fueled by unbearable sorrow, and it really, really hurts. After talking with his mom, Alex's aches came in steady waves long into the night. He demanded to go home. He cursed camp. He lost his dinner. He begged for his mother. Curled up on the bed as far from Alex as he could, Sam fended off the contagion of tears with a pillow over his head. I lay between them, comforting one then the other with back rubs and stories. Just before sleep, Sam whispered, *"Maybe this camp thing wasn't such a hot idea."* Alex crashed after midnight.

The morning after dawned cool and calm; so did Alex. Back on the road for the final ninety minutes, my passengers were subdued. Finally, Sam leaned over to Alex and asked, *"So what's so really terrible about camp?"* *"Nothing,"* declared Alex, oblivious to the night's drama. *"It's great!"* Sam looked doubtful the rest of the way to camp.

A swarm of eager counselors descended upon the stream of arriving cars with a joyous welcome, and Alex was swept away into a field of fellow campers. Sam and I stepped aside to have one last private moment. I gave him a solid hug, and snuck a kiss on his cheek. He hugged back hard and held on. Tears wet his cheek - mine. It was a hard first for me to let this pre-teenager go. And then, in the sweetest voice, firm yet tender, he said, *"It's okay, Mom. It will be all right."*

And so it was.

Sam now describes his camp adventures as if he has always been an overnighter. Isn't that how we all retro-fit our most difficult *"firsts"*? Looking back, even the most awkward transitions become lighter. Our proud stories of survival are spiked with bravado. We at CityMatCH also are having a Summer of hard firsts, notably our first joint national conference. The last few months of planning have been like an endless trip to camp; a few are homesick for simpler conferences past. And we have moved, for the first time, to a new suite of offices off-campus that can accommodate our growth. Phones out of whack, computers down: it's been really messy. I am not quite sure how to comfort the crew through change. I keep wanting to say to each of my amazing colleagues - in Sam's sure voice, *"It's okay, guys. It will be all right."*

And so it will. We'll proudly tell you all about it, after September.

CityResources



Zero Population Growth a national non-profit organization working to slow population growth and to achieve a sustainable balance between the Earth's people and its resources, recently published the *"Kid-Friendly Cities Report Card,"* which can be found at this website: <<http://www1.zpg.org/kidfriendlycities>>. (See also related story on page nine.) ZPG works to protect the environment and ensure a quality of life for present and future generations. ZPG's education and advocacy programs aim to influence public policies, attitudes, and behavior on national and global issues and related concerns.

The Robert Wood Johnson Foundation seeks to improve the health and health care of all Americans through its grantmaking to national programs and organized, multi-site efforts to implement a proven strategy or develop new approaches to a problem. On the web at <<http://www.rwjf.org/>>

One project of the RWJF is **All Kids Count: Establishing Immunization Monitoring and Follow-Up Systems**. All Kids Count is a national network of demonstration projects working to develop and implement community-based immunization registries for infants and toddlers. Immunization registries, health care providers, policymakers and the public are invited to explore their web site for the latest information on All Kids Count projects, as well as immunization registry "best practices," issues, research and resources. All Kids Count is a national program supported by The Robert Wood Johnson Foundation. Contact Information: William C. Watson, Jr., Deputy Director, Tel: (404) 371-0466, Fax: (404) 371-1087, E-mail: wmwatson@taskforce.org or on the web at <<http://www.allkidscount.org>>.

Another is the **Urban Health Initiative**. Responding to growing concerns about the health and safety of children in America, this grant program helps communities identify and address local needs. Over a period of up to 10 years, the program will help several cities around the country determine whether, by bringing young people and their parents together with key urban and suburban leaders, it is possible to achieve significant improvements in the health and safety of children—particularly those in the most distressed urban areas.

KIDS COUNT, a project of the Annie E. Casey Foundation, a national and state-by-state effort to track the status of children in the United States, seeks to enrich local, state, and national discussions concerning ways to secure better futures for all children. Nationally, the principal activity of the initiative is the publication of the annual KIDS COUNT Data Book, measuring educational, social, economic, and physical well-being of children. The 1990 Census significantly undercounted children, according to a study published by KIDS COUNT. This recent publication can be found on the web at: <<http://www.aecf.org/kidscount/>> (See also related story on page nine.)

Leadership Roundtable: MCH Leaders in America's Cities

CityMatCH: What kind of public health leadership is needed in America's cities to assure the health of women, children and their families?

Earl Fox: MCH leaders need to play two roles: advocate for MCH for the whole community, and catalyst. What you need is a leader whose role is concern for the whole MCH area of need and population, not just low income. The issue is having leadership that feels responsible to look out for the whole public health system.

Rob Fulton: Public health leadership has to be visible and visionary for women and children to be heard above the din of other urban priorities. Stealing words from Patch Adams, "Public health leadership has to be passionate and persistent." We have to have the ability to continue to repeat the words of our vision over and over again.

Hani Atrash: Public health leaders ought to have vision and passion for the issues related to women's and children's health. They need to be adamant and determined but modest, selfless and inclusive when it comes to decision making.

Len Foster: Among the greatest challenges of public health leaders will be to work with these managed care providers and organizations to integrate public health practices into the manner in which they provide care. This will be done by convincing them that it is cost beneficial. The practice of public health need not be confined to public health organizations. We are being challenged to extend the public health family by winning converts in other sectors of the health care arena.

Earl Fox: Leadership means doing things that people aren't going to ask you to do, but you see as your role. Taking a leadership role in solving problems doesn't necessarily mean controlling them, but it may mean bringing people together and providing a forum for all the groups to solve them.

Len Foster: A second challenge will be to develop true collaboration among a broad community constituency — to prioritize health within the greater

CityMatCH recently interviewed several key public health leaders about urban maternal and child health. Featured below are selected highlights from representatives of CityMatCH, CDC, HRSA, and NACCHO:

- ▼ **Vicki Alexander**, MCH Director, Berkeley City Health Department, Berkeley, California;
- ▼ **Hani Atrash**, Chief, Pregnancy and Infant Health Branch, Division of Reproductive Health, National Chronic Disease Prevention Program at the Centers for Disease Control and Prevention (CDC), Atlanta Georgia;
- ▼ **Doris Barnette**, Principal Advisor to the Administrator, Health Resources and Services Administration (HRSA);
- ▼ **Earl Fox**, Administrator, HRSA;
- ▼ **Len Foster**, Deputy Director of Public Health, Orange County Health Care Agency, Santa Ana, California; and
- ▼ **Rob Fulton**, Director, St. Paul/Ramsey County Health Department, St. Paul, Minnesota.

context of community needs, and to build the political will to address those policy issues necessary to resolve those which the community considers most important.

CityMatCH: What kinds of skills, knowledge and attributes do public health leaders need to provide this essential leadership?

Rob Fulton: We need to have the skills and knowledge to get a place at the right tables. We have to become table extenders. In my house, we always knew a special occasion was on the way when my Mother would get out the leaves for the dining room table to make it even larger. We have to be the "extenders of tables" in the urban settings so that more folks can take part in dialogues about MCH issues. An important ability of public health leaders is the capacity to bring disparate systems to the tables of conversation and to be the mortar that binds the bricks together to build a solid wall.

Hani Atrash: Public health leaders must be able, in consultation with others, to set priorities for program development and resources allocation based on scientific evidence and potential for success. They must possess communication skills that will allow them to secure support for the women's and children's health issues and the programs they develop to deal with them.

Earl Fox: To do what you need to do, you have to know where you want

to go. If you can't conceptualize where you want to be, you can't galvanize the necessary resources. One essential skill that an MCH director should have is the ability to understand what money is around and to leverage resources. MCH leaders need to know the importance of financing and information both in trying to understand and build a better system.

Len Foster: Public health leaders need to understand the economics of health care delivery, and to develop ongoing communication with managed care or private health care leaders in their communities. Public health leaders must look for common ground. They should attempt to identify where the interest of both sectors converge and then build on that common ground. Public health leaders should not be defensive. Rather, they should seize this as an opportunity to develop a meaningful partnership with private sector providers, and extend public health principles and practices through non-traditional means. *(Continued on page 10)*

"What you need is a leader whose role is concern for the whole MCH area of need and population, not just low income."

- Earl Fox

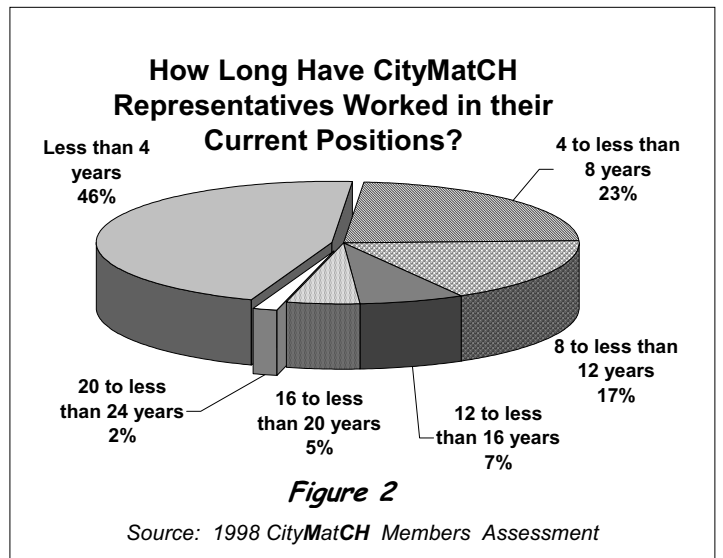
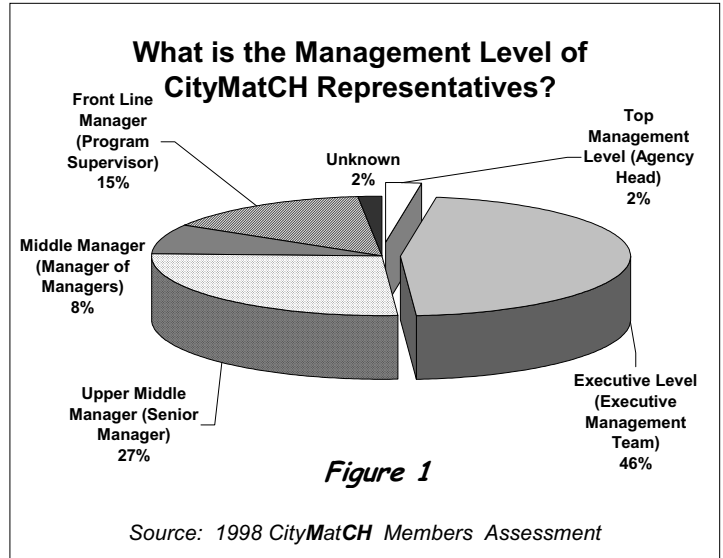
Public Health Leadership for Urban MCH

The designated CityMatCH leaders of MCH in our member urban health departments are mostly mid-career senior level managers (Figure 1) who have worked in the public health field for 10 or more years (81%). They represent a mix of nurses (55% with RNs and 17% with MSN) and physicians (18%). Most (61%) have two or more professional degrees, including one in four with formal public health education (26%). Nearly 1 in 4 is African American (19%) or Latino (5%), and most (86%) are women.

Most urban MCH leaders are health departments veterans. Three out of four (75%) have worked in their current health departments for five or more years; 55% have been with their health departments for over 10 years. Over time, their roles within the health departments have been changing. Less than half (46%) have been working in their current position for fewer than four years, and less than a third (31%) have been in the same position for eight or more years (Figure 2). Currently, over half (57%) have more than 50 employees reporting to them, and nearly half (46%) are part of their agency's Executive Management Team or are the agency head (2%).

Transitions and advancement of urban MCH leaders within their health departments are reflected in the tenure of its current CityMatCH representatives. Nearly a third (31%) of the designated urban MCH leaders have been their health departments' representatives to the CityMatCH national network for less than two years. Only 14% have been the CityMatCH representative for the bulk of the organization's history - seven or more years.

CityMatCH was established nearly a decade ago as a national voice of leaders of maternal and child health whose individual and collective capacities improve and enhance the health and well-being of families and children in America's cities. Our challenge is to foster continuous learning and leadership development to keep pace with changes in health care systems.



Organizing for Urban MCH

Has the organization structure of the maternal and child health related activities in your health department changed in the last three years (since July, 1995)?

YES 37% NO 63%

Why have these changes occurred?

- To "...increase efficiency, decrease duplication, decrease excess cost, and spread the cost of services."
- There has been a "...decrease in client base due to expansion of eligibility for Medicaid."
- "This change was a result of recommendations of a private consulting firm, and the switch from city governance to county governance."

Source: 1998 CityMatCH Members Assessment



What are the Sources of Funds Dedicated to MCH Activities in Urban Health Departments?

Findings from the 1998 CityMatCH Members Assessment reveal the often complex mix of fiscal resources urban health departments draw upon to support their MCH activities.

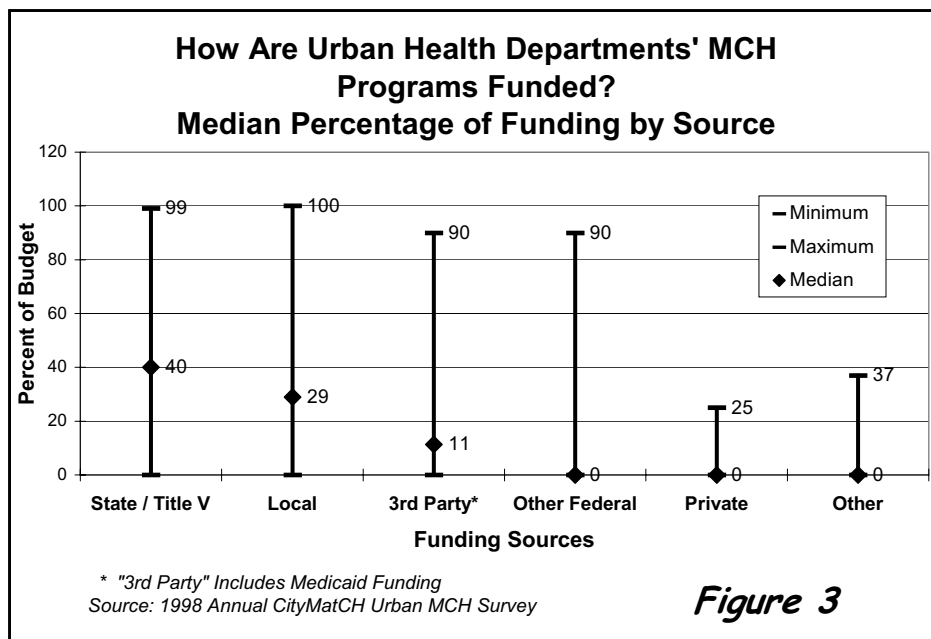
The annual survey asked urban health departments: "What are the sources of funds dedicated to MCH activities?" 90 (73%) of 123 health departments who responded to the survey provided information for this question. The data gleaned reflects the aggregate mix for health departments whose jurisdictions include central cities greater than 100,000 population or the largest city in any state not otherwise represented.

The largest source of MCH funds identified were state and Title V MCH Block Grant dollars. The median percentage of the budget reported was 40 percent. The actual range spanned from zero percent all the way to 90 percent. (See Figure 3)

Nearly half of the health departments reported receiving 21 percent to 60 percent of their MCH funding from state and Title V MCH Block Grant dollars. Just four percent reported receiving zero funding from this source.

Local funding and third-party reimbursements for services were the second and third largest sources of MCH funding. Local funding by definition includes both county and city funding. The median level of local funding was 29 percent with a wide range from zero to 100 percent. For third-party reimbursements, including Medicaid, the median dropped to eleven percent with only 61 percent of urban health departments receiving funding for their MCH budget through this particular mechanism.

Additionally, urban health departments reported utilizing other mechanisms to support their MCH budgets. Nearly half reported receiving other federal dollars beyond Title V MCH Block Grant. In addition, 24 percent reported taking advantage of private sources and 18 percent reported



Major Findings: Funding Urban MCH Activities

- Urban health departments fund their MCH-related activities from varied funding sources and no stereotypical funding patterns exist.
- State/Title V funding and County/City funding are the most consistent sources of funding for MCH activities. However, many urban health departments cannot distinguish between state, Title V federal funding and Title V matching funding in their budgets.
- Some urban health departments are able to find other sources of funding for the MCH activities including other federal grand funding beyond Title V funding, private/foundation funding and other funding.

What is a "Median?"

The median is not an average. It is the 50th percentile where 50 percent of health departments report higher percentages and 50 percent report lower percentages. The median is used when the distribution of responses are not bell-shaped or symmetrical.

using 'other' sources. However, the actual percentage of the maternal and child health budget in urban health departments from these last three sources showed great variance, ranging from zero to 90 percent.

Sources of MCH funding varied

greatly among local urban health departments. As Federal and State pockets tighten, local urban health departments have found new, creative ways to fund essential services. They also look for program funding from sources previously untapped.

Current Leading Priorities in Urban MCH

Health issues and health services related issues are again identified as the leading priorities for Urban Health Departments according to the 1998 CityMatCH Members Assessment. For the first time, however, public health services and infrastructure are also identified as high priority for many urban health departments across the country.

MCH leaders in urban health departments were asked to rate their agency's priority status for 21 different MCH challenges including health issues, health services, social issues, and public health services. All 123 members who responded to the survey answered this series of questions.

More than three fourths of urban health departments reported communicable diseases, under-immunization of children, access to care and adverse perinatal outcomes as a high MCH priority issues for their agency. Communicable diseases refers to both prevention and treatment of diseases including TB, AIDS, sexually transmitted diseases, Hepatitis and outbreaks. Adverse perinatal outcomes includes infant mortality, low birthweight and prematurity.

More than two thirds reported adolescent pregnancy and parenting as a high MCH priority. More than half reported client knowledge, attitude, practice and beliefs, and infant development which includes newborn home visiting, parenting education, early stimulation and education as high MCH priorities. Teenage pregnancy has long been a priority for urban health departments, but the latter two issues have become an increasing priority for many urban health departments over the past couple of years.

In addition, public health services and infrastructure are now reported as high MCH priorities and an overarching priority for many urban health departments. The survey this time included four categories on public health—community empowerment, community services, data capacity and public health infrastructure. All four are reported as a high priority for a majority of urban health departments.

In many ways, these two priority areas are strongly linked together. Only through adequate public health infrastructure and data capacity, can urban health departments partner with communities to address priority health and health services related issues facing women, children and families.

Leading MCH Priorities of Urban Health Departments The Percentage and Number of Health Departments Rating Each as "High" Priority.

Health Issues

- 78% (96) COMMUNICABLE DISEASE PREVENTION AND/OR TREATMENT:** including Tuberculosis, AIDS, sexually transmitted diseases, Hepatitis and outbreaks.
- 76% (94) UNDER-IMMUNIZATION OF CHILDREN:** including a lack of immunization services; low levels of immunization among two-year olds.
- 76% (93) ACCESS TO CARE:** including access to dental, primary, pediatric, prenatal, preventive health services; language, transportation, financial, Medicaid and like barriers.
- 76% (93) ADVERSE PERINATAL OUTCOMES:** including infant mortality, low birthweight, and/or prematurity.
- 69% (85) ADOLESCENT PREGNANCY AND PARENTING:** including teen pregnancy, teen childbearing, teen parenting.
- 54% (66) CLIENT KNOWLEDGE, ATTITUDES, PRACTICES AND BELIEFS:** including parenting; knowledge about resources and services; compliance/missed appointments; follow-through; motivation.
- 54% (66) INFANT DEVELOPMENT:** including newborn home visiting, parenting education, early stimulation and education, and other environmentally related issues.

Public Health Capacity

- 64% (79) COMMUNITY EMPOWERMENT:** including starting Healthy Community Initiatives, focusing on health problems from the community perspective, and working on long-term community change.
- 63% (78) COMMUNITY SERVICES:** including community assessment, developing community support, and providing community services.
- 63% (78) DATA CAPACITY:** including health information systems, developing data units, enhancing community assessment and surveillance, and evaluating activities.
- 52% (64) PUBLIC HEALTH INFRASTRUCTURE:** including financing, training, leadership, mission, refocusing, and support.

Source: 1998 Annual CityMatCH Urban Members Assessment

Emerging MCH Priorities: Old or New?

When urban maternal and child health leaders across the country were asked the top MCH priorities that will *emerge* for their health departments in the next three to five years, the responses carried two major themes. First, many past and current MCH priorities were *re-emerging* again, sometimes with new faces and dimensions. Second, strengthening public health capacity and infrastructure is *emerging* as a major priority for many urban health departments.

After rating the priority of 21 MCH challenges relating to health issues, health services, public health, and social issues, urban MCH leaders were asked to provide three open-ended responses regarding *emerging issues*. All 123 leaders, who responded to the CityMatCH Members Assessment, answered this question.

Access to care, violence and adverse perinatal outcomes were the top *emerging* public health issues reported. Access to care is *re-emerging* as a priority because of the growing problems of the uninsured, nonlegal immigrants, welfare reform, and Medicaid managed care. Violence, although always a problem, is being perceived as more of a public health problem requiring a public health prevention approach. Adverse perinatal outcomes are worsening in many ways although infant mortality overall is improving. Prematurity, low birthweight, and racial disparity are actually increasing in many cities.

In terms of new priorities, the top *emerging* priority is building and strengthening public health capacity and infrastructure. Data capacity, public health infrastructure and community services were second, third and sixth in priority respectively. To provide the ten essential public health services and effectively address current and *emerging* public health issues, strengthening these three areas in many urban health departments is essential.

Although these are the top *emerging* issues, these issues do not necessarily represent a majority of urban health departments. For example, only 34% of respondents listed access to care—the top *emerging* priority—as one of their three *emerging* priorities.

In addition, all of the *emerging* priorities are listed in the current priorities. This finding should not be a surprise. First, public health has always prioritized efforts to work on preventing *emerging* public health issues. Second, these issues will not be resolved quickly so that they will likely remain high priorities for the next three to five years. Third, not every urban health department faces the same issues at the same time. What are currently priorities for some, may be *emerging* priorities for others.

Emerging MCH Priorities

- 1 **ACCESS TO CARE:** including access to dental, primary, pediatric, prenatal, preventive health services; language, transportation, financial, Medicaid and like barriers.
- 2 **DATA CAPACITY:** including health information systems, developing data units, enhancing community assessment and surveillance, and evaluating activities.
- 3 **PUBLIC HEALTH INFRASTRUCTURE:** including financing, training, leadership, mission, refocusing, and support.
- 4 **VIOLENCE:** including family violence, spouse abuse, child abuse, crime, and interpersonal violence.
- 5 **ADVERSE PERINATAL OUTCOMES:** including infant mortality, low birthweight, and/or prematurity.
- 6 **COMMUNITY SERVICES:** including community assessment, developing community support, and providing community services.

Source: 1998 Annual CityMatCH Members Assessment

Calling All Assessments!! Calling All Assessments!!



Checked your mailbox lately? All CityMatCH members were recently sent a mailing which included the 1999 CityMatCH Members Assessment. As in previous questionnaires, information will also be gathered which looks at local health department organizational structure, financing, technological capabilities, and perceived issues and priorities. If you have not yet taken time to complete and return the questionnaire to the CityMatCH central office, please take twenty minutes to do so today - read it, fill it out, and mail or fax it in. Stayed tuned for future editions of *CityLights* for updates on the status of this questionnaire, and for the published results next year.



Technical Assistance and Training Opportunities

CityMatCH annual pre-conference workshops are one of the many ways CityMatCH serves its members. According to the 1998 Member's Assessment, they are also one of the preferred methods.

Each year, the CityMatCH Urban MCH Leadership Conference (*see conference announcement on page 11*), offers several workshops on such varied subjects as Using Data for Urban MCH Assessment, Economic Analysis, and Leadership. These workshops augment the considerable skills of CityMatCH representatives, which they in turn, take back to the local health departments.

The 1998 Members Assessment survey offered a list of ways in which CityMatCH can provide technical assistance to members and/or their health departments. Responders were asked to indicate their preference for each method by checking a box on a five point Likert scale, ranging from least to most helpful. 123 responses provided information for this question.

No dominant preference arises from the data, but the ability to travel clearly presented as a potential obstacle to receiving needed TA. The question specific to travel found that nearly a quarter (22%) of responders cannot travel to attend conferences, almost half could "possibly" attend (41.5%) and about one third (36.6%) are able depending on the conference. Similar responses were noted on a question asking about ability to attend training workshops. Clearly there are funding and staffing issues at work here.

CityMatCH Members' Preferred Approaches to Training and Technical Assistance

% Method Rated More or Most Helpful

CityMatCH preconference workshops	60%
Video teleconference sessions (interactive)	57%
Training Institute of 2 or more days	54%
Other workshops of 1 day or less	53%
Visits of technical assistance teams to your city	50%
Packets of written information on a particular topic	49%
Internet list serves and e-mails	48%

Sources: 1998 CityMatCH Urban Members Assessment



Technology: Do You Have Access Yet?

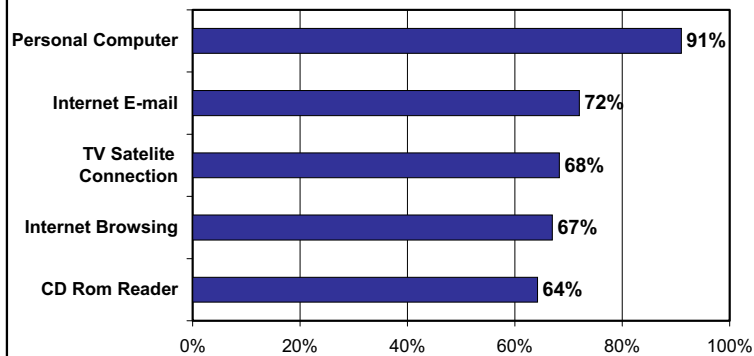
Strengthening public health infrastructure was identified as a "high" MCH priority in a majority of urban health departments. Included in building that infrastructure is the ability to take full advantage of new advanced technology.

So, do CityMatCH representatives across the country have access to this new technology? This question was one area of focus for the 1998 Members Assessment. Almost all of the 123 responders answered the technology-related questions.

Most of the questions focused on personal computers. Nine out of ten urban MCH leaders have access to their own personal computer at work. Using their computer:

- 71% receive Internet e-mail and are able to stay in constant communication with peers across the country and to receive streams of information from valuable resource centers,
- 67% browse the Internet to

Percent of CityMatCH Representatives Who Have Access to Various Technologies



Source: 1998 Annual CityMatCH Urban Members Assessment

review the wealth of MCH information available via the Internet, and

- 64% have CD rom readers to take advantage of learning resources that are available via CD.

The personal computer is the portal of entry into the information highway and serves as the reservoir for holding the valuable information that is found. It is becoming an essential tool that every urban MCH leader should have and know how to use.

In addition, we asked CityMatCH

representatives about their ability to gain access to a site to downlink a satellite TV conference. This technology is becoming a major vehicle to provide information best shared in a video format. Currently two-thirds (68%) of urban MCH leaders reported that they could gain access to such a site. This may be an underestimate, however, of what is available in their community. Many federal grants have been made available to community organizations to make this technology available.

How Are Cities Ranked on Children's Issues?

ZPG Names Kid-Friendly Cities

The Kid-Friendly Cities Report Card, recently released, is the seventh edition of the Zero Population Growth (ZPG) Children's Environmental Index biannual series. ZPG strives to present the best available data on the social, economic, educational and physical environment in our cities--exactly where our children live, grow, learn and play.

The Kid-Friendly Cities Report Card presents a broad and carefully chosen set of data on the status of children under age 18 who live in cities with a population of more than 100,000. If a state lacks a city of more than 100,000, the largest city in the state is used. The Report Card focuses on major U.S. cities, independent cities and outer and suburban cities. ZPG uses several key indicators--such as health, education, public safety, economic status, environment and population change.

A Major City is the main city in a metropolitan area where the MSA (*metropolitan statistical area*) has a population of greater than 2 million. This definition includes 25 Major Cities.

A Suburban City is defined as having incorporated areas of more than 100,000 within the MSA of a major city. These 92 suburbs and outer cities have a combined population of more than 14 million with an average population of about 156,000.

The Independent Cities category consists of cities with populations of more than 100,000, which were neither Major Cities nor Suburbs/Outer Cities. Because there is no city with a population of 100,000 or more in Delaware, Maine, Montana, North Dakota, Vermont, Wyoming and West Virginia, the largest city in these states was included in this category. More than 25 million people live in these 112 cities.

ZPG's Honor Roll of Kid-Friendly Cities

Major Cities

1. Seattle, WA	A+
2. San Francisco, CA	A
3. San Jose, CA	A-
4. San Diego, CA	B+
5. Portland, OR	B
6. Pittsburgh, PA	B
7. Denver, CO	B
8. Minneapolis, MN	B-
9. Boston, MA	C+
10. New York, NY	C+

Independent Cities

1. Fargo, ND	A+
2. Madison, WI	A+
3. Cedar Rapids, IA	A+
4. Sioux Falls, SD	A
5. Cheyenne, WY	A
6. Green Bay, WI	A
7. Lincoln, NE	A
8. Boise City, ID	A
9. Honolulu, HI	A-
10. Portland, ME	A-

Suburban Cities

1. Livonia, MI	A+
2. Naperville, IL	A+
3. Sterling Heights, MI	A+
4. Ann Arbor, MI	A
5. Santa Clarita, CA	A
6. Overland Park, KS	A
7. Sunnyvale, CA	A
8. Arlington, VA	A-
9. Fremont, CA	A-
10. Irvine, CA	A-

Source: <<http://www1.zpg.org/kidfriendlycities/index.html>>

KidsCount: 1990 Census Undercounts Kids by 2 Million

The Census of 1990 apparently undercounted children by more than 2,000,000, according to a study from the Kids Count Project of the Annie E. Casey Foundation of Baltimore. Their recent publication reported that many of these children were from the poorest sectors and that this error has cost the U.S. billions of dollars in Federal aid. Children are undercounted far more than any age group, and the rates vary across sociodemographic groups. The undercount of children in some cities and states is much higher than in others.

The group indicated that Florida, Louisiana, Mississippi and Texas had the highest percentage of uncounted children: 4.5% in each state. Lincoln, Nebraska was the most accurate among the 100 biggest cities in counting children (missing 648 or 1.4%) while Oakland, CA was least accurate (missing 8,717, or 8.6%)

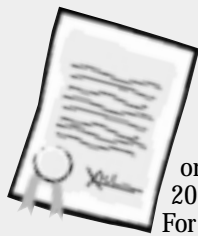
Overall, the census missed 3.2 percent of the country's children, defined for the study as people 17 and younger.

Source: <<http://www.aecf.org/kidscount/>>

Undercount of Children (under 18) in the 1990 Census in the 100 Largest Cities Percentage of Undercount Rate by City

<u>Cities with Least</u>		<u>Cities with Most</u>	
1. Lincoln, NE	1.4	91. Baltimore, MD	6.0
2. Madison, WI	1.9	92. Richmond, VA	6.1
3. Spokane, WA	2.0	92. Norfolk, VA	6.1
4. Fort Wayne, IN	2.3	92. Houston, TX	6.1
4. Mesa, AZ	2.3	95. Atlanta, GA	6.3
4. Des Moines, IA	2.3	95. Washington, DC	6.3
7. Huntington Beach, CA	2.4	95. New Orleans, LA	6.3
8. Omaha, NE	2.5	98. Hialeah, FL	6.4
8. Fremont, CA	2.5	99. Miami, FL	7.2
10. Wichita, KS	2.6	100. Oakland, CA	8.6

Source: <<http://www.aecf.org/kidscount/>>



CityMatCH Elects New Board Members

The following persons were elected or re-elected to the CityMatCH 1999-2000 Board:

For Region I: Lisa Belanger, BSN, MSN, the Program Manager for Family Health Services at the Portland Public Health Division in Portland, Maine, was elected to her first term. Lisa was appointed to the Board last year when the Region I slot was vacated.

In Region V: Agatha Lowe, RN, PhD, the Director of Women & Children's Health Programs for the Chicago Department of Public Health in Chicago, Illinois, was elected to her first term on the CityMatCH Board of Directors.

In Region IX: Vicki Alexander, MD, MPH, MCH Director at the Berkeley City Health Department in Berkeley, California, was re-elected to her seat.

Peter Morris, MD, MPH, Medical and Policy Director of the Wake Co. (Raleigh), NC Department of Health was re-elected to an At-Large seat.

Our best wishes go out to all those who ran for these seats.

Special thanks to Bobbie Brown, MSN, outgoing Board Member from Region V, for her generous service to CityMatCH.

New Faces at CityMatCH

The CityMatCH Central Office is growing to keep pace with our expanded scope of work. Below are some of the newest faces behind the products and services we provide to our members and partners across the country.

Vera Haynatzka, MS, joined the staff of CityMatCH in May 1999. Vera is the lead health data analyst for CityMatCH and coordinates overall data management and analysis.

Scott Santibanez, MD, MPHTM, CDC Epidemic Intelligence Service Officer was assigned to CityMatCH in August for two years. Scott is on assignment from CDC to CityMatCH to both learn and provide consultation in epidemiology and public health.

Jennifer Skala, MEd, joined the CityMatCH team as a Project Coordinator in August. Jennifer coordinates the Data Use Institute and serves as staff liaison to the Capacity Building Action Group.



Leadership Roundtable: MCH Leaders in America's Cities

(Continued from page three)

"CityMatCH can fire the passion for our vision...it can share the stories of others who have such passion and vision."

- Rob Fulton

because people are more concerned with furthering their own particular agency or organization.

Doris Barnette: Increased skills in facilitation would be required for urban MCH leaders. You probably have to become a diplomat in the urban setting because you have a lot of different people doing things, and there are a lot of different people wanting credit for certain activities. And sometimes it's harder to reach a consensus

Vicki Alexander: We also need a strong data basis for decision making, compassion and passion about the work, guts and will power, and the ability to work with elected officials and political processes in an affirmative positive way - not negative and reactive.

CityMatCH: *What must CityMatCH and its partners do to build leadership capacity for urban maternal and child health?*

Hani Atrash: CityMatCH and CDC should work together and with their partners to provide training and technical support for public health leaders to strengthen their ability to use data and information for decision making and to effectively communicate their program decisions and the rationale for such decisions to those who need to know.

Earl Fox: The best laboratory is the laboratory at the community level. I think one of the things that we don't do

well enough is find examples of lessons learned and communities or leaders that have tackled a problem. We need to bring everybody up to a higher level of expertise and ability to do what they need to do in the system.

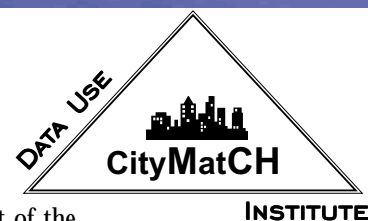
Doris Barnette: The single thing that a leader needs to be able to do is set a high bar and create a climate of expectation that people will then try and reach. It's almost an intrinsic kind of thing, but I think it is critical to leadership. If you have a leader who sets a low bar you're probably going to get just about that.

Rob Fulton: CityMatCH can help build the vision of MCH for urban areas; it can give us the capacity to effectively give visibility to our data to make it useful to be heard above the din of other data and issues. CityMatCH can fire the passion for our vision...it can share the stories of others who have such passion and vision.

Announcing the 1999-2000 Data Use Institute Teams

Nearly twenty urban health department members of CityMatCH applied this year for their communities to participate in the third CityMatCH-CDC Urban MCH Data Use Institute (DUI). Ten city teams (see map) have been selected from an excellent field of applicants. Several features make the 1999-2000 DUI different from previous years. First, half of the teams are supported directly by new partner organizations who want to build data use expertise in two key areas. Second, nearly all of the selected teams include individuals who are outside of the local health department, so as to strengthen community-wide capacity for effective data use. Third, most of the Year 3 teams have more than the three core members whose participation is subsidized by our grant dollars. This means local dollars increasingly are being invested to build local data use capacity. Last, the newest DUI class will include several individual associate members who will be strategic in expanding the Data Use Institute in coming years.

Three of the teams are funded by the National March of Dimes Birth Defects Foundation under the CityMatCH - March of Dimes Partnership for Urban Mothers and Babies. Their projects focus on perinatal health, and their teams include a representative of the local March of Dimes Chapter. Two DUI teams are supported directly by the HIV/AIDS program at CDC to link effective data use to the prevention of perinatal transmission of HIV. The five other DUI teams selected are directly supported by the Division of Reproductive Health at CDC, and their projects reflect a broad range of urban MCH issues. A list of the lead urban health departments for the 1999-2000 Data Use Institute. A list of preliminary team projects is given below. The new class will kick off at the September 1999 CityMatCH Urban MCH Leadership Conference (*see related article, page 12*).



◆ Tri-County Health Department, Englewood, CO:

Combining health indicator data with demographic variables for a clear picture of maternal and child health in their community, then effectively communicate this to community leaders, policymakers and the public.

◆ Genesee Co Health Department, Flint, MI: The Flint Healthy Start project is working to reduce infant mortality through an "Adolescent Model" of service delivery.

◆ Lincoln-Lancaster Co Health Department, Lincoln, NE:

Lincoln will strive to improve health status in two neighborhoods, using GIS to make existing data more available to communities and policy makers, and melding current data with emerging GIS capacity to create neighborhood-specific reports on maternal, child and family health.

◆ Philadelphia Dept of Public Health, Philadelphia, PA: "Welcome New Family" - weaves postnatal home visitation programs together into a unified system; facilitates development of common program elements, i.e. uniform risk assessment and educational materials; and provides direct services to families ineligible for postnatal home visiting services from other sources.

◆ Northern Health Services, Wilmington, DE: Developing a perinatal health profile—examining risk factors related to the racial differences in birth outcomes. Also to utilize other data to give a broader picture of services provided to pregnant women in the city.

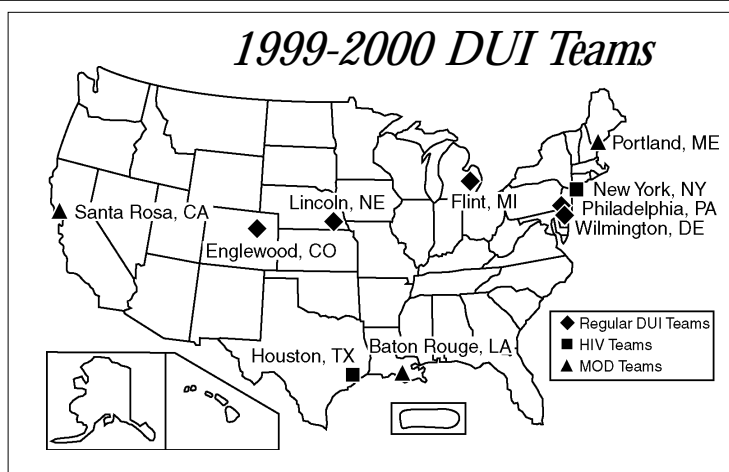
■ Houston Department of Health and Human Services, Houston, TX: A Core Team: the Bureau of HIV/STD Prevention, the Bureau of Epidemiology, and the Bureau of Family Health Services with the Texas Gulf Coast Chapter of March of Dimes, (acting as an auxiliary team member and consultant in advocacy and policy development issues), will work to electronically integrate their existing data, to analyze this existing data epidemiologically, and to identify pockets of need.

■ New York City Department of Health, New York, NY: A collaborative effort of the New York City Department of Health, the State Office of Alcoholism and Substance Abuse Services, the March of Dimes, and the State Department of Health, to enhance existing perinatal transmission prevention programs, and to overcome barriers to services needed to reduce perinatal transmission.

▲ Baton Rouge Parish Health Unit, Baton Rouge, LA: The project is entitled, "Geomapping of Prenatal Care Correlated to Birth Outcomes by Neighborhood." It will match birth outcomes to adequacy of prenatal care received using birth certificate data from Vital Records for women residing in the Baton Rouge city limits as indicated by zip code.

▲ Portland Public Health Division, Portland, ME: This project focuses on the recognized need to address the level of adult smoking that poses health risks to pregnant mothers and children.

▲ Co of Sonoma Department of Health, Santa Rosa, CA: Using Touchpoints, this PACT project will help create stronger parent/provider relationships and improved parent/child relationships. It also seeks to measure baseline data and progress using both process and health outcome indicators.



Data Use Institute Graduation and Reunion!



The Annual CityMatCH Leadership Conference in Baltimore this September will be an exciting time for Data Use Institute participants and CityMatCH members. We will be welcoming the 1999-2000 Urban MCH Data Use Institute Class (*See page 11 for related story*), graduating the 1998-1999 DUI Class, and celebrating the reunion of the 1997-1998 DUI Class.

The 1998-1999 DUI Class will wrap up their Institute year by sharing with the CityMatCH membership during the Data Use Symposium and during the DUI Poster Session on Thursday, Sept. 16th. In addition, they will be participating in all day Leadership training on the effective use of data on Wednesday, Sept. 15th. Plan on attending the symposium and poster session to learn more from your colleagues about using data to improve the health of women, children and families in America's cities.

The 1997-1998 DUI Class will be participating in the first DUI Alumni Reunion on Sept. 14th. Liz Zelazek from Milwaukee, WI, and Gayle Bridges Harris from Durham, NC will be serving as hosts and co-leaders of the DUI Alumni Network. The purpose of the network is to plan ongoing continuing education activities and opportunities for DUI alumni with the intent to further strengthen urban health departments' data use capacity.

We encourage CityMatCH members to consult with CityMatCH staff or DUI participants if you are interested in learning more about the DUI. Grant funding has been secured for at least two more years of Institute training.



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