PULSE

A MONTHLY NEWSLETTER FROM THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

July/August 2016 The Quality Improvement Issue

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From the President

By Eileen Forlenza

President of the Board, AMCHP

Stephanie pulled up to her son's school just in time for recess, so she decided to simply watch for a while. Alec never saw his mom, because she stayed in the car, watching and crying. For the entire recess period, Alec walked the perimeter of the playground. No one played, laughed, skipped or clapped with him. He did not appear to be unhappy – he was just alone. He was not being bullied – he was just isolated. He wasn't bothering anyone – he was just disengaged. Simply put, he was not included. Period.

Within weeks, Stephanie developed a facilitated recess program to assure that all children had access to team building, shared goals and social integration. She engaged the school nurse, physical education team, psychologist, principal, school board and of course, the kids. Some of these community partners had never worked together, but instinctively Stephanie knew they all had a shared goal for the school and the kids. Anchored by their vision of positive outcomes for children, the team created an integrated approach to wellness, including social-emotional health, that really worked! Alec soon had plenty of friends, increased activity and heightened self-esteem. He was on track for a great school year. While Stephanie was motivated by her own son's situation, her dedication to quality and inclusion improved the lives of hundreds of children.

I am certain you see yourself reflected in Stephanie's story – dedicated, inspired and equipped to make a difference. For MCH professionals, there are other components of Stephanie's approach that we know are critical:

1. Families often create innovative solutions because their perspectives are from a different view.
2. Convening non-traditional partners leads to trust building.
3. The solution was not clinically-based; it was com-

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From the CEO

By Lori Freeman, MBA
Chief Executive Officer, AMCHP

This issue of Pulse centers on the theme of quality improvement (QI) – an idea that I truly embrace and appreciate.

Quality improvement is one of those concepts that we've all been exposed to throughout our lives but sometimes never recognized.

As a young mother-to-be, I remember learning of our pregnancy and immediately launching into a very personal QI effort to be the healthiest I could be while carrying our twin children. I solicited the support of my husband, Dan (aka "leadership"), to help me and be part of the best possible positive outcome for our babies. We created our own personal at-home QI culture. We researched and read everything we possibly could about having a good pregnancy and learning to be new parents (aka "planning").

My OB/GYN worked with us to ensure we closely monitored the health of the babies and were progressing toward a successful delivery (aka "measuring). Even after the babies were born, we kept up the personal QI culture in our house. Because we were new parents, we developed and tested many, many processes and routines (from feeding prep to napping schedules to bedtime routines to planning regular date nights), and often kept revisiting these "systems" – tweaking them, improving them and repeating the cycle. Over the years, the continuous quality improvement culture in our home has remained, and we've tried to instill some CQI values into how our kids view themselves and their roles in the world. It's been a wonderful tool for teaching our kids about accountability, self-reliance and the overall ability to control your own outcomes with the right support and culture of improvement. QI has worked for us even in the most personal contexts.

During my own business career, I recall having been exposed as a younger professional to QI concepts in a number of differing professional roles. At the Association for the Advancement of Medical Instrumentation, a core focal point of my work was the development of national and international standards for the use of medical devices. In this realm, QI concepts were used frequently related to quality assurance and equipment safety; we viewed product development through a lens of human factors to ensure ease and quality use of medical instrumentation by anyone touching the equipment, from biomedical engineers to health care providers, patients and caregivers. While at the International Test and Evaluation Association, I actively employed Six Sigma in my work related to assessing effectiveness, reliability, interoperability and safety of technology-based military systems and products throughout their life cycle. Six Sigma is a data-driven QI approach for eliminating defects in a process. It can be applied to manufacturing, transactional processes, product development and customer service – to name a few applications. One of the many things I liked about Six Sigma was that, as systems improvement occurred, so did the morale of those working within those systems.

It was not until I reached the National Association of County and City Health Officials (NACCHO) that I experienced how QI could be truly intentional within a nonprofit at the highest management levels. This brilliant approach was spearheaded under the leadership of Bobby Pestronk, NACCHO's executive director, and led by Grace Gorenflo, a professionally-trained QI expert. NACCHO already had a long history supporting QI with its members, mostly as the public health department accreditation process was being developed and launched. The organization embraced QI so fully that it invested in QI internally to help evolve and improve many of its management processes, product offerings and, at times, entire department structures. In the time I spent at NACCHO, I was involved in at least four intensive QI processes that moved the organization toward greater efficiencies; improved process and understanding; and increased staff morale, engagement and accountability. By the time I departed NACCHO for AMCHP in 2014, I was a self-declared QI advocate and remain so.

"Failure was a valid result from QI and nothing to be ashamed of because, after all, QI is continuous."

I learned so much about QI from my colleague and friend, Grace Gorenflo; her teachings will always stay with me. Grace taught me that there was never one way you had to approach QI. She made sure I understood and could appreciate that not everything was a good candidate for a quality improvement process merely because it represented a challenge or problem to be solved. Sometimes, you have to step back and consider quality planning for the future. And she always taught me that failure was a valid result from QI and nothing to be ashamed of because, after all, QI is continuous.

In this issue of Pulse, you'll learn how QI is being utilized in various ways across maternal and child health to improve outcomes. You'll also gain some insight into how we are working at AMCHP to create our own internal QI culture. Please enjoy your reading!

Finding the Root Cause to Improve Timeliness in Newborn Screening

By Yvonne Kellar-Guenther, PhD
Colorado School of Public Health, NewSTEPs 360
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NewSTEPs 360, a collaboration between the Colorado School of Public Health and the Association of Public Health Laboratories, supports improvements in timeliness of pre-analytic, analytic and post-analytic components of newborn screening (NBS) programs across the U.S. through continuous quality improvement (CQI) initiatives. The CQI approach has benefited many health agencies and organizations by promoting impactful and sustainable change in health care systems.

In June 2016, NewSTEPs 360 – in partnership with the Cystic Fibrosis (CF) Foundation – convened NBS program staff (laboratory and follow-up) and clinicians to identify barriers and solutions to assure timely newborn screening for cystic fibrosis. Participants received training on the 5 Whys approach, conducting root cause analyses and applying this methodology within their multidisciplinary teams to identify underlying barriers to meeting the NBS timeliness recommendations issued by The Advisory Committee on Heritable Disorders in Newborns and Children. The overarching goal of the meeting was to equip NBS programs with tools to improve timeliness in newborn screening for all infants, as well as to identify specific solutions for improving timeliness in CF newborn screening. CF clinicians were engaged in all aspects of the process with the understanding that identification of solutions to improve the overarching system would also benefit newborns identified with CF.

In small groups, teams discussed the barriers and proposed solutions. Facilitators prompted discussions to identify root causes. For example, one barrier discussed was that midwives have a lower percentage of specimens collected in the recommended time frame (prior to 48 hours of life) than do hospitals. This barrier was not the "root cause," though; it was the problem statement. As a result, the facilitator walked the group through the 5 Whys approach to identify the true root cause. After three whys, the group identified the root cause. (See Figure 1.)

Through a facilitated discussion, the group identified challenges in locating midwives as the root cause and discussed solutions to reaching midwives. These included finding professional midwifery groups and working with naturopath providers to assist in outreach efforts to find other midwives in their state.

Another group discussed the challenge of increasing operating hours of the newborn screening laboratory to include weekends. Challenges identified included lack of dedicated funding, limited technical support on weekends and staffing shortages for weekend shifts. Using the 5 Whys approach, the group explored the staffing shortage challenge, and a root cause was determined to be a shift in ex-

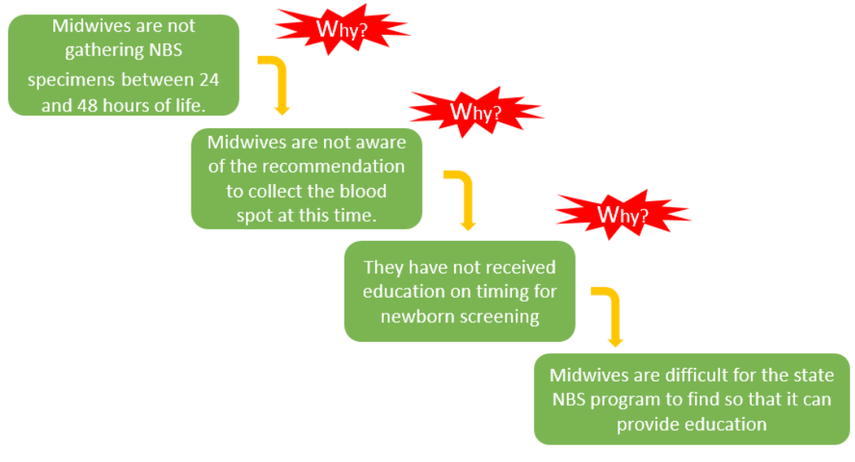

Figure 1. Moving from Problem Statement to Root Cause

pectations for laboratory staff. Laboratory technicians might have been hired with the expectation of a five-day work week and might feel their job duties have changed if they are shifted to weekend hours. Potential solutions proposed were to offer compensatory days for staff working Saturdays and to consider alternate work schedules.

This was the first NBS meeting of its kind, bringing together clinical specialists and public health laboratory and follow-up directors to identify opportunities for improving timeliness for condition-specific newborn screening. The application of CQI techniques in multidisciplinary teams provides opportunities for implementing cross-discipline solutions and for developing partnerships with dedicated personnel working toward a common goal.

For more information about NewSTEPs 360, visit its website.

NewSTEPs 360 is supported by the Health Resources and Services Administration (HRSA) under grant UG8MC28554. The contents of this publication are solely the responsibility of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Changing Systems One Quality Improvement Tool at a Time

By Amanda Cornett, MPH

Senior Vice President for Programs, Population Health Improvement Partners; QI Core Co-Lead and Coach, the National Maternal and Child Health Workforce Development Center***

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Every day, systems surround and impact the health of women, children and youth, including children and youth with special health care needs (CYSHCN) and their families. Often we are so conditioned to how the system operates that we lose the ability to view it with a critical eye. Quality improvement (QI) methods and tools provide a lens from which to view and transform systems. QI methodologies provide the plan for how to go about improving the systems that surround maternal and child health (MCH) populations, from assessing the current system to identifying and testing changes. QI tools provide the ability to implement each prescribed step in the methodology, or can be used as individual, standalone instruments to solve a specific problem.

Below are examples from the National Maternal and Child Health Workforce Development Center (WDC) that capture the essence of using standalone QI tools to move stakeholder groups towards improving systems that serve and improve the health and well-being of MCH populations.

Creating a Shared Vision and Understanding

A key component of improving a system is to create a shared understanding of the system among stakeholders. A process flow diagram provides visible documentation of how a system works. It is used to highlight gaps and variation among current systems or to document the "ideal" system for the future.

By engaging with the WDC, state Title V MCH and CYSHCN programs and their partners created process flow diagrams documenting various systems, including care coordination, screening and referral. Hawaii's Title V program used a process flow diagram to visualize and understand developmental screening and surveillance efforts across the state. The team conducted on-site observations with six stakeholder agencies, created process flow diagrams for each agency's process and shared the diagrams at an in-person meeting with 35 stakeholders. Stakeholders reviewed the diagrams; identified duplication and variation across agencies; and identified standard forms, communication techniques, and educational materials needed to standardize the process.

Georgia's Title V program used a process flow diagram to create an "ideal" child health referral process. During an in-person meeting, approximately 100 child health program staff members worked in teams to draw their ideal processes. Title V program and WDC staff consolidated the diagrams into one process flow diagram that represented the ideal system. The diagram created a common vision among staff and provided an opportunity to discuss roles, responsibilities and resources needed to successfully implement the new referral process.

Identifying Priorities

Identifying common priorities can create buy-in and help move a group to act more quickly. An impact matrix provides criteria to prioritize changes based on their: 1) impact on overall goals and 2) difficulty to implement. States that engaged with the WDC found the impact matrix valuable, as it provided focus to overall project objectives and goals and created space for enlightening discussions with partners by providing opportunities for diverse perspectives.

Colorado's Title V program used the impact matrix to identify and prioritize over 40 programmatic and cross-agency policy and system changes to improve care coordination for CYSHCN. During an in-person meeting, stakeholders ranked each change and identified the "quick wins" (high impact and easy to implement) and "major projects" (high impact and somewhat difficult/difficult to implement). The team placed the "quick wins" in an action plan and incorporated the "major projects" in the state CYSHCN systems integration plan.

Creating Small Rapid Change

Maintaining engagement and momentum is challenging. Often, stakeholders agree on a list of changes, but "analysis paralysis" sets in as they try to anticipate all the "what ifs" of each change. The Plan-Do-Study-Act (PDSA) cycle can help build confidence in a change as it allows a group to quickly try the change on a small scale, make observations and take action based on what was learned.

One WDC state Title V team used the PDSA cycle to test a data-sharing memorandum of understanding (MOU) with a stakeholder group. The team drafted a MOU and shared it with two stakeholders for feedback. Based on that feedback, the MOU was adapted and shared with three new stakeholders, who provided additional suggestions for improvement. Over the course of a few weeks, the team adapted the MOU and shared the final version with the larger stakeholder group.

Another state Title V team aimed to reduce duplication in the referral intake process. After reviewing the intake forms, the team learned that two different forms captured eligibility information. The information was combined into one new form. The team used a PDSA cycle to test the new form with three clients from a pilot site organization. Clients were pleased with less paperwork; however, eligibility staff noted that several additional questions were needed to fully process clients. Based on feedback, the form was modified, and plans were made to test it with five additional clients. Testing the form provided an opportunity for the team to learn on a small scale rather than make the change in a single big step, reducing the chance of failure on a large scale.

Using QI tools can help improve the systems of care for MCH populations by establishing a shared vision and understanding among stakeholders, identifying common priorities and creating opportunities to rapidly test changes on a small scale. To learn more about QI, visit the QI Step by Step Guide or Transformation Station on AMCHP's homepage.

**Population Health Improvement Partners is a national leader in building community and organizational capacity to improve and sustain population health.*

*** National Maternal and Child Health Workforce Development Center offers state and territorial Title V programs training, collaborative learning, coaching and consultation in health transformation.*

Quality Improvement Resources for Public Health and Title V

By Jennifer Farfalla, MPH

Analyst for Quality Improvement and Life Course, AMCHP

Taking on quality improvement (QI) projects can feel intimidating due to all of the tools, methods and skills there are to learn. However, a host of QI resources and training opportunities are geared toward state and local public health departments – and even specifically toward Title V programs. Through our work with our members as well as our own internal QI journey, we at AMCHP identified a number of these resources.

QI Consultation for Title V Programs

The National Maternal and Child Health Workforce Development Center (the Center) at the University of North Carolina at Chapel Hill offers Title V programs free consultation and services related to health care reform. The center features four core areas in which it provides services: health transformation, change management, systems integration and quality improvement. The quality improvement core is staffed by a mix of AMCHP staff and QI experts from the Population Health Improvement Partners. The center is unique in that its services are concentrated on preparing the Title V workforce in particular to respond to today's complex and changing environment. Because quality improvement is one of its four core areas, the Center offers targeted coaching and consultation on quality improvement within health departments and Title V. Request a consultation here.

As a practice partner of the Center, AMCHP's houses Transformation Station, a web-based repository of resources related to health transformation. The quality improvement resources on Transformation Station can be accessed here.

QI Training for State and Local Health Departments

Population Health Improvement Partners (Improve-

ment Partners) in North Carolina is a practice partner of the National MCH Workforce Development Center. Improvement Partners has experience working with state and local health departments to increase QI capacity. It offers two interactive QI training programs designed to build individual skills and organizational QI capacity. The introductory program is Quality Improvement 101, which allows participants to apply the QI methods and tools they're learning to projects at their health departments. Staff learn to use tools such as the fishbone diagram, impact matrix, aim statements, process mapping and value stream mapping. The more advanced training option, the QI Advisor program, trains staff who have a QI skills base to become leaders for continuous quality improvement within their organizations. Staff learn how to lead the QI processes and tools from QI 101 and get experience facilitating a Kaizen Event. Visit the Population Health Improvement Partners here.

QI for Epidemiologists

Due to the need for measurement and critical thinking, QI projects can sometimes fall to the epidemiology department. In December 2014, AMCHP published *QI Resources for Epidemiologists.* The material for this publication originated from a roundtable discussion with epidemiologists about their needs to successfully take part in QI projects. The resource is available here.

In-Person Learning from Experts and Peers

The National Network of Public Health Institutes supports a Community of Practice for Public Health Improvement (COPPHI), which hosts public health department leaders at the Open Forum for Quality Improvement twice a year. Participants learn about concrete examples of applying improvement practices from each other and national experts through oral presentations, roundtable discussions and poster presentations. The event registration is open to the public. Find out more about the Open Forum for QI in Public Health and COPPHI here.

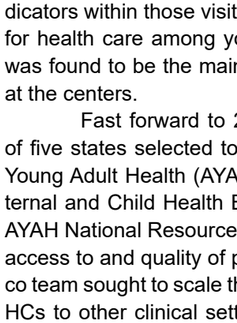
Examples of QI in Public Health Practice

A resource called the Public Health Quality Improvement Exchange (PHQIX) provides examples of QI in applied public health that you can study without having to leave your office. PHQIX is funded by the Robert Wood Johnson Foundation and was created by RTI International. It is an online database of QI efforts conducted by state and local public health departments. You can filter to explore QI initiatives specific to MCH programs at the state and local level. When you click on an initiative, you can learn about the project and useful replication information such as how many full-time employees a QI team had or what type of QI training the organization gave its staff. PHQIX can be accessed here.

Good luck on your QI projects! For additional support contact AMCHP's internal QI advisor, Jennifer Farfalla, at jfarfalla@amchp.org.

QI Wins in New Mexico

By Iliana White, MPH, CHES, CPH
Senior Program Manager, Adolescent Health, AMCHP



Quality improvement (QI) can be a loaded term, and operationalizing it within Title V efforts can seem intimidating. But efforts to improve the quality of health care for adolescents and young adults at one New Mexico clinic show how making small, incremental steps – a core characteristic of QI – can build a foundation for grander improvements to be scaled and spread.

First, some background: New Mexico has a long history of serving youth through its network of school-based health centers (SBHCs). The state Office of School and Adolescent Health (OSAH) in the Department of Health guides policy development on school and adolescent health issues and is involved in workforce development and training for those providing services to youth. In addition, OSAH has a close working partnership with Envision New Mexico, a child health care quality initiative based at the University of New Mexico Department of Pediatrics.

For over a decade, the SBHCs across the state took part in QI initiatives focused on preventive services, including one that examined the quality of comprehensive well-exams in the clinics. Rates of receipt of the well-visits in SBHCs were compared with other statewide measures, and medical record reviews were conducted to verify quality indicators within those visits. SBHCs are viable access points for health care among youth, and the adolescent well-visit was found to be the main reason students access services at the centers.

Fast forward to 2015, when New Mexico was one of five states selected to participate in the Adolescent and Young Adult Health (AYAH) CoIIN, funded by the U.S. Maternal and Child Health Bureau and supported through the AYAH National Resource Center. In its approach to improve access to and quality of preventive services, the New Mexico team sought to scale the QI process that improved its SBHCs to other clinical settings in outlying communities. The rationale was that although the care within the SBHCs was youth-friendly and centered toward the needs of adolescents, this was not evident for young adults once they matured out of the school system. In addition, research shows that young people are less likely to get annual, preventive well-visits after they age out of their adolescent years.

Lead by a multidisciplinary team of Title V leaders, youth advocates and leaders, Envision New Mexico staff, providers, community partners, the CoIIN team selected El Centro Family Health to help replicate the quality and successful strategies employed in the SBHCs at El Centro's other clinics. El Centro is a federally qualified health center that serves eight counties and operates nine SBHCs as well as other community sites.

Why El Centro? Yolanda Montoya-Cordova, the former director of OSAH, said El Centro was selected because it had been part of previous QI initiatives and was an early adopter of QI in its SBHCs. In addition, El Centro's leadership, including its medical director, was willing to try to test the successes from the SBHC QI efforts at a community-based El Centro clinic, in the Las Vegas, N. Mex., area. Data from that clinic showed that the receipt of the well-visits there were below the rates at the SBHCs; this provided an opportunity to implement the QI process.

In the community sites, the CoIIN team discovered that one area for improvement was the readiness of the providers to receive older adolescent and young adult patients. The providers revealed that they were not as confident or trained to deliver services with the AYAH focus. As a result of this revelation, the SBHC team trained the other clinical staff in these sites on components of youth engagement as well as how to ensure that their delivery of services is youth-friendly.

"We basically taught them how to fish," Cordova said. "Intentionality around quality improvement is what made the difference."

The buy-in, training and capacity-building of providers in the community sites were successes that served as a small milestone in the move toward bringing the quality of AYA health care in schools to e other settings. Also, comprehensive well-exams for AYAs will be adopted as a performance measure across the clinical system, not just in the SBHCs that El Centro operates.

The AYAH CoIIN efforts will continue to bring new changes, but this early stage of small achievements can have influence beyond the participating sites: It shows youth accessing preventive services even after they mature out of the school, and that the care they receive is built around their physical, emotional and developmental needs. Cordova hopes other clinical systems serving AYAs in the state will notice El Centro's lead on this effort and follow suit, like a friendly competition.

Several factors helped El Centro's CoIIN team get to this point of the process, Cordova says. The established partnership with Envision New Mexico provided the foundation for adolescent health to be a top priority among health care providers and clinical systems prior to the AYAH CoIIN; El Centro's onsite coaching, web-based training series and technical assistance helped accelerate efforts in previous QI projects. She also emphasizes how the trust and rapport between the OSAH and El Centro Family Health was essential to buy-in among staff, and that data found within medical record reviews was extremely helpful in understanding where improvements could be made and how to look at incremental progress.

Cordova recommends that Plan-Do-Study-Act (PDSA) cycles (which are pillars of QI) be brief yet meaningful in the approach. Also, this QI effort – as well as others that may come along – will require a shift in focus among providers and youth to better understand the power of prevention. This milestone with the CoIIN might seem like a small step, but it can influence more significant and broader improvements for AYA patients to be made across the EL Centro Family Health system – and, it is hoped, across other systems in the state.

Insights on Public Health Accreditation

Having recently been awarded accreditation status by the Public Health Accreditation Board, what would you want to share with another MCH or CYSHCN program going through the process? How will your program benefit from accreditation?

The Arkansas Experience

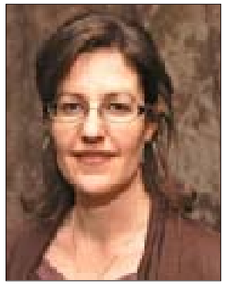
Bradley Planey, MS, MA
Branch Chief, Family Health Branch, Arkansas Department of Health

In Arkansas, individuals from all the major programs and support services in the agency were invited to participate in the workgroup and its associated activities. The accreditation process gives the Title V program a presence in an activity of great focus for the leadership of the agency. It is an opportunity to showcase and explain the Title V program, which can take a backseat to other departments, such as infectious disease, trauma/injury prevention or emergency preparedness, and show off the best practices in your MCH program and its contributions. This greater visibility can lead to more consid-

eration or inclusion in agency planning, which can result in changes in the allocation of resources.

Further, the accreditation process will identify areas in which the agency is weak and needs improving (such as continuous quality improvement, data collection and analysis or staff training) and this can be a direct benefit to your program if you manage this opportunity correctly. By being part of the accreditation process, you can influence what areas are addressed and the selected priorities.

The Nebraska Experience



Sara Morgan
Administrator, Lifespan Health Services Unit, Nebraska Division of Public Health

In Nebraska, both the Maternal, Child and Adolescent Health program manager and the MCH epidemiology surveillance coordinator were involved in accreditation teams. In addition, the coordinator served as staff support for the State Health Improvement Plan assessment (providing data, for example) and sat on the Performance Improvement Advisory Council. Finally, the overall process relied heavily on the MCH Assessment for documentation purposes. Involvement on the part of MCH staff developed into opportunities not only to make contributions to the accreditation process but also to educate colleagues in the Division of Public Health about our work to improve health and life course outcomes for the MCH population, including children and youth with special health care needs.

The opportunities provided by going through the accreditation process include reaching across sectors and identifying common interests, particularly where social determinants of health are concerned; informing public health partners who are involved in more regulatory and compliance roles (water and air quality, for example) about how our work in population health aligns with the essential services and accreditation framework; and shared learning. There were many "ah-ha" moments from others about MCH approaches to evidence-based and data driven practice or efforts to address disparities. In addition, accreditation is a great opportunity to demonstrate to others in the agency the quality and quantity of the MCH work and to establish new partnerships.

Accreditation gives us the ability to further integrate MCH values into the public health culture, and the opportunity to keep improving on achieving standards.

AMCHP's Internal Quality Improvement Efforts

By Jennifer Farfalla, MPH
Analyst for Quality Improvement and Life Course, AMCHP

AMCHP, like many of its members, is on its own quality improvement (QI) journey. Over the past three years, we have taken steps to increase our capacity to perform internal QI projects, offer external QI technical assistance and create a culture of continuous quality improvement (CQI) within our organization. CQI is a process of creating an environment where an organization's staff and leadership are able to identify inefficiencies in their work and propose and implement solutions to those inefficiencies.

In December 2013, AMCHP staffers employed QI tools such as measuring our activities on an operational dashboard, but these tools were limited to use by a few staff members. In order to ensure staff were trained in basic QI tools and methods, AMCHP enrolled staff in Population Health Improvement Partner's QI 101 program. Staff applied these skills to three QI projects that aim to improve the services we offer our members. The QI project topics were (1) improving our identification of emerging issues in maternal and child health (MCH), (2) improving our recruitment of MCH best practices and submissions to our repository of best practices, Innovation Station, and (3) improving our virtual engagement, specifically webinar practices. AMCHP staff applied QI tools to analyze root causes of problems in these topic areas, prioritize our change ideas, test and measure changes, and sustain our change ideas with coaching from Improvement Partners staff. Improvements that came out of these projects included an AMCHP webinar toolkit, a technical assistance (TA) tracker designed to enable trend analysis of TA requests to help identify MCH emerging issues and a new Best Practices Ambassador program.

In order to keep the momentum going after the completion of our three QI projects, AMCHP's analyst for quality improvement (who is a staff member) enrolled in Improvement Partners' more advanced QI Advisor training program to build internal capacity to coach QI methods. As a part of the program, AMCHP created an A3, which is a two-page report on problem solving originally used by Toyota and later adapted for use by other organizations, including hospitals and health organizations, to improve processes. AMCHP's A3 consists of five sections: (1) Current performance, gaps and targets, (2) reflection on last year's activities and results, (3) rationale for this year's activities, (4) this year's action plan, (5) follow-up and unresolved Issues. Our A3 uses data, charts, visualizations and text to communicate a clear picture of ACHP's history with QI, our current state and plan for the future and possible challenges that may arise.

Two main activities that came out of our CQI A3 plan were a survey of AMCHP staff on our current culture and capacity for CQI, and the formation of a QI council that will lead QI activities in the future. Our CQI survey was performed in January 2016 and showed areas where AMCHP is already doing well with CQI and its opportunities for improvement. AMCHP's QI council was created in May 2016 and convened its first meeting in June 2016. The council is in the process of creating a charter documenting a vision for QI at AMCHP and how the QI council will operate to help us fulfill that vision. We aim to create a few quick QI wins at AMCHP, including starting another QI project in 2016.

While AMCHP's QI work created a number of positive tools and changes, challenges to this work still exist. First, staff time is always a limited resource. Although a QI project creates several time-saving changes, we have to invest staff time to bring about these changes. However, all of our QI projects include metrics to measure the increased efficiency of our work and member services, which will show us if our staff time on these activities is warranted. Second, change is not always easy, and we do not want to overwhelm staff with changes. We will address this challenge through careful planning with tools like our A3 and feedback from our staff-driven QI council. While change can be challenging, we are also seeing the benefits of data-driven, mindful improvements and look forward to our future QI activities.

Applying Quality Improvement Measurement to Population Health Initiatives

By Greg Randolph MD, MPH
President and CEO, Population Health Improvement Partners; Professor of Pediatrics and Public Health, University of North Carolina at Chapel Hill

Measurement is a fundamental aspect of quality improvement (QI). Some fear that measurement for population-level improvement initiatives is exceedingly different than in a typical QI project, or even impossible. However, I have good news: the same principles apply; they just require minor adaptations, mostly in the number of measures needed and the related feasibility issues.

At the beginning of any improvement initiative, it is critical for leaders of the initiative team to set measurable goals that address the question, "What are we trying to accomplish?" Once these goals are established, the team can begin to develop a set of measures that answer another key question: "Are the changes we're making leading to improvement and moving us toward achieving our goals?"

Using a Set of Measures

A cornerstone of improvement science is the concept of a system. All systems tend to be complex and dynamic. It's not surprising, that when dealing with the health of a maternal and child population, complexity and the dynamic nature are even greater. Thus measuring the impact of improvement at the population level must take this complexity into consideration, and more measures (e.g., five to 10 measures) might be needed than in typical QI efforts. There will never be a "silver bullet" measure that can accurately reflect improvement within a complex system, so we need to think of a set of measures, including outcome, process and "balancing" measures.

Outcome measures address how policies and services affect the health, functional status and satisfaction of the population targeted in the improvement initiative (or simply, the experience of the population and its members). Process measures address how and what services and policies are provided (i.e., what programs and public health officials do). Balancing measures address potential unintended consequences to the system as it is changed (i.e., what could go wrong).

Outcome measures are very important for all stakeholders, especially initiative leaders, who want to know the ultimate impact of the initiative; they must be a part of any improvement initiatives' measure set. Unfortunately, outcome measures are often slow to change (e.g., MCH datasets like PRAMS, BRFFS and YRBS are primarily outcomes), so inclusion of one or more process measures is required so the team can understand the effects of the improvement effort quickly and is able to assess whether the changes they are making are resulting in improvement. In addition, at the end of the initiative, the process measures can help demonstrate that the intended changes were indeed implemented. Finally, any time that changes are made to a system, there can be unintended, adverse consequences. We don't want to improve one aspect of a system at the expense of another, as this could lead to less or no overall improvement, or even overall harm. Usually the team can identify several possible things that could go wrong early in the planning stage, such as decreasing client satisfaction with the time spent with Women, Infants and Children (WIC) staff when

attempting to increase the efficiency of a WIC site. In that case, we don't want to be more efficient by decreasing the quality of the interactions with staff.

Feasibility Issues – Data Collection and Analysis

It is often best to use existing data sources when possible. In addition to the above MCH data sources, various partners and stakeholders, community or state health assessments, Community Commons and other local, state and national resources can be vital. However, due to the need for both process and balancing measures, teams will often need to collect some of their own data. Feasibility and cost are key issues but can be mitigated by using some of these strategies:

– Sampling strategies are key, so consider using small sample sizes (e.g., 20 to40 observations) collected frequently (e.g., monthly or quarterly) and/or representative convenience samples.

– Simple data collection instruments and methods, like check sheets and very brief surveys, can help minimize costs and effort.

– Leveraging technology can also help (e.g., email surveys or scannable forms).

Finally, due to the dynamic nature of complex systems and the need to track progress, the best way to analyze data for improvement is to report your data graphically in run charts.

Other Considerations

In this era of health transformation and a strong focus on value, we should consider economic impact measures (sometimes referred to as "ROI" for "return on investment") as outcomes as well. Measuring economic impact is consistent with the "triple aim" of better quality services, better outcomes and lower costs that is fundamental to the Affordable Care Act and related federal health policy. Similarly, it is very important to address and measure health disparities in population health improvement work. This can often be done by stratifying measures among priority populations in the population that is targeted for improvement.

Measurement Resources for your Population Health Improvement Efforts

– Our "QI Step by Step Guide" has some useful QI measurement tools. Find it here.

– A comprehensive approach to QI measurement is outlined in this article.

– For an overview of using ROI in public health settings, review this free, full-text article.

Population Health Improvement Partners is a national leader in building community and organizational capacity to improve and sustain population health.

Parent Partners in Quality Improvement

By Pattie Archuleta

Family Health Information Center Project Coordinator and Medical Home Parent Partner Program Coordinator, the Parents' Place of Maryland

As part of a Health Resources and Services Administration-funded grant for state autism spectrum disorders and other developmental disabilities implementation, the Parents' Place of Maryland and Maryland's Title V Children and Youth with Special Health Care Needs program are implementing a "Screening and Beyond" quality improvement (QI) learning collaboration with pediatric practices across the state. The goal is to reduce barriers to screening, referral and diagnostic services and to increase access to medical homes that coordinate care with pediatric subspecialties. As part of this process, parent partners (veteran caregivers of children and youth with special health care needs) are included as equal partners on the QI team. They work in pediatric practices to provide follow-up and resources to families and to provide input as part of the QI process.

In this article, two parent partners share their experiences as Medical Home Parent Partners and demonstrate the value of including parents in these projects. Dianna Speir works in a smaller rural practice and Shannon Svikhart works in two larger urban practices.

What was your role as a parent partner in implementing the QI project in the practice?

Dianna Speir: I was active in all phases of the QI process: attending team meetings, developing PDSA [Plan-Do-Study-Act] cycles and exploring strategies for engaging families. In our protocol, the doctor would have an encounter with the patient and invite me in to consult with the family to help create a care plan. As a team, we would review screening results or specialty evaluations and develop plans. I would also assess the family's need for additional support, such as assistance with school issues, insurance concerns or follow-up with subspecialists or early intervention. I often acted as a go-between from doctor to staff to patient, coordinating what needed to get done for the more complex patients.

Shannon Svikhart: I was also active in all phases of the QI process, but my practices had fewer formal meetings since our teams were so large, and it was difficult to schedule time together. I spoke with the lead physicians every time I was in their practices, once or twice a week, and we would brainstorm ideas for PDSA cycles or discuss challenges to the process. In implementing new office procedures or reaching out to our target population, it seemed that there were unexpected PDSA cycles along the way. For instance, families could be difficult to reach by phone or not responsive to email. We really had to reframe the script that was being used to approach these families. In the end, it was far more effective to meet with families in person.

What did you find successful about the process?

Speir: By meeting with a family in-person, I was able to establish a rapport that allowed them to feel more comfortable sharing information regarding their specific challenges and needs that they might not share with their doctor. I could provide them with the resources they needed and give the doctor more accurate information about the family.

Svikhart : Working with a parent partner had a big impact on the families as well as the practices. The families got higher levels of care from their doctor at a time when they needed it the most. The doctors felt that having me in the office elevated their understanding of families of children with special health care needs, resulting in more compassion and accountability toward these families. The doctors really appreciate the increased level of family engagement.

What was most challenging?

Speir : Some of the office staff in my practice didn't see the value in having a parent partner right away. There was a shift in the office culture over time.

Svikhart : One doctor became overzealous, skipping protocols, pulling me into exams rooms without proper consent and referral – I definitely needed to rein that in.

What did you gain or value through your participation?

Speir : It feels good to help families in such a meaningful way. I wish there had been a parent partner available in the early years of my son's diagnosis -- someone to provide the type of support that we offer.

Svikhart : At the beginning of this project, I spoke with my practices about the potential benefit of this model. As it turns out, the impact of this enhanced care has been far greater than any of us anticipated.

What value do you think parent partners can add to similar QI work?

Speir : We help improve outcomes for the children when we support the family. Parent partners offer families time – time to listen, time to process, time to vent, time to strategize, time to make a plan. The families I work with are often shocked that someone is there to help them.

Svikhart : We offer the QI team firsthand knowledge of what it's like to have this type of family [with a child with special health care needs, including ASD/DD]. We've walked that walk, and we can help these families in ways no one else can. We approach it from a different angle, knowing how challenging it can be. It's as if they're stranded on a little island, and we're rowing out to let them know they're not alone.

To learn more about Maryland's project, click here.

"Letter from the President" continued from page 1

munity-based.

4. Quality improvement starts with a belief that services and programs can be better.

In this era of health care reform, we have an opportunity to commit to improving the quality of our services and programs in a manner that is inclusive and innovative. Across the country, state Title V agencies are uniquely qualified to build from their strengths as "systems builders" to illuminate not only the gaps and barriers but to present solutions that work. The biggest gap in the implementation of the Affordable Care Act is the lack of acknowledgement that health outcomes are not solely dependent on clinical interventions; there are opportunities to address wellness on the playground. If payment incentives were designed to honor non-clinical "health care" I am certain we would have a generation of healthier people. Like Stephanie, sometimes we as MCH professionals have to come out from the parking lot and step in as innovative leaders.

As the president of AMCHP, I want to inspire a shared vision that we can improve our programs and services by integrating systems of care. Stating the problem is part of solving the problem. Sustaining vertical, competitive and disconnected systems is not supporting the best outcomes for kids, youth and families. As a parent of a young adult who requires 24/7 care, I have been involved in myriad quality improvement initiatives for over 20 years. In 2007 when I testified in our state for legislation to support the medical home model, I proclaimed, "'Medical home' is a verb, not a noun!" I often reflected that it doesn't matter where we receive our care, but rather that the actions taken to assure the care is excellent and relevant.

Sadly, I am afraid that our nation's well-intentioned efforts to integrate systems through the medical home movement only segregated specialists more deeply as a "place based" approach triumphed. Creating integrated services and systems of care is indeed a step in the right direction, and I am hopeful that recent investments and initiatives will garner outstanding results.

I assure you that as long as I am serving as president of AMCHP, I will carry the torch for quality, integrated systems of care and services on your behalf. As MCH professionals, we can indeed link arms and cross the bridge together!

All the best,
Eileen

An Epidemiological Focus on Quality Improvement

By Sumrita Bindra
Maternal & Child Health Epidemiologist, Bureau of Family Health, Louisiana Department of Health

Cara Bergo
Mortality Surveillance Epidemiologist, Bureau of Family Health, Louisiana Department of Health

Jane Herwehe
Epidemiology Supervisor, Bureau of Family Health, Louisiana Department of Health

Quality improvement (QI) is a priority at the Bureau of Family Health (BFH): It's an integral component of the CoIIN initiatives, Title V and the general move toward the state's public health accreditation.

Although QI activities have been occurring within the bureau for a number of years, the BFH created a Quality Improvement Coordinating Team (QICT) as the first step of many in formalizing QI. The QICT used many tools to introduce and demystify the principles of QI for the general staff. It illustrated examples of projects employing QI principles and promoted the concept of small wins. Using real-life examples proved to be effective, as it increased awareness of QI at work within the bureau. During QICT meetings, BFH teams can share their QI efforts, discuss strategies and develop ways to foster smoother, well-informed processes.

The bureau's Data to Action Team (epidemiology team) spearheads many QI projects, focusing on improved efficiencies in data collection and management that impact data quality, including:

Streamlining data collection for child death reviews: In accordance with state legislation, Louisiana reviews records for all unexpected (non-medical) deaths for children under age 15. This data informs prevention strategies and data analyses. Data abstraction is time-consuming due to the number of variables included in the Child Death Review case registry. Certain variables are not needed for the specific death being reviewed, such as birth weight for a 7-year-old who died in a motor vehicle crash. The mortality epidemiologist created a data algorithm outlining variables that are needed for certain cases to refine data abstraction. The goal is to increase the quality of the essential data while reducing time wasted on collecting unnecessary data.

Improving Quality of Birth Certificate Data: Birth certificate data are regularly examined for missing and/or underreported data that is outside a predetermined acceptable range. The Louisiana Center for Vital Statistics Quality Manager uses a quality report with each birthing hospital to improve its reporting procedures. Accurate birth records are essential to birth outcomes surveillance.

Gaining operational efficiencies for Pregnancy Risk Assessment Monitoring System (PRAMS): Data from PRAMS are used to inform program development, policy and resource allocation. A threshold response rate of 65 percent is required for generalizability of results. Louisiana's response rate had not exceeded 60 percent since 2004 – due in part to an inability to reach mothers with inaccurate or missing contact information and materials not clearly communicating the benefit of participation. Contact information was improved by electronically linking data sources (such as WIC and Newborn Screening records) to identify alternate address and phone information; this eliminated time-consuming manual searches, which had interfered with time for phone interviews. Through iterative prototype design, the new materials were released in 2015. The combination of these efforts led to an increase in the unweighted response rates from 57 percent in 2014 to 67 percent in 2015.

With a designated QICT leading the way, QI is becoming a regular part of operations at BFH. While the approach to how QI is conducted across programs is evolving, the momentum and enthusiasm for this process is thriving. It is becoming increasingly important to integrate QI into all the work done at BFH in order to create a culture of quality improvement.

Real Life Success Story
Application of Quality Improvement in Alaska's Medicaid Enrollment Process

By Emily B. Vander Schaaf, MD, MPH
Research Fellow, Population Health Improvement Partners; Assistant Professor of Pediatrics, University of North Carolina at Chapel Hill

By Greg Randolph MD, MPH
President and CEO, Population Health Improvement Partners; Professor of Pediatrics and Public Health, University of North Carolina at Chapel Hill

Quality Improvement in Macrosystems

Quality improvement (QI) tools can improve patient care and outcomes by improving process. While much has been written about the benefits of QI in microsystems (i.e., within one clinic, one health department or one hospital department), less is known about how QI can change health care delivery at the macrosystem, policy level. Here we describe the use of QI tools to assess and improve the Medicaid enrollment process in Alaska.

Maternal and Child Health (MCH) Workforce Development Center

The National MCH Workforce Development Center and its expert partners offer states a number of platforms for training state leaders in four core areas of health transformation: quality improvement, access to care, change management and systems integration. In consultation with the Workforce Development Center, states determine which area(s) might best help them improve systems of care for their populations.

Alaska's Medicaid Enrollment Problem

Before Alaska implemented QI training, applicants to its Medicaid program suffered through long processing times, with the backlog of applications reaching approximately 10,000. Pregnant women needing medical care were especially vulnerable to these waits. Similarly, children and youth with special health care needs (CYSHCN) often require frequent specialty care and are in danger during periods of insurance coverage gaps. Knowing this, Alaska's team used QI to evaluate and improve the Medicaid enrollment process for pregnant women and CYSHCN.

Alaska's Use of QI Tools

In 2015, a core team of seven representatives from Alaska's Division of Public Health received training and technical assistance from the National MCH Workforce Development Center, including assistance applying quality improvement tools from the QI Core (staffed by Population Health Improvement Partners). This team included staff who focus on maternal, child and family health as well as parent representatives. After an initial training at the University of North Carolina, a QI facilitator conducted training webinars and an on-site, two-day QI event. There, the team used value stream mapping to examine the process of Medicaid enrollment for CYSHCN and pregnant women. Using this QI tool, they identified the process by which these populations got enrolled in Medicaid, barriers to more prompt enrollment and opportunities to minimize these barriers. The team then gave a presentation to the state's Medicaid leadership, suggesting that the state pilot modifications in the enrollment process for CYSHCN and pregnant women before implementing broader change. Impressed by the effects of value stream mapping, leadership elected instead to use it to evaluate the enrollment process for all Medicaid applicants before implementing broader change.

Effects of QI Training

In semi-structured interviews, core team members credited their QI training for leadership's subsequent motivation to use a similar process of value stream mapping to identify barriers to quick Medicaid enrollment for *all* Medicaid-eligible populations. As a result, changes are underway for the Medicaid enrollment process. Core team members described several additional benefits of the QI training: They expressed an increased collegiality between divisions of the Division of Public Health and better understanding of each other's processes and frustrations. Some endorsed improving the understanding of QI tools and increasing their use in other projects and proposals. All members felt that value stream mapping was a valuable way of identifying process problems in order to create solutions.

*Population Health Improvement Partners is a national leader in building community and organizational capacity to improve and sustain population health.

Engaging Families: A Challenge that Must be Met

By AMCHP Staff

Engaging families in Title V programs is more important than ever – which is why AMCHP just published a survey and series of case studies about family engagement in those programs.

The Title V Block Grant now requires programs to document family and consumer participation, which are key to helping to improve service quality. That's one reason AMCHP conducted a nationwide survey about family engagement policies and practices in Title V maternal and child health and children and youth with special health care needs programs, with funding from the Lucile Packard Foundation for Children's Health and the U.S. Maternal and Child Health Bureau.

Although almost all MCH and CYSHCN survey respondents said they seek family input, their responses also show that programs struggle with the nuts and bolts of meaningfully employing, compensating and engaging families.

The survey findings and case studies provide a snapshot of strategies to support meaningful family engagement, effective and innovative practices, and areas for improvement. Among the survey findings:

- Title V programs embrace a broad definition of family, ranging from program participant to immediate and extended family, as well as youth/young adults.
- Most Title V programs report some form of family participation, such as reviewing block grant applications and writing sections of block grants.
- Most Title V programs employ family members.
- More than three-fourths of programs report providing staff development and training about family engagement.
- Programs use a broad range of engagement strategies, including creating a process for improving family engagement and employing a family leader on staff.
- Most Title V programs use contracts to operationalize family engagement and leverage the expertise of family organizations.
- The key challenges reported are recruiting representation across geographic areas or from remote areas.

The survey report, *Sustaining and Diversifying Family Engagement in Title V MCH and CYSHCN Programs,* is published in a series of easy-to-digest briefs that detail the results in specific areas:

- Creating a Culture of Family Engagement
- Levels of Family Engagement
- Roles of Family Staff or Consultants
- Family Members Employed as Staff
- Sustaining and Diversifying Family Engagement
- Evaluating Family Engagement

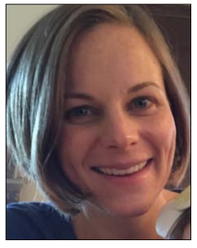
The case studies provide examples of engaging families and diverse populations in five states. See all the reports here.

Member to Member

How does your state incorporate family and consumer engagement into your quality improvement efforts?

Sarah Cox

Principal Planner, Children and Youth with Special Health Needs, Minnesota Department of Health



Sarah Mapellentz, JD, MPH

Family-Professional Partnerships Coordinator, Children and Youth with Special Health Needs, Minnesota Department of Health

The Title V Children and Youth with Special Health Needs (CYSHN) Program, within the Minnesota Department of Health, recognizes and actively relies upon the keen insight of families as we formulate communications, programs and policies that serve Minnesota's CYSHN. Our program's 2013-2018 Strategic Plan, developed in collaboration with families of children with special health needs, provides a framework upon which all of our quality and systems improvement efforts are based.

A key vision element within the strategic plan is increasing family-professional partnerships and shared decision-making at all levels of the system. One way of increasing our partnership with families was through the development of the CYSHN Parent Workgroup, which serves as an advisory resource for the MDH CYSHN Program. The Parent Workgroup consists of eight parents from diverse backgrounds who provide insight on program activities. Because we see these parents and caregivers as vital partners in our quality and systems improvement work, we provide financial reimbursement for their time and contributions, child care cost coverage and mileage for travel.

Together with the Parent Workgroup, the MDH CYSHN Program has adapted and applied a Community Engagement Continuum as a way to quantify our current level of partnership with families and determine where we would like to move in the future. The continuum moves from simply providing outreach to families, to having strong, bidirectional shared leadership. Though historically our family engagement has focused on using families as consultants to gather input or feedback, we are moving toward having shared leadership in program activities. Some specific efforts that have assisted us in moving from simple engagement to true partnerships include:

– Developing new standard operating procedures within units of the MDH CYSHN Program to ensure that parent engagement is involved in projects from the beginning.
– Seeking parent input on the need for tools and how these tools should look (before they are created), rather than only gathering feedback from parents on final products of educational materials, family letters, etc.
– Having families of CYSHN present at staff meetings and at advisory groups about their experiences in navigating the systems of care and support that surround CYSHN.
– Ensuring that families of CYSHN are included as representatives on statewide advisory groups or initiatives that impact CYSHN and their families.

Throughout all of our efforts, we strategically aim to promote family partnerships as we improve and maintain the health of Minnesota's CYSHN and their families.

Michelle Hoffman

CYSHCN Program Family Engagement Coordinator, Washington State Department of Health

Washington incorporates many levels of family and consumer engagement into quality improvement efforts. Since 1999, the Washington State Department of Health (DOH) has had a dedicated, full-time position whose function is to support family engagement. Over the years, as family engagement has become more and more of a proven best practice, family and consumer engagement in Washington has evolved to adapt to the changing needs of both families and systems planning. Like many government entities, Washington has gone through a number of reorganizations with respect to leadership of different agencies and to organizational structures. This has created an increased need for collaboration and partnerships across systems.

Our family engagement strategies have borrowed elements from collective impact and results based accountability in order to address the needs of our newly formed statewide family leadership network. We have created a state agency work group with the DOH family engagement staff as well as staff from our Part C Early Intervention Agency, our mental health agency and our developmental disabilities agencies. This group will serve as "backbone" support to increase internal agency capacity for meaningful family engagement and broaden family and consumer engagement opportunities at the state level. The statewide family leadership network has a steering committee which is made up of family leader organizations who are contributing strategies to engage families into a pipeline of leadership development with the goal of utilizing their experience and knowledge to inform systems planning. In the near future we expect to develop a logic model to align family and consumer engagement work with our block grant strategies.

A View from Washington: What is the Sound of Failure?

By Brent Ewig, MHS

Director, Public Policy & Government Affairs, AMCHP

I feel lucky that I have always been blessed with a generally positive outlook and optimistic demeanor. I agree with Eleanor Roosevelt's maxim, "It is better to light a candle than curse the darkness," and I have tried to use that to guide my work. It has helped me not only survive, but thrive over nearly two decades working in Washington, District of Columbia However, the failure of Congress to act in any meaningful way to address the Zika virus emergency declared last February is one of the most discouraging and disappointing episodes I have seen in any of my years of public health advocacy.

If you've been following AMCHP's Legislative Alerts, you know that President Obama requested $1.9 billion in emergency supplemental funding back in February. After some initial signs of bi-partisan cooperation on a package providing $1.1 billion, efforts in mid-summer broke down over the inclusion of family planning restrictions and envi-

ronmental regulatory changes included in a bill that passed the House largely on a party-line vote. The Senate has since failed twice to muster the 60 votes needed to move forward. Congress is now on recess until early September – meaning that even if members are able to find common ground, any additional funds appropriated this year would likely not reach the front lines of Zika until autumn. In many ways, Congress's inaction has guaranteed that states and localities are on their own and that the window for robust primary prevention this summer is nearly slammed shut. With the Centers for Disease Control and Prevention monitoring over 800 pregnant women with Zika virus infection in the United States and territories, it is likely just a matter of time that the focus will necessarily shift from education and prevention to intensive care coordination.

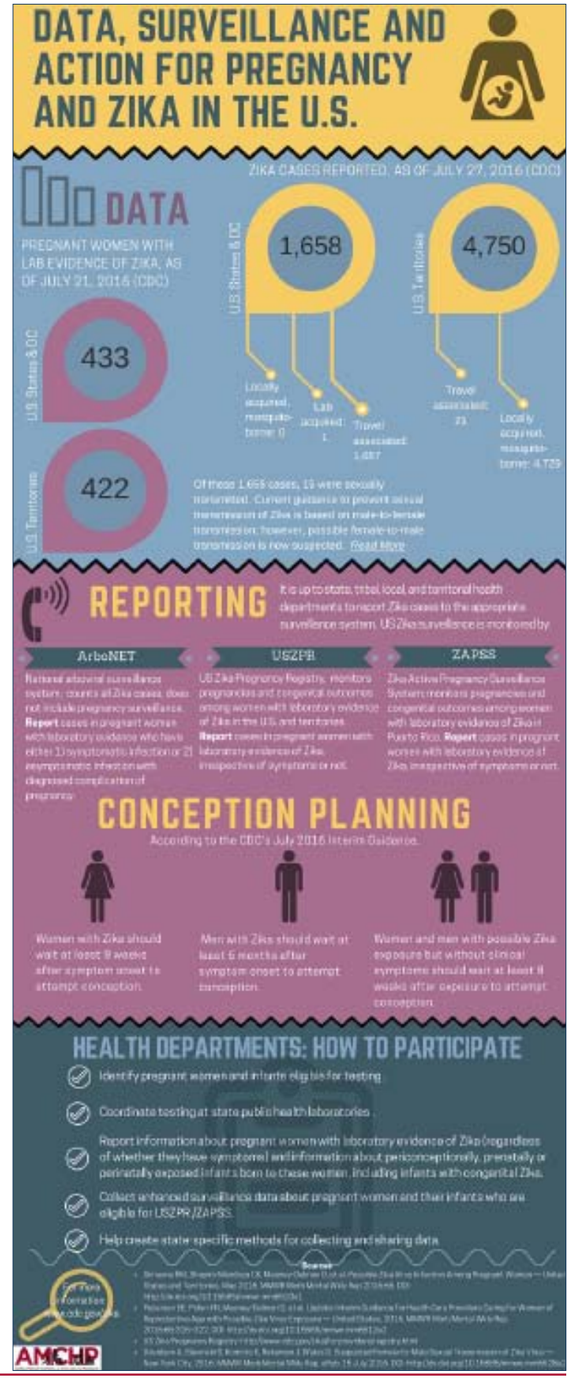
So where do we go from here? AMCHP continues to work with a broad coalition of leading MCH groups to urge Congress to be ready to pass a robust package as soon as it returns in September. Unfortunately, the staff we are meeting with on Capitol Hill report that no negotiations are underway, as both sides seem deeply entrenched in their positions. Our hope is that the confirmed local transmission of the virus reported last week in Florida will create a new urgency to act and will bring all parties to the table to find a path forward.

Zika virus is testing our public health systems in new ways, partly because new information about the virus is discovered on a weekly basis. But whether we are talking about hurricanes, floods, influenza, MERS, SARS or Ebola, we have learned to expect the unexpected. The need for a strong yet flexible public health system could not be clearer, and yet in this summer of discontent Congress is failing to provide even a modicum of support. We will continue to work to change that and keep our candles lit.

Data and Trends

By Lauren Barrison

Epidemiology/Evaluation Intern, AMCHP



Who's New at AMCHP

Dr. Cheryl Clark joined AMCHP as the associate director for epidemiology and evaluation. Dr. Clark received her bachelor's in health information management administration from University of Wisconsin and her MPH from the University of South Florida, with a concentration in public health education. She received her Doctor of Public Health (DrPH) in Epidemiology and Biostatistics from Florida A & M University. She has extensive work experience as an epidemiologist, data/research consultant, evaluator and health informatics consultant. She has worked as a maternal and child health epidemiologist for 16 years and the past six years at a Sr. MCH Epidemiologist capacity.

Who's New in MCH

Linda Cavitt
Deputy Director for Programs, Adult and Family Services
Oklahoma Department of Human Services

Lacy Fehrenbach
Director, Office of Healthy Communities
Washington State Department of Health, Prevention and Community Health Division

Rachel Jew
Title V CYSHCN Director, Purchased Health Services Unit
Texas Department of State Health Services

Sara Morgan
Administrator, Lifespan Health Services (MCH Director)
Nebraska Department of Health and Human Services

Andrea Palmer
Chief, Division of Maternal, Child and Family Health Services
Illinois Department of Public Health

Calendar

AMCHP 2017 Annual Conference
March 4-7, 2017
Kansas City, Mo.

Women's Health Info Series Webinar: Understanding the New CDC Contraception Guidelines
Aug. 25, 2016

20th National Conference on Child Abuse and Neglect
Aug. 31-Sept. 2, 2016
Washington, D.C.

CityMatCH Leadership and MCH Epidemiology Conference
Sept. 14-16, 2016
Philadelphia, Pa.

2016 Infant Health Policy Summit
Sept. 15, 2016
Washington, D.C.

Congenital Cytomegalovirus Public Health and Policy Conference
Sept. 25-27, 2016
Austin, Texas

Society for Longitudinal and Life Course Studies 2016 Conference
Oct. 5-8, 2016
Bamberg, Germany

Adverse Childhood Experiences Awareness to Action 2016 Conference
Oct. 19-21, 2016
San Francisco, Calif.

2016 Northeast Epidemiology Conference
Oct. 20-21, 2016
Saratoga Springs, N.Y.

APHA 2016 Annual Meeting and Expo
Oct. 29-Nov. 2, 2016
Denver, Colo.

Healthy Teen Network 2016 Conference
Nov. 16-18, 2016
Las Vegas, Nev.

AUCD Conference
Dec. 4-7, 2016
Washington, D.C.

Collaborative Improvement and Innovation Networks in the MCH Landscape

Compiled by AMCHP Staff

Collaborative Improvement and Innovation Networks (CoIINs) are teams of federal, state and local leaders working together to tackle a common problem by applying quality improvement methods (e.g., Plan-Do-Study-Act cycles) and engaging in collaborative learning. Using technology to remove geographic barriers, participants with a collective vision or common aim share ideas, best practices and lessons learned, then track their progress using shared measures. Over the past few years, the Health Resources and Services Administration (HRSA), along with federal, state – including Title V – and local partners have used CoIIN or CoIIN-like approaches to develop common aims, use and share evidence-based strategies, and use shared metrics and real-time data in order to improve maternal and child health outcomes.

CoIINs supported by the U.S. Health Resources and Services Administration (HRSA) address a range of topics across the life course, including maternal health, infant mortality, newborn screening, home visiting, child health and safety, school-based health, children and youth with special health care needs, adolescent and young adult health, healthy weight and oral health. Below is a quick overview of the current HRSA-supported CoIINs and CoIIN-like projects, along with related Title V National Performance Measures (NPMs).

CoIIN	Participation	Contact	Related NPMs
Adolescent and Young Adult Health (AYAH)	State teams composed of: state Title V leadership, state adolescent health coordinator, state Medicaid agency, major health plan(s), state chapters of national professional membership associations, youth/ young adult consumers. States: Iowa, Mississippi, New Mexico, Texas, Vermont	Trina Anglin, tanglin@hrsa.gov http://www.amchp.org/programsandtopics/AdolescentHealth/Pages/default.aspx | http://nahic.ucsf.edu/resources/resource_center/adolescent-and-young-adult-health-collaborative-improvement-and-innovation-network-ayah-coiin/	10
Children's Safety Network	MCH Block Grant programs and their partners. States: Alaska, Connecticut, Florida, Indiana, Kentucky, Massachusetts, Michigan, Mississippi, Nebraska, New Hampshire, New York, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Wisconsin, Guam, CNMichigan, District of Columbia	Erin Reiney, ereiney@hrsa.gov https://www.childrenssafetynetwork.org/CSCoIIN	7
Children's Healthy Weight	TBD	Meredith Morrissette, mmorrissette@hrsa.gov	4, 8
Pediatric Obesity Mini CoIIN	Phase 1: Alaska,Louisiana, Ohio, Wisconsin Phase 2: Alaska,Louisiana, Ohio, North Dakota, California, Oregon	Meredith Morrissette, mmorrissette@hrsa.gov http://asphn.org/resource_read.php?resource_id=661	8
Early Childhood Comprehensive Systems (ECCS)	ECCS Impact Grantees	Sandy Sheehy, ssheehy@hrsa.gov	1, 6
Emergency Medical Services for Children (EMSC)	State teams composed of state EMS medical directors, trauma system managers, EMSC state program managers, family representatives and key stakeholders. States: Connecticut, District of Columbia, Florida, Kansas, Kentucky, Michigan, New Mexico, New York, Okla., Pennsylvania, South Carolina, Texas	Therese Morrison- Quinata, TMorrison-Quinata@hrsa.gov	7
Healthy Start	Level 3 Healthy Start Programs: Alabama, Arizona, California, District of Columbia, Florida, Indiana, Louisiana, Massachusetts, Maryland, Michigan, North Carolina, New Jersey, New Mexico, New York, Ohio, Pennsylvania, and Texas (local sites, not states represented).	LCDR Makeva Rhoden, mrhoden@hrsa.gov http://healthystartepic.org/healthy-start/hs-coiin/	1, 3, 4, 6
Home Visiting	MIECHV grantees supporting over 30 local implementing agency teams. States: Arkansas, Florida, Georgia, Indiana, Michigan, New Jersey, Ohio, Pennsylvania, Rhode Island, South Carolina, Virginia, Wisconsin	CDR Monique Fountain Hanna, MFountain@hrsa.gov http://hv-coiin.edc.org/	1, 4, 6
Infant Mortality	State MCH program directors or designee-led teams States: 58 states and jurisdictions	Vanessa Lee, vlee1@hrsa.gov Website: http://www.nichq.org/childrens-health/infant-health/coiin-to-reduce-infant-mortality	1, 2, 3, 5, 10, 14
Newborn Screening	State newborn screening programs and hospitals: Arizona, California, Co.-Wyo., Hawaii, Iowa, Michigan, Minnesota, Montana, Nebraska, New YorkMAC (Delaware, Maryland, New Jersey, New York, Virginia), Oklahoma, Puerto Rico, Tennessee, Texas, Wisconsin	Debi Sarkar, dsarkar@hrsa.gov https://www.newsteps.org/newsteps-360	NOM 12
School-Based Health Services / Comprehensive Mental Health Systems	Teams of school-based health centers and school mental health systems in separate CoIINs.	Trina Anglin, tanglin@hrsa.gov	10

CoIIN-Like Project		Contact	Related NPMs
"Enhancing Systems for CYSHCN through Systems Integration" (aka D-70 Grant)	State CYSHCN programs: Alabama, Colorado, Iowa, Indiana, Massachusetts, Minnesota, Oregon, Rhode Island, Utah, Vermont, Washington, Wisconsin	Marie Mann, mmann@hrsa.gov	11
Alliance for Innovation on Maternal Health (AIM)	States, perinatal quality collaboratives, hospital/hospital systems. States: Maryland, Oklahoma, Florida, Illinois, Mississippi, Louisiana, New Jersey, Michigan Associate AIM states: California and New York	Kimberly Sherman, ksherman@hrsa.gov	1, 2
Alliance for Innovation for Maternal and Child Health Populations, Expanding Access to Care	States with representation from grantee membership entities which include: Title V, governor's office, legislatures, state health officers, hediatricians, families and Medicaid offices. States: California, Kentucky, Nevada, Pennsylvania, Rhode Island, Colorado, Minnesota, Montana, North Dakota, South Dakota, Utah, Wyoming and American Samoa	Sylvia Sosa, ssosa@hrsa.gov	1, 6, 10, 11, 12, 15
Perinatal and Infant Oral Health Quality Improvement (PIOHIOQI) Initiative	States with representation from: state public health and social service departments, children's hospitals, medical/academic universities and nonprofits. States: Arizona, California, Colorado, Connecticut, Massachusetts, Maryland, Maine, Minnesota, New Mexico, New York, Rhode Island, South Carolina, Texas, Virginia, West Virginia, Wisconsin	Pamella Vodicka, pvodicka@hrsa.gov http://mchoralhealth.org/projects/piOhioqi.php	12

For more information about the HRSA/MCHB CoIINs, click here.

Resources

Learn About Epi Support Services
Through support from the Centers for Disease Control and Prevention's Division of Reproductive Health, AMCHP created Epidemiology Support Services (ESS). ESS is a structured way for AMCHP to provide epidemiology support and connections to peer epidemiologists and field experts who can provide insight on applied MCH epidemiology issues. To submit a request or to learn more, click here.

Give Feedback on Preconception Health Indicators
The Centers for Disease Control and Prevention, in partnership with AMCHP, will hold a meeting on the preconception health indicators at the 2016 MCH Epi Conference in Philadelphia on **Sept. 14 from 12:15-1:15 p.m. ET**. The objective is to receive feedback on the recommended preconception health indicators and to describe the prioritization process. We are interested in receiving responses from state and territory staff, particularly MCH epidemiologists, MCH directors and Title X directors, so consider attending to share your perspective. Please register by **Aug. 15**. Registered attendees will be asked to complete a pre-assessment regarding the core preconception care indicators four weeks prior to the meeting. There are no ongoing commitments or requirements afterwards. Please keep in mind that all attendees must be a registered participant of the CityMatCH Conference. To register for the conference, click here. For additional information, please contact Jennifer Farfalla at jfarfalla@amchp.org.

Equity in MCH is Focus of Next Learning Network Call
CityMatCH will host the third and final call for the 2016 Learning Network Series on **Aug. 17 at 2 p.m. CT**. This call will focus on taking the equity lead in our institutions. Join CityMatCH and more than 100 of your colleagues for a call that aims to keep professionals informed and thinking critically about maternal and child health issues. To access the call, please dial **866-740-1260** and use passcode **5529500.** For more information, click here.

National Breastfeeding Month 2016
This year's National Breastfeeding Month theme focus on reflecting back and looking forward in celebration of the five-year anniversary of The Surgeon General Call to Action to Support Breastfeeding (SGCTA). Join the United States Breastfeeding Committee (USBC) to highlight the successes of the past five years and shape our collective direction for the next five. As the NBM16 theme crosses all areas of action in breastfeeding, coalitions and USBC member and partner organizations are encouraged to host events and activities showcasing past wins and highlighting future priorities. To share events with others in the USBC network, please post them to the NBM16 Calendar.

On **Aug 18 from 2:00-3:00 p.m. ET** and **Aug. 23 from 8:00-9:00 p.m. ET**, USBC will host virtual town hall meetings. Organizations and individuals are invited to share written comments on priority action areas and associated implementation strategies for the next five years. The written comments, hosted on separate channels for each sector of the SGCTA, will be open all month, allowing for continuous feedback. Volunteers will review and compile the comments into a report with recommendations for USBC and its network. The report will also be delivered to the surgeon general and the federal Interagency Breastfeeding Work Group. To register for the Aug. 18 meeting, click here. To register for the Aug. 23 meeting, click here.

Webcast Focuses on Preventing Neonatal Abstinence Syndrome
The Centers for Disease Control and Prevention (CDC) will present a new installment of Public Health Grand Rounds on **Aug. 19 from 1:00-2:00 p.m. ET**. The presentation will discuss primary prevention and public health strategies to prevent neonatal abstinence syndrome. For non-CDC staff, a live external webcast will be available via the Webcast Links section of the CDC website.

Discuss Report about Bullying Prevention Law and Policy
The Children's Safety Network will host a webinar on **Aug. 24 from 3:00-4:00 p.m. ET**, to highlight the new report, *Preventing Bullying through Science, Policy, and Practice*. Presenters will review the authors' findings, conclusions and recommendations pertaining to the role of laws and policies in responding to and preventing bullying among youth. To register, click here.

Preparing Adolescents with Asthma and Allergies for Transitions to Independent Living
Join the American Academy of Pediatrics for a free webinar on **Sept. 1 from 1:00-2:00 p.m. ET** to educate practitioners about adolescent transitions from their medical homes. The webinar will include practical tips to use immediately, with an emphasis on transitioning adolescents with asthma and allergies to independent living. To register, click here.

Ask-a-Colleague

CityMatCH would like to know what your health department is doing to engage adolescents and young adults in preventative health care services. How is your health department incorporating positive youth development and engagement

strategies into this work? Please send any information on programs and strategies to Erin Schneider.

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