



# PULSE

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

## Evidence-Based Practices

May/June 2013

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## From the President

### The Search for Common Ground

By Millie Jones, MPH



[common ground – definition](#)  
(n.) Foundation of common interest or comprehension, as in a social relationship or a discussion (2013 ASK.com)

*Area of agreement: something mutually agreed upon, especially as a basis for negotiation, a foundation for mutual understanding (Yahoo! Answers. Best answer chosen by voters)*

Lately, I have been thinking about “common ground” and where it has gone. About 10 years ago, it was trending as a means for working with our partners in the public health community. We embraced the opportunity to identify a challenge, dialogue and collectively develop a common vision. Using “*Future Search*,” my friend and former co-worker, Dr. Richard (Dick) Aronson facilitated relationship building, trust, and shared visioning for the work we were doing in maternal and child health (MCH). This process of seeking common ground fosters such civility by bringing the “whole system” into the room, allowing participants to take ownership and collectively develop a future action.

These days, it seems the conversations regarding MCH are driven by crises. With the recent traumas and emergencies in our nation and local communities, we come together with a willingness and urgency to right a wrong, to support our community, to mourn our losses, and acknowledge our resiliency.

I challenge us to return to the development of a future action with the child as our common ground. For the one commonality we all have is that of being (or having been) a child. Having just celebrated both Mother’s Day and

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Father's Day, I realize that not all of us will have those roles.

If we take all the concerns – health care, healthy birth, school readiness, healthy growth and development, sexuality, transitioning to adulthood – and start the discussion of the future of Title V from the perspective of a child, functioning at peak capacity, with all they need to evolve into a happy and healthy adult. That is a common ground I can live with!

How do we find common ground?

- Identify the commonalities of both organizations, particularly around mission and purpose
- Explore what the value of partnership would be for both parties
- Discuss the potential barriers that would need to be addressed in order to have a successful partnership
- Determine the various strengths of each organization and how they can be leveraged with the other (community wealth)
- Focus on how the partners complement one another and overcome the barriers (*Corporation for National and Community Service. FACES AmeriCorps Applicant Toolkit. Reference Sheet #2*)

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## From the CEO Transitions...

By Michael R. Fraser, PhD, CAE



It is with a great deal of gratitude and profound appreciation that I would like to share I will be leaving AMCHP after six years as chief executive officer (CEO). I have accepted a new position as the executive vice president and CEO of the Pennsylvania Medical Society (PAMED). My last day with AMCHP will be Jul. 26.

I have thoroughly enjoyed my time at AMCHP and together we have accomplished a great deal. My decision to leave was not easy. AMCHP has accomplished a great deal and I am proud and thankful for what we have done together with the board, our staff, members, and our partners. I know AMCHP is in a solid place with excellent, caring leadership and an active, committed membership.

I thank all of you for your contributions to AMCHP and for your support of my leadership. If you have questions or concerns about this transition, please do not hesitate to contact me or our president, Millie Jones. Please stay tuned to the AMCHP website and our next issues of *Pulse* for more information about our transition plans.

Thank you all and I look forward to the continued success of AMCHP in the future!

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## Best Wishes

Mike,

On behalf of the AMCHP Board of Directors and its membership, I wish you the very best in your new adventures. Having been a part of the team that interviewed and recommended your hire, it has been such a pleasure to work with you and observe your success as the AMCHP CEO. You brought a visionary, creative and engaging leadership style to AMCHP and we are all the better for having had you serve as our CEO for the past six years.

Thank you for all you have done for AMCHP. Best wishes in your new career transition.

With gratitude,

Millie Jones, President

## Feature Why Wait? The Value of Sharing Your Emerging and Promising Practices



**By Kate Howe**  
*Program Manager, Child Health,  
AMCHP*

Many *Pulse* readers may be familiar with the AMCHP *Innovation Station*, a database of emerging, promising and best practices in MCH. Since 2009, *Innovation Station* has served as a resource for locating emerging, promising, or best practices related to a particular topic, population, or intervention, as well as a platform for MCH programs to share their successes and lessons learned. While use of *Innovation Station* has increased over the years, states may still be hesitant to submit their work. AMCHP Best Practice Committee members Sarah Verbiest, committee chair and executive director, UNC Center for Maternal & Infant Health, and Deb Wagler, public health analyst, Maternal and Child Health Bureau (MCHB)/Health Resources and Services Administration

## Feature CONT. The Value of Sharing

(HRSA), recently shared their insights as to why programs may not submit to *Innovation Station* and dispelled some of the “myths” around the common barriers to submitting.

### Myth 1: It’s Not Good Enough Yet



Deb Wagler: As a project officer for the block grants, I frequently see states working on innovative examples that would be helpful to share with other states working in similar areas; however, these program designs and initiatives are often not submitted to *Innovation Station*. When I ask a state why they

have not submitted, one of the most common responses I hear about their reluctance to submit is that they believe the example is not formalized enough yet. In public health, if there is anything we know it is that CHANGE is our only constant. We adapt as we go and these examples show strong problem solving that could help others.

We greatly appreciate the formalized and well-evaluated interventions that are shared, but we also need to ramp up those examples that are not fully formed. The latter are often timely to the current environment and meet a need that many other states are likely experiencing.



Sarah Verbiest: I agree! While states may not feel ready to share a practice that isn’t quite at the level of a well-evaluated and replicated “best” practice, it is important to be building a knowledge base and learning from each other. One of the tenets behind the AMCHP continuum of best practices is that a best practice is not a static concept, but rather an evolving

process. With time and opportunity, an emerging practice with a strong foundation, design and evaluation plan would be able to demonstrate effectiveness as a promising, and eventually best practice.

Having a deep idea bank is valuable for the MCH community collectively, but we all need to invest a little of our time to build it by submitting our work! Getting to the level of a best practice is a great standard to aim for, but we all can certainly learn from each other even at the emerging and promising levels.

## Feature CONT. The Value of Sharing

### Myth 2: There's Not Enough Time

Deb: The second most common reason I hear for delaying a submission to *Innovation Station* is because a state may not feel there is enough time to pull together the information or data that they have. We understand that states are stretched thin on time and resources. AMCHP is very supportive and has staff and epidemiologic capacity to work with you and figure out how to package the data you have or describe the plans for the data collection to accompany your emerging practice. In our current environment of increasing emphasis on quality improvement, small tests of change and the days ahead that guarantee broad change in our health service sectors, now is the time to share your ideas! The advantages to submitters include hearing comments from peers for enhancing the work, as well as potential access to epidemiologic expertise to better plan data relevant to your project.

Sarah: Additionally, most of the projects and programs that we, as an MCH community, develop require progress reports, evaluation plans, etc. for funders or our departments. The *Innovation Station* application builds on the information that most programs have already compiled. Many submitters find that they can copy and paste existing information to complete the submission form.

Furthermore, AMCHP is a great resource to help you get started. Staff are available to talk with you about potential applications, offer suggestions to make your application more robust, and even start a draft of your application if you send background and related program materials. AMCHP also can provide some technical assistance or connect you with resources to respond to review comments.

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We hope states will be encouraged to share their in-time, real working examples by submitting ideas they are developing to *Innovation Station*!

If you would like to be considered for inclusion in the *Innovation Station* database, visit [amchp.org/bestpractices](http://amchp.org/bestpractices) to access more information about the best practice submission process or contact [Kate Howe](#).

## Feature Replicating Promising Practices in Iowa and Montana

Last fall, AMCHP released a new request for application for replication stipends to foster connections between states interested in adapting a current emerging, promising or best practice in *Innovation Station*. AMCHP provided technical assistance (TA) funds and coordination to two states – Iowa to adapt the [Florida CMS-CSHCN Youth and Young Adult Transition](#) materials and Montana to replicate the [Rhode Island Pediatric Practice Enhancement Project](#). Both states share their experiences, successes and lessons learned below:

### Montana P6



*Lisa Wilson, Parents, Let's Unite for Kids (PLUK)*

The TA site visit provided the PLUK Parent Center Parent Partner Pediatric Practice Pilot Project (P6) with valuable implementation materials and training, as well as a chance to look to the future and plan and implement with program growth in mind; including agreements with the pediatric offices to allow the PLUK Parent Center to bill for hours beyond those that are grant funded for greater stability and sustainability. There were six site visits at a variety of clinics that provided a wealth of information in a short period of time.

As a result of the TA, P6 has four trained parent partners in pediatric practices in two locations 400 miles apart.

The two-day site visit propelled the effectiveness of P6 ahead by several years from the knowledge and experience of seasoned parent partners. The PLUK Parent Center gained a deeper understanding of program operations, including memorandum of agreements, program supervision and management, logistical details, and fitting into the social setting of the pediatric office.

With the implementation of P6, families and children with special health care needs in the pilot practices will have access to a family-centered medical home and



## Feature CONT.

### Replicating Promising Practices

all of the associated benefits. The new parent partners have already made their practices more family centered, culturally competent, accessible and comprehensive. Additionally, the project has raised awareness in both the family and medical community about not only medical home, but the meaning of a patient or family-centered medical home. Other practices in the state started calling before we had even fully implemented the project, asking if they could get a parent partner. The national recognition extended to the P6 project and PLUK Parent Center by being awarded a technical assistance grant afforded us some additional credibility and helped jump start statewide excitement for the project. Through implementation, we have strengthened relationships with our champion physicians and begun more formal partnerships with the Montana chapter of the American Academy of Pediatrics. We also had organizational growth that will allow us to serve more families in our state.

Additionally, the professional development and education for the new Parent Partners was considerably accelerated. They also began to gain a national perspective and understanding of Title V programs, as well as the purpose of Title V and the force for positive change that family leaders and parent centers can contribute to MCH systems.

Our TA site visit to Rhode Island fostered a mentoring relationship between our Parent Centers and Title V departments. We now have ongoing mentor-mentee calls and are receiving continuing support as our program grows. Through this assistance facilitated by AMCHP, we have avoided many missteps and our program implementation has gone smoothly.

#### Iowa Child Health Specialty Clinics

Anne Crotty, MPH, Child Health Specialty Clinics

Child Health Specialty Clinics (CHSC), the Iowa Title V program for children and youth with special health care needs (CYSHCN), received technical assistance from AMCHP and FloridaHATS to replicate the evidence-based FloridaHATS program. This project designed and pilot tested a transfer of care package for youth transitioning to adult care, and hosted Dr. David



Wood and Janet Hess for a one-day conference. The transfer of care package included checklists for the pediatric and adult primary care offices, a transition plan, a referral letter

to an adult provider, a portable medical summary, and a resource list. Family Navigators (FNs) identified interested youth 17-21 years with mental health conditions. A FN helped complete the transition plan, identify adult providers and create a referral letter. The FN followed-up with all parties to offer continued support.

*"I really like [the process]. Maybe if [adult provider options] were already listed, then when the patient is in for a checkup they can see the options, it would be easier. I really appreciate your help with this."*

Participants suggested guidelines for finding adult providers and tools for those with intellectual disabilities. Forty representatives from organizations serving CYSHCN and family members attended the conference. This included a lively discussion on engaging health care providers, families and educators, as well as feedback on the proposed tools.

This TA provided valuable guidance on designing a statewide transition program and allowed representatives from many organizations to gather for a common cause. CHSC will continue to refine these materials, eventually validating and implementing them statewide.

#### The value of sharing best practices

*"We really appreciated the opportunity to share our experiences in building a Florida strategic plan for health care transition with our colleagues in Iowa. There is enormous value in states learning from each other's successes and challenges, and not reinventing the wheel – especially in emerging fields such as transition to adult care. It was also nice for us to step back and reflect on the work that we've done in Florida, conceptualizing what Iowa and other states might do differently based on their*

## Feature CONT. Replicating Promising Practices

*unique needs, and identifying how we might improve our own efforts.” – Janet Hess, MPH, CHES, Project Director, FloridaHATS and Dr. David Wood, MD, MPH, Director, Jacksonville Health and Transition Services (JaxHATS)*

*“The Pediatric Practice Enhancement Project (PPEP) has been a ‘medical home’ initiative in pediatric primary and specialty care practices in Rhode Island since 2004. During the soon to be 10 years of implementation, Rhode Island has gained a great deal of experience about what it takes to make an innovation a success. The value of providing technical assistance to other another state is that Rhode Island is able to share a wealth of knowledge regarding the lessons learned to assist in replicating the model.*

*The ability of Montana to travel to Rhode Island afforded the opportunity to visit several practices and meet face to face with PPEP site physicians/staff to learn how the PPEP is utilized in their particular site (private, group, hospital-based) and the impact. Of significant importance was the opportunity for HEALTH and RIPIN to exemplify how state systems and community partners work together as partners to promote the success of innovations that are key to creating system changes.” – Deborah Garneau, MA, Chief, Office of Special Health Care Needs, Rhode Island Department of Health; Colleen Poselli, PPEP and Disability and Health Program Manager; and Lisa Schaffran, Associate Director, Rhode Island Parent Information Network*

## Feature Turning Research Findings into Policy and Practice

### ***An Update from the Home Visiting Research Network***

**By Kay M. Gonsalves, MSPH**  
*Home Visiting Research Network Coordinator, HVRN  
General Pediatrics and Adolescent Medicine, Johns Hopkins School of Medicine*



## Feature CONT. Turning Research into Practice

**Anne Duggan, ScD**  
*Home Visiting Research Network Director, HVRN  
General Pediatrics and Adolescent Medicine, Johns Hopkins School of Medicine*



Home visiting can play a key role in the early childhood system of services. For home visiting to achieve its potential, decision makers must make informed choices regarding adoption, adaptation, implementation, coordination, scale-up and sustainment. We need a coordinated, focused and theory-based home visiting research infrastructure to inform such decisions.

The [Maternal, Infant, and Early Childhood Home Visiting \(MIECHV\)](#) program under the Affordable Care Act seeks to improve health and development outcomes for at-risk children and families through the implementation of evidence-based home visiting programs. The transdisciplinary Home Visiting Research Network (HVRN) was established in July 2012 to guide efforts in strengthening home visiting programs through the use of implementation science to improve service models and implementation systems. The HVRN is funded by the HRSA/MCHB.

The HVRN aims to create the infrastructure for a rigorous program of research that informs policy and practice on home visiting as part of the early childhood system of services. Its objectives are to: 1) develop a national home visiting research agenda; 2) advance the use of innovative research methods; and 3) promote an environment that is supportive of the professional development of emerging researchers interested in home visiting. An overarching goal is to promote the translation of research findings into policy and practice.

The first HVRN task is to develop a national home visiting research agenda. The approach drew from the methods of other agenda-setting groups. In late 2012, the HVRN elicited research priority nominations from nearly 1,800 home visiting stakeholders through a Web-based survey. They received a total of 4,267 nominations in response.

## Feature CONT.

### Turning Research into Practice

The HVRN organized and synthesized these nominations into a list of “Top Ten Home Visiting Research Priorities” that reflects the themes identified in these nominations: the current emphasis on home visiting scale-up, the recognized need to strengthen and broaden the benefits of home visiting across outcomes and population subgroups, and growing interest in identifying the core components of effective service models and implementation systems.

The draft research agenda has undergone several rounds of revision following a presentation at the [2013 Pew Quality in Home Visiting Summit](#) and review by the HVRN Steering Committee. In late June, the HVRN will make the research agenda available for public comment. The HVRN will use comments and feedback to revise the document into its final form. Please visit [HVRN.org](http://HVRN.org) in the coming weeks if you are interested in the opportunity to provide comment.

A primary way that the HVRN will advance the use of innovative methods and address the priorities in the research agenda is through a practice-based research network. The HVRN will call this network the Home Visiting Applied Research Collaborative (HARC). The HARC will bridge the gap between research and practice by promoting appreciation of the value of research by practitioners and the value of practitioner views by researchers. This collaborative will further strengthen the evidence-base for home visiting by focusing on research questions generated by the individuals that actually deliver services to families and their unique knowledge and expertise.

The HVRN is currently developing the policies and procedures that will underline the governance structure of the HARC. All programs that use home visiting as their primary service strategy for expectant families and families of children birth to five years are welcome to participate in the HARC, as are researchers who study home visiting. Programs will be able to choose in which research studies they would like to be a part, and will be among the first to know about results and findings. Please continue to check [HVRN.org](http://HVRN.org) for more information, or contact [Kay Gonsalves](#) with questions or comments. We want to hear from you!

## Feature

### Data Systems for Evidence-Based Practice: The Need for Integrated Epidemiology and Quality Improvement Techniques

By **Caroline Stampfel**  
*Senior Epidemiologist, AMCHP*



In MCH programs, we rely on epidemiology and evaluation data to tell us important information about our populations and how effectively we are serving them. Epidemiology data can signal problems to us using incidence or prevalence. Inferential studies can help us understand which groups and behaviors are good candidates for intervention, and what health outcomes are important for the populations we serve. Specific evaluative data from the programs and services we implement are critical: Process measures can tell us what we have accomplished, outcome measures point to what we have changed with our program or practice, and impact measures assess the ultimate difference for those we serve.

As MCH programs and more generally, public health agencies, focus on implementing practices designated as “evidence-based,” there is a burgeoning need to examine and reinforce relevant data systems that will guide the implementation, monitoring and evaluation of evidence-based practices (EBP). Public health data systems need to support quality improvement (QI) techniques to determine if implementation is going as planned, where course-corrections are necessary, and whether the evidence-based practice needs to be adapted to meet the needs of a new population. QI, which, up until a few years ago, was more common in clinical settings, involves implementing rapid cycles of improvement. The Centers for Disease Control and Prevention (CDC) gathered some key information about quality improvement and has adopted a public health definition for QI proposed by [William Riley et al](#) as, “the use of a deliberate and defined process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency,

## Feature CONT. Data Systems for EBP

effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes which achieve equity and improve the health of the community.”

In order to achieve the key characteristics of QI, namely being continuous and responsive, we need to look beyond traditional public health data. For example, epi data, and vital records data in particular, are often not available in the time frame needed for meaningful QI. The process of reviewing vital data for quality and editing can take a year or more from the closing of a vital records year to the release of final data. While this delay has been acceptable for the purposes of final reports and trend analysis, and has even improved with advances in state and national data systems, these data are not timely enough to achieve QI goals. One example of growing recognition of the need for more timely data comes from the [National Association for Public Health Statistics and Information Systems \(NAPHSIS\)](#), which in November 2012 convened a symposium to examine the timeliness issue. The report resulting from that symposium and released in April 2013, [More, Better, Faster: Strategies for Improving the Timeliness of Vital Statistics](#), outlines short- and long-term strategies for the state and national vital event systems to improve timeliness, centered on capital – financial, political and human. Short-term strategies for achieving success include professional development for data providers and the next generation of vital records leaders, evaluation of system performance and return on investment, releasing data to the National Center for Health Statistics more quickly, and sharing best practices through learning networks.

AMCHP sponsored training on QI in San Antonio in 2012, with resources available [here](#). At the AMCHP annual conference this past February, QI was the subject of a mini-plenary where a distinguished panel discussed implementation of QI in public health from different vantage points. To access a recording of this discussion, [click here](#). Panel member Kaye Bender provided this advice to attendees: do something, start small and remember that you can't really break anything by doing an improvement initiative. Since implementation of QI is relatively new to public health, getting our minds around what kind of data are needed and how they can and should be used might take a little time, a lot of practice, and maybe even making a few mistakes until we learn how to do it right.

## Feature Evaluating the Impact of Father Involvement Programming: The SFI Model

### By The SFI Development & Evaluation Team

*Carolyn Pape Cowan, PhD and Philip A. Cowan, PhD, University of California, Berkeley*



*Marsha Kline Pruett, PhD, ABPP, Smith College School of Social Work*



*Kyle D. Pruett, MD, Yale School of Medicine*

As we celebrate Men's Health Month and Father's Day, there is no better time than the present to consider the unique impact of a positively engaged father on child, maternal, family, and community health. A growing body of research points to the beneficial outcomes of father involvement; however, the majority of programs that serve families with young children, especially low-income families, tend to focus almost exclusively on mothers. Agencies and organizations serving the MCH community may wish to consider their father-friendliness and how they enable father involvement to maximize program outcomes. This article describes the [Supporting Father Involvement \(SFI\) Program](#), a practice and research intervention currently being disseminated across the state of California and internationally, as a method of fostering organizational development and growth for agencies and professionals serving at-risk families.

The SFI Program began in 2003 as a research and intervention study in five counties in California. It is the first systematically evaluated father involvement intervention program using a randomized clinical trial design, created specifically for low-income families from various cultural backgrounds. The study was funded by the California Department of Social Services, Office of Child Abuse Prevention and the implementation of the intervention includes a partnership between the agency and local Family Resource Centers and university faculty (University of California, Berkeley, Yale and Smith College). The

## Feature CONT.

### The SFI Model

program is based on the fundamental belief that most fathers wish to be positively involved in their child's life, and is guided by five interconnected family domains:

1. Individual characteristics of the parents
2. Parent-child relationship quality
3. Couple or co-parenting relationship quality
4. Intergenerational transmission of family patterns [parent-child involvement] and relationships
5. External influences, such as employment, and the balance between life stresses (especially those outside of the family) and social supports

The intervention is a 32-hour [curriculum](#), typically delivered over 16 weeks for groups that include either only fathers or couples. It is designed for agencies serving primarily low-income families, delivered by experienced clinicians and case managers and coordinated by designated program staff. The SFI curriculum includes activities, discussions, and open-ended time for participants to raise immediate concerns for group discussion and problem solving. Demonstrating a core value of the program, group leaders do not prescribe specific behaviors for men and women as partners or as parents. Instead, they offer a group environment in which partners can explore their own preferences, goals and ways of relating to each other as partners and parents based on their own culture and values.

The intervention study compared father-only and father-mother interventions with each other and against a control group, and evaluated the impacts on families and children in the five domains. In addition to evaluating the effects of the intervention on the participants, the study assessed changes in outreach to fathers and in the provision of services to support the father role in family life at each Family Resource Center and its affiliated local, county, and state agencies.

The multiphase research study has enrolled nearly 900 families and findings from the study have been published in [peer-reviewed journals](#). In summary, the team found that parents participating in the groups experience reduced stress and anxiety, are more satisfied with their relationship, and employ less harsh discipline. Additionally, their children become less hyperactive and aggressive

than the children of parents in the control group. Of those families that participated in the third phase of the study, which included families referred to the Child Welfare System, preliminary results suggest that participation in the groups resulted in significant decreases in couple violence and harsh parenting, and a breaking of the connection between substance use and marital difficulties. These findings are consistent with studies showing the importance of fathers' positive involvement for children's and families' healthy development and well-being. Agencies housing the SFI project have shown a number of positive changes maintained over multiple years, including improvement in reputation for serving fathers, father-inclusive policies and procedures, and staff preparation to provide services to fathers.

The success of the program has led to a statewide dissemination effort, as well as interest from international governments for its replication. For example, the British government recently decided to fund the implementation of the program in five boroughs of London, and a public-private partnership in Alberta, Canada has funded the program in four provincial sites, with two additional sites implementing the program on their own resources. Today, agencies may contact the SFI program to learn how to participate on multiple levels, including networking, organizational assessments and technical assistance regarding father-friendliness and formal training on implementing the SFI program, including the fathers and couples groups. The program dissemination in California is managed by [Strategies](#), and the [SFI Research and Development Team](#) supports dissemination in states and countries outside of California.

To learn more about how you can become involved in the SFI Program and engage fathers in your MCH efforts, contact [Danny Molina](#), statewide project manager, Drs. [Phil](#) and [Carolyn Cowan](#) or Drs. [Kyle](#) and [Marsha Pruet](#).

To learn more about AMCHP work in father involvement or to share related projects or suggestions, please contact [Andria Cornell](#), program manager, women's and infant health.

## View from Washington The MIECHV Program: An Example of Evidence-Based Policy in Action and a Glimpse into the Future



**By Brent Ewig, MHS**  
Director of Policy, AMCHP

A few years ago, the Association of Maternal & Child Health Programs vigorously advocated for the creation of the MIECHV Program, which was enacted as part of the Affordable Care Act in 2010. The new program provides a total of

\$1.5 billion over five years (fiscal years 2010 to 2014) for evidence-based home visiting. When it passed, AMCHP joined many MCH advocates in celebrating this addition to the Title V statute and hailing it as the single largest new investment we are likely to see in the foreseeable future for MCH programs outside of the ACA insurance coverage expansions.

Since March 2010, state MCH leaders and their partners have been working diligently to optimize this investment and ramp up programs serving some of the most vulnerable mothers, children and families in our nation. For those on the front lines, this work has been so all-encompassing that it seems impossible to believe that in just 18 short months the MIECHV program will reach the end of its first five-year authorization!

Before turning to what we are doing to ensure the program continues, it is worth noting how this program is providing a real-time case study in the evolution toward evidence-based policy. As specified in the statute, MIECHV relies on a tiered evidence structure that focuses investments in programs that have been rigorously evaluated and shown to have positive impacts on children and families, while also supporting the development and evaluation of other promising approaches.

A commentary from then White House Office of Management and Budget Director Peter Orszag crystallized the issue:

*This design differs from the typical approach. We haven't simply created a block grant and told states they can do whatever they want, nor have we dictated a particular program design and told everyone to follow it. Instead, we've said that we're flexible about the details of the program; we only insist that most of the money go toward the programs backed by the best available evidence, and the rest to programs that are promising and willing to test their mettle. – Former White House Office of Management and Budget Director [Peter Orszag](#), June 2009*

Turning to the future – and with apologies to Abraham Lincoln – we are about to embark on a great public policy debate testing whether this or any program so conceived



**Do you have a successful practice that incorporates the life course theory?** Let us know about it! AMCHP is collecting emerging, promising and best practices in maternal and child health and would like to include effective life course interventions and programs including those using life course as a theoretical foundation to improve health outcomes.

Please consider sharing your program through Innovation Station, AMCHP's 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](http://amchp.org/bestpractices).

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

## View from Washington CONT. MIECHV Program: EBP in Action

and so dedicated, can long endure. Rhetoric aside, the stark reality is that congressional action is needed to extend the program beyond fiscal year 2014 when the current authorization expires. The challenges are clear and convincing a deeply divided Congress preoccupied with deficit reduction to extend any spending will not be easy.

To meet this challenge, AMCHP has begun participating in a newly emerging national coalition comprised of advocates, home visiting service providers and others to begin strategizing and supporting MIECHV reauthorization. Thankfully, the recent budget proposal from the Obama Administration gave this work a huge boost and set the stage for reauthorization by including a proposal to expand home visiting by \$15 billion over 10 years as part of a comprehensive plan to [promote early education](#) from birth to five.

In the months to come, AMCHP will be working through this coalition to make the case for continuing MIECHV. We need your help to share the stories and information that demonstrate value and will be calling on those who are able to help us convince policymakers why this is a sound and indispensable investment. Stay tuned for updates and let's look forward to celebrating another victory for MCH!

## Real Life Stories Autism Spectrum Disorders: Making Sure Families Get What They Need



**By Michelle Jarvis**  
*Program Manager, Family  
Involvement, AMCHP*

In this day of technology, it can be a real challenge to sift through the seemingly endless stream of information, opinions and efficacy of treatments for autism spectrum disorders (ASD). Since the

information and opinions can't be filtered, it is incredibly important that families are guided to treatments that are evidence-based and considered 'best practice' by reputable sources.

## Real Life Stories CONT. Getting Families What They Need

One of the most commonly known treatments for ASD is applied behavioral analysis (ABA). This is a data-driven methodology that has shown to be very effective in teaching skills and modifying behaviors for many individuals with ASD, and is typically a recommended intervention. Despite this, a family often times has significant struggles in securing this treatment. To learn more about ABA, please visit [Autism Speaks](#).

There are several factors that can be identified in the struggle to secure ABA services. For one, there is some dispute as to whether ABA therapy is considered educational and therefore the responsibility of the school to provide, or medical and therefore the responsibility of the family or medical insurance to provide. Another struggle is the denial of coverage for ABA by insurance providers based on the claim that ABA is 'habilitative' rather than 'rehabilitative.' To learn more about habilitation versus rehabilitation, please [click here](#).

Personally, I can identify with these struggles. When my son was young and early intensive services were most critical, ABA therapy was recommended repeatedly. However, his school denied providing these services claiming they were not educational therapies. When turning to my private insurance, ABA also was denied. My son received the recommended ABA therapy, but at a significant personal cost. As with many children, this intervention had a tremendous positive impact on him. He learned many skills through ABA therapy and was better able to manage his behavior. I went through several seminar classes to become trained in the ABA methodology in an effort to consistently support him and help him generalize skills. For a period of time, I even worked as his aide in his classroom. Eventually, we moved and his new school recognized the importance of ABA services and was agreeable to providing both a home-based program, as well as consultation to the school team and training to the new aide.

The ABA services my son received were critical in his development. I know he would not be who he is, and where he is today without them. Due to this, while I was in a leadership position in New Hampshire, I worked with many key stakeholders in the state to draft and pass insurance legislation for fair and equal insurance coverage for individuals with ASD. We were successful in getting this legislation passed into law so that other

## Real Life Stories CONT. Getting Families What They Need

families can access ABA therapies through their private insurance, without personal financial hardship. The law in New Hampshire is called Connor's Law, after my son. Connor's Law states that insurance providers can not deny coverage based on a therapy being 'habilitative.' Under Connor's Law, ABA therapy is capped at \$36,000 per year for children from birth through 12 years and at \$27,000 per year for individuals 13-21 years. For more information on Connor's Law, please [click here](#).

## Success Stories Innovation Station Highlight: 2013 Award Winners

By **Veronica Helms, MPH**  
*Intern, Child and Adolescent Health,  
AMCHP*



The AMCHP [Innovation Station](#) is a searchable database highlighting MCH programs that show evidence of having a positive impact on communities. Since 2006, AMCHP has collected emerging, promising and best practices to share with the greater MCH community. AMCHP defines "best practices" as a continuum of practices, programs and policies that range from *emerging to promising* to those that have been extensively evaluated and proven effective (*best practices*).

The following programs represent a sample of success stories from the growing AMCHP database of MCH emerging, promising and best practices:

### 2013 Emerging Practice Awardee

#### Minnesota

The *Minnesota Superior Babies Program* was established to reduce the devastating effects of prenatal alcohol and substance use by promoting healthy prenatal care and parenting. The program is a collaboration between the St. Louis County Public Health & Human Services Department and the Arrowhead Center LLC. Grounded in the social cognitive theory, the program uses a home visiting model with a collaborative, case management approach to

## Success Stories CONT.

provide home visits during pregnancy and up to two years after the birth of the baby in order to reduce the incidence of fetal alcohol related diagnoses and other prenatal drug related effects in children, as well as to increase positive birth outcomes. Results of the program show reductions in drug and alcohol use and improved parenting skills among program participants. For more information on this program, [click here](#).

### 2013 Promising Practice Awardee

#### Kentucky

*Healthy Babies are Worth the Wait® (HBWW) Community Program* is a community-based initiative focused on bringing an end to preventable preterm birth. The pilot initiative, jointly funded by March of Dimes and Johnson & Johnson, was implemented in three intervention sites in Kentucky from 2007-2009 and conducted in collaboration with the Kentucky Department of Health. The pilot used a multifaceted, "real world" ecological design and evidence-based clinical and public health interventions and education strategies for patients, perinatal providers and the general public to prevent late preterm birth. Results indicate declines in preterm and late preterm singleton births in the intervention sites, as well as positive changes in perinatal provider and patient knowledge, attitudes and reported behaviors relevant to preterm birth. HBWW is currently being replicated in multiple states and communities. For more information on this program, [click here](#).

## Submit Your Best Practices!

AMCHP is seeking submissions for *Innovation Station*, an online, searchable database of emerging, promising and best practices in maternal and child health from around the country. Whether it is an effective campaign to promote breastfeeding, an outstanding nurse-family partnership or a proven early intervention program for young children, get the word out about your best practice. Best practices may be featured in AMCHP publications and promoted on the AMCHP website. This is an opportunity to enhance MCH by sharing knowledge and also receive feedback from our expert review panel. All submissions are accepted on an ongoing basis. Submit your best practices today at [amchp.org/bestpractices](http://amchp.org/bestpractices).

## Success Stories CONT.

### 2013 Best Practice Awardees

#### Arizona

The *Arizona Empower Program*, part of the Arizona Department of Health Services Healthy Eating Active Living Child Care Initiative, was a statewide policy change that prioritized health by offsetting child care licensing fees. The program for preschoolers provides 10 strategies to empower children to lead healthy lives and address the alarming rise in childhood obesity and the harmful effects of tobacco. Participating facilities receive a 50 percent discount for child care licensing fees. In addition to reduced licensing fees, participating child care providers receive an *Empower Pack* that includes guidelines and tools that can be easily incorporated into the everyday routine of child care to instill healthy life choices. Technical assistance also is available to help centers meet each of the *Empower* standards. As a result of *Empower*, child care providers did not face extreme increases in licensing fees that would have resulted in the closure of some facilities. Additionally, centers demonstrated higher adherences to nutrition and physical activity best practices policy and providing smoke-free environments. For more information on this program, [click here](#).

### New in Innovation Station

AMCHP would like to recognize all those innovative MCH programs that were successfully reviewed and added to the best practices database in the past year:

- Baby Steps to Breastfeeding (AZ)
- Birth and Beyond California (CA)
- Dare to Dream (RI)
- Empower Program (AZ)
- Get Healthy Together (NM)
- Healthy Babies are Worth the Wait® Community Program
- Internatal Care Program (AZ)
- Parent Child Assistance Program (WA)
- Reproductive Health Assessment After Disaster Toolkit
- Superior Babies Program (MN)

#### Washington

The *Washington Parent Child Assistance Program (PCAP)* is a three-year advocacy/case management model for high-risk mothers and their children, developed by the University of Washington Fetal Alcohol and Drug Unit. Mothers are enrolled during pregnancy or up to six months postpartum, and participate with their families for three years after enrollment. Three theoretical bases – Relational Theory, Stages of Change, and Harm Reduction – guide the PCAP intervention. The PCAP model is informed by research on effective home visiting interventions for low-income populations that have demonstrated the success of strategies including comprehensive focus, frequent visits, and well-trained staff. Evaluation results showed sustained, significant improvements in increased abstinence from alcohol and drugs; increase in stable, permanent housing; decrease in mothers with a subsequent pregnancy; and decrease in mothers with an incarceration. The program was expanded across Washington state throughout the 1990s and 2000s, and now has replication sites in several states and other countries. Evaluation data from replication sites have shown similar positive outcomes. For more information on this program, [click here](#).

To learn more about promising and effective programs in MCH, please visit the AMCHP online searchable database, [Innovation Station](#). For more information about best practices, please contact [Kate Howe](#).



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## Member to Member

**We asked members to share examples of how they identify and use evidence-based practice in their states.**

### **Striving toward Evidence-Based or Research-Informed Service Delivery: Florida's Healthy Start Program**

**Carol Scoggins, M.S.**

*Program Administrator, Maternal and Child Health, Infant, Maternal and Reproductive Health Section, Florida Department of Health*



In 1991, the Florida Legislature gave statutory authority for the Florida Healthy Start Program, which assists pregnant women, interconception women, infants, and children up to age three, to obtain the health care and social support needed to reduce the risks for poor MCH outcomes including infant mortality. The program also promotes good health and developmental outcomes for all mothers, infants and children in Florida.

The services of the Healthy Start Program include risk assessment, nutrition counseling, care coordination, breastfeeding education and support, tobacco cessation counseling, assessment of service needs, interconception education and counseling, referrals and linkages, childbirth education, parenting education, psychosocial counseling, developmental screening, anticipatory guidance, accident prevention, substance abuse prevention education, and in-home visitation. Program services may vary according to the specific community needs and may include funding for prenatal and child health care as a payer of last resort.

Each coalition conducts its own assessment and develops its own service plan every five years, allowing Healthy Start programs to serve diverse and varied populations and geographic areas. However, this has created difficulty in demonstrating the impact of Healthy Start statewide. Representatives from the Florida Department of Health

and members of the Florida Association of Healthy Start Coalitions determined that a redesign of the program was warranted.

In 2011, the Florida Department of Health and the Florida Association of Healthy Start Coalitions began a process to redesign the provision of Healthy Start core service components. The department entered into a two-year contract with a consultant, to develop an evidence-based program planning process to direct the redesign of the Healthy Start Program. The goal is to improve maternal and infant health outcomes for Florida residents by improving service delivery effectiveness through evidence-based or research-informed service delivery.

The redesign process reviewed and evaluated the Florida Healthy Start program components to assess which are research-informed and evidence-based. The process also proposed changes; developed a comprehensive plan for implementing the redesign to ensure program quality and fidelity; identified key effective program elements, processes, and quality indicators to be monitored during implementation and maintenance; and developed a modular evaluation of the redesign of the program that can be implemented in phases.

The department is currently in the implementation phase. During the first year of implementation, beginning July 2013, the Florida Association of Healthy Start Coalitions will begin training on the models selected: Prenatal Plus and Partners for a Healthy Baby. In the subsequent fiscal year, training will begin on the Parents as Teachers program.

The redesign will use the results-based accountability performance measure framework which identifies two types of accountability: population level and performance. This framework will determine who was served, the amount of services provided, quality assurance measures, and client outcomes such as changes in knowledge, behavioral changes, and mother and infant outcomes.

**THE ROAD AHEAD:** Challenges Changes AND Opportunities for Maternal and Child Health **AMCHP** 2014  
amchp annual conference jan. 25-28 washington, dc

## Who's New

### NEW MCH STAFF

### NEW MCH DIRECTORS

#### AMERICAN SAMOA

**Margaret Sesepasara**

MCH Coordinator

American Samoa Department of Health

### NEW AMCHP STAFF



#### **Sophie Wiley**

Sophie Wiley joins AMCHP as the organizational performance and member services intern. This fall, she will begin her final year at American University where she is enrolled in the School of Education, Teaching and Health. Sophie is majoring in Health Promotion with a minor in Public Health and special interest in

maternal and child health.

## Get Involved

### **AMCHP Every Mother Initiative Request for Applications**

With support of Merck for Mothers, AMCHP is launching the Every Mother Initiative to help states address maternal health issues in their community through strengthening and enhancing state maternal mortality surveillance systems (MMSS) and use the data from these systems to take action in developing and implementing population-based strategies and policy change to prevent maternal death and improve maternal health outcomes. The Every Mother Initiative will begin with a 15-month action learning collaborative (ALC) among six states with existing maternal mortality review programs. Core components of the Every Mother ALC include in-person and virtual technical assistance, peer-to-peer site visits between teams, and a Translation Support sub-award to help fund implementation of community recommendations based on MMSS data and analysis. Additionally, these six states will be given the exciting opportunity to serve as pilot test sites for a new maternal mortality data system. This data system, created by the Centers for Disease Control and Prevention, Division of Reproductive Health, is designed to

## Get Involved CONT.

serve multiple purposes including: storing abstracted data elements; supporting the development of case summaries; storing committee review determinations and producing an analytic file. Applications are due by 11:59 p.m. EST Friday, Jun. 28. For more information, [click here](#).

### **AMCHP Women's Health Information Webinar Series: A Home Birth Primer for MCH Programs**

In light of the recent attention on safe birthing practices and the newly released AAP policy statement on Planned Home Births, AMCHP will host the national webinar, "A Home Birth Primer for MCH Programs," on Thursday, Jul. 11, from 2-3:30 p.m. EST. This 90-minute webinar will be moderated by Valerie Ricker, RN, MSN, MS, Title V Director for the Maine Center for Disease Control and Prevention, and will feature presentations by Marian MacDorman, PhD, National Center for Health Statistics; William Barth, Jr., MD, Mass General Hospital/Vincent Obstetrics and Gynecology Service, and Past Chair, Committee on Obstetric Practice, American College of Obstetricians and Gynecologists; Kristi Watterberg, MD, University of New Mexico and Chair, Committee on Fetus and Newborn, American Academy of Pediatrics; and Geradine Simkins, DEM, CNM, MSN, Midwives Alliance of North America. To register, [click here](#).

### **NACCHO and CDC Join Forces in Webinar Series**

The National Association of County and City Health Officials (NACCHO) and CDC will hold a series of four webinars in an effort to help local health departments strengthen communications through marketing and branding, message clarity, new media and evaluation. The schedule is as follows:

- *You Know What You're Talking About, but Does Your Audience? CDC's New Clear Communication Index and How to Use It.* Jul. 17 at 3 p.m.
- *New Communication Channels: What They Are, Why They Are Here to Stay, and Why You Need to be There. CDC Makes It Easy for You.* Aug. 14 at 3 p.m.
- *Building Our Understanding of Health Communication Evaluation.* Sept. 18 at 3 p.m.

For more information and to register, contact [Alisa Blum](#).

### **WAPC Webinar on Neonatal Abstinence Syndrome (NAS) Scoring**

Join the Wisconsin Association for Perinatal Care (WAPC) for a new webinar offering, "Assessment of Neonatal Abstinence Syndrome: Tools for Newborn Nursery

## Get Involved CONT.

Staff.” The webinar will be presented on Jul. 24, 3:30-4:30 p.m. CST. The webinar is intended for health care providers, community service providers, and public health professionals who want to learn more about scoring infants for NAS and share the goal of improving care for infants affected by opioids. For more information, [click here](#).

### **APHA Course on Scientific Writing for Peer Reviewed Publications for Public Health Professionals**

Dr. Michael Kogan, Director of Epidemiology and Research at MCHB and Dr. Sam Posner, Editor-in-Chief of the Preventing Chronic Disease journal at the CDC, will offer their expertise to help public health practitioners turn their work into manuscripts for publication. With assistance from other experienced authors, the course will include both hands-on work and presentations. Participants are encouraged to come prepared with an abstract, manuscript outline, data analysis results or a draft of an article in order to leave the course with a significantly improved manuscript. The course will be held from 9 a.m. – 5 p.m. on Nov. 2 in Boston, MA prior to the American Public Health Association (APHA) annual meeting. For more information and to register, [click here](#).

## Resources

[Agency for Healthcare Research and Quality EBP Report Database](#) – the Evidence-Based Practice Centers (EPC) Program awards five-year contracts to institutions to serve as EPCs. Awardees review, assess, and report on clinical, behavioral, and organizational and financing topics within scientific literature.

[Agency for Healthcare Research and Quality \(AHRQ\) Healthcare Innovations Exchange](#) – helps to improve health care quality and reduce disparities through evidence-based innovations.

[Association of Maternal & Child Health Programs \(AMCHP\) Best Practices](#) – collects, reviews, and disseminates emerging, promising and best practices from public health programs across the United States so that effective models can be shared and replicated among the MCH community.

- [Innovation Station](#) – an online, searchable database of emerging, promising and best practices in maternal

## Resources CONT.

and child health, as well as a list of recommended evidence-based resources.

[Association of State and Territorial Dental Directors \(ASTDD\) Best Practices Approach](#) – provides an online resource for best practice approaches in order to assist state and community oral health programs build promising practices in the context of their environment.

[Association of State and Territorial Health Officials \(ASTHO\) Evidence-Based Public Health Resource Center](#) – is committed to sharing evidence-based practice in public health for more successful programs and policies, greater productivity and better outcomes.

[California Evidence-Based Clearinghouse for Child Welfare \(CEBC\)](#) – provides child welfare professionals with access to information about related programs in the state of California, as well as the research evidence for programs in practice.

[The Campbell Collaboration](#) – this research network aids institutions and professionals in education, crime and justice, social welfare and international development through preparation and dissemination of systematic reviews.

[The Center for Best Practices in Early Childhood Education](#) – mission is to promote the use of best practices in the improvement of education opportunities for children. They serve as a resource to produce and disseminate information based on the recommended practices established by the National Association for the Education of Young Children and the Division for Early Childhood of the Council for Exceptional Children.

[Center for Evidence-Based Practices](#) – located at Case Western University, provides consulting, training and evaluation for institutions implementing innovations to improve outcomes in the field of mental health.

[Child Trends Lifecourse Interventions to Nurture Kids Successfully \(LINKS\) Synthesis](#) – an online resource based on experimentally evaluated programs under the topics of program population, program outcome and program approach.

## Resources CONT.

[CityMatCH](#) – working to strengthen MCH programs and leaders in urban communities in their commitment to improve the health of urban women, families, and communities. Visit their website for a list of promising/best practices.

[Coalition for Evidence-Based Policy](#) – a nonprofit organization that closely reviews all program evaluations within all areas of social policy in order to assist officials in determining those that are most promising.

[The Cochrane Collaboration](#) – through its membership, the nonprofit organization connects more than 28,000 contributors across more than 100 countries and provides the most up to date information regarding the effects of readily available health care worldwide.

[Colorado Office of Interagency Prevention Systems Best Practices Database](#) – is dedicated to assisting communities and programs in implementing interventions based on research evidence in order to best serve the needs of children and youth. Their online database provides information on best practices for prevention and intervention strategies, programs and interventions that improve child, youth and maternal health outcomes.

[The Community Guide](#) – a free resource to help public health professionals choose programs and policies that best fit their community needs in the improvement of health and the prevention of disease.

[Evidence for Policy and Practice Information and Coordinating Centre Library and Database](#) – offers expertise to those seeking research evidence and undertaking systematic reviews. The centre supports the use of evidence in policy and practice through their systematic reviews and development of review methods in social science and public policy.

[Evidence-Based Practice & Policy Online Resource Training Center](#) – provides training materials and related resources to promote evidence-based practice and policy in social work and help professionals create and implement interventions based on the best available research.

[The Finance Project Promising Practice Catalog](#) – an online resource that provides a searchable database of 1,053 promising programs, initiatives, and practices

committed to the improvement in the futures of children, families, and communities.

[Health Evidence: Helping Public Health Use Best Evidence in Practice](#) – this searchable, online database provides access to 3,128 systematic reviews of effective public health interventions. Their consultation service helps organizations and professionals to understand the evidence and apply it to interventions and programs.

[Healthy People 2020 Structured Evidence Queries](#) – an online database provides visitors with reviews on public health interventions in order to reach the goals of Healthy People 2020.

[Iowa Substance Abuse Information Center](#) –links to the most current information and research on behavioral health and provides a 24/7 hotline to assist in finding treatment.

[Konopka Institute for Best Practices in Adolescent Health](#) – supports best practices in the implementation of adolescent focused programs and policies. In their commitment, the institute provides information, programs, and policy support to the youth-serving community at both the state and local level.

[Lippincott's Nursing Solutions](#) – provides guidance and models to help implement evidence-based practices in your organization in order to determine the best care for patients.

[MCH Navigator](#) – a learning portal for maternal and child health professionals, students, and others working to improve the health and well-being of women, children, and families.

- [Webinar: Effectiveness Matters: Using Evidence-based Programs](#) – Dr. Daniel Perkins discusses the importance of accurately implementing evidence-based programs. He begins by defining evidence-based programs and highlighting the significance of randomized control trials, and then continues by conducting cost-benefit analyses for several social programs.
- [Webinar: Capacity Building Webinar #2: Steering Your Public Health Program to Success with Process & Outcome Evaluation](#) – Thomas Chapel, MA, MBA, explains how to use a Logic Model to give a complete

## Resources CONT.

description of the program and provides an interactive case study of the “Making Outcomes More Successful” (M.O.M.S.) program. This module reviews the basic tenants of evidence-based public health. It includes a review of the value of evidence-based public health in improving public health outcomes, using an example of a diabetes prevention program.

[National Association of County and City Health Officials \(NACCHO\) Model Practice Database](#) – provides access to models and reviews of promising practices, with the ability to search by year, category, type and state.

[National Campaign to Prevent Teen and Unplanned Pregnancy Evidence-Based Interventions](#) – an online database provides access to interventions that have shown success in the prevention of teen and unplanned pregnancy through risk behavior change.

[National Governors Association Center for Best Practices](#) – a research and development firm directly serving the nation’s governors. They develop innovative solutions based on research evidence to address public policy challenges.

[National Resource Center for Youth Development](#) – relies on their four core principles of youth development, collaboration, cultural competence and permanent connections aid states and tribes in effectively meeting the needs of youth in child welfare systems.

[National Institute for Health Care Management \(NIHCM\) Promising Practices in Maternal & Child Health Program](#) – facilitates collaboration between health plans and MCH stakeholders to promote the implementation of promising practices in program replication and building.

[Office of Adolescent Health \(OAH\)](#) – the OAH database provides HHS program models for best practices in teen pregnancy prevention and allows targeted searches by population, age, and more.

[Promising Practices Network: Programs that Work](#) – provides online access to summaries of programs and practices that have been reviewed for quality and shown success in improving outcomes for children.

[RTI-UNC Evidence-Based Practice Center](#) – serves as a resource for the health care community and provides systematic reviews of scientific research evidence on health care and health policy. The center additionally conducts research on the best practices for conducting systematic reviews and provides materials for patients and clinicians regarding health care decisions.

[Safe States Alliance Innovative Initiatives Program](#) – is a project highlighting the successful injury and violence prevention programs of alliance members. Through the alliance, members educate policy officials and the general public about injury and violence prevention programs, illustrate the importance and value of such programs, and serve as encouraging examples for communities.

[Substance Abuse and Mental Health Services Administration \(SAMHSA\) National Registry of Evidence-Based Programs and Practices](#) – an online registry of nearly 300 public health interventions committed to evidence-based practices. Participation and enrollment connects members to programs that best fit their communities and provides guidance in implementation.

[Social Work Policy Institute \(SWPI\) Partnership to Promote Evidence-Based Practice](#) – this online resource promotes the use of evidence-based mental health treatments in social work research and education. The website provides tools to help identify EBPs, a list of qualified resources and a database of existing partnerships.

[Turning Research into Practice \(TRIP\)](#) – an online clinical search tool that helps users find the most high quality and evidence-based research for their practice or organization.

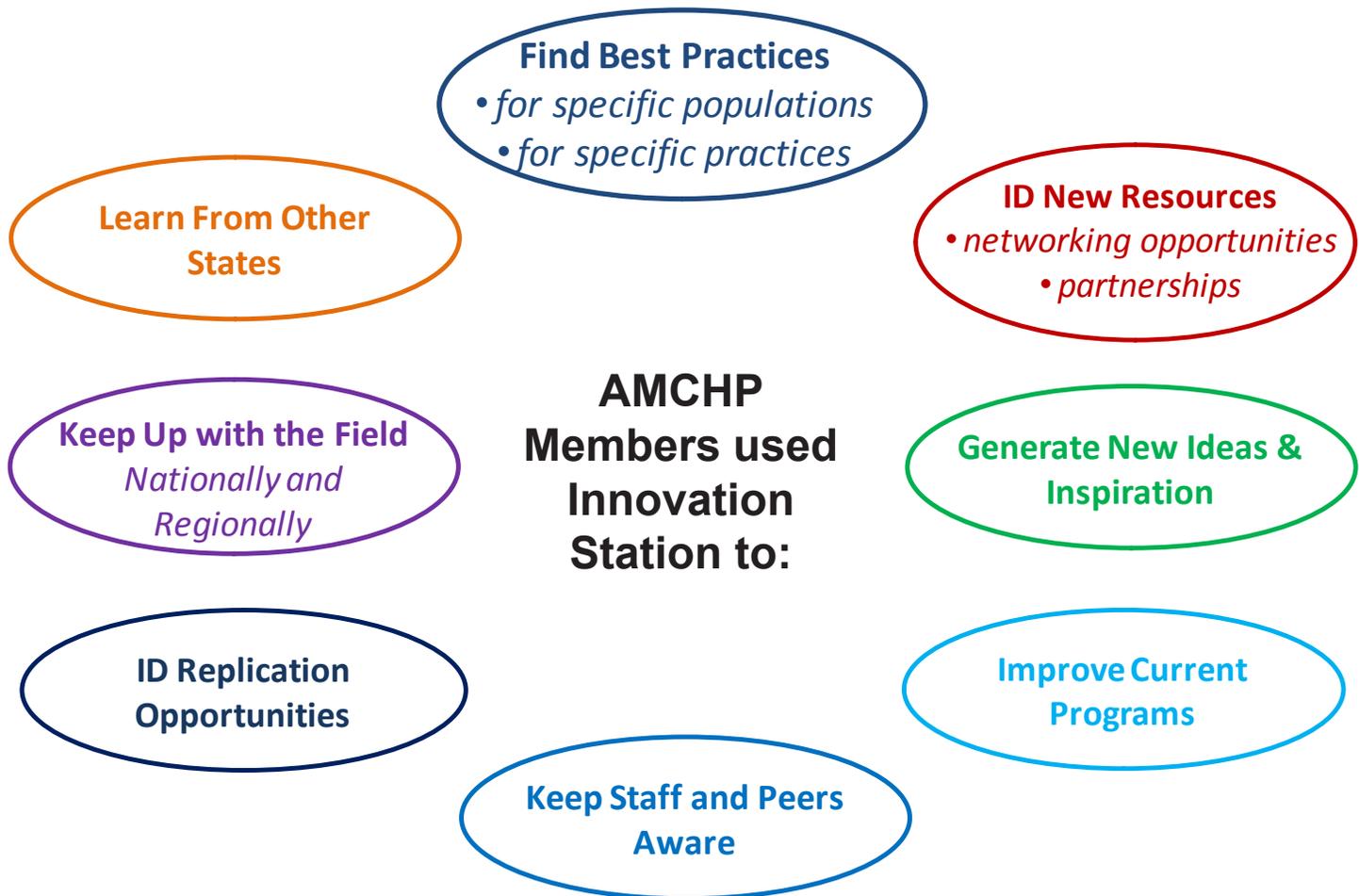
[UMASS Medical: Evidence-Based Practice for Public Health](#) – an online resource provides guidelines for evidence-based practices and systematic reviews in order to help you find and implement the best practices for your public health intervention.

[UNAIDS Summary Booklet of Best Practices](#) – a booklet that describes best practices and their use and success in AIDS prevention programs globally.

## Data and Trends



**50% of respondents have used Innovation Station to find out more about emerging, promising, and best practices**



**Results from the AMCHP 2013 Communications Assessment**

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

**Sophie Wiley**, *Intern, Organizational Performance and Member Services*

## Calendar

### [Third National Cribs for Kids Conference](#)

Jun. 25-28  
Pittsburgh, PA

### [NACCHO Annual 2013](#)

Jul. 10-12  
Dallas, TX

## Calendar CONT.

### [Leadership, Legacy, & Community: A Retreat to Advance MCH Scholarship & Practice](#)

Jul. 15-16  
Oak Brook, IL

### [4th Brain Development & Learning: Making Sense of the Science Conference](#)

Jul. 24-25  
Vancouver, BC

### [2013 University of Minnesota Summer Course in Adolescent Health](#)

Jul. 29-30 and Aug. 1  
St. Paul, MN

### [ARHP 50th Annual Reproductive Health Meeting](#)

Sept. 19-21  
Denver, CO

### [2013 Annual Urban Maternal and Child Health Leadership Conference](#)

Sept. 23-25  
Savannah, GA

### [87th Annual American School Health Association Conference](#)

Oct. 9 - 12  
Myrtle Beach, SC

### [APHA Scientific Writing for Peer Reviewed Publications for Public Health Professionals Course](#)

Nov. 2  
Boston, MA

### [2013 American Public Health Association Annual Meeting](#)

Nov. 2-6  
Boston, MA

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

### Association of Maternal & Child Health Programs

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