An Interview with Michael Fraser

Michael Fraser, PhD, has over 14 years of public health agency and national association experience supporting and serving federal, state and local public health agencies. He has been the Chief Executive Officer of the Association of Maternal and Child Health Programs (AMCHP) in Washington, DC since 2007, and is also currently on the adjunct faculty at the University of Maryland's University College. In the past, Dr. Fraser has worked as the Deputy Executive Director of the National Association of County and City Health Officials (NACCHO), a Regional Program Manager with the Centers for Disease Control and Prevention (CDC), a Senior Staff Fellow at the Health Resources and Services Administration (HRSA), and a Research Scientist at Aspen Systems Corporation. Dr. Fraser received his doctorate and MA in sociology from the University of Massachusetts at Amherst, and his BA in sociology from Oberlin College.

This interview – which was conducted by Michael Lu, MD, MPH, Associate Professor of Obstetrics & Gynecology and Public Health at UCLA – is the sixth in a series of interviews with national and international experts in life course health development. The series is produced by the Maternal and Child Health Life Course Research Network (MCH LCRN), which is managed by the UCLA Center for Healthier Children, Families and Communities, and made possible by funding from the federal Maternal and Child Health Bureau (MCHB, grant #UA6MC19803).

ML: How did you first become involved in life course research?

MF: At AMCHP, we do a lot of advocacy and networking with state MCH programs, and I think the first time I heard about it was when you gave a talk on it a long time ago. Certainly since then, it has bubbled up through the states' interest in work that takes a life course approach, and thinking through what research says and how that can be translated into how their departments and organizations are structured and to ultimately change outcomes. There is little scientific research that we do here at AMCHP, but certainly on the operational level, there are some really interesting ways that states have begun to incorporate the life course perspective into the work of their organizations. What we really want to see happen is getting those states together to talk about that because it is a framework being used to integrate silos within health departments, as well as change the way people working in MCH at the state level think about the way they support different interventions. I think states have a real desire to share with each other, more on the operational side and the management side, and discuss what this all means for state health departments.

In terms of gains, it is incredibly powerful to think through the way interventions like access to prenatal care – which has been focused on so intensely over the past few years – are just a part of the solution to improving birth outcomes, and what needs to happen now is [figure out] what else we need to do. It's really important to make connections between social factors that influence health and health policies and other kinds of policies in the states. There is a real desire for states to communicate with each other about this topic, and we are trying to meet that need informally by trying to convene states to do that peer-to-peer exchange. But there need to be some more thoughtful approaches to how research is integrated into practice at the state and local level where the accountability is - how to show states ways to build a life course perspective into their programs when their work is so siloed and categorical. Thinking through what this means for real specific population of children and youth with special

health care needs, which our members do a lot of work with, is also a piece folks have said is in need of more discussion.

Ultimately we believe it, but what does it looks like to move it into our practice? I was just in a state that has 90 funding sources in their MCH community health program, and they are trying to confront the challenge of using all those resources to move forward a life course approach to health across all their programs, not just MCH. They have done some neat stuff, but it's a huge challenge.

ML: What role do you see this network play in overcoming some of these barriers and challenges?

MF: I think we need to think through the biological and biomedical research that you do and that's so important, but also how to translate research to practice. There needs to be some sort of life course 101 toolkit: how does this fit into what the states do, what are some of the key pieces of literature and research that can inform their work, state strategies that are either best practice or model practices around integrating or retooling a health department to implement life course perspective more fully, what are the specific ways that MCH can lead or convene partners to move a life course agenda forward in their state with other partners like Medicaid who could pay for a lot of this, community health centers that might be a significant provider of services, medical providers, etc.

ML: Have you participated in any other research networks that you have found beneficial to your work that we can consider modeling the LCRN after?

MF: I have a network, but it's not a formal or structured network. The email summaries and traffic that the [LCRN] currently provides are a good thing, and that simple peer-to-peer exchange is so important and is really what a network is about, and it would also be good to provide a way to more efficiently share findings and common problems and discussion points.

ML: One question commonly raised is, life course is an interesting theory but what are the implications for practice based on what we know to date?

MF: That is the key question for our members – they are looking for concrete, tangible resources to help them answer that very question: this makes sense, we understand it, it's consistent, it's important, it's foundational to MCH, we've all been talking about this for a while under different names, but how exactly this can overlay a health department or a practice organization that is not structured that way? I was recently in Rhode Island talking with their Title V director about what they've done. By taking a life course perspective in all their work, they have created a series of touchpoints between the different programs in their agency, such as chronic disease and MCH, and they looked at all the ways in which the programs should be connecting and aren't. For example, their diabetes program really wasn't focusing on gestational diabetes, but through conversation around the life course perspective and what the department does for pregnant women overall, not just in terms of the MCH program, they were able to introduce a gestational diabetes component to their work. Looking at their tobacco cessation program, they realized that much of their work was policy change, so they refocused on preventing initiation of smoking in young people and retooled and added activities to their tobacco cessation program for pregnant women and introduced the

policy-level interventions to their MCH group, which hadn't traditionally focused on that, so the MCH group started thinking, well if the tobacco folks can do this legislative kind of work, what would we like to see happen for MCH? There were a lot of connections made there by taking this perspective, with implications not only for the organizational chart and what it looks like, but also for their grant deliverables and project reports – the kind of work the department does – and it was incredibly exciting and exactly what people were looking for, but not something that was easy to find. That's one thing we really want to share, not just the Rhode Island story, but also the other leading states that have picked this up – what are they doing, how are they doing it, and what is it doing in terms of outcomes for their state?

ML: As part of this initiative, we are going to be gathering 8 or 9 state of the science papers – any suggestions for topics?

MF: The question for practitioners and bureaucrats like my members is what to do with those papers once they come out and how to disseminate them. For a population that is looking to invest their state and federal resources into improving MCH outcomes in their state, how can we get them the best science, the emerging findings and the stuff that really matters so they can retool their interventions and rethink their portfolio. There is a huge lag, and it may never happen in some places, because that kind of work is not something that is at the fingertips of Title V directors. So looking for best practices that could help move the needle on state MCH needs, and getting that to the folks who are actually accountable for reporting those outcomes annually and get funding to do so – that kind of effort translates to interventions, programs or policy changes that are based in the science that you all are producing.

ML: What are the top priorities for translational research?

MF: Which interventions that actually produce outcomes? How can communities and states use the research? We know that reducing stress leads to better birth outcomes, but what does that actually mean for a state or community working with pregnant women? We know that racism and economic challenges in communities can lead to poor outcomes, so what are some places that have taken that on and made change? Operational and evaluation research, off the bench, looking for interventions that show efficacy, evaluating model programs, centering the group work that is being done in communities.

We did a life course perspective town hall at our meeting in February, and according to our members and the conversations they had, some of the biggest needs are training for staff around how to actually implement the life course model, how to frame the message to gain support in conservative states, what are model structures for cross-agency partnerships and planning around this so it's not just MCH, making life course relevant to children and youth with special health care needs, a life course 101 toolkit, strategies to implement the life course in agencies, how to measure and evaluate implementation, success stories, general literature and resources, a fact sheet on who should be involved in implementing the life course perspective in a state and what are their roles, outcome measurement, and how to translate theory to practice.

ML: We know how busy you are, and it's not always a guarantee that if we build it people will come, but what would make it easier for you to actively participate in the network over the next 3 years and beyond?

MF: I think working it into things that people are already doing. Rather than creating something new, putting it into where people already go for information: our website, our publications, our conferences, the kinds of webinars that we do get a lot of pickup. I think, like you said, putting it up on the web somewhere on a site doesn't really pull people – we have to push it out to people and use existing channels that people already access and see as credible for getting their work done. We really do want to make sure that the work the network is putting out is going to inform practice quickly so that we can make those changes that we know we can make, not just become another part of the literature, but actually become part of practice. I don't know what the science is around a lot of that translational research, but I know there is some, and we really need to get on it and help our states move this forward.