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Activating_MCH_Leaders_for_Impact_(7-31-20)
8/12/2020

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>> BEN KAUFMAN: I lastly, would like to very briefly introduce our two speakers for today, individuals I'm lucky enough to call my colleagues here at AMCHP. First, our CEO Jonathan Webb who has extensive experience in public health leadership, both at national organizational level, as well as at the local public health department level. Also, our Director of programs, Caroline Stampfel, who I think in 2020 is marking 15 years of public health practice, and is an MCH epidemiologist by training and has worked at the state level as well. With that, I'll turn it over to Caroline and Jonathan. Thank you everyone for being here, and really excited to share today's content.

>> JONATHAN WEBB: I'll start while Caroline is pulling up the slide and just say welcome and thank you, Ben, for the opportunity to share today. I know Caroline is going to walk us through the learning objectives for this afternoon, but we really appreciate your leadership, Ben, and embrace and helping us to get to this moment and giving us this opportunity. One of the things I wanted to highlight before Caroline started was that as we're going through this presentation, although we are sharing information with you, we really want this to be a dialogue. We want it to be interactive and allow you to be vulnerable. We'll be vulnerable as we share some of our experiences, as we hear some of your experiences. We believe that's the only way we can truly meet your needs today, hopefully, in allowing us to support your efforts as leaders in the MCH base. Really, challenging you to get involved, get engaged in the conversation. Although we are sharing information out, we really want this to be as interactive as possible so we make sure we're learning and growing together. With that, I will stop and let Caroline start us off.

>> CAROLINE STAMPFEL: Great. Thanks, Jonathan. Welcome, everyone. It's really our pleasure to be here and talk with you a little bit about the roots of Maternal and Child Health in this country, and our connection to leadership and the journey beyond. Today we hope you'll be able to explore the roots of Title V and Maternal and Child Health, discuss that structure of Title V, including flexibilities and constraints, examine our future and opportunities for MCH practice and leadership, and as Ben noted, touching on the leadership competencies around the MCH knowledge base and context and working with communities and systems. That's where we're going today. To guide us along the way, there's a lot of Title V history. There's some really deep roots of MCH in America. We thought we would structure this around some key questions to guide us. We'll start with AMCHP so you know where we're all coming from, especially if you are joining us for the first time. How did Title V and Maternal and Child Health in America really get started? That's this thing about a Block Grant? Why do we do needs assessment? We'll talk about flexibilities and constraints and why there's so much emphasis on data. Then we'll start to explore some opportunities. So where are there levers that you have as a leader in Maternal and Child Health? Where does change really come from? What does partnership and collaboration look like as we look at the future of Title V? We know they are essential. So what does that mean? What does it look like? What does a Title V leader look like? Hopefully that helps us to get our minds around how we are connecting that past to the present and future. I'm going to let Jonathan start us off with who is AMCHP.

>> JONATHAN WEBB: Thank you, Caroline. We are the association of Maternal and Child Health programs, for those of us who are not familiar with us. We have shorten that to AMCHP. We have the privilege of being the membership organization working primarily with the 59 states and territory MCH directors, [indiscernible] directors, adolescent health coordinators, but we also include families in our membership. We have youth. We have some organizational

memberships as well. We really get the opportunity through our work with our membership to advance the mission that is listed here on the screen. We lead and support programs nationally to protect and promote the optimal health of women, children, youth, families, and communities. It was important for us, even though it may seem like a mouthful, to make sure that we included all of those populations in our mission and vision statement; women, children, youth, families, and communities. We believe they're all interconnected. It was important for us and our Board to make sure those populations were all called out. As part of our mission, we envision a nation that values and invests in the health and well-being of all women, children, youth, families, and communities so they may thrive; emphasis on thrive. What we are privileged to do with our membership is to support groups in -- from a technical assistance perspective in conducting needs assessments, identifying programmatic solutions through us, keeping our finger on the pulse of innovation, that we can share across our membership, help our membership with implementation of those best practices and response to the needs they've identified. We have the privilege of advocating on our member's behalf. Taking the things that we learn from you, things we learn from the industry, and raise the volume, raise the temperature across the spaces we get a chance to play in, at the legislative level with national leaders, and from a media perspective, trying to make sure that funding and the issues that are important to our members and their constituencies are front and center for the legislative populations that we are engaging. We get the privilege to try to increase funding that supports the work you're doing in the communities and around the country. This is who we are. This is our mission and our vision. In order to get to this place, we went through a thoughtful, and admittedly biased, but a thoughtful strategic planning process where we did a few things to kick off. One, we stepped back and had some conversations with stakeholders. I joined AMCHP about two years ago now, and the Board gave me the ability to engage with a number of stakeholders, even though the process was close to being final. They allowed me to back up a little bit and sit with 70 or so stakeholders, and that included community organizations, included individuals, included board leaderships, states. The focus around that was really wanting to hear from the people who we serve and interact with, what they saw as our strengths and our weaknesses. Given all of the groups like us, they had an opportunity to work with. It was important for me to hear what their perspectives were, what their issues were, what they thought we should be working on. Where they saw us really having a competitive advantage and a differentiator. Those were the elements we wanted to bring back to our board to be able to focus in on those areas. We tried to avoid that being all things to all people, and really be laser-focused in on who we were and what levers we had the best impact -- could have the best impact on. It did not mean we were going to engage in other areas. It meant we were going to be really focused on doubling down on the things that were our strengths, which means that sometimes we would lead, sometimes we'd follow, sometimes we would just be mindful of things going on around us. It really started to put us in a different mindset. That is especially relevant when we get to later points in the conversation when we talk about collaboration. What's important to us from a partnership standpoint is we lead out an ego. We understand who we are and what we can bring to the table, but knowing where our strengths and weaknesses are gives us a really strong framing around how we engage with partners on work we believe is important. We landed on this strategic plan. Some of the things that came out of our conversations with our partners was that we were really the connective

tissue or the bridge between our membership and, you fill in the blank. Our membership and federal agencies, our membership and other members, our membership and community organizations. For that reason, we named our strategic plan "a bridge or action." Below that is a restatement of our mission and vision. This is a three-year strategic plan, and we're about a year into it. We thought it was important through our listening session and through conversations with the stakeholders to identify the problems that we were trying to address and call them out, be very specific about them, try to assign some metric to them so in three years we could get a better sense how we progressed towards those goals. For that reason, you'll see in the upper left-hand corner, the challenges. These aren't all the them, but we have a few here and there's another sheet we didn't put in the slide here that identifies a few more. Things like a lack of evidence-based or lack understanding of the evidence-informed, evidence-based practices and the role we could play in making sure our members and those in this Maternal and Child Health community had a better understanding of the evidence base out there that they can pull from. Making sure that families and children of youth with special healthcare needs were getting service in a functioning system, and the data we have seen indicated that wasn't necessarily the case. How could we support that comprehensive and well-functioning system? Looking at our workforce. Making sure we could help our members to attract and retain the most highly-competent people for the work they were doing. What we saw from our research, from research of partners around us, it looked like more than half of our workforce was planning on leaving the workforce in the next five years. From my perspective, there are a couple of reasons why people leave opportunities. One, they're running from something or running to something. If people are running to something, then God bless them. It's our role as people who are trying to support their professional development to help them to get to where they find their ultimate happiness. If they're running from something, what do we need to do to make sure what that is understand what that this is they're running from; and how do we solve for that? In either event, in five years, it looked like we were going to have half of our workforce stepping away, so we wanted to call those things out, be mindful of it because we could hopefully play our small role in advancing the conversation and the issues that we were identifying as problem areas. Two other quick things I'll point out here, when we looked at our strategic plan, our work fell into two areas. Infrastructure areas that were back-bone type of things. How do we, again, increase the evidence base? How do we support the retention of -- attracting a retention of qualified individuals in this space? Things along those lines. How do we increase the investment in this space? We also had things we identified that were issue areas. If we do what we're supposed to do to the infrastructure side, make sure we have the right people in the right seats, we have increased the temperature level around, the noise around, the issues we are looking at, we've done all of those things, the issue areas we'll be focusing on -- our members are better situated to address them. One of those examples is this chasing zero here in red. Driving maternal -- to zero. We believe one is too many. Our focus is to get that number to zero. There's a couple issue areas we're focusing on as well in terms of youth and family engagement. We have a metric around children with special healthcare needs in those systems. This is a snapshot of the strategic plan. The last thing I'll say about this, it was really important for us to try to -- although it may seem a little bit corny, we wanted to make sure -- we adjusted the way the plan looked and place more visuals in our plan. We wanted to be reminded every time we see this plan who we are serve. Not just a statistic,

not just numbers and the theory, but to be able to see images of the people we're serving every day to keep us laser focused on how we move forward. Could we go to the next slide, Caroline? This is just a very quick plug for the work -- how to get involved in the work we're doing. We have a 19-member board. Here is an outlining of the structure of our board. We have a number of committees here that are either boards of our committee, or -- excuse me. Committees of our board or committees of our association, which provides anyone on this call through membership to get engaged in this work. One of our newest committees here is a health equity committee that we can talk offline about, but these committees really help us to define the strategy for our internal approach to work, and how we engage with our members in the external communities as we move forward. This slide was really important for me as we talk about leadership in this context. There were two things I wanted to draw out from here. One, you probably heard before that in order to lead well -- and I've actually benefited from being surrounded by great leaders or mentored by great leaders, in my opinion, I felt one of the consistent qualities that folks had, in addition to the passion and the ability to engage people, was a firm understanding of where they had been and where they wanted to go. You've probably heard the mantra before that those who cannot remember the past are condemned to repeat it. My addition to that is those cannot remember the past, or those who refuse to acknowledge the past are condemned to repeat it. I think two components of being a good leader in this context, in my opinion, is understanding where you've been so you don't -- and how you got to where you are so you don't repeat the mistakes or the challenges you learned from the past in that way. Also, you acknowledge the shoulders you're standing upon so you can build upon the successes that have happened before you. We wanted to make sure we put this front and center because in our conversations today, we are going to talk about the history. We are hopefully going to provide you with some vision or help you to craft your vision to where you want to go. We believe in order to do that, it's important for you to understand the shoulders you're standing on and also the history and the mistakes and the challenges that happened in the past that we can then not repeat them and build upon successfully there.

>> CAROLINE STAMPFEL: Thanks, Jonathan. I wanted to share a quote that I think was particularly relevant for today. The quote is: "Children should be repeated are not pocket editions of adults because childhood is a period of physical growth and development, a period of preparation for adult responsibility, and public and private life. A program of children cannot be merely an adaptation of the program for adults nor should it be -- This is a quote from Grace Abbot, who was the second chief of the Children's Bureau, which we will learn about in a few minutes. She spoke these words during the great depression. I find a lot of connections and parallels to how we think today, particularly being in a global pandemic situation, how we continue to serve children through a pandemic using things like tele-health and seeing emergency expansion of measures and depression of the economy. So, we have to remind ourselves just because we're trying to move quickly doesn't mean that we don't have special programs to serve kids, and it doesn't mean one size fits all because it works for an adult that it will work for kids. I just wanted to use that as an example of how the past can help inform our present and our future. With that, we'll talk a little bit about how Title V and Maternal and Child Health in America started. Some of you may have heard a little bit about Title V and its roots. Just to underscore, the roots of Title V and Maternal and Child Health work are the roots of public health in so many ways. We have a shared history. Maternal and Child Health really

emerged from this effort to ban child labor, and the movement around social justice started by so many women who were crusaders for ending child labor. On the slide, you see people like Florence Kelly and James Adams and Lillian Walt, who were part of things like the National Child Labor Committee, working at a house in Henry Street Settlement House really see on the front lines of what was happening to children and recognizing that in the time they were living and working that one in five children died before the age of 5. The life expectancy overall was only 49 years. 1 in 150 women died in childbirth, really very pressing issues. They took up these issues in the form of crusading against first child labor and then with an underscore of social justice. On the bottom right, this is Julia Lethrup, the first director of the Children's Bureau. We will talk a little about her and the other leaders of the Children's Bureau. They all believed bringing science plus political will to address social problems would actually result in change. Here is our Children's Bureau. Their purpose is on the slide. I have the directors here who were -- it was led by some would describe fierce women, until 1968, when it was restructured. It was the first organized effort at the federal level to protect children. It became the first national government office in the world that focused solely on the well-being of children. They focused on child labor laws, education, juvenile courts, birth registration, which became the foundation of so much of the data that informed Maternal and Child Health, preventing infant mortality and preventing maternal mortality. Endorsing activities like prenatal care, infant health clinics, visiting nurses, public sanitation, milk stations, and education of moms. So, this foundational Children's Bureau was how we formalized the protection and support of Maternal and Child Health. The ladies across the bottom are in order from Julia, Grace, Katherine, Martha, and another Katherine. These are the leaders of the Children's Bureau. I also wanted to point out that history brings us back to the formalizing of support for the Maternal and Child Health workforce. So the Children's Bureau really worked to professionalize the workforce. And the picture on the slide is child welfare workers in Minnesota, so there were efforts to formalize training. These continue to this day around pediatrics, obstetrics, adolescent health, nurse midwifery, nursing, social work, nutrition, and overall global public health. I wanted to give you a few highlights of MCH's chronology. We are not do a detailed, deep dive of each of these steps, but if you're interested in learning more and doing that deep dive, definitely check out the 75 years of Title V book that came out in 2010. That's a note that it's 2020. It's the 85th anniversary of Title V. What I hope that you take away from reading a resource like that and learning about the history is the context, figuring out the why of our work. Why do we do the work that we do? Why are some of the structures and the constraints that we have in place? What are some of the flexibilities there? This is the brief timeline. I mentioned the creation of the Children's Bureau, which happened in 1912. There were a series of Acts that were shaping and supporting Maternal and Child Health support in America. That end result was the Title V provision in the social security act. That is really the beginning of what we think of the as the modern day Title V Program. There were major changes in the 1980s with these [indiscernible] packages. I'll talk about the structure later. In 2015, going through another process of transformation, that has implications for how we think about measurement, in particular. I strongly encourage you to read the detailed history, and to recognize that as we mark the 85th anniversary of Title V in 2020, we're thinking about the future. What do we want to say when we reach 100 years of Title V? Then I wanted to touch a little bit on what it means to understand history, not just globally for Maternal and Child Health, but in a local context also.

In shaping this presentation, we talked about how the places that we work have their own histories, and it's our responsibility as leaders to really understand what that history is. Place matters, not just because of the current policies and systems and environment in place, but because every place has its own history. Things are not just the way they are. They were made that way, and we need to understand how the systems and structures of power exist in different places so we know what we have to do when and undo to get to where we need to do. Sometimes we talk about dismantling those systems. I have two examples on this slide that I wanted to share, just as a true example of how places are centering on their history first so they can understand their context and move forward. The first one on the left is Louisville Metro has put together a health equity report, and the entire first part of the report centers on Louisville Metro's history, understanding a detailed timeline that grounds people in the history of the place from colonization and slavery, to redlining, white flight, and refugee settlement. Really starting from, how did we get here? So we can understand where we are. On the right-hand side, I had just a snapshot of slides from Dr. Kimberly White Ethridge who walked us through during a plenary. It was all about infant mortality and the social determinants of health and Nashville, but recognizing that the social determinants of health didn't just happen. There's a deep historical context for how Nashville came to be and understanding that goes all the way back to colonization. So really understanding that those historical context are so important and really tell the story and lay the foundation for the huge disparities and infant mortality between Black and White infants we see today. Really, underscoring that history shapes us, and not just our global history, but our local context. At this point, we wanted to take a moment to reflect and give you a chance to chat in or to -- I think we can do unmute and share, if you feel up for it, to reflect a little bit on some of these questions. What resonates with you from the history of Maternal and Child Health? What do you want to learn more about? Who has inspired you in your leadership journey? How are those people who have inspired you -- how are they in touch with the history of Maternal and Child Health, and the history of the place they live and where they work, and the history of the institution or organization that employs them? Please feel free to chat in your thoughts. Make sure you share it with all of us. If you use your chat feature, share with all panelists and attendees so we can be part of that conversation. I'll say as part of a leadership journey, I am most certainly inspired by all of those fierce women who were crusading for child health and leading federal bureaus at the time where there was a rare opportunity. Those are some of my inspirations. Jonathan, who has inspired you in your leadership journey?

>> JONATHAN WEBB: I've been blessed, as I mentioned earlier, to have a number of great folks who were mentors to me. One of them is a dear friend of mine. When I was leading the community health division in Evanston, Illinois. I don't know if anyone on the call is familiar with Evanston. It's a suburb of Chicago. The health director at the time, her name is Evanda Thomas [phonetic]. She was this larger-than-life woman that -- I don't know exactly how to put it into words easily, but she was first and foremost, she was brilliant, she was knowledgeable about almost every area. She had this really deep passion for people. She had this ease and way of connecting with people. She had this presence. I don't know. I think she also came from a musical family, so I don't know if it was this confidence that she had from performing with them. There was a confidence in every room she went into. Some of the things I took from her, she was unapologetically who she was. She was knowledgeable and pushed issues,

but did it in her own way with respect. She advocated for people who didn't have voices in the city of Evanston. Just watching her work rooms politically, whether she was talking to folks at City council or whether she was engaging with city managers or whether she was working with state legislators who came to talk to us, or dealing with hospital system leaders or health system leaders or community members, she had this genuineness that was always there. I admire her for all of those qualities. I don't want to take too much time. I see comments coming through here. One of these things, concepts, that I ascribe to, more is caught than what is taught. Sometimes you can sit down with folks and have this really defined way of these are the things you should learn, here is this professional development plan, yada, yada. All of those things are great, but sometimes people learn by watching others and seeing the example people set. I learned a lot from her and watching the examples of how she moved in those spaces.

>> CAROLINE STAMPFEL: Great. Thanks, Jonathan. There's a bunch of chats. I think we complicated things by -- I don't think people can unmute themselves. We'll continue to receive some of your inspirations in the chat. Thank you so much for reflecting on this. We hope that at the conclusion of this webinar that you'll have the set of reflection questions, especially for our Leadership Lab folks as you work toward your development plans and talking with your lab mentors as well. Really some wonderful inspirations here. Thank you for sharing these. Jonathan, do you want me to go ahead to the next section?

>> JONATHAN WEBB: Yeah. I will jump in there. I'm looking through these great questions and comments that are in the chat box here. Really appreciate you all getting engaged. So, thank you for sharing. I'm going to spend just a brief few minutes here talking about Title V, for those who may be new to this space, just to provide a little bit of context. Title V is the MCH services Block Grant. It was birthed out of the Social Securities Act in 1935. It's the nation's longest-standing public health legislation solely focused on improving the health of all mothers and children. It includes children with special healthcare needs. Title V got to where it is today through a variety of key legislation. If you're interested, we have resources that are available to explain that full history for you. Ultimately, Title V appropriates funds to states and territories, there's 59 of those in total, to do various activities. We highlighted a few on the screen for you. This is by no means an exhaustive or all-encompassing list. Also, appropriates funds to special projects of regional and national significance, also called SPRANS, research and training for MCH and children with special healthcare needs. These are a few of the examples of areas where appropriated funds to states are used. Next slide, Caroline. Title V became a Block Grant in 1981 under President Reagan. It returned power back to states, which in my opinion, was a good thing because it would do some of the administrative challenges and burden at a higher level and allow states to be more responsive to the needs that were happening in their area. It gave that flexibility that we believe was really important in addressing your -- the challenges in your state or territory. Here are the consolidated seven programs connected with the Block Grant. States requires -- it requires the State Health Administration administers the block grant -- to connect back to the earlier slide, SPRANS listed on bullet number three is how [indiscernible] and other TA centers are funded to assist states with implementation of Block Grant programs. This is again the Block Grant in a nutshell. We have resources that can give you a much deeper dive into this history and the nuts and bolts here. Every five years, as part of this Block Grant process, states conduct a needs assessment. As it is stated in the needs

assessment, it identifies the areas of greatest concern or opportunities in your spaces. You can best prioritize the needs happening in your states and territories. Each year, states submit a Block Grant application, which outlines your approach to those strategic priorities for the year. The Title V MCH services Block Grant uses three tiered -- a three-tiered performance measurement framework that includes national outcome measures, national performance measures, and evidence-based or informed strategy measures. That is the national outcome measures, national performance measurement, and evidence-based or informed strategy measures framework. The performance measurement framework is designed to demonstrate the impacts of state and Title V programs on key health outcomes for MCH populations. States are asked to select five MPMs, national performance measures, out of 15. States may create one or more state performance measure and one or more state outcome measure. Annually, states are also then asked to report on these measures. We'll talk about this a little bit later in the presentation. It's one of those important mechanisms for accountability. We can better understand the success we've had as a community towards improving the needs of women, children, youth that we -- families we serve.

>> CAROLINE STAMPFEL: I'm going to talk a little bit about that five-year needs assessment process. First, let's start with why. Why do we do this? Before we talk about the things that are on the slide, one of the things that I learned, especially as an epidemiologist and trying to support evidence-based practice is that people make important decisions every day without a whole lot of data. They do that for a variety of reasons. It's because sometimes the data aren't accessible to them, maybe they've never seen the information configured in a way that is translated and makes sense to them, or it might be that they don't even realize that there's relevant data for that conversation, for that decision point. Or they've asked for information and have been told no so many times they stopped asking for it. We know that in order to achieve the best outcomes for the people we serve, we need to be grounded in the best available information. When we think about needs assessment, the purpose is to create this accurate and complete picture of the strengths and weaknesses of the public health system supporting Maternal and Child Health populations, to use that information to inform priorities, to really understand what the gaps are in the services, and we talk about needs and capacity in the needs assessment process. Really, setting an agenda for the next five years. That's what this five-year needs assessment is about, planning for the next five years so you can truly understand what's going on, allocate dollars and other types of resources to meet those needs, and then ultimately, the goal here is to improve maternal child family and community health outcomes. One of our former Title V leaders said, "If you don't know where you are, you won't know where to go next." A needs assessment is a great starting point. The needs assessment isn't the goal. The goal is to understand where to go next. When we think about needs assessment, what's the how? What's the whole process? What happens during a needs assessment? For some folks deeply engaged in Title V now, you know that the 2020 needs assessment is due. This is setting a priority for the next five years. It roughly follows this process that's on the slide. It's a cycle of steps, including engaging stakeholders, assessing needs, and identifying desired outcome measures and mandates. What do we need to be doing with our funding and our priorities? Looking at the strengths and the capacity of the different systems. And then selecting some priorities, setting performance objectives, developing an action plan that really says here is how we're going to translate our priorities into

action for the next five years. Seek and allocate resources, the Block Grant comes with funds, but there's requirements to match. Monitor progress for impact on outcomes and report back to stakeholders. I think in practice though, it looks a little more like this, which is that most of the needs assessment process is happening on the right side here, steps 1 through 4. 5 through 9 are about the state action planning process. Even further, we would say that this is not a linear process, even though it seems like it might be because there's some steps. It's not a straight-line path from engage stakeholders to report back. You might think about this as iterative in the process of engaging stakeholders and looking at data, sharing that data back, thinking about strengths and capacity, again, sharing that information back. Really centering on this process of stakeholders. Thinking about how you define stakeholders. When we did some needs assessment technical assistance, we started out with the premise it's never too early or too late to engage stakeholders and think about stakeholders broadly as this group of people who have lived experience, people who have to navigate and live in the systems that you create and support, and people who may experience oppression by those systems. All of those people need to be engaged as part of this stakeholder engagement and understanding needs and gaps. It's by no means a straight line, and by no means a one and done. There's a constant iteration that goes on, and one of the hardest parts can be getting from steps 3 to 4. How do you decide when you're done understanding what the needs and the gaps and the strengths and the capacity are and move on to actually being able to select some priorities? I did also want to talk about some of these flexibilities and constraints within Title V. This is a nuts and bolts kind of thing. There are some rules with the Block Grant that must be followed. For example, there's a match requirement. States must match \$4 of Federal Title V money that they receive with at least three nonfederal dollars. You have to be able to demonstrate that when it comes time for Block Grant reporting. Another thing you'll hear people talk about is 30/30/10, which means 30% of the funds need to be used for preventive and primary care service for children, 30% of the funds are to be used for children who need special healthcare needs services and programs, and no more than 10% can go towards administration. This is one of those hard and fast things that you have to report on through the Block Grant. There are some other requirements, things like systems. Children and -- special healthcare needs programs. Assume a leadership role in the development of family-centered, community-based coordinated systems of care. There's coordination that is required across other types of maternal and child health programs. So you will hear people talk about EPSDT, early and periodic screening diagnosis and treatment program for Medicaid. Supplemental food programs, like WIC, and other related education and health programs. You do have to document a -- of understanding or agreement with Medicaid as part of the Title V process. In terms of other flexibilities and constraints, there are a large number of reporting requirements, Jonathan mentioned there's a Block Grant application each year. Each year there is a five-year needs assessment. Embedded within both reports is that they must reflect the health of the entire Maternal and Child Health population in the jurisdiction. You can include lots of information, but there is a must include in terms of having numbers of pregnant women and infants covered by Medicaid. There's forms that go along with all of these requirements. We really feel like it's important to understand what the boundaries are for these programs because there's so much flexibility. So things can bend, but you can't bend so far that you break through one of these constraints. On that thought, we wanted to foster a little more reflection on constraints in your work. How do you react to

constraints? Are you the type of person who looks for opportunities within those constraints? Do you feel like your creativity is limited by the rules and restrictions that come with federal programs, grant programs, things like that? What are some of the ways you can explore and create possibilities within constraints? Thinking about your larger team, especially now as a leader, how will you build your skills and your bench of teammates to take collective action? How do you use the power that you have within the structures that you work in to remove or remake constraints? Jonathan and I were reflecting on how sometimes the rules are the rules, but is a constraint truly a restraint to your work, or is it a perceived restraint or a perceived barrier? I think some of that goes back to things I mentioned before from an epidemiologist perspective. People stop asking for something if they're always told no. That's maybe not a real barrier. That information may exist somewhere. How do you think creatively about how to get past some of those perceived barriers? We talk a lot about this in quality and improvement. Are we doing something because it's always been done or have we examined that process? If we really live those quality-improvement principles, every system is perfectly designed to get the results it gets. If you want something different, you have to do something different. Please feel free to share your reflections in the chat. Jonathan, I'll invite you, if you want to reflect on any of these questions.

>> JONATHAN WEBB: Thank you. You covered a lot of ground there. One of the things I would add to the constraint piece is that the constraints or restrictions may have been applicable for -- and very relevant at one point in time. At a different point in time, the current point in time, do those restrictions and constraints still apply? I think there's ways to respectfully challenge that within your systems, just to better understand if this is truly a constraint or if there are innovative ways to focus on it. I'll highlight a constraint or restriction I had. This also will dovetail into the partnership conversations that we'll talk about a little bit later. In my work in the local health departments I was engaging in, we had a budget constraint for a program we were trying to launch. This program, we all felt it was beneficial, but we have always been in that position to do more with less. We were coming up against our budget and the city manager's budget and others and were not able to make this program move in the way we thought we could. Long story short, my team and I started to have conversations with our corporate partners who would benefit from this program because this was a program focusing on chronic disease prevention. It was a very visible program, so there was opportunities for our business community members to really get some -- seen as a good community partner, good neighbor. We put together a strategy where we thoughtfully engaged them in an appropriate manner from a fiscal standpoint. We were able to fully fund this program through external dollars. That program was started about 12 years ago. It received the national award. It's still running to this day. One of the things, as far as I know, about a year ago at least. We had a restraint. We were presented with a challenge. Because we were creative about how we were approaching it, not only was the program only to come to fruition for the people we served, but we were able to bring in a whole new set of stakeholders and brought into the work we were doing. That was one of our success stories. The program received a livable city award from the counselor of mayors, which was interesting for us. It was just not taking necessarily no for an answer, but seeing a challenge, seeing a problem, and trying to find creative solutions to piece things together.

>> CAROLINE STAMPFEL: Thanks, Jonathan. There's some robust conversation happening in the chat box too, how people think about their constraints. Also, wanting to learn what some of those constraints might be and how to proceed in a I think, particularly pertaining to evaluation, if there are possibilities for equitable evaluations. Fantastic. Thank you for continuing the conversation in the chat box. I am going to keep us rolling and talk a little bit about data. I said to Jonathan, this is the part I wanted to do, because data is my jam. There's a pretty heavy emphasis on data in the Title V Block Grant. There are a lot of performance measures. One of the transformations from the Block Grant of the '90s to the 2015 transformation was a reduction in some of the measures from 18 national performance measures down to 15, reduced quite a bit on some of the capacity measures. There's still a really heavy emphasis on data. There's a nice tie-back on the roots of the Children's Bureau where they were pioneers looking at infant mortality, in particular, malnutrition, and studying why that child death rate was so high and how to bring it down. The origins of those pediatric growth charts that we're so familiar with were because of the birth registration system and the efforts to weigh and measure millions of kids to create those growth charts. This slide has two examples looking at seasonality of infant death, one, and infant mortality related to father's earning, looking at that economic tie. So much of this was important as the formation of Maternal and Child Health came through the country's Great Depression. We had 40% of the nation's population living in poverty at that time. Using the data as the underpinnings for social reform. I think more practically speaking, when we think about measurement, we think what gets measured, gets done. What we measure reflects what our priorities are. I think that's something I want you to take away from this measurement framework for Title V. We mentioned the transformation in 2015 before. One of the benefits of the transformation was tightening up this measurement framework and creating some connections between national performance measures and national outcome measures through this measurement framework. I wanted to frame this as, first of all, all of these things link together. Jonathan mentioned before the national outcome measures, national performance measures, and the ESM, the evidence-based and informed strategy measures. There's some assumptions about how they're linked together. One is that we're choosing evidence-based strategies and priorities, we're measuring the how we do that with ESMs. That they're linked to performance. If we do these evidence-based strategies and we do them well for the population we're serving, that may require adaptations to and evidence-based or best practice. If we do them well, we'll impact these performance measures. The assumption is if we improve performance, we will actually improve our outcomes. That's the framework we're operating within when we're thinking about Title V action. Overarchingness is the state priorities. How do these measurement priorities fit within that global state priority? If for some reason -- there's 15 national performance measures. States choose 5. If for some reason there's not a national performance measure that speaks to the state priority there is this opportunity to create state performance measures. That's the blue SPM box. There's a really nice way to tie together what you're measuring to reflect your priorities that hopefully you have identified through the needs assessment process. Under that foundational underpinning of what the needs and challenges are, the capacity of this system to meet those needs and challenges, and the action plan forward. How do you address them? I get this question a lot. I did want to talk a about what the heck an ESM is. It's a measure around an evidence-based or evidence-informed practice. I

think a lot of them end up being process measure. How well are we doing the strategy that we identified? If you think of them as a bridge, I think that's helpful. It serves as a bridge between the strategies that the Title V program selected and the national performance measures and outcome measures that you're trying to impact. That's your ESMS. There's formal definitions. I highly recommend you check out the paper by Michael Cogan [phonetic] and company who really explored what these ESMS were all about as part of the transformation of the Block Grant. Think of them as that bridge, if that's a helpful analogy for you. I think I'll pass over to Jonathan to talk a little bit about the punch line of measurement.

>> JONATHAN WEBB: Thank you, Caroline. In a nutshell here, it's all about the accountability and impact. I'm not going to walk through every slide here. I'll let it sit here for a second for folks to peruse. All of the strategies, all of the pieces that Caroline outlined around the measurements that she talked about is really a way to demonstrate their value around the investment and the accountability that we -- the accountability in the sense that here is what we're hoping to achieve, here is how we are planning to get there, here is where we ended up, type of thing, which is an important component, in my opinion, of any programmatic effort. There are a couple things I will call out from this slide. One, the Title V in that upper left-hand box there, the yellowish box. This is a significant investment from the federal -- Title V MCH federal state partnership, which then obviously sort of underscores the need for us to be really accountable for this amount -- these amount of funds going into this work collectively, being able to tell a story about what the impact of that work was. One of the things AMCHP has the privilege of doing is advocating on behalf of this community for increased dollars. Even though there's been a significant investment, we know it's not enough. So, we still are advocating to bring new funds into this space. Being able to demonstrate how these initial funds are used, helps us to tell that story at the legislative level. The other thing that I wanted to briefly highlight here, I guess the second row, yellow, the last yellow box on the right there, included -- I wanted to highlight the fact we have 48 million children served through Title V who are supported directly and/or are enabling services for 2 million children with special healthcare needs. A lot of folks who would depend upon these resources and the programs that these resources are able to support. So, again, I'm making sure there's an appropriate investment, and the space is important to us, but also being able to have the metrics that Caroline outlined, the ESMS, NLM, and the MPMs give us that accountability measure to then go back and advocate for additional dollars here. Next slide please. Here is where we get into some of the leadership traits and components here. We hope to have a robust discussion with you very shortly here. As we're looking and talking about these Title V, we're outlining the history, outlining some of the nuts and bolts, some of the things to give you a better understanding as leaders of where there may be opportunities to pull and push levers to help impact things in your areas. The piece that I'd like to bring out here is that as you are trying to identify the levers that you, as a leader, are trying to impact and influence, it really is important for me personally to understand the root causes of the outcomes that you're experiencing. There's been a lot of conversation, appropriate conversation, in recent months, but there have been conversations around this for past several years around equity, health equity, social justice, and racism. These aren't new phenomena in our country, but the conversation, the decibel level has been turned up a lot. From my perspective, it's important as we're looking at these specific outcome measures to not lose sight of the context and the root causes of these outcomes and

be very mindful on which lever we need to pull to address these -- the challenges we're facing. We borrowed this. One of the things that the team has -- a term I've introduced to the team is R and D, for some folks it might be research and development. For us it means rip off and duplicate. We're going to R & D this from a respected colleague in this space, Dr. Michael Warren, who has talked about his approach in his leadership role around addressing the issues we're facing in MCH. It's around accelerating upstream together. As you're identifying the levers that you're trying to pull, where you can push, first understanding what the root causes and challenges are, but then applying these three principles to it. There's a sense of urgency, obviously, around creating equitable systems. Being just and dismantling systems of racism that we know are directly impacting the health outcomes of our communities. Upstream. Dr. Warren has talked about. I don't know how many of you have heard him share this story, but it always stuck with me, around a gentleman was walking in the woods, walking by a river and saw people who were floating down that river. Dr. Warren talks about how this gentleman jumps into this river and starts pulling people out, pulling people out, and is there for a period of time. Another gentleman sees this other gentleman pulling folks out of the river, and walks by this individual. The gentleman who is in the river pulling folks out is asking him, why don't you stop and help me and get these folks out of the river? The gentleman who walks by says I'll go upstream and see why people are being put in the river in the first place. For me, that is a nice summary of the approach we need to take to this work. When we think about levers that we're trying to pull, there may be programmatic levers that we are addressing to impact the people in the river now, but what systemic levers, what systematic can we pull to go upstream to keep people from getting put in the river in the first place? The lever is, in my opinion, one that's unique and specialized, but it should have an immediate impact while looking for the long-term solution. The other piece that's important about how we pull these levers, it's important to do it together. Even in that example, one person can't pull people out of the river while they are also getting folks from going into the river. You need multiple people involved and engaged working together to advance equity, to create just systems and dismantle the racism is directly impacting the communities we serve. What we wanted to highlight here as we're talking about being equitable, addressing health equity, and systematic racism, there's a lot of conversation now, a lot of things that have been out in this space. I'm of two minds about this. One, if you are a new entrance into this conversation, we absolutely want you as a leader to get a firm understanding of history, get a firm understanding of how to navigate and operate in these spaces, understanding what the challenges are. We applaud those efforts and want to facilitate conversations around what got us here and what will get us there. But on the other side of my thinking is, this is not a new issue. There has been information out there. This is a heavily-researched area. There's a lot of great context out there, and at some point, not to say it hasn't happened, but we need to be really urgent, going back to the accelerate comment earlier. Really urgent about not having analysis paralysis, and learning, learning, learning, but not applying. Understanding what got us here, but then also identifying those steps that will get us there and taking action and accelerating that movement to get us there. Where does change come from? I've seen some of the conversation that's happening in the chat box. This is not an exhaustive list of levers to pull and where to make change. One of the things that we were highlighting in terms of activity or engagement with organizations like AMCHP is that many of you may have constraints in terms of the big levers you can pull. Working through an

organization like ours, we can advocate and work on your behalf because we understand through you some of the challenges that you or constituents are experiencing. There's the marriage between the big policies, politics, and those type of things and the little policies that you may have the ability to impact in your everyday life. I talked about systems. Very important to understand how -- to Caroline's point either. How the systems that we put in place, the way they are designed, are they getting the outcome that we're designing them to have? One of the conversations that we've been having -- if we can have a really frank conversation now or whenever we get a chance to engage person to person, the conversation around the systemic racism. Is the system is actually set up to work the way it's been working? We're trying to impact systemic racism. We have to look at how we're changing the system because the system is performing in the way it was designed to. If it's putting people in positions where outcomes are desperate, let's take a look at the system so the outcomes are more equitable. Looking at the environment around you and understanding the political landscape. I think one of the conversations that -- the comments someone put in the chat box was around the challenges that they may experience internally around their moves. What is the environment you're in immediately? What is the environment outside of the four walls of your building? What are those things you need to be mindful of as you're looking to explore population needs and make changes based on what you're hearing from the populations? How do you navigate that environment? Understanding the environment that you're in, knowing where the barriers are, knowing where the challenges are, are some suggested ways to drive towards change. I do want to emphasize this point here, the community engaged work. I've had, again, the privilege of working domestically and internationally in communities at the national and at the local level, and where I have been most successful, personally speaking, is when I took the time to engage with the community to understand what the challenges were, what they wanted to work on, and how I could best support what they were doing, understanding that many of the solutions that exist are in the communities already. There's assets there that are worth building and supporting. But there may be barriers that are preventing them from being large-scale solutions. How do we work alongside the communities to really get them engaged in the work we're trying to do, alongside them, so we're not coming into an environment with a paternalistic mindset that says here is the way we should be working and they're along for the ride? Getting that community engaged work may help to adjust the environment around which you're working in because those community members could be advocating outside the walls to get this work done, if they understand what you're trying to do, and you're engaging them in the work and working with them as partners and valuing their lived experiences and their contribution to the work that you're doing. I will touch on these two briefly because I want to get through the slides and have discussion around this. As you're looking to make change, we'll talk about this later, but you are change agents and it's also -- but it's also important to understand who certain gatekeepers might be within systems, within communities. What folks need to get on your team as you're looking to make some of the innovative changes you're hoping to make? Identifying the individuals that have influence that can work around the change you're trying to influence. We talked about this throughout, but understanding that leadership is not just an -- activating leaders is not just a strategy for decision makers at the top. There's leaders at the director level. Leaders who are working in the communities, leaders who are working in the trenches, so to speak. Understanding how to

engage, motivate, and align with those folks is more impactful than sometimes we give that credit for. Another mantra I have, and Caroline has heard this before. I'm the cliché king I think maybe. Teamwork makes the dream work in my mind. The challenges that we are facing are too large for any one individual, one organization, or even one state to do by themselves. In that thinking, how do we strategically partner and collaborate with those around us? In the example I offered earlier, one of the things I've learned the hard way in many respects, in my career, is that the public health challenges that we're facing, the maternal challenges that we are facing, are rarely isolated to Maternal and Child Health and public health. How do we look to get outside of our spaces to thoughtfully engage other players who are impacted by and have a vested stake in the outcomes of the work we're doing? Healthcare, clinical partners, housing, corporate partners. All of these folks, whether it's the defined term as public health, they have a vested stake making sure we have a healthy workforce, vested stake in making sure they have healthy communities around them. How do we, if we're looking at that full life course theory and social determinants of health, how do we engage key members in the conversation? One of the ways that we have encouraged folks to do that is by avoiding a scarcity mindset. Although we may have limited resources, not staying there. Looking for the creative solutions to get out of that scarcity mind set. In the way I mentioned earlier. The city that I was working with didn't have a ton of resources, but the business members in our community did. How did get them invited into the space with a value proposition that brings them into the conversation thoughtfully? It's not just our work that they helping us to do in a philanthropic way. It's a collective work. If we benefit, they benefit and vice versa. Title V programs, have this history of being asked to do more with less do more with less. We don't have to stay there. If we aligned to some of the principles of getting involved so we can advocate on your behalf, looking to partners outside of your immediate network. There's ways to expand our tent. As we're looking to build these partnerships, some of the things we've employed in the past is making sure there are clear expectations for what partnership looks like, being very strategic and thoughtful about how we engage these new partners and conversations, what their role will be, our role, what are the outcomes that we're expecting to have happen? What are the milestones that we are expecting to hit? We're trying to solve this problem as three years out, what do we have to do in six months to make that a reality? What do we have to do in 12 months to make that a reality? Having those small bite-size chunks attached to the work that we're doing, really helps to bring those partners in and keep them engaged because it's not just a long engagement with no end in sight. There's a thoughtful step-by-step approach. It takes time to build that relationship, to build out that map, but it's well worth the effort to do that. While we're moving to the next slide, one of the things I will say about partnership when we're looking at engaging with community organizations and our health team has helped us to align to this framing. Although we may want to move quickly, we are encouraging folks to have progress move by the speed of trust. We have encountered as we were looking at our anti-racism work, our way of partnering with community members who we should have been engaging with all along, we weren't always, for historical reasons, and this goes back to way it's important to understand history, for historical reasons, we haven't been seen as partners always. In that respect, we need to take our time to make sure this doesn't seem like an exploitation or engagement for a specific purpose and there's a trust built to allow us to engage as partners. When you're working through these different partnerships, progress at the speed

of trust is one of the reasons we're really focusing on in our spaces. I'll let this sit here for a second and let you look at. I want us to have time to dialogue. This is our last slide because we covered a lot of ground. I know this will not be the only time to engage with each other. These are ideas we as a team wanted to share with you for what we thought Title V leaders look like. Again, as we started individuals who had a firm understanding of the past, but really had a strong vision and were looking to cultivate that vision, knew where they wanted to go, and allowed folks alongside them who could help them get there. Folks centering equity, going back to the strategic plan, making sure we didn't lose sight of who we were engaging. If we don't lose sight of who we were engaging, we should be surprised when we're having meetings and those people aren't at the table or not front and center. Centering that equity so we're engaging our communities to make sure whatever product we come out with impacts the end user, and we know it impacts them in the right way because they were at the table thoughtfully and all along the way. Thinking upstream. We talked about that. There are very strong reasons why we have to build programs to get people out of the river. We should be looking upstream if we're really focused on not -- understanding why people are getting in the river in the first place. Being actively anti-racist. This is again a moment that we're having now as a country, but it really is a critical moment because as we come to this understanding and this acceptance that racism is a public health crisis and it's directly impacted our health outcomes, if we don't work on how to be anti-racist, then we're destined to repeat the mistakes of the past. One of the things we talked about in the anti-racism statement we can provide you at any time, a hard look at ourselves to understand where we were falling short, and by calling that out, we can then track and measure how we don't make that mistake down the line. This is a new space for us as an organization. Because we're moving at the speed of trust and building relationships and getting stronger connections with our partners, the community and the national level, we hope we can be vulnerable and ask questions. We're not coming in with a we-know-it-all mindset. One of our colleagues Andrea Cornell [phonetic] has a term busted lips. We're getting busted lips as we go through this, but we're asking questions to make sure we don't walk into that wall again. The purple level, is straight forward, we need to be inclusive, all in and steadfast. It's not a sprint. It's a marathon. We look to build partnerships in meaningful ways, understand the constraints around us so we can figure out where we need to be flexibility, challenge the restraints when we need to, and bridge the generational and cultural gaps that exist because this is a new workforce, new way of doing things. COVID has showed us -- a light on that, that we have to be mindful of the differences and approaches to doing work, and that's ever-present now, but that generational gap and cultural gap bridging is essential for us in the work we're doing. I will pause there and ask you guys to take a look in the mirror because when we think about what a Title V leader looks like, it really is you. We're here to support you in your journey and your respective areas. We're excited to have this opportunity to dialogue with you, but also to get insight into how we might support you along the way. I think we have time for a couple of reflection questions here. Given all that you've heard today, just reflecting upon how you will be an agent for change. What opportunities do you have to lead from where you are? What skills will you need to do that? What strengths do you have now that you can build upon in this new [indiscernible]. I'll let that question breathe for a moment and look to have some comments in the chat box. Caroline, do you have any thoughts about your change agent ability?

>> CAROLINE STAMPFEL: I think I tie that to that last question about building on strengths. Really leaning into what I know are my strengths. I'm naturally -- I gravitate towards data for information and really pushing not just for information, but information for action. That's something I felt I can lean on. In the spirit of as a leader asking questions. What's the so what? Why do we care about this particular number? How can we put a face or an experience to that number? Really being able to blend what we know from our statistics, what we can see from our evidence-based practices with the actual experience of a person, a family, a youth? Just being able to center that in our work to help us and guide us forward.

>> JONATHAN WEBB: Thank you, Caroline.

>> CAROLINE STAMPFEL: I think we're ready for the Q&A. I know there's a couple questions cued up, Ben.

>> BEN KAUFMAN: Yeah. This is Ben. Caroline, you had just mentioned centering families and centering youth. There was a question from Merrill earlier about where you fit in Title V. I was hoping you add answer that.

>> CAROLINE STAMPFEL: Yeah. There's definitely a few places. One is within that framework of population domains. There are several national performance measures that address the experience of youth like the adolescent well visit, the experience of medical home For care, an experience for transition, for all kids, but in particular, children and youth who have special healthcare needs. I think from a practical perspective, we think of youth in a few different ways in terms of services and supports from Title V. But then also, and maybe Jonathan can speak to this as well, we're looking to youth voices as leaders. How do we do a better job of embracing youth and understanding and being challenged by in some ways that generational gap in a lot of cases? Ben mentioned celebrating 15 years of public health practice work, which means I have not been a youth in a while. So being able to bridge those gaps and center the experience of the people who are meant to be served.

>> JONATHAN WEBB: Yeah. I would happily add to that, Caroline, that the movements we're seeing, especially with respect to not just here, but it's getting a lot of attention obviously with anti-racism and equity, are largely being driven by our youth. We have made an effort to engage youth in the conversation because they have been asking for that, wanting that, and our response in many cases is to push people -- or put people in boxes. Right? And the youth with really -- they're leaders in their own right. They have lived experience. We're in this work with them. We should be looking for opportunities to have them lead and guide us in the work that we're trying to do. We're excited to be a part of that journey with them.

>> BEN KAUFMAN: This is Ben again. I'll mention this a little bit later that we're going to have a Leadership Lab webinar in the next several months on embedding racial justice and health equity frameworks in MCH. There was a question, a practical question from Dulce Bustamante [phonetic]. Are there guides for incorporating equity into MCH organizations, things like hiring, contracts, management, et cetera? How do we make change internally?

>> JONATHAN WEBB: That is a great question. One of the things that you will see from us shortly -- let me start by saying there are actual organizations that help governmental entities explore that. There's groups like GARE. I believe it's the Governmental Accountability -- I forget the exact acronym. It's GARE. They are one of the groups that helps governmental organizations take a look at their policies and their approaches around racism and explore where they may be falling short. As part of the race-forward group. One of the things we'll be

doing is the AMCHP is going to be connecting with groups like that, but hopefully providing resources to our members who want to engage in that work so we can look inward at our policies. We'll do it as an organization for ourselves, and we're inviting any of our members or partnering organizations who want to explore that work as well to do it alongside us. Thank you. Someone put that in the box. I could not remember to save my life. Governmental Alliance on Race and Equity.

>> BEN KAUFMAN: There was one last question I hope we can get to before we close out, around intentionally engaging fathers in the MCH space. Caroline or Jonathan, if y'all had any thoughts on that. It was a question from David Armstrong.

>> JONATHAN WEBB: I'm smiling because I've got a ton of thought about that. I'm a father of two. One of my -- my oldest lives with a special healthcare need, and I think there definitely needs to be more emphasis placed on men in MCH. Yeah. I don't know how much more to say about that other than historically, or maybe even from a system's perspective, sometimes men are often looked at as not wanting to be engaged, an afterthought. In my circle, that's the farthest from the truth. There's fathers who are excited to be a part of all the conversations that I've been able to have in MCH. Just looking for an invitation to be there, or in many cases, when they're involved in conversations, that they're not looked at with a side eye for being there. I think it's a great point to bring up, and we're looking for ways to advance that as well. It goes back to my comments, my corny comment earlier about teamwork making the dream work. My wife and I have been a great team, and it's hard to think about not being involved in conversations together about things that impact all of us in our families.

>> CAROLINE STAMPFEL: I could add a tiny bit to say that when we revisited AMCHP's mission and vision, we intentionally talked about families and communities and most certainly thinking of fathers as part of that network and that knitting together of communities. Yeah. Excited to see where that work takes us.

>> BEN KAUFMAN: Well, I believe those are all the questions we have. Thank you so much to Jonathan and Caroline for your presentation, and for the prompt to reflect. I think it's -- we can talk about history and we can talk about structure, but putting it in the context of what that really means for each of us as leaders and for the systems we're leading, I think it's a powerful framework and I'm grateful to everybody for all of your comments and your questions.