

## **An Interview with Cheri Pies**

Cheri Pies, MSW, DrPH is a Clinical Professor in the School of Public Health at UC Berkeley, and former Director of Family, Maternal and Child Health programs at Contra Costa Health Services. She is actively involved in the practical application of life course theory to the work of state and county health departments. We recently sat down with Cheri to hear her thoughts about the future directions of life course health development research, and her vision for the Maternal and Child Health Life Course Research Network (MCH LCRN). The interview was conducted by Shirley Russ, MD, MPH, Health Sciences Professor of Pediatrics at the David Geffen School of Medicine at UCLA, and Attending Physician in the Department of Academic Primary Care Pediatrics at Cedars-Sinai Medical Center, and Sepideh Rabi, Medical Student at the David Geffen School of Medicine at UCLA.

This is the second in a series of interviews with national and international experts in life course health development. The series is produced by the 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 (grant # UA6MC19803).

*SR: How did you first become involved with research that contributes to our understanding of how health develops across the life course?*

CP: I first came across the issue of life course at a conference at UCLA in 2003, through hearing Michael Lu [MD, MPH, Associate Professor of Obstetrics & Gynecology and Public Health at UCLA, and Co-Principal Investigator of the MCH LCRN]. I was working as the MCH Director at Contra Costa Health Services - I served in that capacity for 14 years and just recently retired from that job - and Michael was one of the speakers that day. At that point I began to think, "How can we take that theoretical framework and apply it to practice at the local level?" I don't feel I've been doing research in the traditional sense, but I have been working on translating what we know into practice for a number of years.

In 2005, at Contra Costa Health Services, I launched a 15-year initiative to integrate the life course perspective (LCP) and life course framework into the county health department's delivery of the maternal and child health program. This initiative involved the education and training of 220 staff over a period of several years to make a paradigm shift in how we do our work and how we plan to do future work at a county and state level. At the same time, I began to also raise some of these issues with the State of California Department of Health Services, Maternal and Child Health Branch, and began to talk about how we in California can begin to learn more about the life course and the social determinants of health. I wanted to encourage a shift from looking at the prenatal care/medical model as a panacea. Over the course of the last 6-7 years, I've conducted education and training around what life course is from a practice perspective, helping to develop interactive learning activities. I've hosted an international life course meeting that Neal Halfon [MD, MPH, Director, UCLA Center for Healthier Children, Families and Communities; Professor, Departments of Pediatrics, Health Sciences, and Policy Studies at UCLA; and Principal Investigator of the MCH LCRN], Milton Kotelchuck [PhD, MPH, Senior Scientist in Maternal and Child Health at the MGH Center for Child and Adolescent Health Policy, MassGeneral Hospital for Children, and Visiting Professor of Pediatrics at Harvard Medical School], and Michael Lu helped me coordinate in 2008.

We published [several publications](#) as a result of that.

*SR: So you heard Michael and got inspired by him, and then you immediately wanted to put the ideas into practice. Are you still working with Contra Costa?*

CP: I'm working with them and with Alameda County as a consultant. At Contra Costa, as part of our life course initiative, we launched a program called BEST (Building Economic Security Today) based on the life course principles 12-point plan that Michael Lu had written an [article](#) about. The program focused on steps towards improving people's health over the life course by changing their ability to have financial stability and security. I've been continuing to work with Contra Costa County as we launch and integrate that program into our WIC program. With Alameda County, they've launched a much larger initiative called the Building Blocks Collaborative (BBC), a countywide initiative involving partners from all sectors - health, social services, environmental, economic. They are using a life course framework to guide their work, and they've developed a life course bill of rights. I'm helping them to move forward with their whole life course systems redesign effort in Alameda County.

*SR: That's very interesting and exciting to hear that you've had so much impact there. What, in your view, have been the biggest achievements in life course research to date?*

CP: The work I'm most familiar with include the [study](#) by Paula Braveman [MD, MPH, Professor of Family and Community Medicine and Director of the Center on Social Disparities in Health at UCSF] on the links between child health and life course health, and Neal Halfon's [work](#) on life course health development over time. Certainly Michael Lu's writing. It's not research per se, but more conceptualization. There's also the [concept paper](#) that Milton Kotelchuck and Amy Fine [MPH, an independent health policy and program consultant] published. There's research that Cynthia Harding [MPH, MCAH Director for Los Angeles County] and Michael Lu are doing in Los Angeles on [LAMBS](#) (Los Angeles Mother and Baby Study) looking at protective factors and risk factors.

*SR: A number of the U.S. papers are conceptual. We haven't had many datasets that can be analyzed from a life course perspective, unlike in the U.K. where there is the work of David Barker [MD, PhD, FRS, Physician and Professor of Clinical Epidemiology at the University of Southampton and Professor in the Department of Cardiovascular Medicine at the Oregon Health and Science University] and Michael Marmot [MBBS, MPH, PhD, FRCP, FFPHM, FMedSci, Director of the International Institute for Society and Health, and MRC Research Professor of Epidemiology and Public Health at University College, London].*

CP: I also think of the [work](#) of James Collins [MD, MPH, Attending Physician, Division of Neonatology at Children's Memorial Hospital, Chicago, and Professor of Pediatrics at the Northwestern University Feinberg School of Medicine] and Richard David [MD, Division of Neonatology, John H. Stroger Jr. Hospital of Cook County, and the Department of Pediatrics at the University of Illinois, Chicago]. They've looked at environmental and neighborhood level factors on birth outcomes. They've also done really interesting work across the generations on the health of grandmothers, and have an interesting dataset. I was on a panel with Jimmy a couple years ago and I just heard him speak again recently this summer in Chicago. They have some very solid research.

*SR: Tell me about some of your work earlier in your career.*

CP: Early on, much of my work was on ethics in reproductive health - artificial insemination, in-vitro fertilization, women's right to choose, substance abusing women's right to have children. In the last 15-20 years as I've moved towards working at a local health department level, I'm more interested in the broad range of maternal and child health, the social determinants of health, and how that influences health across the life course. Now I have a language for what I'm interested in.

*SR: Where are the biggest knowledge gaps in your area of research?*

CP: From my perspective, I would say the biggest knowledge gap is on how to apply a theoretical framework to already existing practice - to a practice that has been focused on a medical model for so many decades. When we talk about moving from theory to practice, there needs to be a better understanding of how you shift a paradigm.

*SR: What do you see as barriers to closing these knowledge gaps?*

CP: One barrier is funding – specifically, the current model of categorical funding streams. Until we have a broader understanding of how money is being spent to improve the social determinants of health and reduce risk factors, and really look at children's health as the health of families - until we are able to understand the importance of the intermingling of those topics – I think categorical funding is going to be a very large barrier to applying theory into practice. This is what I see on a day-to-day basis. Working with county organizations, the staff may say, "These are great ideas, but who's going to pay me to switch gears and do that?" When we talk about life course and health equity, we're looking at the issues around access to care, involving fathers more, and reproductive social capital. We are talking about these issues, but funders don't really work that way.

*SR: There's a big gap between what people will pay for and what is needed to put a theoretical framework into practice. What role can the LCRN play in helping to overcome these barriers and close knowledge gaps in your area of research?*

CP: Well, I would like to see legitimacy given to evaluating some of the practice activities that are currently being undertaken by several communities around the country to implement more of a life course framework. I think that with the help of very skilled researchers who understand evaluation and program implementation and program development, the LCRN could be useful to the application of theory to practice by asking some of the hard questions: Which programs are working? Why do they work? Are we seeing a change over time? In the article by Kotelchuck and Fine, they had a formula, T<sub>2</sub>E<sub>2</sub> (timing, timeline, environment, equity). So, what is the timing of these interventions, and is there a change over time? How does the environment change, and is there any impact on health equity? To me, if the LCRN can spend just part of its time on the integration of theory and practice, it would be such a huge benefit to the families and communities we serve.

*SR: What would be a "dream project" for you to work on within the LCRN?*

CP: It would be that. It would be an opportunity to work with skilled researcher/evaluators to establish some criteria by which to evaluate the multiple

programs currently being implemented throughout the U.S. – in both small communities and big cities - to assess their effectiveness in program/service delivery, but mostly to measure their impact on the lives of the children and people receiving services across the life course. It has to be longitudinal. Like the National Children’s Study (NCS) - it has some of that. But it’s more focused on communities working together on a similar framework. We have 15-20 communities that are starting to implement a life course initiative. I’d love to be part of a group that was given an opportunity to do some evaluation.

*SR: Next question: Have you participated in any other networks that you found beneficial to you in your work, and that we should consider as good models for the LCRN?*

CP: I’ve done a lot of work with CityMatCH, and they’ve developed “learning communities.” I have found those to be very useful for my own intellectual stimulation and my own work. Sometimes the remote phone conversations are interesting, but well-structured in-person meetings are very valuable. People share information on a website or internet or email in terms of what they’re doing over time.

*SR: Was there any expectation that you would all work together on a common project, or was it an intellectual exchange of ideas?*

CP: The expectation was that you’re doing your own project in your own city with your group of people and then you get together to consult, to get resources and advice from your colleagues. There was a shared camaraderie in ensuring the growth of the project. You were both a consultant and consultee.

*SR: What was it about these networks that made it so effective? You mentioned some well-facilitated face-to-face meetings. Is there anything else you would highlight?*

CP: It was designed to be non-competitive. People were encouraged to see their work as important and to see each other as colleagues rather than competitors. That was an important aspect of what CityMatCH did – they created an understanding of working together towards one larger goal. They used a variety of techniques and activities to mix the group up, to get people to know each other and rely on each other and see each other as colleagues. You really had to rely on each other or be competitive in a fun way. It instilled a sense of respect for people and what they can do. I was teamed up with some folks from Tennessee. I didn’t know anything about their capacity. I was blown away and surprised not just by the intellectual integrity of the group, but also their creativity and innovation.

*SR: How can we best design the LCRN so that it is useful to both senior and junior researchers?*

CP: I don’t have a good answer to that question. When you talk about research, there’s such a pressure to do research and to publish, and to “elbow others.” I don’t exactly know the answer. I don’t feel I have a good enough handle on it. I do think there needs to be an open sharing of resources and information. It’d be great for people to be mentors or to have a mentor. I think Michael Lu has benefited tremendously from having both Neal Halfon and Milton Kotelchuck mentor him. It’d be wonderful to know who’s interested in being mentors.

*SR: What is something unique the LCRN could do to support you in your research endeavors?*

CP: It would be useful if there were a clearinghouse of information for grants, and a clearinghouse of researchers who wanted to partner with people in academic or practice settings. That would be helpful as a way of introduction.

*SR: We know how busy you are. What would make it easier for you to actively participate in this network over the next three years and beyond?*

CP: It's a priority for me to meet face-to-face with people. I can't seem to figure out the learning community online - I'm not technologically astute! I need someone to walk me through it. I think webinars will be just wonderful, with opportunity for discussion where you can raise your hands and ask questions. Also, it would be great to record the webinars for people who can't attend so they could click on a link and hear the webinar and see the powerpoints.

*SR: What should the LCRN do to advance the translation of research into practice?*

CP: I think David Barker's research looking at the fact that people born low-birthweight were more apt or inclined to develop chronic disease and die from that later in life....speaks to a need to improve prenatal care. How can we prevent low birthweight at an even earlier stage through preconceptional care.

*SR: You've articulated that this is an important area that needs methodological work.*

CP: Yes, and I think longitudinal studies and GIS mapping and the ability to look at communities and environments over long periods of time – I guess that's where new methodology would help.

*SR: One question commonly raised is "Life course health development is an interesting theory, but what are the implications for practice based on what we know to date?" How would you answer that question?*

CP: The implications for practice are vast. One implication for practice is what does it mean for pediatric medicine or for care delivery in a well-child clinic. If an adolescent girl is pregnant, or has a sibling who is pregnant, what are the implications for their future health? The importance of putting some effort into determining what kinds of practices would address most effectively these risks across the life course would be so important. It's going to be different for each community we're in. The implications for practice are exciting!

*SR: What do you see as important next steps?*

CP: There has to be a way to communicate life course to university students, the academic world, and workers in local and county agencies so that all can understand. To communicate this information through interactive games, through powerpoint presentations, through dialogue and discussion, and through idea generation on practical applications is a priority. It takes more than one shot to translate knowledge into practice. People have to hear it in several different ways and times, and there needs to be opportunity for discussion and to be critical, but also to be enthusiastic so they feel

the excitement. There also have to be examples – Mario Drummonds [MS, LCSW, MBA, Executive Director/CEO of the [Northern Manhattan Perinatal Partnership](#), and Principal Investigator of the Central Harlem Healthy Start], people in Wisconsin, Michael Lu with [LA Best Babies Network](#), or Contra Costa County with [BEST](#). It gets you thinking, “Could it work here?” I love it!

CityMatCH has a life course game, based on a form of chutes and ladders that was created by my students. There’s a similar Canadian game. It teaches you about different influences at different stages of life, and provides an interactive way to learn about life course. Also, there’s [Unnatural Causes](#), the PBS documentary. In any class I teach or do, I require people to see it ahead of time. It’s a series of 6 different half-hour-to 1-hour-long pieces. Barker and Marmot are in the first one, “In sickness and in wealth.” It provides you with an understanding of social determinants. Michael Lu is in the one called “When the Bough Breaks.” It’s educationally and socially and politically provocative. The information looks at public health. I encourage everyone to watch it. You can go online and see snippets. It gave me ideas for BEST.

*SR: What do you believe are the highest priority topic areas that this network could focus on to advance the state of life course research for the maternal and child health field?*

CP: I’m of the thinking that intergenerational health, the social determinants of health, and environmental health (reproductive social capital) are important. I’m less inclined to study separate stages in isolation - preconception, prenatal, pregnancy, postnatal and beyond - because it chops up perspectives across time. When you’re looking at maternal depression, for example, it crafts itself as one topic area when, in reality, you need to look at many intersections. I’m answering this question in terms of someone who does practice – how do we impact social determinants and impact them across the life course? What do we need to know to make changes in those social determinants? Those are the interest areas I think are compelling. The whole concept of intergenerational health and James Collins’ work is of interest to me. Research is not just in the academic setting or on the bench - we need to look at systems redesign and what people in practice need in order to evaluate the outcomes in their work.

*SR: Cheri, thanks so much for taking the time to talk with us, and we look forward to further discussions in the LCRN.*