



PULSE

A BI-MONTHLY NEWSLETTER FROM THE ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

Child Health

July/August 2015

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From the President

By Sam B. Cooper III, LMSW-IPR



I hope that everyone is enjoying the summer months and finding some time for yourselves and your families. I can't think of a better way to relax than to find a shady spot, have a cool drink, and review the latest copy of *Pulse*! Our members, partners and staff have pulled together a variety of items for this issue that are focused on child health.

Obviously, during these months when we are encouraging our little ones to explore and engage with the great outdoors, focusing on injury prevention and safety is critical. I won't mention any specific names, but I have it on good authority that before the days of seatbelt use and child safety locks, a rambunctious five-year-old "helped" his little sister get a better view of Yellowstone National Park by boosting her out the back of the family station wagon. Thankfully, and amazingly, no serious injuries occurred. How quick and inventive are these little humans that are dependent on the care of their families and communities.



Everyone has a role in supporting efforts to prevent water-related injuries, hyperthermia, motor vehicle accidents, sports injuries, and other threats to our children. Thank you for the work that you do every day to protect and to improve the health of the children in your area. A special note of gratitude is sent for those responsible for developing and reviewing the Title V MCH Services Block Grant report



From the President CONT.

and applications that were submitted in July. The funding through the federal-state partnership that supports the work of MCH programs and partners throughout the country makes this a safer and healthier place to grow up.

Slàinte,

Sam

P.S. The five-year-old was eventually forgiven by his little sister.

From the CEO

By Lori Tremmel Freeman, BS, MBA
Chief Executive Officer, AMCHP



Happy Anniversary, everyone!

This is truly a year of milestones for our important work. This year marks the 25th anniversary of the *Americans with Disabilities Act*, and 40th of the *Individuals with Disabilities Education*

Act. Medicaid also celebrates 50 years and Title V will celebrate 80 years this August. Now is an opportune time to celebrate these anniversaries and consider ongoing practice and policy priorities and implications for moms, dads and their families. It also is a time to examine how far we've come, where we want to go and the opportunities to help us get there.

Obviously a clear standout among the many milestones and nearest to our hearts and work is the 80th anniversary of Title V. It's amazing, but not altogether surprising, that the Title V program is the senior-most leader in terms of longevity and endurance as a public health program. And not just by a few years! With 30 MORE years of history than the other nearest milestone achievement, Medicaid, all of our members should be particularly proud that the work done through our maternal and child health programs has long been and continues to be recognized as sustainable, of crucial importance to the health and well-being of our great country, and has stood the long-term test of endurance.

Since our past shapes so much of who we are today, take a moment here to review some interesting facts about Title V and about AMCHP. Being reminded of the rich history of Title V and AMCHP, and our accomplishments, provides the opportunity to think about how to share and educate others about why maternal and child health programs and our organization REMAIN relevant and important today more than ever before in our country's history.

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1935

New Deal; Social Security Act; Title V created as part of sweeping social change, rather than health, legislation

1944

First recorded meeting of the association (ASTMCHCCD) Association run by volunteer members/leaders; some support from federal Children's Bureau.

1960's-70s

Great Society; other health and welfare programs enacted- Medicaid, Community Health Centers, Family Planning, etc.

1969

Title V administration transferred to Public Health Service

From the CEO CONT.

1981

New Federalism proposals for large block grants prompts association to mobilize to preserve Title V/ federal-state MCH commitment. Title V preserved, but amended to form MCH Block Grant- some requirements removed, some small programs added. Title V Appropriation is \$373M.

1987

Modern day AMCHP is born! Association changes its name (broadening from directors to programs), incorporates, applies for MCH grant

1988

Title V appropriation reaches \$527M

1989

Major changes in Medicaid and in Title V, improving accountability

1996

Welfare reform enacted, including Title V abstinence education provision

1997

SCHIP enacted; Title V Appropriations drop to \$681M, after reaching \$687M in the mid1990s.

1998

Title V appropriations restored to \$700M

2000

Child Health Act, including authorization of Healthy Start, enacted. Title V authorization ceiling raised to \$850M

2010

Affordable Care Acts adds three new sections of Title V Statute including Section 511 providing \$400M annually for Maternal, Infant and Early Childhood Home Visiting Programs; Section 512 authorizing (but not yet funding) \$3 million annually for services to individuals with postpartum conditions; and Section 513 providing \$75 million annually for the Personal Responsibility Education Program (PREP)

2013

Across the board cuts due to budget sequestration cut \$38 million from Title V program, dropping program funding from a high water mark of \$730 million in 2003 to \$607 million in 2013.

2015

AMCHP leadership helps restore federal Title V funding to \$635 million – nearly restoring cuts due to sequestration but continuing to lag behind documented needs. Maternal and Child Health Bureau Associate Administrator Dr. Michael Lu engages states and other stakeholders in a transformation of the MCH Block Grant designed to revamp the performance measurement framework and enhance our ability to describe how Title V makes a difference improving the lives of women, children, families and communities.

Take some time right now to remember and honor the past and accept a challenge from me to pay it forward. Tell someone new this week – a friend, a business acquaintance, a family, a doctor, a community partner – about your MCH program, your work, and what it does to ensure that all women, children and families have an opportunity to live healthy and productive lives. Spread the messaging! Cathy Hess, AMCHP's first executive director, most eloquently wrote these words that I'll leave you with here: THE NEXT CHAPTERS (in our history) AWAIT OUR IDEAS & CONTINUED COMMITMENT TO IMPROVEMENT.

The FUTURE is NOW: Integrating MCH Transformations



AMCHP 2016
January 23-26
Hyatt Regency Washington

Feature

Wyoming Uses the AMCHP Life Course Indicators to Shift Early Childhood Focus

By Danielle Marks

Women and Infant Health Program Manager, Wyoming Department of Health

Ashley Busacker

Senior Epidemiology Advisor to MCH, Wyoming Department of Health

Michelle Sullivan

Principal Organizer, Building Communities Where Children and Families Thrive

In 2014, a coalition of Wyoming early childhood stakeholders initiated efforts to shift a focus on school readiness (Kindergarten/Pre-K) to broader, more integrated, community-based efforts. The new focus emphasized investment in the prenatal period and in early childhood relationships. The coalition envisioned a multisectoral, community-based partnership that addresses upstream determinants of health and building community prosperity. Their vision emphasizes the role of toxic stress, early relationships, poverty and the environment – where children and families live, work and play – on short- and long-term health outcomes for children, families, and communities. The challenge to the coalition was effectively communicating this vision with a broad range of nontraditional stakeholders that includes local business leaders, policymakers and civic leaders.

At the same time, the Wyoming maternal and child health (MCH) epidemiology program was calculating the AMCHP Life Course Indicators and realized that in order for these indicators to gain traction in the state, they needed to resonate with stakeholders. Soon after the start of the indicator project, the early childhood coalition asked for data to help them explain the shift in focus to their stakeholders.

As a precursor to the statewide summit, the coalition wrote a white paper detailing the need for the focus shift. The coalition leaders worked with MCH epidemiology staff to select relevant life course indicators for Wyoming. Starting with the AMCHP ‘short list’ of indicators, the list was narrowed to include indicators that most effectively supported the coalition’s narrative. The selected life course

indicators were:

- Adverse childhood experiences among children
- Experiences of discrimination among children
- Households with a high level of concentrated disadvantage
- Household food insecurity
- Prevalence of preterm births
- Stressors during pregnancy

In September 2014, the coalition presented the white paper to stakeholders at a summit, “Building Communities Where Children & Families Thrive: The Science of Early Childhood.” According to Michelle Sullivan, principal organizer of the summit, “[the use of the indicators in the white paper] provided participants with common data and a narrative that emphasized the idea that community prosperity begins in infancy.”

Although the summit targeted statewide stakeholders, a community-level coalition in Sheridan County emerged. As part of the AMCHP Life Course Intensive TA Project, MCH program and epidemiology staff worked with the coalition on further narrowing the indicators, framing a subset of the selected indicators, making them relevant at the local level, and developing a call to action for nontraditional stakeholders. We learned the importance of defining a target audience, crafting communication products to meet audience needs and expectations, and having a clear, succinct message.

The AMCHP project resulted in a presentation featuring a narrowed list of indicators that connect community prosperity and early childhood stress. The indicators (maternal stressors during pregnancy, adverse childhood experiences, and food insecurity) were estimated for Sheridan County to show the local impact of the problem. We felt this would resonate with nontraditional stakeholders, and spur action in a community that has relatively good early childhood outcomes when compared with the rest of the state, but still has room to improve. The presentation includes background information based on indicator narratives from the Life Course Indicators Online Tool and a ‘call to action’ section, which includes language suggested by the FrameWorks Institute Talking About Early Childhood Development toolkit.

Despite the end of the AMCHP project, the partnership between the Wyoming MCH program and the coalition

Feature CONT.

WY Life Course Indicators

continues. A finalized presentation will be given to the coalition and potential stakeholders. Additionally, Wyoming MCH is developing a life course website to feature the partnership and provide common language and life course data to help other communities and stakeholders effectively implement the life course framework in their work.

Feature

Moving Toward Alignment of Early Childhood Systems – On-site with Guam

By Dorothy Cilenti, DrPH

Clinical Assistant Professor, Maternal and Child Health, UNC Gillings School of Global Public Health



Kristen Hassmiller-Lich, PhD

Research Assistant Professor, Health Policy and Management, UNC Gillings School of Global Public Health



Sharron Corle, MS

Associate Director, MCH Leadership Development & Capacity Building, AMCHP



As part of their work with the National MCH Workforce Development Center (the Center) Cohort 2 intensive training and adaptive consultation, Guam is seeking to develop and implement a comprehensive plan for alignment of early childhood programs in several areas of their infrastructure, including public health and education systems. The project aims to analyze current systems of early childhood education, health and social services, develop common measures across systems and close gaps in early childhood programs. The project also seeks to implement evidence-based, family-centered practices in early childhood programs, reduce duplication of early childhood services, and increase enrollment and provision of early childhood systems to ultimately improve health outcomes of children from birth through age eight.

In June, three members of the Center traveled to Guam to provide on-site training to a diverse team of 25 parents, staff members from the Title V agency, and other health,

Feature CONT.

Center On-site with Guam

human services, and education professionals serving children in the territory. Key MCH programs included in the meeting were Project Kariñu; the Early Childhood System of Care, a program that provides promotion, prevention and intervention for children zero to five and their families, related to the development of healthy social and emotional well-being; Project Bisita, the home visiting program, which uses two evidence-based programs: Parents as Teachers and Healthy Families America; and Project LAUNCH, a Substance Abuse and Mental Health Services Administration-funded project that provides services to children and families who receive their health care at Guam Community Health Centers with a focus on developmental screening and comprehensive prevention and wellness promotion services through a medical home model.

Center staff spent three days with the team exploring and testing methods for creating integrated service systems to better meet the educational, emotional and health needs of Guam's youngest children.



The meeting started by increasing participant understanding of the transforming health landscape in Guam and the urgency for developing contemporary workforce skills to optimize the health and well-being of children in this changing environment. Several leadership activities focused on individual and team strengths. The first day concluded with a discussion of collective impact and how this framework for action may be useful in launching systems integration efforts in Guam.

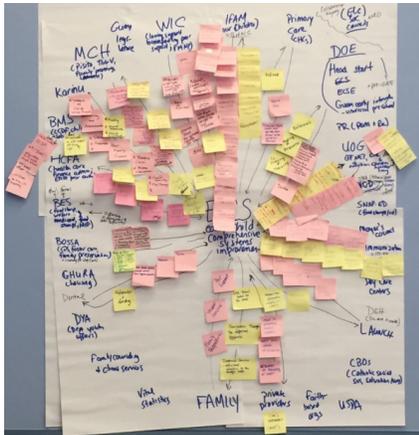
Parents shared their system support maps that described their roles and responsibilities as parents, and the resources they need on the second day; including parents in the meeting was extremely important in understanding how families experience their interaction with a variety of often disconnected service systems. Participants identified the value their agencies bring to the system, and how engaging with system partners offered significant added value. The group then developed a system map using the life course framework to lay out the services already in

Feature CONT.

Center On-site with Guam

place for pregnant women and young children and layered financial data on top. This visual depiction generated much discussion about ways to align funding and programs to improve integration, smooth transitions between programs, and reduce duplication and inefficiency.

On the last day, participants began describing more detail about the services their organizations provide pregnant women, infants and young children through process flow diagrams. As various diagrams were shared, the group was pushed to think about ways that services could be better integrated for children and families, or organizations could collaborate to more efficiently meet their goals. After, the group was guided through a discussion about what a better, redesigned early childhood system would look like. Participants identified shared measures that they would work on collectively as they moved forward in their collaborative work. Following a prioritization exercise using an impact matrix, the participants worked on action plans for implementation.



At the conclusion of the three day meeting, Center staff and Guam leaders agreed to several next steps, including two follow up virtual trainings on strengths-based development and causal loop diagramming. The site visit and facilitation are important elements of the Center's intensive cohort model. To learn more about the Center, please navigate to <http://mchwdc.unc.edu/>.

Feature CDC Essentials for Childhood Initiative: Progress and Early Lessons Learned

By Sandra Alexander, Joanne Klevens and Renee Wright

Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention



Safe, stable, nurturing relationships and environments are essential for healthy development and can prevent or buffer adverse childhood experiences, such as child maltreatment, which have serious immediate and lifelong negative consequences.



The Centers for Disease Control and Prevention (CDC) developed *Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments*, a framework that outlines strategies communities can consider to 1) raise awareness and commitment to promote safe, stable, nurturing relationships and environments; 2) use data to inform actions; 3) create the context for healthy children and families through norms change and programs; and 4) create the context for healthy children and families through policies (<http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html>).

In October 2013, five state health departments (California, Colorado, Massachusetts, North Carolina and Washington) received CDC funding to implement the *Essentials for Childhood* framework using a collective impact process over a five-year period (http://www.ssireview.org/articles/entry/collective_impact). Collective impact is particularly

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Feature CONT.

CDC Essentials for Childhood

appropriate for solving complex social problems that no single organization or sector can solve alone. In a collective impact process, a backbone organization (organizations with staff, resources and skills) identifies and convenes key stakeholders from different sectors and facilitates consensus around a common agenda (i.e., shared vision, goals and strategies) and shared metrics to track their progress. Work groups are created to implement the strategies; this usually requires reaching out to new stakeholders. These work groups identify what

efforts must be aligned and coordinated so that they are mutually reinforcing; what efforts should be stopped; and what efforts need to be developed or enhanced to fill gaps. The backbone organization facilitates progress and coordination through continuous communication.

In addition to the five funded states, more than 30 additional states use their own resources (i.e., “self-supported states”) to participate in this initiative at different levels (e.g., participate in conference calls, webinars,



Table 1. California Essentials for Childhood Initiative:
Safe, Stable and Nurturing Relationships and Environments
Strategic Direction, Goals and Work Groups

Strategic Direction: Strengthen Families’ and Communities’ Capacities to Create Safe, Stable and Nurturing Relationships and Environments for Children

Goals: Identify, align and enhance the California Essentials for Childhood Initiative partners’ and their stakeholders’ efforts to:

Programs and Systems Integration Work Group

1. Build upon families’ assets to strengthen their knowledge and skills to provide safe, stable and nurturing relationships and environments for their children.
2. Achieve the highest level of well-being for families and children, with special attention to those who have experienced socioeconomic disadvantage and historical injustice, including vulnerable communities and culturally, linguistically, and geographically isolated communities.
3. Prevent child maltreatment and other childhood traumas and implement trauma informed policies and practices throughout public and private organizations and systems.
4. Improve the quality of and expand the accessibility to programs and services supporting families and children.
5. Enhance the integration of systems and networks that support families and children to improve communication, services, accountability and outcomes.

Community Engagement and Public Awareness Work Group

6. Engage communities and strengthen their capacity to act and take leadership roles in creating safe and stable environments that support families and children.
7. Build public support and commitment (or ...“public commitment and political will...”) for policies and programs that promote safe, stable and nurturing relationships and environments for families and children.

Public and Private Sector Policy Work Group

8. Embed and incorporate families and children as priorities in public policies.
9. Increase the number and scope of private sector policies and practices that support families and children.

Shared Data and Outcomes Work Group

10. Improve and enhance data management systems that use common measurements to increase accountability for shared indicators and outcomes for families and children.

Feature CONT.

CDC Essentials for Childhood

meetings, actively implement the *Essentials for Childhood* framework). The state initiatives have been successful in bringing to the table decision makers representing several federal initiatives, such as the child care and development block grant; Head Start/Early Head Start; Maternal, Infant, and Early Childhood Home Visiting grants; the Community-Based Child Abuse Prevention grant; and Race to the Top Early Learning Challenge grant as well as philanthropic and community organizations creating an enormous opportunity to align substantial funds and efforts.

By March 2015, all funded states and several self-supported states reached consensus on a shared agenda and created work groups. For example, the California vision is “all California children, youth, and their families thrive in safe, stable, nurturing relationships and environments.” They proposed 10 goals that were assigned to four work groups (see table 1).

Colorado envisioned “a future where children and families thrive in places where they live, learn, work and play” and proposed to “advance policy and community approaches to 1) increase family-friendly business practices across Colorado; 2) increase access to childcare and afterschool care; 3) increase access to preschool and full-day kindergarten; and 4) improve social and emotional health of mothers, fathers, caregivers and children.” Their four workgroups each focus on one of these goals.

Important lessons learned to date include the following:

- Relationships among partners are key to success and well worth the time spent building personal connections and trust
- The collective impact process should build on strong state collaborations and requires patience, persistence, focus, and continuous communication
- Engaging cross-sector, executive level leaders early is important to get their buy-in
- Early focus on environmental factors (e.g., poverty, homelessness) that impact children is key
- Backbone organization staff require excellent facilitation skills and the ability to let partners reach consensus

Moving forward begins the hard work of implementing the strategies to be identified by working groups. CDC and the states will continue to document the process and monitor key indicators to establish the impact of the initiative.

For more information, visit <http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html>.

The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Feature

CHIP and the Affordable Care Act: Positive Changes and Questions for the Future

By **Stacy Collins, MSW**
Associate Director, Health Reform Implementation, AMCHP



Created in 1997, the Children’s Health Insurance Program (CHIP) was designed to finance health care for children caught in a coverage gap – those whose families earned too much to qualify for Medicaid, but too little to afford commercial health insurance. At the time of passage, Medicaid eligibility levels for children ranged from 100-133 percent of the federal poverty level (FPL) nationally, and the uninsured rate for children under the age of 19 was 14 percent. Enactment of CHIP, coupled with changes in Medicaid, raised eligibility levels for children over time to a median of 235 percent FPL.

Today, CHIP finances health coverage for more than eight million children. Together, Medicaid and CHIP helped reduce the uninsured rate for children to a record low of 7 percent in 2012.

Positive Changes to CHIP under the ACA

The Affordable Care Act (ACA) has strengthened CHIP in the areas of enrollment, eligibility and financing.

The ACA established new enrollment and renewal rules for Medicaid and CHIP, designed to create a simplified, “no wrong door” process for children and families. States are required to implement these new procedures regardless of whether they adopt the Medicaid expansion for low-income adults. The ACA also included a “maintenance of effort” requirement, whereby states must continue the eligibility thresholds for children under Medicaid and CHIP that were

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CHIP and the ACA

in place in March 2010, through Sept. 30, 2019. The ACA also offers states the option of providing CHIP coverage to children of state public employees.

The ACA extended federal CHIP funding through September 2015. CHIP was recently funded for an additional two years (through September 2017) under the “doc fix” bill (P.L. 114-110), signed into law by the president in April. With this recent reauthorization, the ACA provision that increases the federal CHIP matching rate takes effect. With the start of fiscal year 2016, the rate will rise 23 percentage points, resulting in matching rates ranging from 88 percent to 100 percent.

Risks to CHIP in the ACA Era

As originally envisioned, the ACA would create a comprehensive system of health coverage for low-income Americans through the insurance marketplaces, tax subsidies and an expanded Medicaid program. Most ACA architects envisioned a system in which children and parents would be covered under the same health care plan, thus eliminating the need for a gap-filling program like CHIP. In addition, some states see a CHIP phase out as helpful to stretched budgets. Although states pay only a small share of the cost of CHIP, health coverage for the same low-income families would be cost-free for states if they eliminated CHIP and directed families to the health insurance exchanges.

But a phase out of CHIP in the near future poses risks for children’s coverage. A major concern is an apparent mistake in the ACA, known as the “family glitch,” that could make employer-sponsored insurance too costly for many low-income workers. Under the ACA, anyone who is offered “affordable” insurance by their employer is not eligible for federal tax credits. Affordable insurance is defined as employee-only coverage that does not exceed 9.5 percent of a worker’s income. Premiums for family coverage, however, are typically three times as much as individual coverage. Without a CHIP program, children in families opting out of expensive employer coverage may likely go uninsured, if they don’t otherwise qualify for Medicaid.

The financial burden on families covered through exchange plans is generally greater than CHIP coverage. Exchange plans have substantially higher out-of-pocket expenses, including copays and deductibles. And although they must comply with ACA minimum essential coverage

requirements, exchange plans often have fewer child-specific benefits and less robust provider networks than CHIP. In any discussion of the transition from CHIP to exchange plans, access to specialized pediatric providers – and increasingly narrow networks – have emerged as major issues for families who have children with special health care needs.

Beyond 2017

The two years of additional CHIP funding provides an opportunity for policymakers and advocates to tackle the issues of affordability, child-specific benefits, and network adequacy that must be addressed before transitioning children from CHIP to exchange plans or employer sponsored coverage. Recommendations include fixing the “family glitch,” refashioning CHIP as a pediatric-specific exchange plan, or creating new rules that decrease cost sharing for family coverage purchased on the exchanges. Moreover, policymakers need to understand the role that CHIP continues to play in meeting the unique coverage needs of children in low-income working families, and that CHIP should not be abandoned until comparable coverage is guaranteed.

Feature

World Breastfeeding Week – Let’s Make it Work!

By Carolyn McCoy, MPH
Senior Policy Manager, Health Reform Implementation, AMCHP

Aug. 1-7, 2015 is World Breastfeeding Week. The theme this year is “Let’s Make it Work!” Within this theme, there is a call for “concerted global action to support women to combine breastfeeding and work.” The opportunity to fulfill this call to action in the United States is better than ever.



The CDC annual report card indicates that in 2013, 77 percent of mothers initiate breastfeeding after the birth of a child. Yet, breastfeeding rates fell to 49 percent nationally after six months. Disparate rates among racial and ethnic groups persist with 55 percent of African-American women initiating breastfeeding. However, while these rates are

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World Breastfeeding Week

improving, breastfeeding rates among African-American women remain lower than the rates of other racial or ethnic group in the United States, particularly among those living in the south. Breast milk provides the ideal nutrition for infants. The benefits of breastfeeding for children are well established and include increased immune response, thus lowering instances of ear infections, diarrheal disease, and risk of certain allergies. Breastfeeding also has been shown to reduce the likelihood of obesity in adolescence, and type 1 and type 2 diabetes. Additionally, the skin-to-skin contact and closeness between mother and baby contribute to bonding.

Persistent barriers for women to initiate and continue to exclusively breastfeed include a lack of accommodation to breastfeed or express milk at the workplace; experience or understanding among family and community members of how to best support breastfeeding mothers; opportunities for breastfeeding mothers to communicate and support each other; and up-to-date instruction and information on breastfeeding from health care professionals. Among other community supports for mothers who wish to breastfeed, the Affordable Care Act (ACA) provides an opportunity to lower barriers for breastfeeding mothers returning to work who wish to continue breastfeeding. Under the law, most private health insurance plans (including those available on the new Health Insurance Marketplace) are required to provide coverage for women's preventive health services – including breastfeeding support, supplies and counseling – with no cost sharing (they can no longer charge a patient a copayment, coinsurance or deductible when services are delivered by a network provider). These breastfeeding benefits must be provided in conjunction with each birth. The ACA also amended section 7 of the *Fair Labor Standards Act* (FLSA) that requires employers provide reasonable breaks for an employee to express breast milk for her nursing child for one year after the birth of the child. In addition, employers are required to provide a place – other than a bathroom – that is shielded from view and free from intrusion from coworkers and the public for nursing mothers to express breast milk during the workday. These requirements, however, do not preempt state laws providing greater protection to employees. Employers with fewer than 50 employees are not subject to FLSA break time requirement if compliance with the provision would impose an undue hardship.

Title V and public health leaders have an opportunity to help inform the populations they serve as well as their

partner organizations about these important supports for breastfeeding mothers. An AMCHP [issue brief](#) highlights examples of state Title V programs that have partnered with other state-level agencies, and organizations to assist with the implementation of this important law. Many questions remain, however, states are encouraged to reach out to each other as well as AMCHP and the Office of Women's Health for resources and connections to organizations that stand ready to help!

In partnership with the Association of State and Territorial Health Officials (ASTHO), AMCHP hosted a national webinar, "Making room for Moms: Building Lactation Space and Implementing a Model Policy in State Health Departments" on Tuesday, Jul. 21. This webinar highlighted state efforts to implement a model policy to support breastfeeding mothers at work, and included advice and photos on how state health departments developed lactation rooms to support their new moms. [Click here](#) to access the webinar recording, slides and other resources shared during this learning event.

How are you working to support breastfeeding in your community? Let us know! Tweet us at @DC_AMCHP using the hashtag #makingroomformoms.

Feature

The Raising of America: Using Partnerships to Strengthen and Leverage the Importance of Early Childhood and the Future of our Nation

By Piia Hanson, MPH

Senior Program Manager, Women's & Infant Health, AMCHP

Kate Taft, MPH

Senior Program Manager, Children and Youth with Special Health Care Needs, AMCHP

As we shared in [Pulse](#) last winter, [The Raising of America: Early Childhood and the Future of Our Nation](#) is a five-part documentary series scheduled for national broadcast in November 2015, that explores how a strong start for all our kids can lead to a healthier, stronger and more equitable

Feature CONT.

Raising of America

America. The *Raising of America* documentary series and public engagement campaign consists of three parts: 1) a documentary series, 2) a national public engagement campaign, and 3) a companion website, <http://www.raisingofamerica.org/project>.



To date, more than [550 organizations](#) across the nation have joined the campaign to screen the series to change the conversation about what we can – and should – do to improve conditions for families with young children. With support from the Doris Duke Charitable Foundation (DDCF), AMCHP is partnering with the CDC Division of Violence Prevention, National Association of County and City Health Officials (NACCHO), and the Healthy Heartlands Collaborative (HHC) to assist with dissemination of the documentary. Here are some recent examples of how AMCHP and partners are using the *Raising of America* as a tool to foster dialogue and action toward what we as a society can do to ensure all our children have an opportunity for a stronger start:

- The CDC Division of Violence Prevention, AMCHP, NACCHO and HHC are working in partnership with support from the DDCF and the CDC to use the *Raising of America* with their supporters to encourage local, state, and national partnerships to create the safe, stable, nurturing environments and relationships all babies need to thrive. Each partner will adapt key engagement resources to best serve their different audiences. A webinar is scheduled for late fall to provide additional updates on how people are using the *Raising of America* documentary and campaign tools. (A partnership and RoA overview webinar was held last January. Recording and materials are available [here](#).)
- The CDC Division of Violence Prevention is currently working with the American Academy of Pediatrics to develop resources that will assist pediatricians who participate in the *Raising of America* activities and will be disseminating the various *Raising of America* campaign tools with many partners, including Essentials for Childhood, DELTA focus, and other grantees.
- The CDC Division of Violence Prevention will hold its own *Raising of America* launch event in early October.

The companion website will be heavily promoted through CDC social media channels including the main Injury Center Twitter account, [@CDCInjury](#) and [VetoViolence](#) Facebook page, so stay tuned for additional updates!

- AMCHP and NACCHO are developing tip sheets for how state and local public health agencies (respectively)

can use the *Raising of America* documentary and resources in their early childhood work. AMCHP also developed several templates and additional resources that Title V programs can use, including:

- Facilitated agenda example for a screening event
- Screening feedback handout (short)
- Discussion handout (moving to action/moving forward)
- Discussion guide for team breakouts
- Commitment to Action to document next steps from your stakeholders

The AMCHP tip sheet and resources are available at <http://www.amchp.org/programsandtopics/CHILD-HEALTH/projects/early-intervention-svcs/Pages/default.aspx>.

- In August, AMCHP will mail a copy of the *Raising of America* DVD and tip sheet to each Title V program in every U.S. state and jurisdiction.
- AMCHP and NACCHO, in partnership with several other DC organizations, are excited to host a Capitol Hill discussion this fall on early childhood policy and using the *Raising of America* documentary to ensure a healthy start for all children and families.

AMCHP will continue to update [our Web page](#) with resources from our partnership activities and examples of how our members are using the documentary and campaign resources in their states.

For more information about *Raising of America*, visit <http://raisingofamerica.org> or click on the links below:

- [See highlights from the campaign](#)
- [Watch the opening trailer](#)
- [Join the campaign](#)
- [Follow Raising of America on Facebook](#)
- [Buy the DVDs](#)

Feature

A Look at the Cost of Child and Adolescent Injuries

By **Rebecca Spicer, PhD, MPH**
*Children's Safety Network,
 Economics and Data Analysis
 Resource Center*



In 2010, 13,819 children and adolescents aged zero to 19 died of an injury. An estimated 310,500 were hospitalized and more than nine million were treated and released from the emergency department. Another 12 million plus injuries were treated in physician offices. However, these numbers tell only part of the story. While incidence data are useful for assessing the magnitude of the problem, costs better account for multiple injury consequences – death, severity, disability, body region, nature of injury – in a single unit of measurement.

The CDC Web-based Injury Statistics Query and Reporting System (WISQARS) Cost of Injuries Module puts cost of injuries right at our fingertips. This brief report 1) examines the burden of injury using 2010 injury costs by cause to children ages zero to 19 and 2) compares total costs and cost per injury by cause. We include all fatal, hospitalized and emergency department visits treated and released. Costs include both medical and work loss costs. Medical costs include medical care, rehabilitation, follow-up care, long-term medical and institutional care, prescriptions,

coroner services in the case of fatalities, and the costs of health insurance claims processing. Work loss costs include short-term work loss and the value of wage and household work that a child will be unable to do if he or she is killed or permanently disabled. It also includes wages and household work that parents are unable to do when caring for their child.

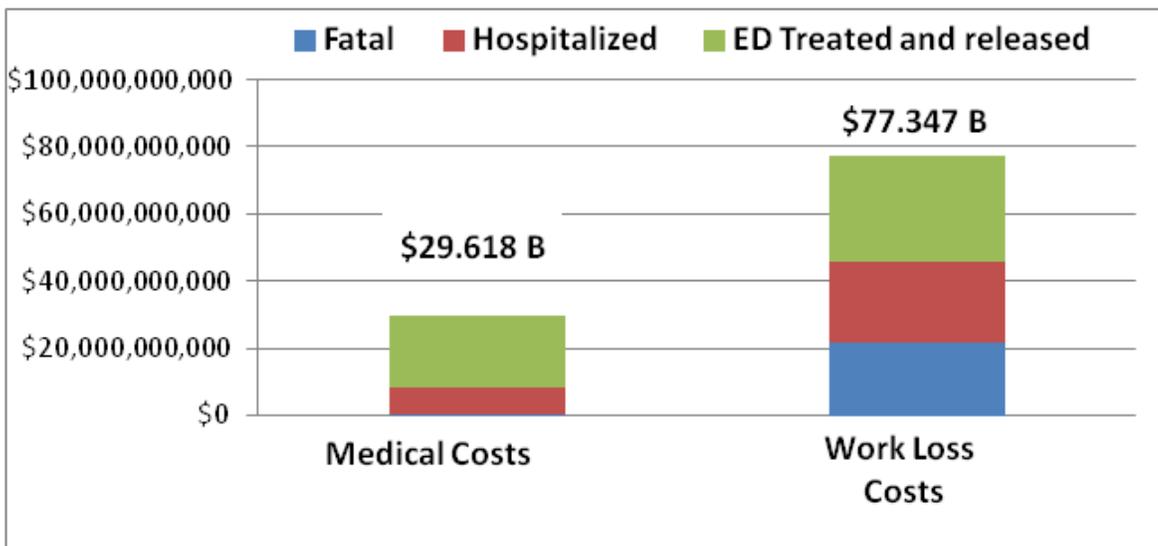
Fatal and medically treated injuries resulted in nearly \$30 billion in medical costs and \$77 billion in work loss costs (Figure 1). This excludes the costs of the 12 million plus injuries treated in physician offices. Medically treated injuries contribute a large portion of total medical costs while medical costs are small among fatalities. However, work loss costs that the fatally injured child will not contribute make up a substantial portion of total work loss costs.

Unintentional falls, struck by/against, and motor vehicle occupant injuries are the leading contributors to total costs (medical plus work loss) (Table 1). The causes of the most severe injuries are quite different. Unintentional drowning, self-harm/suicide, and unintentional firearm injuries are the leading causes of severe injury according to cost per injury (Table 2). These leading causes include a large proportion of fatalities that result in high work loss costs.

Thus, cost analyses add another dimension in setting priorities and are useful for comparing injury causes, assessing related health burden, and planning cost-effective prevention strategies. In fact, the cost of childhood

injuries provides a compelling case for the consistent implementation of evidence-based child safety measures and reinforces the importance of the Affordable Care Act emphasis on prevention and wellness. While we present national estimates of injury costs, the CDC WISQARS Cost of Injury Module

Figure 1. Total Cost of Injury Among Children and Adolescents Aged 0-19, by Cost Category



Feature CONT. Cost of Child/Adolescent Injuries

Table 1. Leading 10 Causes of Injury Among Children and Adolescents Aged 0-19, Ranked According to Total Injury Cost (*Costs include Medical and Work Loss Costs, in 2010 U.S. dollars)

Rank	Cause	Total Cost*
1	Unint. Fall	\$28,196,000,000
2	Unint. Struck By/Against	\$15,035,000,000
3	Unint. Motor Vehicle Occupant	\$14,791,000,000
4	Assault/Homicide	\$10,167,000,000
5	Other Unintentional	\$6,715,000,000
6	Unint. Pedal Cyclist/ Pedestrian	\$5,291,000,000
7	Self-Harm/Suicide	\$5,002,000,000
8	Unint. Overexertion	\$4,954,000,000
9	Unint. Bite/Sting	\$3,319,000,000
10	Unknown	\$2,680,000,000

Table 2. Leading 10 Causes of the Most Severe Injuries (defined by cost per injury) Among Children and Adolescents Aged 0-19 (*Costs include Medical and Work Loss Costs, in 2010 U.S. dollars)

Rank	Cause	Cost*/Injury
1	Unint. Drowning	\$386,900
2	Self-Harm/Suicide	\$54,487
3	Unint. Firearm	\$35,996
4	Unint. Motor Vehicle Occupant	\$28,609
5	Assault/Homicide	\$23,781
6	Unint. Pedal Cyclist/Pedestrian	\$15,492
7	Unint. Poisoning	\$15,306
8	Other Unintentional	\$13,268
9	Unint. Fire/Burn	\$12,117
10	Unknown	\$10,386

also allows state and local health departments to generate reports using their own counts of fatalities, hospitalizations and/or emergency department visits.

Data Source: NCHS Vital Statistics System for numbers of deaths. NEISS All Injury Program operated by the U.S. Consumer Product Safety Commission (CPSC) for numbers of nonfatal injuries. Pacific Institute for Research and Evaluation (PIRE), Calverton, MD for unit cost estimates. Accessed online: https://wisqars.cdc.gov:8443/costT/cost_Part1_Intro.jsp.

View from Washington

By Brent Ewig, MHS
Director, Public Policy & Government Affairs



My wife and I recently began making plans for a trip sometime next spring to celebrate our 10th wedding anniversary. Check with me this time next year for photos and stories of what I'm sure will be a fantastic adventure! More immediately, AMCHP is observing two policy-focused anniversaries. These include the 50th anniversary of the Social Security Amendments of 1965 - which created the Medicaid program on Jul. 30, 1965 - and the 80th anniversary of the underlying Social Security Act -



AMCHP is collecting emerging, promising and best practices related to child health!

Does your program address an MCH best practice? If so, consider sharing your program through Innovation Station, the AMCHP searchable database of emerging, promising and best practices in maternal and child health. Through this opportunity, you can:

- Share successes with your peers
- Enhance the MCH field
- Contribute to program replication
- Get expert feedback from the Review Panel
- Receive national recognition

The online submission process is simple and applications are accepted on a rolling basis. For more information, contact [KiYonna Jones](mailto:KiYonna.Jones@amchp.org) at (202) 266-3056 or visit amchp.org/bestpractices.

You can also [click here](#) to refer an innovative MCH program that we should know about!

View from Washington CONT.

which created Title V maternal and child health program on Aug. 14, 1935.

Both Medicaid and the Title V MCH Services Block Grant are commonly thought of as ‘health’ programs, and improving health is certainly central to their statutory mission and purpose. However, the anniversary of the Social Security Act provides us an opportunity to reflect on the intersection of health and poverty, and the role of federal legislation in both alleviating the ill effects of poverty and preventing poverty in the first place.

Focusing on Medicaid first, the evidence shows that beneficiaries were as likely as those with private insurance, and significantly more likely than uninsured adults, to report having a regular source of care. Furthermore, individuals with Medicaid report getting recommended preventive care services at higher rates than did those who are uninsured.

Policy Changes to Reduce Childhood Poverty

Increasing employment and making work pay more for adults with children

- Increase the Earned Income Tax Credit for lower-income families with children
- Increase the minimum wage from \$7.25 to \$10.10
- Create subsidized jobs for unemployed and underemployed individuals ages 16-64 in families with children
- Make child care subsidies available to all eligible families below 150 percent of poverty
- Make the Child and Dependent Care Tax Credit refundable with a higher reimbursement rate

Ensuring children’s basic needs are met

- Base SNAP benefits on USDA’s Low-Cost Food Plan for families with children
- Make the Child Tax Credit fully refundable
- Make housing vouchers available to all households with children below 150 percent of poverty for whom fair market rent exceeds 50 percent of their income
- Require child support to be fully passed through to TANF families, fully disregarded for TANF benefits, and partially disregarded for SNAP benefits

See more at: <http://www.childrensdefense.org/library/PovertyReport/EndingChildPovertyNow.html?referrer=https://www.google.com/#overview>

When focusing specifically on how Medicaid insulates people from further impoverishment, evidence from the Commonwealth Fund shows that “adults with Medicaid were significantly less likely than either privately insured or uninsured individuals to report difficulty paying medical bills, being contacted by a collection agency about unpaid bills, having to change their way of life to pay medical bills, or paying off medical bills over time. Those with Medicaid were also significantly less likely to report skipping services because of the cost of care compared with adults who had spent time uninsured.” In an era where high medical bills are the number one cause of personal bankruptcy, the importance of adequate health insurance is clear.

AMCHP leaders also are discussing how the Title V MCH Services Block Grant can provide tools to address poverty as one of the single largest determinants of health. One manifestation of this emerging is in the MCHB supported Collaborative Improvement and Innovation Network to Reduce Infant Mortality (IM CoIIN) where states have identified the need to implement evidence-based policies and programs and place-based strategies to improve social determinants of health and equity in birth outcomes. And at the individual state level, Minnesota is one of the leaders in the field creating a [Center for Health Equity](#) within the Department of Health. This center has published white papers on [paid leave and health](#) and [income and health](#), and has made advancing health equity a central goal for the state.

Other states are actively leading in this area, and at the federal level a bill has been introduced entitled the Child Poverty Reduction Act of 2015 (H.R. 2408), which seeks to create a national child poverty target, with the overall goal of halving child poverty in the United States in 10 years and completely eliminating it within 20. To help create a map on how this could be achieved, our partners at the Children’s Defense Fund recently produced a report showing that these policy eight changes {see box} would create a 60 percent reduction in childhood poverty.

Navigating the intersection of health and poverty is not easy, but we at AMCHP have been encouraged that it is increasingly becoming part of the national policy dialogue in recent years. We look forward to adding your voice to this discussion and continuing to support those policy and programs that will make a difference for all moms, children, families and communities.

Real Life Stories

CYSHCN and Oral Health

A visit to the dentist can be challenging for any parent. Add a child with special health care needs to the equation and it can become infinitely more difficult. Following are real life stories from parents of children with special health care needs and how they challenge the system to get the care their children need.

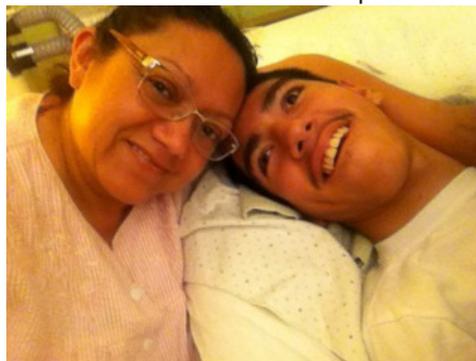
By Loni Jorgenson, Iowa

As the mother of a daughter with autism I know managing oral health for special needs children can often be challenging. As my daughter has gotten older she has been better able to cope with having her teeth brushed. When she was younger, she would often gag while having her teeth brushed. I found using a finger toothbrush with soft silicone bristles was often helpful to help prevent sensory issues. Using social stories with pictures and rewarding children with stickers or other simple incentives also can be helpful. Once my daughter was able to cope with using a typical toothbrush, she liked going along to the store to help pick out her own toothbrush with her favorite character. Some children prefer electric toothbrushes since the vibration can help distract them from the brushing. There also have been times when my daughter disliked the taste of the toothpaste she was using, which can make brushing even more difficult. There are many flavors of toothpaste available; have your child pick a flavor they enjoy. The best solution to managing oral health is to experiment and find which methods work best for your family!



By Mariana Murillo, California

Getting basic oral health care for a child with special needs is costly in both time and money, even for families who have insurance coverage. In California, for families with Medi-Cal the challenge begins with finding providers who are willing to provide basic services. What's surprising is when a family has dual coverage; the process can be just as formidable. When extensive care is needed, the perseverance and tenacity of parents play a large role in getting children with complex



health care needs the dental care they require.

Our family entered into the labyrinth of accessing care for our son Oscar in 2012. Oscar is covered through both private and public insurance benefits. Oscar is 17 years old, non-verbal and has cerebral palsy. He began waking up in pain and through a process of elimination we figured out that, like typical teens, Oscar needed his wisdom teeth removed. Due to Oscar's complex medical needs our experience in accessing care was far from typical. Oscar required hospitalization and general anesthesia for the surgery. After consulting specialists in four cities, it took us nearly a year to find a provider who would do the surgery. Feeling like we were finally making headway we soon learned that our insurance denied the hospitalization. [We later learned that the authorization was not granted due to an error in coding when staff at the doctor's office completed the request. Providers, train your staff!]

In desperation, we found another doctor who agreed to do the surgery. He did not accept Medi-Cal, Oscar's secondary insurance, but extended us a reduction in rates. The day before Oscar was to enter the hospital, the surgery was cancelled. The anesthesiologist felt that the hospital was not equipped to care for Oscar in case of emergency.

In 2015, 31 months after the initial diagnosis, surgery was successful. We paid out-of-pocket for most of the services. We were denied financial assistance by two state funded agencies charged with the job of providing care and service coordination to help families with children with developmental disabilities and special health care needs. They reasoned, "All children this age have wisdom teeth problems and the needs were not related to Oscar's developmental disability." If that's the case, why did it take almost three years to get his needs met?

It's been nearly three months and Oscar is doing well. As a parent, I've worked as Oscar's case manager since his birth and as a parent mentor to families for almost 15 years. Providers who recognize the needs of children with complex health care needs must be recruited to fill the enormous needs. Providers need staff trained on how to properly request authorizations. Hospitals need to open the doors to oral health care providers. Coordination of care

Real Life Stories CONT.

is critical, family support and system navigation is a must. Lives depend on it.

By Teresa Nold, South Dakota

Living in a rural state as South Dakota, access to medical care can be a challenge. Add in a specialty such as Dental or orthodontia care, the challenge is doubled.

My son has multiple disabilities – cerebral palsy, Moebius Syndrome, Trigeminal Trophic syndrome – a combination of these has led to several health issues. When he was younger, we had no problem locating a dentist who works with South Dakota Medicaid. Over the years, as his teeth were growing and changing, we felt that we should consider some orthodontic work. His dentist would reply each time we ask “oh, but he’s got disabilities,” and would end the discussion with that.

We still felt like something could be done. We saw a different dentist... and with her support, we began to make phone calls. We were referred to a clinic that would put our son on a waiting list up to a year. A year?! You’re kidding. We began to call other private practices. It was so disheartening to give them all the information then the conversation ends with “who’s his insurance provider?” “Medicaid” we answer. Then we get the “Oh we don’t work with Medicaid” sympathy talk. We then contacted the state office of Medicaid and asked if they would support us going out of state. We said our son deserves a choice with immediate access to quality care. There was some hesitation. Our phone call ended with the state office doing some checking and will get back to us. We later received

a call from them saying Medicaid will approve going out of state. So challenge solved? Not really.

We go to Minnesota for his orthodontic care and are still in the middle of it all. The doctor and staff are terrific to



work with. We had a bit of an emergency one weekend. I made a few phone calls to local orthodontists to see who was available. One said he could meet us in 30 minutes. But then once he discovered he wasn’t a patient of his and that he has Medicaid? “Oh, I can’t work with him because I wouldn’t get paid.” Come to find out, Medicaid has paid the clinic in Minnesota a lump sum up front for care for our son. Because they did that, we can’t go elsewhere. The emergency? He was just fitted with braces

and a bracket came loose, all we needed was a dab of glue to put the bracket back in its place. Instead, I ended up on the phone with the orthodontist from Minnesota guiding me to slide the bracket out and cut the wire with a fingernail clipper.

An additional challenge for us as a family, three out of the four of us are Deaf. Finding a dental clinic willing to provide an interpreter is pretty difficult in South Dakota. In Minnesota accommodations are provided, no questions asked. We are so grateful for that. Our son is able to participate in his appointment, and we are able to function as parents and not interpreters.

My biggest advice to parents? Your kids deserve access to quality care regardless of type of insurance. Start asking questions, challenge the system. They need to hear where the problem areas are.

Success Stories

Youth & Family Services, Inc. Boys' Health Advocacy Program

By Burke Eilers, MS, BS
*Director, Youth & Family Services
Counseling Center/Youth Trauma
Center/Boys' Health Advocacy
Program*



Sharon Oney, BA, MEd
*Youth & Family Services Grants
Administrator*



Who would have thought that mentoring could be so critical to a boy's health? When the Boys' Health Advocacy Program began 10 years ago, the advocates accepted referrals of boys, ages four to 17, with unmet health care needs and ensured that they received medical, optical, and dental care. In time, they came to realize that their clients' overall health and well-being was much more complex.

The boys often experienced poverty, hunger, homelessness, abuse or neglect, chaotic or transient lifestyles, substance abuse in the home, emotional or behavioral problems, and/or a host of other issues. The advocates recognized the need to identify and address as many of these factors as possible in order for healthy change to occur.

The Boys' Health Advocacy Program now works to promote physical and mental health, prevent or reduce risky behavior, provide a trusted adult mentor, increase access to community resources, and provide academic support. Many at-risk youth think they have little or no opportunity for success. This approach offers opportunities to build on their strengths, increase life skills, and participate in enriching experiences that help the boys set goals and direction for their lives.

The program offers several components for at-risk boys:

- **Prevention Education** including life skills, healthy relationships and preventing risky behaviors
- **Health Promotion** focusing on nutrition and fitness and linking the boys to health care
- **Mental Health** assessments and trauma-focused treatment
- **Family/School Involvement** that promotes academic success and parenting skills
- **Transportation**, which is necessary for most at risk boys to be able to participate
- **Mentoring** that provides the support of a trusted adult who reinforces positive behaviors

Of all the components, mentoring is proving to be the key that makes the program effective with at-risk boys. As one participant stated, the Boys' Health Advocacy Program "gives us a fatherhood mentor who spends time with us, gives us things, and teaches us things...Without this program there wouldn't be anything or anybody to help us with our lives...That's why this program is important."

Learn more about this program on AMCHP [Innovation Station!](#)



Replicating "Best" Practices: AMCHP Best Practices Technical Assistance Project Request for Applications *Coming Soon!*

As part of our efforts to improve MCH outcomes by sharing effective and promising practices, AMCHP is offering technical assistance funds of up to \$10,000 (for up to two states) to replicate or adapt a current emerging, promising or best practice in [Innovation Station](#). Applicants will need to demonstrate readiness to adapt the practice in order to maximize technical assistance resources. Log onto Innovation Station today to start thinking of all the wonderful innovations you can implement in your state, jurisdiction or territory. Request for applications will be released in August, so stay tuned!

Success Stories

Supporting Couples at the Transition to Parenthood: Family Foundations

By Mark E. Feinberg
Research Professor, Prevention Research Center, The Pennsylvania State University



The Department of Defense concern with a service member's readiness for duty has transformed over the past decade with the recognition that "family readiness" is a key factor determining an individual's operational capacity. The growing awareness of family readiness has prompted a move to develop and disseminate programs for military families that support positive family functioning, such as Family Foundations.

Family Foundations is implemented as a brief series of classes before and after birth, preparing couples for the increase in responsibilities and strains of early parenthood. How couples weather and emerge from the transition to parenthood influences the future course of family relationships and parent and child adjustment. The key goal of Family Foundations is to promote healthy and cooperative co-parenting relations as fundamental bedrock of positive couple romantic and parent-child relations.

Family Foundations has demonstrated positive program impacts on a broad array of parent, child, and family relationship domains from birth to seven years old (Feinberg et al., 2010, Feinberg and Kan, 2008, Feinberg et al., 2009). Data from randomized trials indicated that pregnant mothers assigned to Family Foundations with medium-high levels of cortisol, financial stress, etc. demonstrated lower levels of preterm birth and experienced shorter hospital durations after birth. Data analyses also illustrated that Family Foundations enhanced co-parental support while reducing co-parental undermining, parental stress and maternal depression.

Children in families exposed to Family Foundations showed better adjustment than control children:

- Age 1, Family Foundations children demonstrated greater capacity for self-soothing than control children
- Age 3, Family Foundations children showed greater social competence, and boys showed fewer emotional

- and behavior problems relative to control children
- Age 7, teachers reported that Family Foundations children demonstrated better academic adjustment, fewer mood and anxiety problems and fewer disruptive behavior problems than control children

Family Foundations successfully piloted a version of the program for low-income teens becoming parents and is currently testing a version for high-risk parents. Other program versions are being developed for online, interactive delivery and for parents with a young child diagnosed with Autism Spectrum Disorder.

Although a few local community organizations have adopted Family Foundations, the Defense Department represents the first large-scale dissemination. Program developers are currently consulting with policymakers to consider how federal block grants may support civilian dissemination through state maternal and child health systems.

Learn more about this program on AMCHP [Innovation Station](#) and by visiting their website www.FamFound.net.

Success Story

Georgia Shape Targets Childhood Obesity

By Emily Anne Vall, PhD
Obesity Project Manager (Georgia Shape), Office of the Chief of Staff, Georgia Department of Public Health



Georgia Shape is a statewide, multiagency initiative of Gov. Nathan Deal that brings together governmental, philanthropic, academic and business communities to address childhood obesity in Georgia.

In 2009, Georgia mandated statewide fitness assessments through public school physical education classes and currently assesses more than one million students annually. Georgia Shape is diligently working toward improving student body mass index (BMI) and aerobic capacity (AC) measures through various statewide physical

Success Stories CONT.

activity and nutrition interventions.

Georgia Shape programs, such as Power Up for 30 (PU30), help empower school leaders and faculty members to engage students in physical activity every day while utilizing their existing resources. PU30 is a free one-day training program that helps teams of educators integrate an additional 30 minutes of physical activity before, during or after school, as well as improve physical activity levels in physical education classes and recess. PU30 is unique in that it analyzes each school environment prior to training so educators can build custom physical activity action plans that align with their school's capabilities.

Pilot data suggest that PU30 can not only improve student BMI and AC measures, but also increase minutes of physical activity in the classroom and during recess. The goal of PU30 is to inspire every school in the state to pledge and implement the program. **As of July 2015, more than 350,000 students have been touched through the program.**

In partnership with the Georgia Department of Education and HealthMPowers, our technical assistance provider to schools, **Georgia Shape has engaged more than 600 schools across the state through PU30.** The resounding success of PU30 inspired a new iteration of the program that will be developed with Georgia Shape partners for middle schools and early child care environments.

Learn more about this program on AMCHP [Innovation Station](#) and their website www.GeorgiaShape.org. You can also connect with Georgia Shape online by following the organization on [Facebook](#), [Twitter](#) and [Instagram](#).

Member to Member

We asked AMCHP members: How has the Early Childhood Comprehensive Systems (ECCS) helped build your state capacity to improve state infant and toddler child care quality?

VIRGINIA

By Bethany Geldmaker, PhD

Project Director Early Childhood Comprehensive Systems Grant, Virginia Department of Health

Member to Member CONT.

The Commonwealth of Virginia has a number of state quality child care initiatives focusing on children birth to three. Initially funded in 2003, the Virginia ECCS grant builds on the state's systems integration work. The broad goal of Virginia ECCS is to build state capacity to foster professional development of the early childhood workforce that:

1) enhances knowledge and skills of the early childhood workforce and those who support them; 2) supports the implementation and sustainability of evidence-based practices; and 3) increases the size of the workforce skilled in supporting the social-emotional and physical development of young children (birth to three) in inclusive and natural environments.



The purpose of the current ECCS grant is to prevent and reduce the risk factors associated with adversity in early childhood environments, reinforce healthful behaviors by improving the quality and delivery of birth to three child care quality initiatives and increase community and state linkages that will support improved health and developmental trajectories by fostering safe and nurturing relationships. The project integrates *Caring for Our Children 3* (CFOC3) standards into early childhood professional development initiatives to improve the quality and delivery of initiatives for children aged birth to three.

Three primary objectives provide focus and structure to the work: Objective 1: Increase community and state early childhood professional development linkages that will support improved health and developmental trajectories; Objective 2: Enhance the knowledge, skill, and competency of the early childhood workforce and those who support them; and Objective 3: Increase the size of the workforce skilled in supporting the social-emotional and physical development of young children (birth to three) in inclusive and natural environments.

The Early Childhood Mental Health Virginia Advisory Board (ECMHVAB) serves as the state ECCS Team. Project SEED (Social Emotional Education and Development) Virginia is a cooperative agreement between the Virginia Department of Social Services, Virginia Department of Health, and Virginia Commonwealth University's Partnership for People with Disabilities (PPD) on behalf of the ECMHVAB. Project SEED, under the leadership of

Member to Member CONT.

ECMHVAB, supports a variety of child care professional development projects braiding funding from partner agencies and organizations. Projects include trainings, coaching and mentoring for Ages and Stages Screening (both ASQ-3 and ASQ-SE) and Positive Behavior Support (CSEFEL, Infant Mental Health Endorsement), all of which are linked to ECCS.

NEW MEXICO



By Giovanna Rossi, Collective Action Strategies President; Gloria Bonner, ECCS Project Director, New Mexico Department of Health; and Janis Gonzales, MD, Title V Director/Family Health Bureau Chief & Medical Director, New Mexico Department of Health

To build capacity to expand developmental screenings, the New Mexico ECCS initiative provides trainings to community programs, such as home visiting and early care and learning, on the administration and scoring of the most commonly used developmental screening tools. During the first two years of the grant, 543 early childhood providers have been trained in using the Ages & Stages Questionnaire screening instruments in both urban and rural areas of the state.

An early care provider survey was developed and distributed to licensed and registered child care directors, home visitors/supervisors, head start and early head start directors. The survey captures and documents developmental and behavioral health screening and referral activities in current practice in early care and education settings for children age birth to five. The ECCS team will synthesize findings and discuss next steps as

informed by these findings.

Also, formative research was conducted in order to gain insight into the values, barriers, and motivators of parents of young children and assess their informational needs regarding child development and child well-being. The research activities included written surveys with parents and professionals (childcare workers, early childhood educators, health providers) and Focus Group Interviews with parents of children zero to three in various communities around the state.

LOUISIANA

By Lindsay Usry
ECCS Coordinator, Tulane Institute of Infant & Early Childhood Mental Health



Current efforts of the Louisiana ECCS, in collaboration with various partner organizations, include: facilitation of the Young Child Wellness Collaborative, an action learning collaborative focused on early childhood adversity; development of the Louisiana Risk and Reach in Early Childhood report, which provides data about children under five and the programs that serve them; facilitation of the Early Childhood Policy Leadership Institute, a program to educate leaders about the importance of early childhood and to cultivate champions for young children; development of the Louisiana ACE Initiative and ACE Educator Program, a statewide effort to increase awareness of the impact of childhood trauma; and promotion of Vroom, an app developed by the Bezos Family Foundation that encourages positive “brain building” parent-child interactions. Importantly, ECCS funding has enabled Louisiana to maintain a staff position dedicated in part to monitoring for new opportunities to increase collaboration, improve quality, and infuse state efforts with expertise from infant mental health and other related fields. In the past year, this monitoring for and exploring of opportunities has led to the creation of the Louisiana ACE Educator Program as well as promotion of Vroom. Louisiana ECCS also is aligned closely with Louisiana LAUNCH and Maternal, Infant, and Early Childhood Home Visiting program.

Who's New

CYSHCN DIRECTOR

GEORGIA

Donna M. Johnson

Director, Child Health Intervention, Maternal and Child Health Section
Georgia Department of Public Health

AMCHP Staff

Iliana White

Iliana White joins AMCHP as the senior program manager, adolescent health. Iliana previously served as a program manager at the School-Based Health Alliance. There, she directed the technical assistance and training activities for the organization's Hallways to Health initiative, a national school-based learning collaborative focused on behavior and systems changes for healthy eating and active living utilizing school-based health centers as catalysts for improvement. She also managed the Alliance's Leadership Fellows Program, aimed at training health professionals to build their capacity and leadership skillset in school-based health care. Iliana has worked for a variety of sectors and organizations, including the National Cancer Institute, the U.S. Office on Women's Health, National Women's Health Network, Planned Parenthood of Indiana, Indiana's Tobacco Retailer Inspection Program, Indiana Prevention Resource Center, and Society for Public Health Education. She graduated from Towson University with a BS in health science, concentration in community health education, focus on maternal and child health. Iliana earned her Master of Public Health in public health leadership and practice from Indiana University.



Linnard Corbin

Linnard Corbin joined AMCHP as the accounting/office assistant. Linnard will spend time supporting our finance and accounting area while also managing the front office. Linnard is a recent graduate of Frostburg State University with a Bachelor's of Science Degree in political science and history and a concentration in American studies. In addition to AMCHP, he has most recently worked with NACCHO.



Get Involved

Submit Your AMCHP 2016 Session Proposal Today!

We invite you to submit a session proposal for the 2016 Annual AMCHP Conference (January 23 to 26). The theme for the 2016 conference is The Future is Now: Integrating MCH Transformations. The AMCHP Annual Conference is the ideal venue to present your ideas, research, innovative programming, best practices, and effective strategies to MCH and other public health practitioners, directors of state programs, federal officials, advocates, family leaders, researchers, and health care providers. [Click here](#) for complete information about submitting your session proposal and for the online submission form. The deadline for submissions is Friday, Sept. 4, 2015.

National MCH Workforce Development Center Coffee Talk Series – Don't Miss the Final Presentation!

This series, hosted by the National MCH Workforce Development Center Change Management, concludes with the final topic – managing change. The series consists of an archived 20-minute video for AMCHP members to access at their leisure and an AMCHP-hosted Twitter chat on the content shared during the archived video. [Click here](#) to learn more about each talk and to register!



Coffee Talk 4: Managing Change

Presenter: Brenda Jones, DHSc, RN, MSN, WHNP-BC, Deputy Director, Office of Women's Health, Illinois Department of Public Health

Managing change is not an easy task-especially some of the "moving the needle" efforts currently gearing up in the Title V programs! Successful collective impact efforts require a few key conditions-among them a united plan among the many individuals and organizations that impact the issue as well as collaboration among the key players. While the effects of collective impact are often outside the control of a single individual or organization, achieving change within those systems is dependent on great leadership at both the individual and organizational levels. This presentation will share a brief overview of the leadership skills and capacities needed to lead collective impact initiatives, followed by Brenda's personal experience in creating collective action among key players during a major statewide MCH reorganization.

Video Release: Oct. 7

Twitter Chat: Oct. 28 2-3 p.m. EST

Get Involved CONT.

MCH Workforce Center Cohort 4 Application Deadline Extended

The National MCH Workforce Development Center has extended its deadline for applications to its Cohort 4 training and practice laboratory program. Consider working with the Center to enhance the capacity of your workforce to implement new Title V action plans with skills in systems integration, change management, and quality improvement. All the Center's offerings leverage transformative activities happening in states and territories as a result of Title V and health & Medicaid reforms. Applications are now being accepted on a rolling basis (through Sept. 30) until the Cohort is full. Interested applicants should submit an application as soon as possible (spots are filling up quickly) but no later than Sept. 30. Applicants are encouraged to contact the Center before writing their application, to

Developmental Screening Title V National Performance Measure – New Resources!

The AMCHP State Public Health Autism Resource Center (SPHARC) recently developed a set of resources on state systems for developmental and autism screening. These resources were specifically geared toward helping Title V programs develop action plans around the new National Performance Measure on developmental screening (NPM#6). These resources are a first step based on a scan of current programs and activities and include:

- A compilation of example state strategies and strategy measures to improve developmental screening
- Including a table of current screening related objectives and measures from select federal and national programs, initiatives and surveys
- A case example of how a state could use SPHARC and other AMCHP tools to develop objectives, strategies and measures related to the developmental screening NPM#6
- A national landscape document of federal and national programs that have a specific objective/measure around developmental screening
- A state matrix of which states have/had certain grant or technical assistance programs related to developmental screening

These resources and more can be found on the [SPHARC website](#).

discuss their practice laboratory ideas and to confirm that space is available. The application is available on [Transformation Station](#) at [amchp.org](#) and at [mchwdc.unc.edu](#). If you have any questions about the process, your project ideas or to confirm availability of training slots please reach out to Amy Mullenix at [amy_mullenix@unc.edu](#) or 919-843-4457.

Emergency Preparedness and Response Resources for MCH Populations Webinar

The CDC Division of Reproductive Health (DRH) has responded to disasters for more than a decade, from the Sept. 11 attacks to the Ebola Virus outbreak in West Africa. In the aftermath Hurricane Katrina, the need for literature and resources to address critical questions regarding the impact of disasters for women of reproductive age, pregnant, and postpartum women became evident. DRH collaborated with local, state, and federal partners to develop a wide array of tools to assess post-disaster reproductive health needs and respond to them. These tools apply to a variety of disasters including natural disasters, infectious disease outbreaks, and preparedness for an anthrax bioterrorism event. In partnership with the CDC DRH, AMCHP is hosting a webinar to highlight resources available for states to assist with disaster preparedness. The webinar Emergency Preparedness and Response Resources for MCH Populations, is scheduled for Tuesday, Jun. 16 at 2 p.m. EST. [Click here](#) to register.

Resources

[Administration for Children and Families: Caring for Our Children Basics Health and Safety Foundations for Early Care and Education](#) provides information about the minimum health and safety standards experts believe should be in place where children are cared for outside of their homes. The publication seeks to reduce the conflicts and redundancy found in program standards linked to multiple funding streams.

- [Birth to 5: Watch Me Thrive!](#) is a coordinated federal effort to encourage healthy child development, universal development, and behavioral screening for children, and support for the families and providers who can care for them. Birth to 5 will help families and providers celebrate milestones, promote universal screenings, identify possible delays and early concerns, and enhance developmental support.

Resources CONT.

- [Birth to 5: Watch Me Thrive! A Compendium of Screening Measures for Young Children](#): The purpose of this compendium is to identify a set of first line screening tools that meet certain quality parameters set by aforementioned federal partners.

[Centers for Disease Control and Prevention \(CDC\): Children](#): Offers child health spotlights, research studies, health and wellness resources, statistical snapshots, conferences, and events:

- [Center for Disease Control and Prevention: Infant Mortality](#) discusses the factors that cause infant mortality and the prevention measures that can be taken to reduce these risks.
- [Centers for Disease Control and Prevention: Newborn Screening](#) provides information about why it is important screen newborns. Newborn screenings include a blood test, hearing screening, and a screen for critical heart defects. Screenings are important because even if a newborn looks healthy, certain medical conditions cannot be seen just by looking.
- [Centers for Disease Control and Prevention: Nutrition and the Health of Young People](#) provides information about the optimal nutrition young children should be receiving, as well as ways to prevent cardiovascular disease, high blood pressure, diabetes, and obesity.

[Healthy Children](#) provides information about immunizations, injury prevention, proper car seat usage, preventable diseases in children, and other topics relevant to child care.

[Healthy Families America \(Home Visiting for Child Well Being\)](#) targets overburdened families who are at risk for child abuse, neglect, and other adverse childhood experiences. The age group that the organization focuses on is birth to age five.

[Home Visiting Applied Research Collaborative](#) discusses the national home research agenda to contribute to the improvement of family dynamics, child health, and development.

[Maternal and Child Health Bureau](#) (Health Resources and Services Administration) is the government program responsible for ensuring the health and well-being of the entire population of women, infants, and children.

- [Maternal, Infant, and Early Childhood Home Visiting Research Network](#) documents early home visiting's potential to improve family functioning, parenting, child health, and development.
- [Health IT for Children Toolbox](#) is a compilation of health IT information targeted at children's health care needs. It ranges from pediatric electronic medical records to children's health insurance coverage. Also allows for the opportunity to link other child care services to the toolbox, such as Head Start, foster care, and schools. Health IT is intended to be used as a one stop resource to improve child health care.
- [Talk, Read, Sing Together Every Day! Toolkit](#) is a suite of resources that can help enrich children's early language experience beginning from birth. Resources include tip sheets for families, preschool teachers, and infant/toddler teachers and caregivers, as well as a fact sheet that highlights the evidence behind the benefits of being bilingual and embracing children's home language. All fact sheets are available in English and Spanish.

[National Association for the Education of Young Children](#) targets children from birth to age eight on various issues, including prevention of childhood obesity.

- ["Early Sprouts" Establishing Healthy Food Choices for Young Children](#) publication discusses ways to ensure that young children are receiving a proper nutrition, which is vital to their development.

[National Healthy Mothers, Healthy Babies Coalition](#) is an organization founded on the U.S. General Surgeon's conference on infant mortality. It provides resources and interviews with experts on issues in child care such as birth defects, protecting infants from the sun, and immunizations, and other relevant topics.

[National Institute of Child Health and Human Development](#) was developed to conduct and support laboratory research on pregnancy, fetal development, and birth for developing strategies that prevent maternal, infant, and childhood mortality, and morbidity.

[National Maternal and Child Oral Health Resource Center](#) addresses current and emerging problems within oral public health for women and children.

Resources CONT.

- [Promoting the Oral Health of Children with Special Health Care Needs- In Support of the National Agenda](#) is a publication about caring for the oral health of special needs children.
- [Title V MCH Block Grant Oral Health Toolkit](#) provides an overview of the 2015 block grant application and strategies state oral health programs may consider to ensure that oral health is an integral part of maternal and child health. The application, needs assessment, and reporting, are based on three-tiered framework of performance measures, outcome measures, and strategy measures.

[National Resource Center for Health and Safety in Child Care and Early Education](#) provides helpful information on state regulations for proper child health care.

[New Risk Factor for SIDS? Peak in Cot Deaths Associated with Heat Waves](#) addresses the role that hotter outdoor temperature has in Sudden Infant Death Syndrome.

[Sudden Unexplained Death in Childhood: A Comparison of Cases With and Without a Febrile Seizure History](#) investigates whether a subset of children with sudden unexplained death in childhood and a history of febrile seizures may parallel those in sudden unexpected death in epilepsy.

[Yale School of Medicine: Minding the Baby](#) is an intensive home visiting model intended for first-time young mothers and their families. The interdisciplinary intervention brings together a home visiting team including a pediatric nurse practitioner and a licensed clinical social worker to promote positive health, mental health, life course, and attachment outcomes in babies, mothers, and their families.



Data and Trends

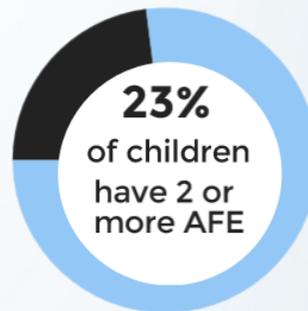
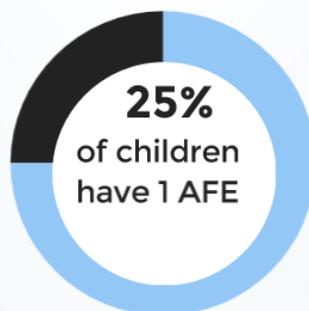
Why do Adverse Family Experiences Matter?



What are Adverse Family Experiences?

Potentially traumatic events or circumstances experienced by children that can have long lasting negative consequences on health and well-being into adulthood.

- (1) socioeconomic hardship,
- (2) divorce/separation of parent,
- (3) death of parent,
- (4) parent served time in jail,
- (5) witness to domestic violence,
- (6) victim of neighborhood violence,
- (7) lived with someone who was mentally ill or suicidal,
- (8) lived with someone with alcohol/drug problem,
- (9) treated or judged unfairly due to race/ethnicity.



Different populations experience different risk of AFE

To view the full AMCHP ACEs infographic, [click here](#).

AMCHP will start featuring infographics from our members! If you have a great infographic to feature, e-mail the submission to jfarfalla@amchp.org.

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Calendar

AMCHP Events

[2016 AMCHP Annual Conference](#)

Jan. 23-26, 2016
Washington, DC

Want your event listed on the AMCHP MCH Events Calendar? It's easy! Just complete our [online submission form](#).

Calendar CONT.

MCH Events

[CSTE Annual Conference](#)

Jun. 14-18
Boston, MA

[8th Biennial Childhood Obesity Conference](#)

Jun. 29-Jul. 2
San Diego, CA

[NACCHO Annual 2015](#)

Jul. 7-9
Kansas City, MO

[2015 CityMatCH Annual Urban MCH Leadership Conference](#)

Sept. 27-30
Salt Lake City, UT

[2015 ASTHO Annual Meeting](#)

Sept. 29-Oct. 1
Salt Lake City, UT

[AAP National Conference and Exhibition](#)

Oct. 24-27
Washington, DC

[2015 APHA Annual Meeting & Exposition](#)

Oct. 31-Nov. 4
Chicago, IL



Association of Maternal & Child Health Programs

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