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USF College of Public Health Oral History Project
Oral History Program
Florida Studies Center
University of South Florida, Tampa Library

Digital Object Identifier:	C53-00063
Interviewee:	Dr. Donna Petersen (DP)
Interviewer:	Dr. Ellen Daley (ED)
Interview date:	March 6, 2013
Interview location:	The Lawton and Rhea Chiles Center for Healthy Mothers and Babies
Transcribed by:	Alexandra Curran
Transcription date:	March 18, 2013 to March 26, 2013
Audit Edit by:	Kimberly Nordon
Audit Edit date:	March 25, 2013 to March 29, 2013
Final Edit by:	Barbara Lewis
Final Edit date:	April 1, 2013 to April 4, 2013

Dr. Ellen Daley: Okay. So, thank you very much for joining us today. We are talking to Donna Petersen who is the Dean of the College of Public Health and an MCH expert in many, many areas who is giving us her time to talk about her impression of the history of the discipline, and her own experiences, and some of her thoughts about where we need to be heading, and so many issues. So thank you very much for coming to talk to us.

Dr. Donna Petersen: My pleasure, thank you.

ED: Okay, and could you tell us a little bit about you first started in the field. How you got involved in maternal and child health and—

DP: Yeah I actually love telling this story. I got an undergraduate degree in behavioral science and came home and was astonished to find no want ads for behavioral scientists. And—so I had a—I think a lot of people—it takes you while to kinda decide who are and what you want to do with your life. But I was always interested in nutrition. And so I started looking for graduate programs in nutrition. And what I kept finding were more like food science programs, chemistry programs. Like how do you find a new—the best new flavor of ice cream or something. No, no, no, that's not what I want. I want to help people eat well and be healthy. And the book—and this—you can't make this stuff up, the Petersen's guide to graduate school. You had to go to the library. Libraries are building with books. Books are things you take of shelves and read. But, and they were in volumes A through M and M through Z. Well, the A through M volume, every time I pulled it off the shelf it opened to Johns Hopkins. That's where it opened. Now I have a friend who they said probably ran around and cracked the binder there so it would open there.

But one day, after I don't know how many times I'd been looking through these books, I actually looked at Johns Hopkins University and found the School of Hygiene and Public

Health, as it was called then, and found a community nutrition program. And I said, “This is it! This is what I’ve been looking for.” And normal people would have said, “Oh, now that I know what I’m looking for I’ll look for all the other community nutrition programs.” But didn’t. I said, “Oh, well this is where I must go.” And so I sent off for an application, ‘cause that’s what you had to do, you had to write a letter and then they would mail you an application. And I read through all the materials and I realized I didn’t qualify for any of these programs because, at that time, most of school of public health at the time, you had to have an advanced degree to get into the Master of Public Health Program.

But because I had decided this is what I wanted to do and this is where I wanted to go, I applied and I said, “I know I’m not qualified, but this is what I want to do.” And I got a letter back from the fellow who ran the community nutrition program at the time and it was three page single-spaced letter about everything that was wrong with Johns Hopkins and how they wouldn’t know a community nutrition program if it slapped them in the face. And he said, “But, you seem to be applying in earnest, even though you don’t qualify for anything, so I’ve sent your application over to the Maternal and Child Health Department, ‘cause that seems like a good fit for you.” And I went back and opened the booklet of materials and I was even less qualified for that one. That one was very—they had a big nurse-midwifery program at the time and—it was a very clinically oriented program and I thought, “Well, that’s the end of that.” And then I got a phone call from the chair of the department and he said, “We’ve been thinking about creating a new master’s degree for people who don’t have advanced clinical skills but who have passion for the field, and would you be interested?” And I said, “Sure.”

ED: How long ago was that?

DP: Nineteen eighty-two.

ED: Wow, great.

DP: Nineteen eighty-two. So I said, “Yeah I’d be interested.” And he said, “Well, we’ll get back to you.” And then he wrote me a letter and said I’d been accepted to this program and it was just all so—it just was meant to be. So, went and really was learning from zero. I mean I had no background. None. No background in biology, no background in health, no background in—and you’re in classes with people in their thirties and forties who are accomplished professionals. You know, the head of the health department of name a—name a country. But in way that—I think that was good for me because I came in completely open-minded, very fresh if you will. I had no pre-conceived ideas, and the program was phenomenal. The Maternal Child Health Department at Hopkins at that time was very, very strong. There were a lot of very strong departments at that time. We had great faculty, great connections to the community, working very closely with the health departments, state and local and a lot of community groups. And they were very supportive. I got very involved in a lot local coalitions and advocacy groups and they were very, very supportive, so. And so once I fell in, there was no—there was no crawling back out of this (laughs). It was exactly what I wanted to do.

ED: So then what was the first job you had in MCH?

DP: So after I graduated with my master's degree, I worked for the Maryland Department of Health and Mental Hygiene in the MCH program. I worked for the division director and he had a larger division. He had the MCH programs as well as all the health promotion, disease prevention kind of programs but I—they made up a job for me. I was the Special Assistant for Maternal and Child Health. And that's a whole 'nother story that I won't bore you with today. Why I got that job. I got that job and I just—it was wonderful and I was sort of the—what's the word for it? Where I had no real direct responsibility, I just worked on the things that came up when they came up. And so when it was during the—I was the liaison to the legislature during legislative session; I worked on a variety of proposals for the state to put forth: the Block Grant proposal. I—

ED: Wow, what great training.

DP: Yeah, I mean I—and then the assistant commissioner used to pull me off to do stuff. Like, I remember working on a—the accreditation of the state institutions. I don't know anything about state institutions. And I think one of the most fun things I did, the—my boss who was pediatrician, has always been interested in incarcerated youth in the state. And like every state we had our juvenile detention facilities and there were short-term facilities and then there were the long-term facilities. And he—it always bothered him that we locked up these kids and what were we doing for them? And at that time, the Juvenile Services Administration, that was the name of the organizational unit, was in the health department and they were in fact in the same hallway as all the MCH programs.

And it was like there was a force field, like you wouldn't ever walk over there. And so he said, "Okay go over there and talk to them." And there was a an RFP [request for proposal] out from the Maternal Child Health Bureau—it wasn't the bureau then I think it was the Office of MCH at that time, and it looked like it might fit. So we actually wrote a grant application and we got it funded.

ED: With them?

DP: To look at the health needs of incarcerated youth in the state of Maryland. And it turned out they had many health needs, of course, and this was before we had any real understanding—it's sort of amazing. I can't believe I'm this old, but we didn't really understand these connections between health and behavior and educational success and things that now we just—we just understand. So the idea that maybe kids who were acting out and ending up in the juvenile court system maybe had some underlying health issues was just a sort of bizarre concept. But in fact, a lot of these kids, it turned out, had already been known to us; they were already known to us. They were on the Medicaid program, they were in the Children Special Needs Program, they were in the special education system, they were in the—I mean these kids were not—these weren't random, you know, acts of youthful—you know, I mean these were kids who were troubled kids.

They known to Social Services, they were known to Child Protection. A lot of them were foster kids. So then you start saying, “Okay, so we’re spending an awful lot of money churning these kids through all these multiple systems.” And that’s when I really started kinda getting this notion of what systems really meant. How—and then how does that work? I still don’t think we figured it out but—so that was really wonderful and then, long story, I got hired back at Hopkins and enrolled in the doctoral program because a friend of mine told me I should do that. (laughs) And I said, “I don’t want to do that. Please don’t make me.” But he was right, he said, “No, you need a doctoral degree. It’s like a admission ticket. If you don’t have it you’ll only ever get so far.” So I worked pretty much full time and went through the doctoral program at the same time. And—but that was good for me.

So I kept working. We ran series of projects for the states in the mid-Atlantic region. So I got to keep doing what I loved, which is working for state health departments and working on this whole system idea. Started doing some teaching as a graduate student and—I don’t know, it all just—it all came together. Kept working with all the different coalitions, and there were a ton of ‘em at the time. The Maryland Prenatal Association, the Maryland Healthy Mothers, Healthy Babies Coalition, the Maryland—the Women’s Health Coalition, there were just a whole slew of them. The Commission on Hunger and —but they were all essentially doing the same things, just kinda approaching them from different points of view, so. My basement was a storehouse for all the materials for all these different groups, but it was fun so I got a real good, sort of, multi-perspective view of what maternal child health is all about. And it’s many, many things happening in many, many different arenas. Which makes it fun.

ED: It’s a great—that’s a great base to start from, to do that kind of work. That’s great.

DP: Yeah it was great.

ED: So how long did you stay in Maryland?

DP: Eight years. So I got there in ‘82, left in—well left in ’89, and left because it was time to leave. I decided we’d become dull. My husband was also in the field. We actually worked together and we worked constantly. And so we didn’t really do much else. So whenever we got together with friends all we wanted to talk about was work, and then we realized we were getting boring and so we needed to got do something else. And I’ve been invited—I was on a sort of an advisory committee for, again, a maternal child health funded grant project at the Minnesota School of Public Health. It was around adolescent health. And I went out there for the first meeting to the Twin Cities, I’d not ever been out there, and I just feel in love with it. It was just the most fabulous place and I decided, okay, that this was where I want to live; this is where I want to work. So I was kinda on it.

And the university advertised—they were looking faculty in the MCH program and they wanted one more senior, one more junior, it was perfect, so. My husband kept saying, “Where? Isn’t it cold there? Why do I want to go there?” I said, “Cause we have to get

out of here and this is a great place to go." So, long story short, we went out there and they very much wanted my husband and he fit a niche there that they needed at the time. And it wasn't quite the right fit for me 'cause I really didn't want to be in academia. That was never my goal. I really wanted to work in a state health department or with some group that worked with state health departments, is what I wanted to do. But I met someone from the state health department who was on the search committee and she said, "Yes, we would love you," and it took a while to find the right job but finally the right job came along and so moved out there in '89 to direct the Children's Special Health Needs Program for the state of Minnesota. I moved out there pregnant. Lived in a really interesting apartment out by the airport and what is now the Mall of America, which was being built while I was living there.

ED: Really?

DP: Yeah. The airplanes would—I could see people's faces as they went over.

ED: That's close.

DP: Hang on can't talk." (makes noise) (ED laughs) So that was the—it's hard to get a month-to-month rental 'cause I was looking for a house. So yeah, so I went right to a state Title V program, which is really what I had wanted to do, in a great state with a phenomenally progressive health department. At that time, it was absolutely super.

ED: Can you describe Title V, just in case somebody watching this is—

DP: Can I describe Title V? Yes, with pleasure. So, Title V of the Social Security Act is the legislation that authorizes maternal and child health programs in this country. And it's got a really interesting history. People have said, and it's never been refuted that this is the longest standing piece of law in our history. Meaning, that it was enacted in 1935, when the Social Security Act was enacted. Every other part of the Social Security Act has either been closed—that's not the word I want but—repealed or so dramatically changed that it bears hardly any resemblance to the original act. This one remains almost, at least the core language of it—the core foundation of it, remains virtually the same and we can't find any other law like that in any sphere.

So it's got some staying power, there's an enduring quality to what Title V is about, which is a statement that it is in our interest and our responsibility to take care of our children and our—the people who raise them and care for them. So, children and their families are the responsibility of a society because they represent the future. And that's basically what—the original legislation is only about a paragraph long. It's very short. It just says, "Hey guys, take care of the kids. Thanks a lot. (both laugh) And here's some money to help you do that." Very forward thinking. It also set up this notion of a partnership between the government at the federal level and government at state levels. And gave states a lot relative autonomy, recognizing that every state is different; every state's population is different. And even though there were some—you know, yes, we all care about some of the same populations and some of the goals, at the end of the day

states have to have the flexibility to do what makes sense in their state. So that was unique about it. There are other aspects of it that are unique, but all have stood the test of time.

ED: Who authored that original Title V? Do you know?

DP: Oh boy, I don't know that we know exactly who it was. It was the women of the Children's Bureau. I'm not sure if was Grace Abbott or Martha May Eliot, Katherine—I actually it have been Katherine Lenroot. It might have been Katherine. Katherine's the one that Frances Perkins—Frances Perkins was the Labor Secretary and the Children's Bureau was in the Department of Labor. You might say, "Why in the world is the Children's Bureau in the Department of Labor?" Because when it was created in 1912, it was mostly about children in the labor pool. It was a great concern at that time about the welfare and the wellbeing of children, so they put the Children's Bureau in the Labor Department. And Frances Perkins was the Secretary of Labor at that time and they were writing the Social Security Act. I'm not going to remember—the Committee on Financial Security or something was the name of the Congressional committee that was writing the Social Security Act. And she sent Katherine over and said, "Hey, go make sure they're taking care of children and moms."

ED: Of the kids.

DP: 'Cause there had been a piece of legislation prior to this, enacted in 1921, that was repealed in 1929—that's a whole 'nother story—but timing is everything so 1929, "Yes get rid of that program for children and women and families." And then, of course the Great Depression, the stock market crash, the Great Depression and there was then great concern for what was happening to families. So she sent Katherine over to make sure that there was something in there for women and children. So she may have authored that herself. So, the Children's Bureau was a wonderful place where really creative, progressive minds got together and really focused on the needs of America's children and Title V came out of that.

ED: So when you talk about running a Title V program in a progressive state that does this well, in Minnesota, in those years, what are the elements that cause you to say, "This was run well. This state did it well." What aspects of MCH were done well there?

DP: That's a really good question. Part of it was just the overall culture of that agency. It had a leader, at the time and probably even before then 'cause you couldn't create this this quickly, but the leadership was very strong and the leadership recognized that the agency needed to be staffed with high-level, highly skilled professionals. And you might say, "Well, aren't all agencies staffed with highly skilled professionals?" Not always because these are often very political. Some of the leadership positions, you know a couple layers down in the organization, may go to people who are owed a favor for political reasons. Or, state agencies, depending on where they are, where the state capital is, sometimes it's hard to hire people with particular skill set, but you need to fill the job so you'll fill them. This particular health department located in the Twin Cities, actually

on the Minneapolis side of the river—if you know Twin Cities, the capital is over in Saint Paul but we were actually on the campus of the University near the health schools. Which was tremendous 'cause we were right near the medical school, right near the school of public health, school of nursing, I mean within blocks.

So we had ready access to students, students had access to us, there was a lot of back and forth, lot of research going on, a lot of—you could get to the experts. And not that you can't in others, but the fact that you're right there and you run into each other in the parking lot, or going out for a walk, or getting Vietnamese food for lunch down the road, just created a different kind of an environment. Then you have this really strong leader at the top, who built this incredible cadre of highly professionalized, highly skilled staff. And we didn't—we were a small agency, we're actually much smaller than a lot of other state agencies so, you know, the lean and mean kind of concept. So when I—and I went from being the Children's Special Needs Director—I was promoted to be the Division Director of all of MCH, which was all the Title V programs and WIC [Women, Infants and Children] at the time. It was later expanded, and I inherited a lot more programs, but at the time the MCH part was pretty traditional MCH. So we had the family planning programs, we had WIC, school health, and you know all the programs you would think of. But we had just an incredibly dedicated staff and many of these people were the—they were one-person programs.

So the person in charge of reproductive health for the entire State of Minnesota, there was one person. One person ran all of Child Health, one person ran—so you say, "Well okay, that's not even funny, that's like laughable." But the State of Minnesota in its infinite wisdom some years prior had come up with a system where they created a mechanism for the local governmental entities to relate to the state in a way that, almost like the way I described the federal state partnership for MCH, in a way that let the local entities have the autonomy and the flexibility to do what made sense within their communities. So the state became—I hate to use the word "pass-through" 'cause that makes it sound like it was passive, but it wasn't. So the monies that would from the federal governments, whether it's the preventive services Block Grant at the time or cancer screening programs, or the MCH programs, the WIC program—plus, whatever the state chose to put into health would go—would come from the state health department to these community health service agencies, they were called.

And the legislation that created them, you had to have a certain population size to be a community health service agency. So in some of the more rural areas multiple counties would come together to achieve that population mass. So you were working with a group that was of a size sufficient to get work done and you worked with them in a partnership. We provided data, we provided technical assistance, we advocated for certain things, but at the end of the day they were making local decisions for their local communities. And I think in an MCH context, which is how the federal-state model works, the state-local ought to work the same way and it did there. And it did, so in a really, really beautiful fashion.

So we had our own statute that spoke to—okay, so the monies that came that flowed from Title V would go down to the community health service agencies for, and then we kinda laid out, for child health, reproductive health, children's special needs, you know just a while array of things. And then was—and then they could do other things that if they wanted dependent on local needs. But they had to do needs assessments and send those back to us. And then we took all those needs assessments and came up with a technical assistance-training menu for the year and we could tailor it to meet the needs of the local entities. So, now you can see where—okay so maybe one person in charge of child health, they're not alone. They have all of these agencies that they're working with throughout the state, you know, in a partnership. So it really created a very, I think, rich program and a strong program. I think we were better informed about what was going on locally because we had these eyes and ears out there. And we could then do the things that are rightfully done at the state level like the data and the policy level work and let them worry about the actually implementation and the delivery of the services and the local organization of a health response, the building of a health capacity at the local level. Which is really where it needs to be.

So I think you sort of add all those things up. Great leadership, great relationship with the university, just incredibly talented staff working though this local structure and then all the other health providing entities, the hospitals, the societies—Pediatric Society, (inaudible). I mean we all just—there was a sort of a shared sense vision and mission and people just came together and made things work. That doesn't mean we didn't have our challenges but I thought it was a phenomenal model and one I really was happy to be a part of, even for a short time. I learned a huge amount.

ED: As far as you know, is that model still in place in Minnesota?

DP: Yeah, I don't think they've changed that much. They've changed some other things but by in large I think that's still the way it functions. I know—I forget when that legislation was passed. I wanna say in the 80s. So it's been a while but—

ED: Do you know any other states that have that same kind of—

DP: No. Not—

ED: That's it.

DP: Not in that. Not in that way. Not quite like that. There may be others I'm just not aware of any others.

ED: So, how long were you there?

DP: Five years.

ED: And then?

DP: Five years. And if it wasn't so cold I'd probably still be there but my husband was from South Carolina. He said he couldn't—his little face would be pressed against the window in the winter. (laughs) "Where are the azaleas?" "Under the snow, honey." So he went out actively looking to go somewhere warmer and so we ended in the University of Alabama at Birmingham, which was, again, a very interesting opportunity to learn a completely different way of doing things and a completely different approach in a completely different culture. You can imagine going from the Twin Cities to Birmingham, being from New York. I mean this is—

ED: Different.

DP: It was interesting. I moved pregnant again. It was my MO. I get pregnant and then I move.

ED: Okay.

DP: I'm not pregnant, don't worry.

ED: Okay.

DP: (laughs) I'm not going anywhere.

ED: So you were in back in academia?

DP: Yeah, so then what happened was he really wanted to move, so you know, you make these decisions in your life. I was so happy in Minnesota. Loved the work, loved my colleagues, loved my peers—was a whole interagency thing going—I mean it was just a great place to be. But in the southeast part of the country, and I think this is still true, you can't get the level of a position—and I was pretty high up in the agency, if you're not a clinician. The model is still very much a medical model. And so, I just was not going to find that kind of job. And in Birmingham, I mean maybe if I was in Montgomery, which is where the capital is, but in Birmingham that just really wasn't going to happen, not immediately. And I was pregnant so it was kind of difficult to be looking for work. So they gave me a visiting faculty appointment for two years 'cause they wanted my husband so they said, "Well, we'll throw her a two year appointment." And that way—which was nice because then that gave time to get settled in really—see if I could something else. Because people kept telling me, "Oh no, no, we'll work—we'll find you something that you'll enjoy.

But what I found I enjoyed, which I always enjoyed, was being with students. And so I did some teaching, I wrote some grants. You know, the stuff faculty folks do and kept my hand in MCH. I was working through a consulting firm in D.C. who had a big MCH contract at that time to do technical assistance for a lot of the state Title V programs, so I did a lot of work for them, which was great. I've now been in I think more than half the states doing direct consultation work with their MCH programs, which has been great. So I was doing that and spending some in the Alabama Department of Health and kinda

getting to know the Alabama system ‘cause they’re all different. Every state has a different set-up, different system, different culture, different philosophy. The mission is the same. The core mission is the same but how it’s carried out varies so you have to learn those things. And in fact just one funny story, I was—I went to Montgomery for the first time and I don’t even remember why I was down there. But I went down there and I could park right in front of the capital building, which was bizarre because in all my years of being in Maryland and Minnesota during legislative session you can’t park anywhere near the capital building.

So I’m like, “Why can I pull up right in front of the capital building, this seems bizarre.” And the reason I was at the capital building—I forgot the most important part of the story—I was teaching a policy class, Maternal and Child Health Needs Assessment Planning Policy. And I thought, “Well I better find out how it works here because it’s different,” as I said. “So I’ll go to the capital.” ‘cause when you go into the capital in Saint Paul there’s this huge information kiosk and they’ve got all kind of, you know, there’s web stuff you can access, they’ve got all these beautiful written documents about how things happen and so I thought, “Well I’ll find it in the Alabama capital.” So first—okay I can park in front of the capital building, that’s odd. Then I get out and the meter only took dimes. Well, who has a dime? (both laugh) Who carries dimes?

So I’m out there like trying to—I’m trying to beg people for dimes. “You know I have dollar—I’ll give you a dollar for dime,” and the dime was worth like four hours or something. I thought, “Where am I? This is like—” Well, then I find out the capital, beautiful, beautiful building, gorgeous, great historical significance, is largely a museum. It’s not actually a functioning capital building. Where the legislature meets is in a different building. So that explained why I could park in front in the capital building. So I walk over to this other building where they point me and I walk in and there’s no information kiosk. There isn’t anybody. There’s a women next to a metal detector, taking a nap. And I’m like, “Metal detector?” I mean I’d never seen a metal—and I could’ve just walked right around her and got on the elevator but I thought, “Well I guess I should (laughs)—I don’t even know what to do.” Well I—so I decided to wake this women up and she made me go through the metal detector. Got on it and I asked her where I might find some information and she kinda looked at me funny and said, “Well try the fifth floor.” So I said, “Okay.”

So just as I get in the elevator, and just as the doors are about the close, somebody yells, “Whoa, whoa, wait, wait.” So I hold the door open and it’s Fob James, who was the governor of the state of Alabama at the time. Fob James hopping on the elevator and he’s got a guard, a big bodyguard, big, three chins big. And the door closes and he looks at me and he says, “Now what in the world’s a nice lady like you doing in a place like this?” And I was so speechless I said the only thing I could think of, which was truth. I said, “Well I’m new here and I’m teaching a class on public policy and I thought I would come here and find out how the process works here in the state of Alabama.” And they looked at each other, the governor and the guard, and they went “He he he he he,” and they looked at me and he says, “Well little darling if you figure that out you call me and let me know.” (laughs)

ED: This is like something from a movie, you know that. It really is.

DP: And I said, “Yes sir.”

ED: Yes sir.

DP: Fifth floor I got out. I though—fifth floor I get out. It’s like utter chaos. Turns out fifth floor is the House and there’s people running around yelling and screaming. There’s a rope, like you see in a museum you know the velvet rope. And there’s all these young women and men and I discerned quickly they were pages and they were trying to get the —they couldn’t cross the rope. That became very apparent. So they’re shouting to get the attention of whoever, whatever, member they’re trying to reach to get a message to or a— so it’s just like complete chaos. And there’s a woman behind a—at a desk and I walked over and I said, “Excuse me I am trying to find some information on how the legislative process works.” And then she’s like, “What! Huh? What.” So finally she says, “Try up a couple floors.” So I go up and the doors open, and this where the Senate meets, and the doors open it’s like “whoosh,” and there’s like carpeting and comfy chairs like this and people sitting around quietly deliberating the issues of the day. It’s like—

ED: Really?

DP: You can’t even make this stuff up.

ED: No.

DP: And there was a woman, very nicely coiffed and dressed sitting behind the—and, “May I help you?” And I told her what I wanted and she said, “Well, I’m not sure this will help. We do have one brochure we give to school children,” and I said, “Well better than nothing,” and walked out. (laughs)

ED: That would be me.

DP: That sounds pretty—that was pretty funny. But I got to—in fact now I remember it, what I was down there for was the Medicaid Program in the state of Alabama, it’s its own agency like it is here in Florida and big agency. And very—a really progressive group of people, really interested in children’s health and wanting to do more with Medicaid—this is pre-CHIP—wanting to do more with the Medicaid Program—really wanting the Medicaid program to work better for children. So we got involved pretty early on in doing some of the data analysis work for them to try to figure out how they could do a better job identifying eligible children, getting them into care, making sure providers would see them. You know, all the things that go into that. And then, of course, the Health Department folks were just terrific in Alabama, just a great group of folks in MCH, working really hard.

ED: How different was that system than the Minnesota system? DP: Completely. It's like many Southern states; it's the state, like Florida, the state health department runs all the local agencies. They are arms of the state except for those few large urban areas that have home rule, which is the legal term that means they are autonomous. So the Birmingham, the Mobile, I am not sure about the others, those two for sure had home rule. So they ran their own health departments. They got the same resources from the state and the same—but the others were all, in essence, arms of the state. So very, very different model and much more heavily clinic patient care driven. The community health service agencies in the state of Minnesota were not providing clinical care, except for maybe the ones in the large urban centers. They were doing public health. In Alabama they were doing clinical care; they were doing primary care. 'Cause that's what needed to be done in those communities.

So it was very, very different. But, you have—you do what you need to do. That's again, that's the beauty of the model, of the Title V model. You let states do what needs to be done, with some consistent requirements and some level agreement that there is a public health emphasis undergirding the whole thing. But if you—if in your community the only way you're going to improve outcomes is by delivering the care yourself then that's what your going to do. As opposed to another state that has a robust network of providers who will see challenging cases, low-income families and the like. So, it's a nice way to see that model in action that, "Oh yeah, this is very different." Same federal law, same federal language, but you can operate it very differently—

ED: Different process.

DP: Depending on your local contacts and your local needs.

ED: And how long were you in Alabama?

DP: Ten years.

ED: Ten years.

DP: Ten years. Birmingham was just being, sort of, rebuilt out of its old past. Birmingham had been a steel mill town that dried up. I'm not even sure when. And then, it's now healthcare and banking.

ED: Is it?

DP: Oh, they're huge industries. The University of Alabama at Birmingham is the major employer of the state of Alabama, which tells you something. But the city was kind of on its last legs when we got there, but there were a group of folks who decided they weren't going to let that happen and invested a lot—there was a lot of local investment poured into that city, and it's now lovely. If you've ever been there, it's just a beautiful—I mean just where it sits at the end of Appalachias. It's in the foothills. It's this gorgeous, hilly,

lush, verdant, just a beautiful, beautiful place. And the city—they really invested wisely and made the downtown really vibrant again.

ED: Wow.

DP: And lots of cultural things. Beautiful museums, beautiful art gallery, theatre, ballet, nightlife, great restaurants, great chefs. There just was a really—actually hated to leave. (laughs) I liked it there.

ED: No kidding. And then you came to Florida.

DP: Then I came to Tampa, yes, in 2004. Not pregnant.

ED: Okay.

DP: Yeah, that was a different thing.

ED: Still in academia.

DP: Yeah so then what happened was once I kinda got in academia then you sorta get tracked that way, you know. And I ended up being the associate dean, that's another long story, but I ended up being the associate dean, which then the natural order of things, then you're supposed go to be a dean, so. This opportunity, there were several of you here that I knew because MCH is a small circle.

ED: Yes it is.

DP: From when I went to Hopkins in the 80s—I don't remember how many MCH departments there were at that time but there were quite a few. And now I think North Carolina may be the only one left in the country. There's only one department of MCH, the rest were merged or folded into something—yours was always part of Community and Family Health, as I understand it. But the department was created and named in recognition of the fact that MCH was a central part of it and this program was always well regarded. So I knew a lot of you. And so a lot of you followed me around at APHA [American Public Health Association] that year. (laughs)

ED: Yes we did.

DP: "Why won't you come and look at us?" and I said, "Okay, I will 'cause I like all of you."

ED: So, sort of tracking this idea of what you've seen and you've experienced in your career in MCH, what kind of, sort of, significant changes have you seen? Like your mentioning, you know, there were so many MCH departments and I remember that too, and then you watch this thing get whittled away, and whittled away, and now there's one,

you know, identified. What kinds have you seen both in policy or in practice and what do you attribute that to?

DP: So, the first thing that comes to mind, and I think because I had just mentioned it and you repeated about the change in the academic units, is the changes in states. It used to be that you could find the MCH division or unit or whatever on a health department org chart. They all had them. Probably that was function of the way Title V was created. It—to get the Title V funding, you had to have an MCH unit to receive the funds, and that went back to the earlier law, which in some cases led to the creation of state health departments where there were none. So it wasn't just that you didn't an MCH, we didn't even have a health—"Darn we have to get a health department to put an MCH unit in so we can get this money."

So there were MC—and they were called that, maternal and child health, MCH. You could find them, you know? And there was—I'm trying to figure out when this started happening. Probably even in the 80s, there was a lot of discussion—so there were sort of two things going on. One was a lot of discussion about—well it's not just mothers and babies. You know, MCH can't just be about mothers and babies. And it—truth be told it never was. I don't know why they picked that name. It was probably for some political reason at the time. But it always about families, about women, about the health of communities, I mean it was always about that. But somehow that name, maternal and child health, almost came under attack. You know, where's the 'M' in MCH. Where's women's health? Where's fathers? What about families?

And, you know, you have to remember all those things that were going on at the time around the Welfare Program and well your forcing people to not be married to get welfare benefits. And women are having babies just to get welfare—you know, and you're destroying families. So I think there were all those movements going on. This notion of MCH seemed—just didn't really do what people wanted to do. And then, at the same time there was this just proliferation of states thinking that that if they—if they could reorganize themselves out of the economic challenges that they were facing. So, you know, there had been—I'm told there were boom times. I never have seen these (laughs) but I was told that were times when these health programs were flush with and health departments had all kind of money. And then, you know, when Ronald Reagan came into office and there was a lot of downsizing and cutting and the MCH Block Grant was cut by 25 percent when the Blocks were created.

And suddenly states were faced with significant budget cuts and somehow the idea that if we—if you reorganize you can reorganize your way out of these. So you saw a lot of reorganization taking place where even whole health departments were merged into other agencies so to make these large umbrella health and human service agencies. And you saw MCH programs within health departments either being re-titled something else 'cause we didn't want to call them MCH anymore, or being merged into other configurations. So, just in that time period you'd hard pressed to find—you know if I said to a group of students, "All right I am going to give you half and hour. Find the MCH program. I mean here's two states go find the MCH." I think they'd have a hard time

finding it. I mean thankfully the Internet—they could probably find it. But if you had to go the old fashioned way and find an—I think you'd have a hard finding where it was.

And in other cases it was split up, so it was dispersed. The responsibilities were dispersed. And the language in Title V never mandated that you had to have an MCH program that looked like this with this kind of director. We actually had some discussions about this at one point. About going in and saying, "We ought to put in a language that you have to have somebody qualified to run these programs." Because, you know, when you splitting them up and you send them hither and yon and who knows where they're going to end up, where's the focus for MCH and the state? 'Cause that's really the beauty of the law is that it places in each state somebody with the focus and the accountability for the health of all the women, and children, and adolescents, and families, and fathers, and grandmothers in the state.

But when you defuse that then that function becomes harder to maintain. So, I think that's been in some way not helpful to us. I think when you don't have that identifiable unit it's much harder to advocate for and it's much harder to see it. So that in my lifetime has been a huge, huge change. Of course everything going on with health insurance and health coverage has been, you know—who even—who can even understand it. And this sort of endless attention between, well yeah we get that children are our future and we want to do the right thing by children. But boy we make it hard to do the right for children. We make it really, really hard. We make it hard for families. We make it hard for agencies. We make it hard for organizations. We don't make it easy for us collectively to take care of our children and that's been heartbreaking in a way just to watch some of these things and people do—

ED: And what do you think the origin of that change is? Is that a social change, is it purely economic, is it cultural, what do you think it is?

DP: You know, I don't know. You can—there's lots of different things theories out there. You know people always say, "Well children don't vote so they have no voice so nobody pays any attention to them." And while that's true in a way, they're also pretty inexpensive. When you look at—really, kids aren't that expensive from a societal point of view. But they do compete for resources, and there's a lot of deep feelings about who is or is not entitled to what or not service, or program, or lifestyle, or—I—we've seen, you know, it's been a relatively—I forget where I was reading it but, you know, sort of—there's as much social upheaval now as there was in the 60s, just without the riots. You know? I mean almost like we—there is as much going on now. But because people aren't out in the streets, you don't necessarily see it.

And I think just the changing of the population, the way the population looks, the demographics, whether it's age, ethnicity, immigrants. The economic divide just gets worse. The fact that, I don't know what percentage, 40, 50 percent of college graduates can't get jobs. It's just there's lot of interesting things going on right now and to say, "Well we need to help our children," when there are so many just desperate needs out there. It's very, very challenging.

ED: What are you seeing in terms of changes in research in the area of MCH?
DP: Wow, that's a really good question, Ellen. Well, the good news is we finally—and again you have to think about who funds research in this country but, you know, the sort of the biomedical model of research, of health research has been the dominant, that's been the dominant research modality, and if you weren't doing that research it was difficult to get it funded or get any attention for it. This whole systems idea I think got people recognizing, certainly in the 90s, that all the bio-medical research in the world wasn't going to help you get child A to clinic X with service Y with follow up Z. I mean, you know, that there was a need for research that looked at how all of these things come together to make a difference in the life of a child or a group of children.

And so we saw the MCH Bureau, who you know back when—and they have a small research portfolio but they used to fund the same kind of research NIH funded. And partly it was because to do anything less, or—and I shouldn't have even used the word—but to do anything otherwise made you less was what I was trying to say. Right? Well, we have to do that research 'cause that's what research is. No, it's not. Research is lots of things, and the fact that we collect voluminous amounts of data in field—oh my heavens. And a group of folks, again it was in the early 90s, petitioned the bureau and really got them to understand that for a small amount of money they could answer a whole bunch of questions with the data we'd already spent a lot of money collecting. Because, before—you couldn't get that kind of research funded. "Well, what do you mean you're going use—collect—you're going analyze data that's already been collected?" "Well, what about the new data?" "We don't need any more data, we're drowning in it." So that was a real sea change.

So, the MCH Bureau really shifted what they would fund and they started funding more applied and translational research, more of these small grants that—to use the data that's already there, more systems approaches. The whole systems development initiatives that they designed in the 90s to help states actually start actually start building systems and encouraging researchers to support it with research. And then, you even saw the NIH kinda say, "Oh well wait, there's more going on out there." And the whole road map and prevention and all sorts of other—and then you had other foundations kind of stepping up and trying to fill that research gap with the Robert Wood Johnson Foundation, Pew [Research Center] and Kellogg and others saying, "You know what, we really have to think about research in a different way about, you know, children aren't—one they're not little adults. And two it's not enough to just get them to a—get thee to a health care provider." There's all these—in fact that's often the least contributor to their overall health.

And then, of course the big research breakthrough, if you will, which again is one of those things that we we've always known intuitively, is that what happens to children, or fetuses, or women before they conceive, affects the life of the that child throughout their whole life. That's one of those obvious "duh" kind of things. But now we are— have a growing body of research evidence of it and to support it with hard, even biomedical, data to support the fact that this hypothesis is actually true. And so, you know I love to

say that we kinda went from, if you think about, you're creating a health department so that you can have MCH program. Sort of MCH being king to MCH can't find it anywhere. Or even when I ran an MCH division, I used to love to go to the budget fights. We would all go and present our budget requests to the commissioner and then she'd decide what she was going to put forward and they'd say, "Oh, well I don't even know why you're here. You're just MCH." Like I didn't need any money or I didn't—you know.

And so this—I was just MCH, then there was no MCH. Well now it's like, "Hey, hello. Guess what. Ha ha. I'm everything because if you don't do this right, you know, oh you're just chronic disease (makes noise), you know, who needs you. If you give me all the money." Right? So it's sort of been this interesting kinda ebbs and flows. And I'd like to think that this whole new focus on life course, or fetal origins or all the different terms people use, will really re-invigorate this field.

Because I feel like it's been a little kinda sleepy for a while and partly that's 'cause folks are just hanging on for dear life. State budgets have been slashed. There's very little support for public health. There's very little support for public anything and I think really good people are working really, really hard just hanging on. And the idea that you have any energy left to be creative is just—so I'm really hopeful that this new approach really will kinda gives us shot in the arm that we need.

ED: Where do you see—I agree with you about that idea of, you know, the "duh" moment of—first it was life span. I mean, even that was, seemed pretty revolutionary, but to look at life course where you're talking about inter-generational issues, the generation before the present and the future. Which really did seem kind of like a paradigm change for all of us. Where do you think that came from?

DP: You know, I don't really know. I mean, I know everyone talks about the Barker Hypothesis as sort of being the first time people started thinking about it because he brought the data to it. He brought data to it. He—and it was pretty crude, if you look at his original—okay so, if you're looking birth weight on a continuum, the lower the birth weight at birth, the greater the fill in the blank at adulthood. High blood pressure, diabetes, you know, it was like a "whoa" that was like a real "aha" moment. But then there other great thinkers out there who'd been thinking about this stuff for a long time, Neil Helfand, Michael Lou, Neil Cuttlechuck, Cheri Pies, I mean there's a whole cluster of folks that have been thinking about this. So I'm quite sure—you know it's funny how these ideas appear and they germinate; they take hold and they flourish. Probably people have been thinking about this for fifty years and couldn't get anybody to listen to them.

ED: Sure, sure.

DP: Which is often the case but I really think—not only that it will kinda re-invigorate us but I think it really is an important approach to how we understand the value of the investment we make in children and families and women.

ED: And I also think if you look back on—I'm thinking of when I was at Michigan and we—you were looking at MCH issues and everything was so biomedical and you listened to people start to say, "Look it this is not enough." I mean, so we know about low birth weight and they through a ton of money at something and say, "Let's try this," and that wouldn't make any difference. And then they'd throw a bunch of money at something else and say, "It must be—." And I'm trying to think of some of the programs we used to hear about or some the approaches and, you know, you just—you couldn't crack it and I think eventually—

DP: Well, artificial surfactant, that was it.

ED: Yes

DP: Artificial surfactant was going to—

ED: That was going to fix it. Yep.

DP: —take care of all the preemies and we'd never have to worry about it again. And I remember and I—his first name was Ron [Bloom], and I'm so sorry I can't remember his last name. He was an neonatologist at the University of Maryland Med Center, part of the Maryland Perinatal Association, wonderful, wonderful guy. And he—and you know, I—it was always amazing to me that these very hardworking clinical providers would join these coalitions or these—and show up at meetings. And so I remember saying to him one day, "God you're so busy." He said, "Donna I can't send one more premature baby back to the place that created it in the first place." Right? And I—this was like 1983, you know, and I remember thinking, "Wow, that's really interesting." So he gets these—these, you know, and spends hundreds of thousand of dollars and he can keep them alive and he can them home. What's home? Home is what created this in the first place. He said, "I just can't do it anymore so I gotta come out. There's gotta be another answer out there because this isn't it." And then, even then, you know I guess amazing—you know even then he saw, "Wow miracle baby is always in the paper." Miracle baby, how every many pounds, it keep getting lower and lower. Oh, going home. And then, you know, and then we had the opportunity to start following them and a lot of them do fine but a lot of them don't.

You know. And so it's like, "Okay so, miracle baby isn't this wonderful. Dr. so and so saved the miracle baby," but where are the supports for that family going forward into the future? Where is the social investment in this decision that you made at this point in time? And so we—the good news is there's still a lot a really good work to be done. (laughs) In this field there's still a lot question we haven't answered. There's still a lot of challenges that we can't even get our arms around yet, but every little bit helps. Every one of those brainstorms that says, "Maybe we all look this a different way, helps move us—helps move up forward."

Part 1 ends; part 2 begins.

ED: So, we've talked a little bit about some of the changes in MCH over time; and research and programming and policy. What do you think when you think about the leaders or the people that you've mentioned—some of the leaders in the program, what makes for excellence in MCH? What have you—who, who when you think about that, what have you seen?

DP: So I—you know any point in time there's always going to be great people to work with. When I—I went to Minnesota in '90—'89, '90, and I don't even remember, but the way the Association of MCH Programs was organized, there were regional councilors. So whatever that region was—it was region 5, whoever the regional councilor was left or something. So, they needed to fill in before the election. And my boss at the time came running down the hallway and said, "Hey, how'd you like to be the regional councilor for the (inaudible) and I'm like, "The who for the what? I don't even know…" So I said, "Sure, that sounds great."

So, I'm like thirty years old and I go to my first meeting and Peter van Dyck from Utah, Bill Hollinshead from Rhode Island, Bill Buchanan from Arkansas—just trying to think of some of these—the guy from New Jersey, I can't think of his name. But like these were giants in our field. People who both ran programs and had published, so you knew them 'cause you read about them, you read their work. People who you'd heard speak at national meet—I mean just incredible people. And I remember we were meeting in Galina, Illinois, and I had gone out—and I forget what time the meeting started, maybe in the afternoon, and I'd gotten there early and I was walking around. So I'm a new mother and I go into this little shop and I find this really cool teddy bear for my daughter and I came back and I realized I was—I didn't have time to go to my room. So I walk in this room (laughs) with the teddy bear. They're like, "Oh you must be Donna, (laughs) the youngster from the Minnesota programs." It was absolutely hilarious.

But the conversations were just so rich and I guess, you know, you start to look at this people and here I am in a situation trying to understand what's going on, solve problems, be a good—inspire my staff and work with different communities; you know, it's a lot. But I think a lot of it really gets back to both the personal attributes that I think many leaders just naturally possess, not that you can't learn them, I think you can, but great communicators, very articulate, compassionate, empathetic. When you speak with them you really feel like you're speaking with them even though these are these giants in the field. You know, keeping you're staff motivated and empowered to do the work that has to be done. Relating well to all the different constituencies. So being able to go to the legislature and answer crazy questions and going to an angry group of parents or community folks and being able to mollify that, understanding that it's not personal. I think that's something you have to kind of come to that on your own but you do feel like you're being attacked, but you're not, you're just the embodiment of the thing that they're angry about. Being willing to speak your mind, understanding that, you know, not, you know, you may bet fired or you may—(laughs). You don't to ever offend but you want to be able to speak your mind.

I remember being asked to be on a panel responding to an author and he'd written a book and I don't remember the title of the book, but the premise was people didn't need a hand they needed a staircase. Do you remember this? It was this notion that they just needed the steps and he was a very good speaker and I actually—I read the book, it was an interesting book. He talked all—he talked a lot about the projects in Chicago and why that was a failed concept from the beginning. But then he really lashed out at public programs and the government and how we made these horrible decisions and—and so they wanted me to respond for it 'cause I was representing the government, somebody else was from a community. So he was clearly prepared for me to defend and argue and I said, "Well, actually believe he's absolutely right." Everyone kinda looked at me and it was a huge crowd, it was public forum, and I said, "But you know, what I want the people in the room to understand is what the government does, they represent you and they act on your behalf and they listen to you. You may not believe that they listen to you. So let's talk about the Medicaid Program or the SSI Program." Remember the whole crazy check thing? I think that was what was going on at the time.

I said, "So you out there said that you didn't want anyone, you didn't want anyone who wasn't deserving of that program to get that program. That's what you said. Well the only way we can guarantee that no one slips through the cracks is to set up such burdensome and onerous screening requirements because otherwise how can we—and, you know, those people are out there and they're always going to find a way in and then we have to add yet another—which makes them expensive, they're administratively expensive, they're challenging for people. So the end result is many, many people who could benefit from these programs, who are technically eligible for these programs, don't get into these programs. And they end up being a burden, they end up in your emergency rooms, all the things you say you don't want but you've made it loud and clear you didn't want anybody not eligible getting into the program." And it was like, people were just—this author was clearly deflated—he was ready for a fight. He was just itching. And I said, "No, I agree with you. You're absolutely right. But you have to understand where these things come from. Bureaucrats don't sit in their offices and dream up ways to make your lives horrible. We respond to what you tell us you want and that's what you said you want. Now personally I'd rather let a few, you know, undeserving—whose undeserving? Especially when we're talking about children." You know, it's ridiculous.

But, I forget what question you asked. (laughs) Leaders, leaders. So leaders—I think leaders have to really understand what the vision is that they're trying to do. They have to keep their eyes on that vision. They have to motivate the people around them; be able to engage people. And the leaders I've had the great fortune to work with over the years, who I've watched and learned—and not taking it personally and picking yourself back up and going back in the arena, you know? 'cause that's your job, that's your job.

ED: What do you think the challenges facing MCH, and we don't have enough time in the world for you to actually—as I'm asking the question I'm thinking, "What are the challenges—"

DP: At what level?

ED: I know. If you think about students watching this interview and preparing future MCH professionals and leaders, what are the things that you would want them to know to look at the challenges that are facing us?

DP: So, let me say one thing that I should've said before, that relates to this, which is the other big change I've seen in my lifetime is the re-emergence of the data as driving decisions. And people that have heard me before—the charge to the Children's Bureau in 1912 was to investigate and report on all matters pertaining to the child life and welfare among all classes of our people. But the important part is: "…investigate and report on…" The initial charge of the first federal agency in this country devoted to children was to investigate and report. That meant collect the data, analyze it, and disseminate it. Report it. And we went through a period there, the dark days where there was no data reporting required, budgets were cut, all the data people went away, and that was horrific and I think those of us who lived through those days know that you don't ever want to go back there again. 'Cause without data yours is just another opinion. And that doesn't mean the data—everybody reads it and goes, "Oh, yes this is obvious, this is what we must do," I don't mean that at all. But without it, you're naked.

And so I think when we think about—that's one of the biggest challenges we face I think is having the right information when we need it to make the decisions that we need to make to advocate ethically and responsibly and not just shooting from the hip. So, I just wanted to make that point. But I think the other thing is—and I'm not even sure how to say this because it's, again I don't think it's a concept any of us have fully figured out yet —but this notion of life course in systems. (laughs) Like, you know, this whole system thing we're still trying to get our arms around that, to really understand what it means and how it works. But if you're going to be an effective MCH professional, at whatever level you're at, you got to understand that, you've got to be thinking about it. And chances are you'll have some job that has some defining characteristics. Like even in Minnesota the reproductive health person—that was her focus, but she still had to think about everything that potentially impacted on that population, the good and the bad.

And so that means, if you're going to be effective—an effective professional—you've gotta understand those things. That means you've got to reach out and get to know those people. That means you've gotta understand where the leverage points are, where the opportunities are. There was a—I love these little studies done by the Public Health Foundation, which is the research arm of the American Public Health Association. This was in the 80s. And the leaders of the government agencies HERSA—it was ADAMHA at the time now it's SAMSA, the Alcohol, Drug Abuse, and Mental Health Administration, HICFA, Health Care Financing Administration, which is now CMS. ADAMHA is SAMSA, HERSA is still HERSA. But they had kinda gotten this notion that—kinda what I was saying before about the youth offenders—that we all probably know the same people; that we're treating the same, we're paying through Medicaid for social abuse treatment through primary care centers through, you know these.

And so why weren't we sharing data was the question at the time. 'Cause maybe we could be more efficient. We'd be more efficient and maybe provide more optimal care. So the question was, "Why don't we share data?" And they put this survey together and was it hardware incompatibility, was it software incompatibility, was it that we don't define our terms the same way as it—you know, blah, blah, blah. Well it turned all survey collected, that the one thing that mattered was if you had a personal relationship. If the data guy from one agency had a personal relationship with the data guy from the other agency, they'd find a way to share the data. Didn't matter if it was completely incompatible, they'd find a way.

So, to me that's just saying that a lot of it really boils down to personal relationships, your interpersonal skills, your ability to communicate effectively, your ability to be somebody people want to work with, and you can't really stress that enough. If you're not someone people want to work with you can forget ever building relationships across components of the system. It's not going to happen. And sometimes that means being quiet, sometimes that means not getting what you want out of an encounter or a series of encounters, sometimes it means you have to give something in the hopes that you'll get something back later down the line. You've gotta negotiate and sometimes you've gotta take the fall for somebody. But if you don't build those relationships you'll never get what you need. So, you know, and sometimes you'll say, "God, you know, why haven't you?" Well because—because that problem that looked so simple to you—

Here's an example. What could be simpler than giving a child a vaccine? Right? Isn't that a straightforward public health intervention? I know what it is, I can count it, I can—right, that's easy right. There's nothing easy about getting a vaccine into a child. (laughs) Nothing, nothing. And I don't have to tell you. But think of all the things that have to happen and be in place for that child and that needle to meet and that—and vaccinations are pretty simple. When you talk about preconception care or service systems supports for children with multiple complex medical conditions—makes your head hurt. (laughs) So, in some ways you gotta be willing—you gotta be tolerant about ambiguity, gotta be willing to kinda live in chaos. You won't always have all information you need and sometimes you got take a back seat because you gotta maneuver. And all that, and you still have to have all the data, you still better know the science and you still better—you need to know that. You might never play that card, but you better need to know it. I mean you better need to know it; I mean you better know it; because you're going to need to know it. (laughs) 'Cause if you're ever asked, then you have to produce. I don't know if I answered your question. It's just—

ED: That's all right. Actually I was going to ask you, and you probably did, what do you wish you had known? I mean now—being here right now, what do you wish you had known about the field of MCH or the skills you needed to be in MCH? What do you wish you'd known that you know now?

DP: Well I think a lot of it, you can't know because it comes with maturity. You know, how to separate yourself from the situation, how to take your ego out of the equation. And people can tell you that but until you get smacked around a few times— (laughs) so

part of it is I think you just—you have to kinda learn those things. But I think that's critical. And I've worked with people who never learned that lesson. I'd say, "That had nothing to do with—what are you upset about? That had nothing to do with you." You know really—I mean it's like I'm kinda flabbergasted. I wish I knew more about, not so much the legislative process, I get that, but really how the people think in those positions. It took me a while to figure that one out, and I think part of it's understanding how to communicate to different groups of people and not be insulting and patronizing, but just understanding people are going to come at this from a different level and different place.

I was well prepared and that's part of the—that's why I'm having a difficult time answering your question. I was extremely well prepared. That program was phenomenal. My master's program was phenomenal, partly because it was a brand new program, as I said, and they kinda ran around behind us, hovering, making sure we—and because it was a brand new program and they hadn't really sorted out what they wanted us to do yet they had us do everything 'cause they didn't know what to have us do. So we went to—there was a doctoral student class—this is why I never wanted to be a doctoral student by the way—every Wednesday afternoon, twenty-four—I almost said twenty-four months out of the year. (laughs) It felt that way. Fifty-two weeks out of the year, every Wednesday afternoon doctoral students, every member of the faculty would be there and the doctoral students—they would rotate and wherever they were in the rotation schedule they presented where they were in their research. So if they were just creating, coming up with ideas or if they were at the protocol stage, wherever they were. And new doctoral students reviewed research grants. They critiqued research grants. So they said, "Well what do we do with these," and there were two of us in this program. "What do we do with two master health science?" "Well let's let them do that, too. Lets let them go in there and—," it's completely insane. But boy did I learn how to write grants and review grants because it's all about validity. What else did they have? They had us do all—we took the doctoral comprehensive exam because they didn't know what else to have us do.

ED: Wow.

DP: I did very well, thank you.

ED: Good for you.

DP: (laughs) Just the curriculum was intense—was incredibly intense, but it was so exciting to me. And my friend who was in there with me, we were the same way, so we like—and we weren't working 'cause we figured there was no way. So we just like took everything we could take and like learned everything and these incredible people. And then I mentioned they were so well connected through the local government, the local health system, the state government, so we got a lot of exposure, which I think is really important in master's—I don't think we do enough of that at a national level. I think we do a better job at USF than other places do. And then I did a six month full-time field experience at the Office of Disease Prevention and Health Promotion in Washington D.C. and worked with some of the incredible leaders of the time. Again, you know this is the 80s, this is—they just wrote the first Healthy People, they just the first set of objectives

for the nation and this office is the one that managed all of that. They knew I was interested in MCH, so I got involved in the National Healthy Mothers, Healthy Babies Coalition.

I spend time at the Bureau. I was in HERSA. I worked with the Office of Public Affairs. I manned the HIV Hotline that Ed Brandt and Chet Coop put together. I mean it was just an —I was so well trained, so well trained. I don't think everybody has the benefit of that experience. And then working, as I said, working through my doctoral program with these regional projects, working with six state health departments on a whole array of different projects. The grants were set up to provide sort of collective training on topics that they agreed to and then specific technical assistance. And then we would always write a report, because maybe you don't have that need today but you might have it tomorrow. And we produced this, volumes of material. We spent a lot of time in these states and I really got a feel for how state MCH programs work and the challenges that they face. So when I got to Minnesota, even though I was young, I just had a whole lot of experience. So when you asked me that question, the things that come to mind are more personal.

You know, I had to learn—"Donna, that wasn't very nice." (laughs) I had to learn patience, really, and taking a back seat. Letting someone else have the glory. It's—that stuff's hard. It's hard. But I think if you're going to be effective, all the knowledge in world, all the data in the world, if you can't get it somewhere then it doesn't—then it's useless. So it's both, you know, kinda the hard stuff and then the soft stuff. And the soft stuff, you know, since staying up all night at a hearing a the legislature, in case they call on you and when they call on you at five a.m., "What? You want me to do what?" (laughs) But you learn. You learn those things.

ED: Charlie Mahan, who talked to us last week about his experiences and his recollections about MCH, talked a lot about—his experiences were different, but he came to a lot of the same kinds of the conclusions that you did. And he talked a lot about the data and how important it is that we have data to drive what we do. And he talked about different MCH sort of specialists, you know that we need people in different areas to have expertise and that the expertise and the data makes such a difference to us. And then he talked a lot coalition building. He did a lotta work, as you know, working at both local and state and then federal coalitions, he did a lot of state work. And it seems to me that, from what both of you are saying, that's a skill.

DP: Absolutely.

ED: That we really have to—

DP: Absolutely. No, I'm glad you said that. Yeah, because again even the vaccine, even what seems like a simple intervention, a good coalition can make that happen where it won't otherwise. And because so much of what we do is so interrelated to everything else going on out there and because we're competing for resources and attention and time and everything else, getting a group of committed people together to really work on

something with you is huge. And if you're in the public sector, if you're working the public sector, you often are very limited in what you can do or say or—I've been in, you know, moments where I had total freedom to go talk to legislators, testified, nobody reviewed what I was going to say. To the extreme opposite where I wasn't even allowed to drive by the building because I might look at it sideways and convey something that somebody didn't want conveyed, and everything in-between.

And so I sometimes get frustrated with my colleagues but then I remember, "No, I mean they may be in a situation were there's simply nothing they can do about it." You can't, you know, you wanna take risks and speak out and do the right thing, and yeah you might get fired, but boy you don't want get fired if you have to get fired because people are depending on you to do these jobs. And sometimes you simply can't speak or act or doing anything. Well, that's not the time to go out and say, "Hey, I need to build a coalition 'cause I need you people to be my voice." It's way to late for that. You build it, you build it way back when and you have it ready and mobilized and activated. And when it's working right, you don't have to do a thing. They just—they go on their own and they know what the message is. You've given them the data they know. They know.

And they bring their passion and their spirit and their own stories. And you know in policy arena there's nothing like a good story, a heart-wrenching story, to motivate people to act. Even—especially if they're on the fence. You know, something that gets to their gut, their heart, they'll act on. And we can't do that. I'm the state MCH Director; I can't go in there and tell them some sob story. That's not my job, but that's what I have all these other people there for. And so if you do that right, they not only are helpful to you in the formulating of the ideas or coming—what's going to work in this community but then boy, when you want to move to action and get resources, they're indispensible. You can't do it without them. So yeah, people haven't figured that out, yeah that would one of those critical skills that you have to—(laughs) if you haven't figured that out, you're in trouble. But I told you, I sort of raised by groups of lone wolves, by groups of coalitions. I mean I've worked with some of the best. In Maryland there, these women were—and it was predominately women that ran these coalitions 'cause they were women's issues.

But we had a lot of really good strong men get involved too, like Ron—I'm gonna think of his name before the end of this—and a couple others that just kinda came out and said, "There's got to be more to this because all the—I pour my heart and soul into these patient encounters, clinical encounters, I give it all I got and I'm not making a dent out there." And so that's the other good thing about coalitions is that they give people a place to go to get involved, to get engaged, and to say, "Yeah, I want to contribute in a different way," and then you can really do magic with those things. If you—you know, people get excited and they'll volunteer their time. People will give money to those—they won't give money to the state health department, I can tell you that, but they'll give money to the coalitions for whatever it is: childhood injury prevention or violence prevention or early-childhood whatever or pre-term birth prevention. You know, people will, they'll get motivated.

ED: That's great. Okay, any last thoughts that you would like to share—

DP: (coughs) Excuse me.

ED: —about MCH? If this—if you thinking that this could either be to teachers of MCH, ‘cause this is going to be an innovative teaching tool, so teachers of MCH or students of MCH who might be watching it.

DP: Wow, that’s quite an opportunity. Oh boy, it’s such important work that we all do. It really is important work and, like much of public health, we’re not the only ones doing it. That’s the other thing to remember. MCH happens all over the place, which is why that systems approach is so important. Why having data is so important. And you remember, we’re often the only ones with any data. I mean, that’s the other—people forget, we get used to having it. And I might have told you this, this is somewhat off topic but I did a study for Hillsborough County Commission wanted to know about ER use among the patients that are served by the indigent health care plan in the county. Did they over utilize the emergency room? So they had this hypothesis that if you gave people who had not had insurance an insurance card they would then overuse the emergency room because they now had access. So it turns, as we hypothesized, that people really don’t change their behavior just because you give them a blue card, or a green card or no card or free cards. People overuse the emergency room all over the place. It’s just sort of a function of lots of, lots of different things.

But we analyzed the data. We used an algorithm that had been in New York State for ambulatory care sensitive conditions. You can really track when people are going to the emergency room when they shouldn’t have. When they should’ve either gone to an outpatient center at that moment or had this treated a long time ago and then it wouldn’t have turned emergent situation. So the data—we had graphs, we had charts, we had data tables and they—a colleague of ours who helped me analyze that data—I said, “Well you oughta come with me to the county commission meeting.” So I’m presenting this, and of course, there are as many opinions on that board as there are members of the board, and I got challenged all over the place and people were questioning and at the end of the however many—in don’t know how long I was questioned, I turned around and this young man was just completely—(laughs) he, “I always thought data was just—it was just data.” Like it’s just a fact. You I said that before, “You know you have the data, everyone will say. ‘Oh yes that’s obvious.’” No, no, you have to have it, but that doesn’t mean people suddenly go, “Oh, yes I see. Yes, that’s very obvious. Thank you very much. Now I know what to do.” You know, it just doesn’t happen that way. It just doesn’t happen that way. But boy, you better have that data and you better know what you’re talking about when you go in there.

But, you know, I didn’t—I showed them the data but I talked, I didn’t say, “Now, lets look at the third column from the—.” You know, jeez, people’s heads explode. And then I was just at another county commission meeting down in Bradenton and it’s the same kind of thing. Some of the questions you’re just, “What in the world are these people talking about.” But, boy you gotta get in there and you gotta do it, you have to do it ‘cause that’s what we’re about. And MCH as field, I don’t care what people call it now; it’s always

going to be MCH to me. It's always going to be the Johns Hopkins School of Hygiene and Public Health, too. (laughs) Now it's the Bloomberg School of Public Health. But, again conceptually MCH has always been about investments we make today for the future. And taking care of our children is, I think, the best job there is because it's just—it's what we need to do as a society if we're going to sustain ourselves. And I think we've made a lot of mistakes—I mean, I think even—you're asking about research—even understanding. And it was amazing when Peter van Dyck, who is now the MCH Bureau Director, got up at a national meeting and said, "You know what, I think we finally figured out that we can't solve in nine months what a lifetime has produced."

But didn't we think that, "Oh my gosh, if we could only get these women into prenatal care, we could have a healthy baby." I mean now it's ludicrous. When you about it now you say, "Why did anybody ever think that was a good idea?" Well it was a good idea because it was preferable to doing nothing, but it was so short-sighted and I think we do—we tend to kind of fixate on it, "Oh this is it, this is what we got to do," and we have to be able to sit back and say, "Let's think about this a little more." So we need people that are good thinkers and passionate and motivated and not afraid to get dirty, and not afraid to get yelled at and still go home and say, "I did a good job today. I made a difference." 'Cause that's what it's about.

ED: Thanks a lot Donna.

DP: Thank you Dr. Daley.

ED: Thank you Dr. Petersen.

End of interview