PULSE

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

Life Course Perspective
March/April 2014

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AMCHP
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

From the President

By Millie Jones, MPH

"Any action we take today should be seen through the eyes of someone seven generations in the future" – recurring theme in many Native American cultures.

As we thoughtfully engage in Title V Maternal and Child Health (MCH) Transformation 3.0, it occurs to me that we can adopt life course principles for our work specific to the Transformation 3.0 process. Life course incorporates the connection between an individual's life and the historical and socioeconomic context in which that life unfolds. So it is with Title V and the Transformation 3.0 work we are doing.

For nearly 80 years, Title V has been a core public health program focused on the mothers, women, children and youth, including those with special needs, throughout this nation. MCH has always focused on a generational approach with the intent to make the health and well-being of each generation better than the last. Our mission has not changed.

Title V MCH Services Block Grants are a critical component for the work of our nation to do all we can to have healthy individuals now and into the future. As we set our trajectory for measuring performance, defining what difference we are making and moving the needle on improving health outcomes let us all be committed to define our work and the legacy of Title V MCH for generations to come. We can't rest on our laurels. We owe it to our children's children's children to do all we can as a nation to seek continuous improvement for our families and our communities.

Feature

Leveraging Partnerships to Close Gaps: A Peek into the Life Course Indicator Narratives

By Andria Cornell
Program Manager, Women's and Infant Health, AMCHP

Jennifer Leone
Intern, Women's and Infant Health, AMCHP

AMCHP released a set of life course indicators late last year – so what's been happening since then? AMCHP has been adding indicator narratives to the Life Course Indicators Online Tool, and working with states to design and provide trainings around calculating the indicator set. This article will highlight four of the life course indicators: Voter Registration, Experiences of Race-Based Discrimination or Racism among Women, Bullying, and Adverse Childhood Experiences (ACEs). Why are these topics important in a life course framework?

- These four indicators represent the breadth of the indicator set, and their measurement brings these nontraditional measures of risk or protective factors, capacity, and outcomes under the umbrella of those important to the MCH population and the programs and systems that serve them.
- Each of these topics has implications for equity and are marked by significant disparities.
- Diverse and complex partnerships and collaborations are required to close gaps and see improvement in the indicators. The level of systems integration and partnership required is consistent with the changing MCH landscape and the Title V MCH Services Block Grant.

The following text has been excerpted from the Leverage and Realign Resources sections of the indicator narratives developed by state teams and refined and adapted based upon external feedback. AMCHP continues to add completed narratives to the online tool on a rolling basis, but the narratives for these four indicators are currently available. Download them today!

Voter Registration
Narrative: PDF
Category: Social Capital
Numerator: Number of adults registered to vote
Denominator: Total eligible population
Data Source: Current Population Survey (CPS)
Similar Measures in Other Indicator Sets: None
National Comparison: 71.20%, 2012

Social capital is a hard concept to measure. Measures of civic engagement help by serving as proxy measures that quantify levels of social capital within and across populations. Voter registration is a conventional proxy for measures of civic engagement (Mercyhurst Center, 2011) and can serve as an indicator of social capital within and across populations. Initiatives to improve voter registration can attract new partnerships into public health practice, including community organizers, social justice groups, civic groups, and civil rights advocates. Of note, the Affordable Care Act includes a requirement that health exchanges adhere to the National Voter Registration Act and provide information on voter registration (Sink, 2013). Voter registration information integrated into exchange enrollment provides a new opportunity to increase civic engagement and empower community members.

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Leveraging Partnerships

Experiences of Race-Based Discrimination or Racism among Women
Narrative: PDF
Category: Discrimination and Segregation
Numerator: Number of women who answer Yes to the question "During the 12 months before your new baby was born, did you feel emotionally upset (for example, angry, sad or frustrated) as a result of how you were treated based on your race?"
Denominator: Total number of women who recently had a live birth
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)
Similar Measures in Other Indicator Sets: None
National Comparison: 8.80%, 2009-2011 (Phase 6; calculated using states included in the national data set)

Betancourt et al defined a framework for cultural competence that addresses barriers to appropriate care at the organizational (leadership/workforce), structural (processes of care), and clinical (provider-patient encounter) levels (Betancourt et al 2003). Experiences of racism occur at all levels of patient interaction, therefore, work to ensure culturally and linguistically appropriate care must extend beyond just the provider-patient relationship. All members of facility or practice staff should be included in training and implementation of cultural competence. Health care systems can also engage community services that work to eliminate racism to develop programs for their institutions. Efforts to address the experiences of discrimination in health care and health research have utilized the concepts of "undoing racism" and community-based participatory research (CBPR) to begin the conversations around racism and begin to establish trust (PISAB 2013, Yonas et al 2006). Efforts to "un-do" racism and achieve equity require more than a short-term training and will include an authentic partnership between care providers, public health, and communities, including community leaders, to improve experiences of care and equity in health care in the long term.

Bullying
Narrative: PDF
Category: Discrimination and Segregation
Numerator: Number of 9th through 12th grade students (12-17 years) who reported having been bullied on school property or electronically during the past 12 months.
Denominator: 9th through 12th grade student population (12-17 years)
Data Source: Youth Risk Behavior Surveillance System (YRBSS)
Similar Measures in Other Indicator Sets: Healthy People 2020 focus area IVP-35.
National Comparison: 25.50%, 2011

While bullying is not a new issue for programs serving youth, the awareness of the harmful effects of bullying and understanding of the risk factors is relatively new. The Task Force on Community Preventive Services found strong evidence that universal, school-based programs decrease rates of violence among school children. These programs were delivered to all children in a particular grade or school, regardless of prior violence or risk of violence, and effects of the program were found at all grade levels. The Task Force on Community Preventive Services has recommended the implementation of universal, school-based programs to prevent violent behavior, including bullying. Expanded bullying education programs for students and staff are needed in order to address this public health issue. Continued research will contribute to a better understanding of bullying risk factors and the development of effective interventions. Further school funding is needed for programs that identify support mechanisms for current bullying victims and educate students and staff on the severe impacts of bullying.

Adverse Childhood Experiences (ACEs)
Narrative: PDF
Category: Childhood Experiences
Numerator: Number of children whose parents responded to the National Survey of Children's Health (NSCH) that their children were exposed to adverse childhood experiences (9 questions related to ACEs)
Denominator: Total number of children

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Data Source: NSCH
Similar Measures in Other Indicator Sets: Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
Benchmark Area Reduction in Crime or Domestic Violence: Screening for domestic violence
National Comparison: 0 Adverse Childhood Experiences= 52.07%
1 Adverse Childhood Experience= 25.32%
2 or More Adverse Childhood Experiences= 22.61%, 2011-2012

ACEs information provides opportunities for data-driven approaches to improving both pediatric and adult primary care. This may include mental and physical health risk screening in childhood and beyond. Innovative public health partnerships in relation to ACEs include collaborations with mental/behavioral health services, child abuse/neglect programs, and law enforcement. Additionally, the assessment of ACEs risks within the MCH community could be of use for other public health promotion and disease prevention programs including chronic disease and communicable/sexually transmitted disease (Fine and Kotelchuck 2010; Shonkoff et al 2009; Foege 1998). Protective factors (e.g., child's positive relationship with a caring adult, easy temperament of the child, health insurance coverage for the child) can be more important than risk factors as they mitigate the negative effects of risk factors such as ACEs (Werner and Smith 1992). Public health and other partners could work together to support policy and program interventions that pay more attention to leveraging support for positive factors.

Feature
Using Life Course Theory in Evidence-based Practice: Healthy Women, Healthy Futures

By Su An Arnn Phipps PhD, RN
The University of Oklahoma College of Nursing, Project Director, Healthy Women, Healthy Futures

The Oklahoma Healthy Women, Healthy Futures (HWHF) is a one-year program based on the life course perspective to address the

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interconception health of women living in poverty. HWHF was developed in 2008 in conjunction with Community Action Project (CAP) Tulsa and Educare early childhood education programs (ECE) to address the health equity of mothers whose children attend the ECE centers. Both Educare and CAP Tulsa have innovative family financial, education and neighborhood initiatives. HWHF is offered at six ECEs located in diverse geographic areas of Tulsa County experiencing the highest mortality and premature birth rates. Approximately 100 women attend the program annually.

Life course theory addresses the importance of early programming to one's future health and development through both intergenerational programming (a woman's preconception health) and prenatal programming (in utero). Life course considers the cumulative impact of life experiences, including multiple stresses over time that many women and families living in poverty experience. HWHF attempts to reduce such risk factors, which diminish health, and improve protective factors by improving women's access to primary care and other health services and through health education and care coordination.

The HWHF goals are to improve maternal health and infant birth outcomes by:

1. **Improving women's knowledge of health promotion measures and disease prevention practices.** Weekly hour and a half culturally relevant health education classes are taught on site at the ECEs by the nurse educators, who also provide individualized instruction at home for those with chronic illnesses. In addition to disease prevention, nutrition and exercise, the curriculum addresses the possible contextual risks of participants, such as stress, family conflict, domestic violence, and depression. Women learn the importance of intergenerational and prenatal programming on their health and that of current and future family members.
2. **Assisting women to improve their health through development of a health plan, which incorporates healthy lifestyle practices and a reproductive life plan, and by facilitating access to services.** Each participant is a member of a care coordinator and nurse educator team. Admission assessments and plans of care are developed by the HWHF staff and participant team during home visits, and reassessments are conducted at the end of each semester with participants serving as their

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Using Life Course Theory in EBP

own "controls" to determine changes in lifestyles, knowledge and health. Qualitative data (participant feedback) gathered at these times reflect changes in the health and health practices of children and other family members as a result of women applying new knowledge to family health.

Evaluation data has shown that HWHF leads to health improvements related to improved knowledge and resultant behavior change; lifestyle improvements, such as increased exercise and better nutrition; and healthy pregnancy outcomes among participants despite 30 percent of pregnancies being moderate to high risk. Of the 41 pregnancies, 37 have resulted in term births with four late preterm births (34-36+ weeks gestation). All infants were at average weight for gestational age. Participants frequently report that their current pregnancy was different or better than their previous pregnancies. As women's knowledge of health and wellness grows, they become empowered to change their own behavioral patterns and practices throughout their life, and influence the lives of family members and future generations as well.

For more information about HWHF, visit hwhf.ouhsc.edu. Funding is provided by the George Kaiser Family Foundation.

Healthy Women, Healthy Futures is listed as a Promising Practice in the AMCHP Innovation Station database. For more information, visit amchp.org/innovationstation.

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Feature

Engaging Youth in Public Health Initiatives

By Rena L. Large, MEd, CHES
State Adolescent Health Resource Center/Konopka Institute for Best Practices in Adolescent Health, University of Minnesota

Meaningful youth engagement is essential for including youth voices in the development of programs and policies that serve and impact them. State MCH programs solicit stakeholder input during the development stages of many programs, and especially the five-year needs assessment, and use a variety of approaches to involve youth and collect their feedback. The State Adolescent Health Resource Center (SAHRC) at the University of Minnesota has documented examples of youth engagement efforts within state health agencies in an effort to disseminate successful strategies and lessons learned. A selection of those examples is presented here.

In March, 2014, SAHRC at the University of Minnesota hosted a webinar showcasing state health agency strategies that engage youth in meaningful ways to shape Title V/MCH and other public health initiatives. The webinar featured state adolescent health coordinator colleagues from Wyoming, North Carolina and New York for a lively discussion on engaging youth in state levels needs assessments.

In 2013, the **Wyoming MCH program** established a dedicated adolescent health staff position to build a new, in-depth adolescent health program from scratch. As part of this new direction, a two-part focus group strategy is in process to solicit **youth input for the next Title V five-year needs assessment**. Part one is engaging youth through 10 community meetings around the state between March and May 2014. The community meetings will recruit a mix of urban, rural, and frontier youth of all ages through local youth serving agencies. Part two of this process will convene additional youth focus groups in 2015 to develop actionable strategies for addressing each youth health priority identified in the needs assessment. As part of this process, the MCH program will also contract with three to five young people to serve on a planning committee to give them an equal voice with adult planning partners.

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Engaging Youth

Over the last year, the **North Carolina Division of Public Health** (NCDPH) has been convening **youth focus groups** around the state to explore strategies to promote adolescent health in the community and inform the work of the recently established NCDPH Adolescent Health Resource Center. Youth are recruited through community partners to solicit diverse youth perspectives. Focus groups conducted to date have included youth and young adults with disabilities, and youth participants of existing youth empowerment groups. A relationship with the University of North Carolina has provided substantial resources for the effort, engaging graduate students to craft focus group questions and create a facilitator's guide.

The **New York MCH program** has long engaged youth in meaningful ways to shape youth-focused programming through an extensive partnership with the ACT for Youth Center of Excellence, an intermediary funded by the New York State Department of Health (NYS DOH) to provide technical assistance, training, evaluation, research and information dissemination. ACT for Youth facilitates an active statewide youth network to participate in the development of educational materials for the NYS DOH and advise on issues important and relevant to youth in the state. Youth are engaged as consultants, discussants/speakers, and focus groups participants on critical adolescent sexual health issues including: family planning and reproductive health; preconception health; and binge drinking and preventing fetal alcohol spectrum disorders.

The March 2014 webinar built on an October 2013 webinar which showcased a broader range of youth engagement in state public health initiatives including:

The **Alaska Division of Public Health Women's, Children's and Family Health Section** manages a state-level youth advisory group, the Youth Alliance for a Healthier Alaska, which positions youth as equal partners in shaping state Title V/MCH adolescent health program and other health programs and to create interventions designed to improve the lives of adolescents in Alaska. Any state program can enlist the alliance to review their materials and youth oriented programs. The alliance meets once a month, engaging a diverse group of energetic youth, ages 14-18, from across Alaska.

The **Iowa Department of Public Health, Bureau of Family Health** engaged youth as advisors for the creation of an interactive website, IAMINCONTROL.org, dedicated to helping teens take control of their lives and make the healthiest choices for them. The site launched in 2012 and continues to engage youth as blog and site contributors. The website also provides youth with 24 phone and online access to trained counselors maintained by the Iowa State University Extension.

The **New Mexico Department of Health, Office of School & Adolescent Health** engages youth as trained actors/teachers to build skills among school based health center (SBHC) providers and coordinators for communicating with adolescents in clinic settings. **New Mexico YouthCHAT** partners with the Public Academy for Performing Arts High School in Albuquerque to train youth actors to develop characters and portray health issues provide constructive feedback to SBHC providers and coordinators during mock interviews. Piloted in May 2013 at a state-level SBHC conference, the program continues to engage youth as actors/teachers and in being replicated in Spring 2014.

LESSONS LEARNED

A consistent theme throughout these youth engagement examples is that:

- Significant relationships with community partners, academic institutions and other partners with access to youth research, information and youth themselves are key to successfully and meaningfully engaging youth
- Youth engagement lends a critical insight into the real life concerns and perspectives of youth and engages youth in their own health care, decisions and programming
- Youth engagement encourages a positive, resiliency focused frame for youth programming

For more information on these examples, audio/video archives and samples of tools, forms and products that can be used as examples for other states interested in implementing similar youth engagement strategies, visit the National Network of State Adolescent Health Coordinators website.

Feature

Using a Standardized Approach to Understand Infant Mortality: The State Infant Mortality Toolkit*

By Charlan D. Kroelinger, PhD
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**The findings and conclusions in this article are those of the authors and do not represent the official position of the Centers for Disease Control and Prevention*

What is a standardized approach to understanding infant mortality and why is it important?

Infant mortality is considered a measure of population health, and for countries, states, counties, and communities it is indicative of underlying issues such as quality of care, access to services, health inequity, and risk behaviors. The World Health Organization defines a live birth as delivery of an infant, 'irrespective of duration of pregnancy, which…breathes or shows any evidence of life (e.g., beating of the heart, definite movement of voluntary muscles) whether or not the umbilical cord has been cut or the placenta is attached.'[1] An infant death can occur immediately following a live born delivery up to the 364th day of life. The interpretation of the WHO definition of a live birth (e.g., what constitutes a breath or voluntary movement) and subsequent infant death impacts infant death reporting, calculation of the infant mortality rate, and programs and policies identified to impact infant mortality, particularly among those infants who die at delivery. Variations in reporting, along with changes in main causes of death over time,the gestational age or birth weight of the infant (i.e., maturity) at birth or maturity-specific mortality (i.e., excess deaths among sub-groups of infants by weight, for example, very low birth weight births) impact the infant mortality rate (IMR). A standard method that progresses through a series of straightforward analyses is essential to providing critical information for informed decision-making to state, local, urban, and tribal programs. The State Infant Mortality (SIM) Toolkit provides standard and structured guidance for IMR analyses.

Through multiple initiatives like the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality or the Secretary's Advisory Committee on Infant Mortality (SACIM), states and jurisdictions across the country have already or will soon have the opportunity to work on focused strategies to reduce infant mortality. Additionally, the transformation of the Title V MCH Services Block Grant is on the horizon. As part of these opportunities, states, localities, urban areas, and tribal organizations can use the SIM Toolkit as part of the foundation for infant mortality activities – by increasing understanding of what is driving infant deaths in various settings and moving from data to practice.

What does the SIM Toolkit contain and how can my agency/organization best utilize it?

The SIM Toolkit contains information on developing an IMR analytic strategy, beginning with forming a team of experts and stakeholders, to conducting an overview investigation, to then developing a focused investigation of infant death based on specific analytic results provided during the overview investigation. The toolkit provides a basic framework for establishing the time period of interest, identifying a study population, and calculating baseline infant mortality rates that can be used by States, localities, urban areas, and tribal organizations. Next, recommendations are made for review of reporting changes, including changes in the definitions of cause of death, and changes in reporting requirements for birthing facilities. Changes in the causes of infant death over time are examined, and trends in adverse pregnancy outcomes contributing to the IMR are reviewed to identify areas of further focus. Examining the age at which infant deaths occur, specifically considering changes in the number of low birth weight or preterm births and survivability of infants within each birth weight grouping is the final stage

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SIM Toolkit

of the overview investigation. Examples of approaches in the toolkit include implementing the Perinatal Periods of Risk, including information from a Fetal and Infant Mortality Review, and standardizing causes of infant death by examining multiple classification systems. The focused investigation narrows the analytic plans to examine specific maternal socio-demographic characteristics and behavioral risk factors, the attributes of the social and physical environment, and systems of care specifically for at-risk neonates. The toolkit provides recommendations on examining the built environment, developing community assessments, and understanding regionalized systems of care. When used in a systematic way, these analyses culminate in provisional evidence on the causes and contributors to infant death so that programs and policies can be better focused on at-risk or vulnerable populations.

To access the full SIM Toolkit, visit amchp.org/programsandtopics/data-assessment/InfantMortalityToolkit/Pages/default.aspx.

Has the SIM Toolkit been tested in multiple settings?
The toolkit includes vignettes and clear examples of each type of analysis by state health departments. The standardized approach for the toolkit was developed by the original five states who participated in the State Infant Mortality Collaborative from 2004-2006: Delaware, Hawaii, Louisiana, Missouri, and North Carolina. Additionally, the toolkit provides two longer case studies developed by Delaware and Louisiana which provide a step-by-step guide to completing the overview and focused investigations. The toolkit was additionally tested by the Wyoming Department of Health as a pilot site. Following use of the toolkit by these six states, the Centers for Disease Control and Prevention (CDC) and AMCHP, in partnership with state health departments have recruited additional pilot use among two tribes and one community. Follow-up publications will include the experiences of these two pilot sites. CDC and AMCHP would like to remain informed of the planned use of the toolkit among states, counties, urban centers, and tribes in order to gather feedback on utility and comprehensiveness.

How can my agency/organization provide feedback on the use of the SIM Toolkit?
Feedback on usage of the SIM Toolkit can be provided directly to AMCHP, (Caroline Stampfel, cstampfel@amchp.org). Feedback will be used to further enhance the toolkit, revise any errors, and develop new tools that are useful in multiple settings to examine infant mortality. AMCHP also welcomes feedback from users on programs and policies implemented as a result of Toolkit usage. This feedback will be used in development of effective practice examples. AMCHP, CDC, and March of Dimes invite and encourage you to use the SIM Toolkit, and we look forward to learning from your experiences as states, counties, urban areas, and tribes in using this standardized approach to understanding infant mortality.

1. World Health Organization Statistical Information System (WHOSIS): Indicator definitions and metadata. http://www.who.int/whosis/indicatordefinitions/en/. Accessed on Mar. 28, 2014.

View from Washington

The Path to Home Visiting Program Reauthorization

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

At the end of March, the U.S. Congress passed and the president signed the so called 'Doc Fix' bill **that includes a six month extension for the MIECHV program**. This represents a solid interim victory and reflects the work of a broad coalition of stakeholders. Thanks to each of you that participated in the National Day of Action and weighed in with elected officials. This step reflects nascent bipartisan support to continue this vital program to improve outcomes for vulnerable families. It provides Congress additional time to consider a longer-term reauthorization before Mar. 31, 2015 – the new expiration date.

Perhaps most importantly, it provides some insight and encouragement that despite the extreme partisanship and gridlock in Washington, DC, programs that are evidence-based and that encompass life course concepts such as early programming, critical periods and protective factors can be translated into investments that will make a difference for some of America's most vulnerable families and communities.

View from Washington CONT.

Just a few days after the temporary extension passed, the House Ways and Means Committee Subcommittee on Human Resources convened a hearing to "begin thinking about next steps." This hearing (testimony available here) demonstrated strong bipartisan support for the concept of home visiting. This committee is chaired by Rep. Dave Reichert (R-WA) who happens to be a former sheriff and spoke about how his support for MIECHV is based on his belief that investments in programs like home visiting help prevent the societal problems that sheriffs deal with on a daily basis when families are not supported and children suffer from neglect and abuse.

During his opening statement, Chairman Reichert also laid out three important areas for potential change we will watch moving forward, saying:

> *"We also need to think about whether the program's mix of supporting proven and promising approaches continues to makes sense. And we should consider whether this program should continue to have 100 percent federal funding, especially since some of the positive outcomes we hope to see will benefit our state partners. For my part, I am interested in how we can apply the basic discipline of this program – which uses taxpayer funds to support what we know works to help children and families – to other government programs that today can't say the same thing."*

The last comment about using the frame of 'what we know works' to justify use of taxpayer funds reflects both the confidence in the evidence base for home visiting, and also provides a helpful reminder of the need to ensure that we are documenting the evidence base for services provided by the more flexible Title V MCH Services Block Grant. Work underway now to refine the Title V performance measures and include process and structure measures should help us make this case.

As for a longer home visiting reauthorization, AMCHP staff are continuing to work with a broad coalition of stakeholders to strategize now on how to assure a longer reauthorization when the next Congress revisits the issue in early 2015.

Real Life Story

Layers: A Mother's Perspective on Raising Special Needs Children Using the Life Course Framework

By Kris Green
Title V Parent Services Manager and parent to four sons in Anchorage, Alaska

I started with a query to Google, looking for framework to the MCH Life Course Model. From Dr. van Dyck's preface Rethinking MCH: The Life Course Model as an Organizing Framework[1] – the following statement seemed to jump off the page – giving me an image to describe this journey so many of us are on with our special needs children.

He writes, "By combining a focus on health equity and social determinants…*life course offers a rich and layered understanding of how health develops over a life time and across generations.*" It is the words "layered understanding" that give title to this journey.

Perhaps some of you may jump to that image of an onion – with layers being peeled away to explore the complexity of parenting a special needs child across a life span. However, that is not what I am suggesting with the layer metaphor. The Life Course Model, as a path to health and wholeness for families with special needs children is less about peeling away each layer and more about building on the layers of strengths and possibilities. It is the very challenges that our complex children overcome that serve as another layer or hopeful step closer to a future bright with good health and options in adulthood.

The Life Course Model recognizes that many factors contribute to health across the life span. The four core concepts are: timeline, timing, environment and equity. My children's experiences during milestone stages of early years, adolescence, and now adulthood are very different than the normally developing child; and despite their challenges, I have the same boundless hopes and dreams of a healthy tomorrow for my children. Like other families nationwide with children experiencing special needs, the task is daunting, and yet for many, out of love for our children and the desire for them to reach their full potential, it can be an inspiring journey.

Real Life Story CONT.

Critical pathways to health are either built or diminished over the life course. For my children, the critical nature of a premature birth and admission to a NICU put them on the path (a foundational layer) of developmental delays, therapies, and life-saving interventions. A deeply troubling traumatic experience in their early adolescence added a PTSD layer of behavioral and mental health issues. In adulthood, they are now affected by choices made in early adolescence; yet each successful step to overcoming the challenges gives way to a stronger layer. Yes, early programming and exposure to adverse events in critical periods did have a cumulative effect. However, their life-altering experiences add layers of wisdom and strength beyond their years. My job as a mother is to mitigate the risk factors and help them identify and strengthen the protective factors that will give them the resiliency to reach their full developmental potential.

Parenting children with special needs, using the Life Course Model, is about building a life and future by acknowledging the layers and honoring the uniqueness that it gives our children. It is not running from the fact that some layers are difficult; it is about constructing the best possible future despite the challenges.

The MCH Life Course Model is critically important, especially now. For those of us working and living in the field of parent driven advocacy and action, the community layer is my hope that a bright future exists due to the MCH promise of promoting health and wholeness one person, one family, and one community at a time.

1. Health Resources and Services Administration Maternal and Child Health Bureau. Rethinking MCH: The Life Course Model as an Organizing Framework (2010 Concept Paper). http://mchb.hrsa.gov/lifecourse/rethinkingmchlifecourse.pdf. Accessed on Apr. 9, 2014.

Success Story

The Wisconsin Healthy People at Every Stage of Life Framework

By Susan Uttech, MS
Director, Bureau of Community Health Promotion, Wisconsin Division of Public Health

How It Began

The Wisconsin Division of Public Health, Bureau of Community Health Promotion (BCHP) has supported the life course approach to improve health outcomes for some time. Research was beginning to inform BCHP about the origins of chronic disease and the complex interplay of protective and common risk factors (Halfon and Hockstein 2002; Lu and Halfon, 2003). For example, babies born at a low birth weight are more likely to have heart disease, hypertension and diabetes later in life. BCHP staff recognize that we are better, together.

In 2007, an existing division-wide program integration work group reviewed more than 300 program messages and consolidated them into six key messages for all programs to use as “the elevator speech” describing what we do to have Healthy People at Every Stage of Life (HPESL). The six key messages were:

- Plan ahead
- Eat well
- Be active
- Stay clear of tobacco
- Stay safe
- Achieve mental wellness

In 2008, Wisconsin was selected by the CDC as one of four states to participate in the Negotiated Agreement Pilot (NAP) to focus on chronic disease program integration. Participation in the NAP project provided the impetus to further develop, share and use the framework. BCHP staff incorporated and improved the HPESL framework by developing a matrix with embedded program specific messages within the broader HPESL framework applied over five life stages (or age groups) across the life span. For each life stage, the HPESL framework depicts a set of core messages which fall into the overarching categories of

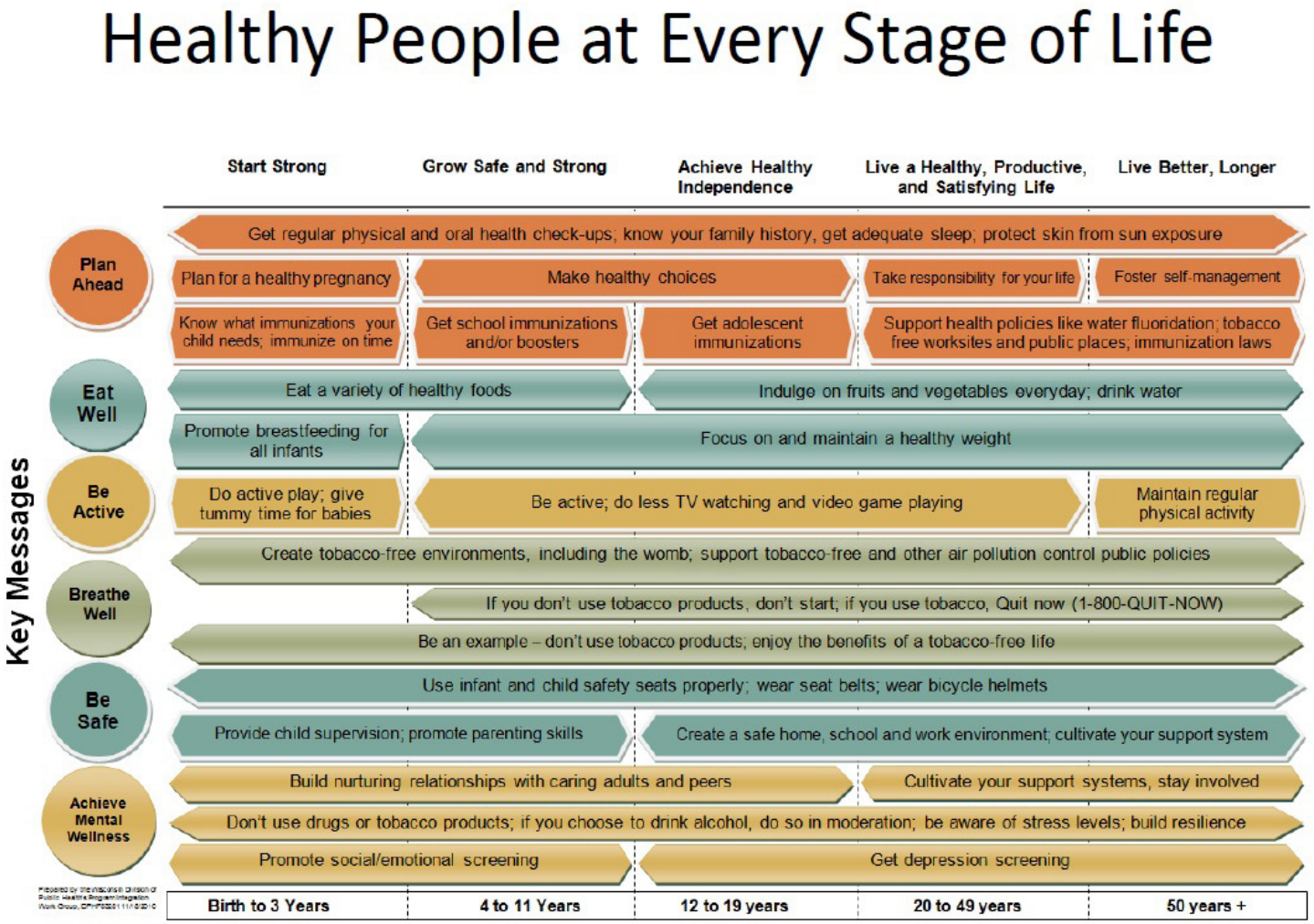
Success Story CONT.

the key messages. The HPESL framework describes how health promotion and disease prevention efforts fit together across the life course.

How the Framework is Implemented in the Bureau
The majority of BCHP staff were actively involved in developing the framework resulting in significant "buy in" among staff. Evaluation results during the NAP project showed that many staff used the HPESL framework. On surveys conducted during 2010-2012, staff were asked if they have used the HPESL framework in the past month, and if so how. On each survey, 20 percent of respondents reported that they used the HPESL framework in the past month.

Out of the 133 examples described, the most common reported uses of the framework were for: program planning, developing messages, communicating with partners, creating funding applications and explaining with BCHP does.

Accomplishments Related to the Framework in the Bureau
BCHP staff said the framework lead to efficiencies in multiple areas by providing structure, reducing duplication of activities, providing guidance for program planning, and sharing messages to use across all BCHP programs. Staff also noted that having this clear, defined framework has provided stability and focus and helps BCHP to stay on course with its mission. In addition, the framework was helpful to reduce turf issues among programs and encouraged programs to look at modifiable risk factors (such as diet, physical activity, tobacco exposure, and alcohol use) when planning programs. As a result, staff



Success Story CONT.

were more inclined to "think out of their program box" and explore how a focus on modifiable risk factors could promote a life course approach. Examples of some topics that were pursued included: gestational diabetes; smoking during pregnancy; and children and youth with special health care needs and chronic disease prevention.

Who's New

NEW MCH STAFF

NEW TITLE V & MCH DIRECTORS

OKLAHOMA

Joyce Marshall, MPH
Director, Maternal and Child Health Service
Oklahoma State Department of Health

TEXAS

Tammy Sajak, MPH
Director, Office of Title V and Family Health
Texas Department of State Health Services

NEW TITLE V DIRECTOR

CONNECTICUT

Marcie Cavacas
Title V Director
Connecticut Department of Public Health

NEW AMCHP STAFF

Krista Granger
Krista Granger, MPH, joined AMCHP as the program manger, data and assessment for the women's and infant health (WIH) team. In her role, she contributes to the advancement of maternal and child health outcomes by performing a variety of planning and program implementation, research, and evaluation projects related to WIH and MCH. Prior to joining AMCHP, Krista worked as the deputy project coordinator for an

Who's New CONT.

HIV prevention project in South Africa to oversee data monitoring and evaluation, quality assurance, and project promotion. She completed a practicum in Honduras, working to implement a community health worker program focused on improving community access to maternal and child health services. Krista received her Bachelor of Science in health science from Clemson University and completed her Master of Public Health in epidemiology at the University of Texas School of Public Health, where she focused on global health.

Amy Haddad
Amy Haddad joined AMCHP as the associate director for government affairs on Mar. 17. Most recently, Amy served as the director of public policy for Children's Cause for Childhood Cancer and brings more than seven years of Capitol Hill experience, including six years as legislative assistant to Rep. Lois Capps (D-CA). Rep. Capps is consistently rated as one of the strongest champions for maternal and child health in the Congress, and sits on the House Energy and Commerce Committee, which has jurisdiction over Title V MCH programs. Amy also worked two years for the Telos Group in Tel Aviv, Israel. She holds a Bachelor of Arts from Emory University in Atlanta, GA. Amy will be leading our work to advocate for Title V appropriations; supporting the priorities on our policy agenda; representing AMCHP in various policy coalitions; and helping support our Legislative and Health Care Finance Committee.

Get Involved

Title V Five Year Needs Assessment Virtual Training – Part 2: Nuts and Bolts on Using Data
Title V legislation requires each state and jurisdiction to conduct a statewide, comprehensive needs assessment every five years. Hard to believe that the time has come for Title V programs to prepare for the next comprehensive needs assessment! The needs assessment process can be a useful tool for strategic planning, strategic decision making and resource allocation. It also provides a way for Title V programs to benchmark where they are and assess progress over a five-year period. To assist states or jurisdictions in preparing their assessments AMCHP is hosting a series of virtual trainings to provide guidance on

Get Involved CONT.

the needs assessment process. The second webinar, The Nuts and Bolts on Using Data, is scheduled for Thursday, May 1 from 3-4 p.m. EST. This webinar will feature a presentation from Caroline Stampfel, MPH, currently the senior epidemiologist at AMCHP and formerly an MCH lead analyst with the Virginia Title V program, on using data in the needs assessment process. Ms. Stampfel's presentation will be followed by two states-in-action profiles, Rhode Island and Alaska, who will share their data strategies, resources and lessons learned from conducting the five-year needs assessment process. In order to capitalize on the information presented in the virtual training, AMCHP recommends that states consider team participation in the training, i.e., participation from both program and data staff. Click here to register.

Building and Retaining a Resilient MCH Workforce for Tomorrow

Several forces, such as full implementation of the Affordable Care Act and enduring budget cuts, deficits and hiring freezes, are having a huge impact on the knowledge and skills needed for a competent public health workforce. To continue to effectively meet the needs of children, families and communities they serve, building and retaining a resilient MCH workforce has become especially critically important for state Title V programs. In order to support state efforts to maintain a talented workforce, AMCHP is hosting the Building and Retaining a Resilient MCH Workforce for Tomorrow webinar on May 15 at 2 p.m. EST. This webinar will feature stories from two states, Michael Warren, MD, MPH, FAAP, director of Maternal and Child Health for the Tennessee Department of Health and Meredith Pyle, systems development chief in the Maryland Office for Genetics and People with Special Health Care Needs, highlighting their successes in building a resilient workforce. The webinar will also feature a brief overview from Mark Law, PhD, director of operations for CityMatCH, of two concepts, Positive Psychology and Emotional Intelligence, that have demonstrated effectiveness in building a resilient workforce. Click here to register.

Save the Date: Linked by Life Webinar

The Linked by Life webinar titled "Wisconsin: Turning the Ship Towards Implementing Life Course Theory, Social Determinants of Health and Preconception Care," jointly sponsored by the Preconception Health and Health Care Initiative and the Maternal and Child Health Bureau (MCHB) will take place May 6 from 2-3:30 p.m. EST. The webinar will illustrate how the Wisconsin Department of Health Services adopted and executed life course theory to expand preconception care throughout the state, connect MCH and early childhood modes of care while addressing the social determinants of health. Speakers also will reveal how they combined the assets of their MCH and chronic disease divisions to improve overall women's health. The presenters will communicate why other local and state health departments should adopt this strategic intent in order to reduce racial disparities in birth outcomes by becoming an MCH Life Course Organization. To join the event participants should click here. For audio, dial in to the toll-free number: 800-988-9658 and use the passcode #5218751 for the event.

innovation station Sharing Best Practices in MCH

AMCHP is collecting emerging, promising and best practices related to the life course perspective!

Does your program address a best practice related to life course theory? 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 Kate Howe 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!

Get Involved CONT.

Save the Date: Upcoming Webinar on the MCH Navigator!
The MCH Navigator, funded by MCHB at Georgetown University, is a learning portal that provides access to state and local MCH professionals for free, providing competency-based online trainings to meet professional development needs and ensure that the Title V workforce has the knowledge and skills to address the needs of the MCH Community. On May 21 from 1-2 p.m. EST, John Richards, research director for the McCourt School of Public Policy at Georgetown University will provide an overview of new and familiar features of the new Navigator website, and will explain how professionals can access learning opportunities directly through the site and how departments and organizations can use the Navigator to encourage and track staff development. After this event, participants will be able to:

- Understand the history of the MCH Navigator, how it assists in learning the skills needed for being a member of the Title V workforce, and learn about new key features of the website
- Learn how to identify specific MCH Navigator trainings and resources based on individual needs
- Learn about the MCH Navigator's Self-Assessment tool and how to develop a customized learning plan for success
- Understand how the MCH leadership Competencies and the Public Health Core Competencies assist in structuring your learning needs both in the MCH Navigator and through HRSA TRAIN

Please click here to register.

Resources

Association of Maternal & Child Health Programs (AMCHP) – AMCHP is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.

- Innovation Station – The AMCHP searchable database of emerging, promising and best practices in MCH. The Innovation Station allows you to learn more about MCH programs across the United States and to benefit from the lessons learned by your peers.
- Life Course Metrics Project – In early 2012, AMCHP launched the Life Course Metrics Project, a collaborative effort to identify and promote a standardized set of indicators that can be used to measure progress using the life course approach to improve maternal and child health. The project is funded with the support of the W.K. Kellogg Foundation.
- State Life Course Resource Center – These websites provide tools and resources that are specifically targeted to the state level.

Association of University Centers on Disabilities (AUCD) Life Course Perspective - This website contains resources that are intended to introduce and reinforce life course theory. They have been designed and organized by an interdisciplinary work group of leadership training programs.

CityMatCH Life Course Toolbox – The MCH Life Course Toolbox is an online resource for MCH researchers, academics, practitioners, policy advocates, and others in the field to share information, innovative strategies, and tools to integrate the life course perspective into MCH work at the local, state, and national levels.

Got Transition Updated Six Core Elements of Health Care Transition 2.0 – These comprehensive tool packages are available for three transition processes: 1) transitioning youth to adult health care providers, 2) transitioning youth to an adult approach to health care without changing providers and 3) integrating youth into adult health care. These packages include sample policies, registries, transition readiness/self-care assessments, condition fact sheets, medical summary and emergency care plans, transfer letters and checklists, young adult orientation

Resources CONT.

material, care plans, feedback surveys and measurement approaches. These tools may be adapted and customized for an individual practice.

MCH Life Course Research Network – This Health Resources and Services Administration (HRSA) website provides researchers, practitioners, policymakers, and consumers with a mechanism for interacting, sharing information and tools, and engaging in collaborative and innovative projects, including the development of a life course research agenda.

MCH Navigator: Life Course – This resource page contains targeted resources and learning opportunities on life course for MCH professionals. This collection is intended to assist the MCH workforce integrate the life course perspective into their work at the local, state and national levels.

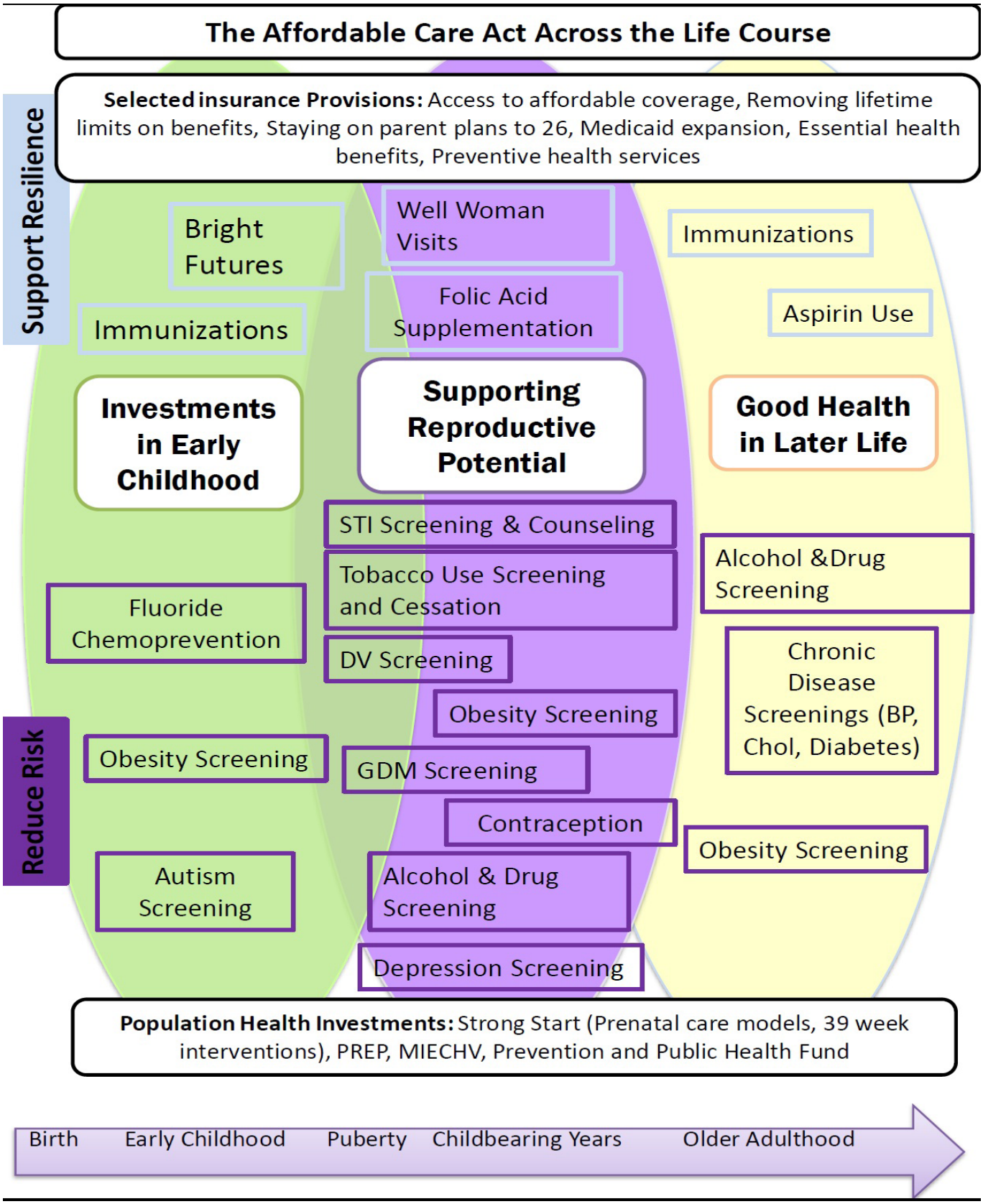
A Life Course Approach Resource Guide Developed by the MCH Training Program – This HRSA website provides a number of key resources to help MCH training programs explore the implications of the life course perspective for efforts to improve the health of all women, children, youth and families. Visit the site for fact sheets and policy briefs, peer-reviewed journal articles, presentations and course lecture series, examples of local initiatives and more.

- Rethinking MCH: The Life Course Model as an Organizing Framework – This 2010 concept paper synthesizes the best thinking on MCH life course and outlines how the theory might be used to frame the upcoming MCHB strategic planning process. The paper also provides a series of examples on how a life course perspective might be incorporated into MCH research, programs, policies, and partnerships to optimize health outcomes and reduce disparities across the population.
- Moving from Theory to Practice – Orientation to the life course approach from the perspectives of three well-known practitioners: a pediatrician and professor, an esteemed researcher and public health expert, and an activist-advocate-attorney-author. Webcast with video, slides and transcript.
- Life Course Perspective – Life course proponent, researcher and public health expert Milton Kotelchuck, PhD, MPH, explores the development and implementation of the MCH Life Course and the MCH field and relates how the life course paradigm should influence needs assessments. Webcast with video and transcript.
- Life Course Health Development Model – Introduction to the Life Course Health Development model and its implications and applications for measurement, for intervention, organization of services and policy development. Webcast with video and transcript.
- The Intersection of Life Course, Health Equity and Social Determinants of Health: Translation to Action – Foundation of ideas to build upon, focusing on the intersection of social determinants, life course, health disparities, the interventions that address them, and implications for implications for infant mortality reduction and policy. Keynote presentation and panel discussion. Webcast with video, slides and transcript.

AMCHP is For Babies

On Saturday, May 3, AMCHP staff will participate in the 2014 March for Babies in Washington, DC to support the March of Dimes in improving the health of babies. Click here to support our team, AMCHP Steps for Babies!

Data and Trends



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Karen VanLandeghem, MPH, *Senior Advisor, National Center for Health Reform Implementation*

Calendar

Confronting Family and Community Violence
May 1-3
Washington, DC

National WIC Association Annual Education and Networking Conference
May 18 - 21
Pittsburgh, PA

Calendar CONT.

30th Pacific Rim International Conference on Disability and Diversity
May 19-20
Honolulu, HI

Supporting Children Affected by Parental Co-Occurring Disorders: Substance Abuse, Mental Illness, HIV
Jun. 30-Jul. 2
Seattle, WA

NACCHO Annual Conference
Jul. 8-10
Atlanta, GA

ASTHO Annual Meeting and Policy Summit
Sept. 9-11
Albuquerque, NM

CityMatCH Leadership & MCH Epidemiology Conference
Sept. 17-19
Phoenix, AZ

APHA 2014 Annual Meeting and Exposition
Nov. 15-19
New Orleans, LA

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

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