



PULSE

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

May/June 2016

The Health Equity and Social Justice Issue

Table of Contents

From the President	1
From the CEO	2
Prosecuting Drug-Dependent, Pregnant Women Hurts Families	3
Alliance for Innovation on Maternal Health Begins Disparity Bundle Development	4
A View from Washington	5
Emerging Issues: Facilitating Access to Health Care for Justice-Involved Populations	5
Teen Pregnancy Initiatives Show Historic Outcomes	6
LGBT Bathroom Bills and Adolescent Health	7
Children’s Mental Health and Parity	8
Coalition Grows to Extend Life Expectancy	9
Building a Movement to Improve Low-Income Communities	10
Gestational Diabetes: Consequences and Solutions	11
Revealing the Scope of Severe Maternal Morbidity in New York City	12
Medicaid Expansion: Through a Health Equity and Economic Justice Lens	12
Paid Family Leave and Health Equity	13
Doula Care and Health Equity	14
Data and Trends	15
Calendar/Who’s New	16
Get Involved	17
Resources	19
AMCHP Board	20
AMCHP Staff	21

From the President

By Eileen Forlenza



I grew up in a neighborhood not far from the Houston Astrodome. My friends and I spent our summers playing sandlot ball, diving for pennies at the local pool and catching lightning bugs in Mason jars. My mom was the only stay-at-home mom in our cul-de-sac, where others were nurses and teachers. All the dads borrowed

each other’s Craftsman tools and gathered on the back patio on Saturday nights for a serious game of pingpong. At the time, I thought it was a pretty “All-American” childhood experience.

I was naive. I now know I was actually living through a powerful experiment in equity and inclusion. I remember first hearing the term “redlining” when I was eight years old – although I did not know what it meant. I just knew that the other white families had moved away and that my dad was attending a lot of meetings at the Jones’ house next door. I heard adults throw around terms like “white flight” and “forced integration.” While I did not know it intellectually, I felt that things were tense in my neighborhood. Despite the fun I was having playing with the new kids who moved in and the talk at school about how things were “separate but equal,” I could tell that others did not treat my new friends equally.

These experiences are the pillars of my worldview. I know that equality does not mean equity. I experienced white privilege but did not know there was a name for it. Alas, as an adult “forced integration” took on new meaning for me as a parent of a child with disabilities. Attempting to navigate multiple health care systems as a parent can make social justice and health equity seem like distant goals; however, I am committed to possibilities and solutions that will result in lasting change.

As the president of AMCHP, I want to assure you that this organization is committed to taking an authentic ap-

Continued on page 11

From the CEO

By Lori Freeman, MBA

Chief Executive Officer, AMCHP



This edition of Pulse begins a new approach in 2016 to focus issue themes on select core values and major initiatives at AMCHP, including health equity and social justice, quality improvement, consumer and community engagement and evidence-based/informed practice.

This change of focus allows each theme to be a focal point and for articles from various other areas of MCH – such as women’s and infant health, CYSHCN, child and adolescent health, health reform implementation, and workforce and leadership development – to contribute to our discussion of these high-level, broader themes.

Health equity and social justice present an important first topic to address. It has been encouraging this past year or so to see health equity and social justice emerge as a necessity to advance current public health initiatives. Interventions can and do often improve certain health outcomes; yet, there is new willingness to recognize that unless underlying conditions that affect people’s health and well-being are acknowledged and addressed alongside traditional public health and clinical interventions, progress will be slow and our goals illusive.

There are some excellent recent examples (many more than noted here) of intersections in AMCHP’s work with partners and funders where we see the importance of health equity and social justice playing out in real time and showing strong influence and promise.

The March of Dimes – The March of Dimes recently hosted a two-day strategic planning session for its Prematurity Campaign. The purpose of the meeting was to develop a five-year strategic map for mobilizing support to meet aggressive preterm birth rate reduction goals. You might remember from one of my previous Pulse articles that March of Dimes has established ambitious goals to reduce preterm birth rates in the U.S. to 8.1 percent by 2020 and to 5.5 percent by 2030 with a focus on high-burden populations and areas. If the 2020 goal is achieved, 210,000 fewer babies will be born preterm (1.1 million fewer if the 2030 goal is achieved), resulting in savings of \$67 billion in health and societal costs. The meeting was a unique attempt to conduct a strategic planning session with a full collaboration of 30 different organizational leaders.

By the end of our time together, we had drafted a strategic map with a central challenge to “Achieve Demonstrated Improvements and Health Equity in Preterm Birth.”

This was a rather significant development with the focus on health equity across five major strategic priorities including: a) increasing effective use of evidence-based clinical and public health practice; b) expanding discovery and accelerating translation; c) prioritizing population- and place-based strategies; d) developing and implementing messaging, policy and practice strategies; and e) securing the funding and resources required for success. I was also particularly impressed that we also agreed to three crosscutting, important themes across these five priorities: 1) emphasizing the health of women and adolescents; 2) engaging families, communities and other strategic partners across sectors through a collaborative infrastructure; and 3) optimizing the use of data and evaluation to drive learning and success.

There’s much more to come from these efforts as a partner with March of Dimes in the Prematurity Campaign, so stay tuned for next steps as we further synthesize the mapping and proceed with implementation planning, identifying tracks of work for the next year and communicating the strategic map to our various publics and other constituencies.

ASTHO – As a member of the affiliate council of the Association of State and Territorial Health Officials (ASTHO), AMCHP was briefed last September by Dr. Ed Ehlinger, Minnesota commissioner of health and new ASTHO president, on his 2016 ASTHO President’s Challenge, “Advancing Health Equity and Optimal Health for All.” Dr. Ehlinger

challenged states to go back to their roots, change how they do their public health work and change their public health practices in order to help ensure the conditions in which all people can be healthy. The emphasis of the challenge is to use a “triple aim” for health equity including: a) Expand the understanding of what creates health and change the narrative that health is determined mostly by medical care and personal choices. In his remarks, Dr. Ehlinger reminded the group that medical intervention only contributes about 10 percent to individual health; b) Take a “health in all policies” (HiAP) approach, with health equity as the goal. Understanding how policies relating to transportation, housing, education, public safety or environmental protection can impact health outcomes is part of the HiAP approach; however, Dr. Ehlinger challenges us to add the health equity lens by considering who is benefiting and who is left out; and c) Strengthen the capacity of communities to create their healthy future by involving them in creating policies and

systems that improve conditions for their residents. You can read much more about the challenge [here](#).

Best Babies Zones – An example of both cross-sectoral and place-based efforts, particularly in the context of health equity and social justice in MCH, is the work AMCHP and many other organizations do to support Best Babies Zones (BBZ). The initiative is a multi-sector approach to reducing infant mortality and racial disparities in birth outcomes and improving birth and health outcomes. The focus of this work is on mobilizing communities, at a zonal/neighborhood level, to address the social determinants that affect health by targeting economics, education, health and community. BBZ is funded by the W.K. Kellogg Foundation and is being implemented in three cities: Cincinnati, New Orleans, and Oakland, California. AMCHP is a national partner and member of the BBZ Policy Corps that helps to strategically position and grow the initiative. BBZ also has an important subcomponent, the Multisector Advisory Group, which focuses on bringing partners from other sectors to the table and ensuring multisector engagement at the local level. This group helps to identify indicators for the project and what sectors should be included and prioritized for engagement given the indicators selected: how to engage sectors effectively, how to identify each sector’s contribution, how to tie sectors to health and how to broadly influence policy change and multisector engagement above community levels. If you are interested in learning more the importance of healthy equity in the context of this work, I recommend two readings: “Growing a Best Babies Zone: [Lessons Learned from the Pilot Phase of a Multi-Sector, Place-Based Initiative to Reduce Infant Mortality](#)” and “[Developmental Origins, Epigenetics, and Equity: Moving Upstream](#).”

Because healthy equity and social justice are part of AMCHP’s core values, this work is crucial and should be actively considered in all of our approaches and activities. As part of AMCHP’s 2016-2018 strategic plan, our evidence-based goal reflects this approach by increasing the capacity of states and territories to use evidence to drive policy and program design to improve MCH outcomes and health equity. Please enjoy reading how health equity and social justice are being incorporated across many other facets of MCH and public health in this issue.

Prosecuting Drug-Dependent, Pregnant Women Hurts Families

By Emily Eckert

Program Associate, Health Reform Implementation; AMCHP



The concept of stigmatizing and punishing pregnant women and new mothers for having drug dependency problems is not new in the United States. ProPublica reports that since 1973, women have been prosecuted for illicit drug use during pregnancy in at least [45 states](#). According to the [National Advocates for Pregnant Women](#), a group working to protect the rights and dignity of pregnant and parenting women,

[more than 800 women](#) have been jailed for drug dependency issues in the last decade alone.

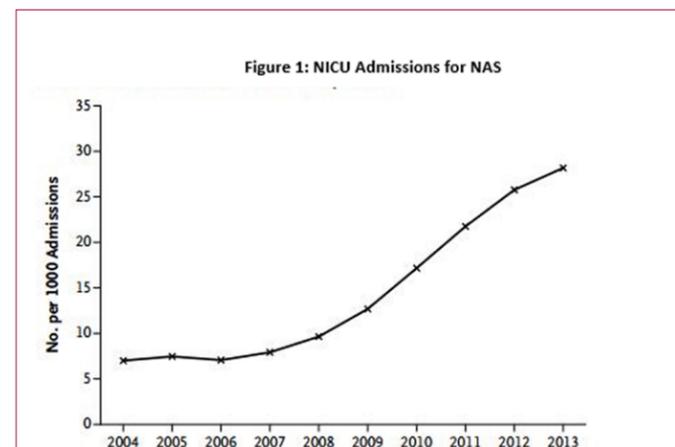
These indictments are part of a broader national initiative to curb opioid use and reduce the rate of infants born with [neonatal abstinence syndrome](#) (NAS). NAS is a drug withdrawal syndrome that most commonly occurs after in-utero exposure to opioids. The number of babies born with NAS in the United States has risen in recent years, with one study reporting that the rate of neonatal intensive care unit admissions for newborns with NAS increased from seven cases per 1,000 admissions in 2004 to [27 cases per 1,000 admissions](#) in 2013 (see figure 1). Prenatal care is proven to greatly reduce the [negative effects of substance use during pregnancy](#) for both mother and baby; however, pregnant women with substance use disorders may be dissuaded from seeking care for fear of the potential legal consequences.

There are serious legal consequences for the use of illicit substances during pregnancy. As of March 2016, substance abuse during pregnancy is specifically considered a criminal act in one state, and it is considered an act of child abuse in 18 states. In three states, drug use during pregnancy is grounds for involuntary civil commitment to a treatment center. Eighteen states have laws requiring health care workers to report suspected drug use by a pregnant woman to local authorities, and four states require hospitals to perform a drug test if drug use during pregnancy is suspected.

This breadth of [state laws](#), though ostensibly designed to curb addiction and produce optimally healthy infants, actually results in poorer health outcomes. According to the [American College of Obstetricians and Gynecologists](#) (ACOG):

“It has been encouraging to see health equity and social justice emerge as a necessity to advance current public health initiatives.”

"Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse. Legally mandated testing and reporting puts the therapeutic relationship between the obstetrician-gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient."



ACOG further concludes that "drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus."

The criminalization of pregnant women with substance use disorders is a social justice issue that disproportionately impacts low-income women and women of color. Though no research indicates higher rates of substance use during pregnancy for black women versus non-black women, black women and their babies are more than [1.5 times more likely to be drug tested](#) in a hospital setting than are non-black women, and [10 times more likely to be reported](#) to public health officials. One study found that [other factors](#) besides race can also contribute to the likelihood that a pregnant woman or new mom be tested for illicit drug use. These factors include lower socioeconomic status, being unmarried, having less than a high school education, being unemployed and having Medicaid or no insurance coverage at all.

Serving [nearly 1.5 million pregnant women](#) and more than three million infants under age 1 annually, the [Title V Maternal and Child Health Services Block Grant](#) has an important role to play in addressing illicit drug use during pregnancy. One way Title V can make a difference is by promoting the [well-woman visit](#) (National Performance Measure No. 1). The well-woman visit provides a unique opportunity for physicians to talk with their patients about reproductive life planning, mental health, diet, intimate partner violence and substance use. Having these conversations with women before and between pregnancies can increase the chances of healthy birth outcomes. Fifty states and ju-

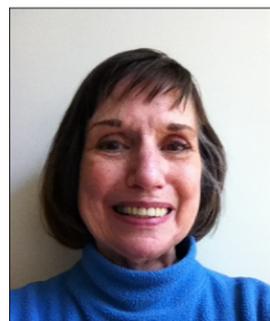
risdictions selected NPM No. 1 as a focus area in their 2016 Block Grant applications.

All states should work to ensure that the proper services and supports are available to all women with substance use disorders. This can be accomplished in part by removing the stigma of substance use during pregnancy and reducing explicit and implicit bias in the health care system.

Alliance for Innovation on Maternal Health Begins Disparity Bundle Development

By Jeanne Mahoney

Senior Director, AIM Program, and Senior Director – Providers' Partnership, American College of Obstetricians and Gynecologists



An exciting initiative is moving forward to empower every state, perinatal quality collaborative, hospital network/system, birth facility and maternity care provider to save women from mortality and preventable severe complications during pregnancy, labor and delivery.

The U.S. the Maternal and Child Health Bureau shared an update on this national campaign – the [Alliance for Innovation on Maternal Health](#) (AIM – Maternal Health) – in a [previous issue](#) of Pulse. The American College of Obstetricians and Gynecologists is leading the way – in partnership with numerous national and state leaders including AMCHP – to work with states and health systems to implement maternal safety bundles through data-driven quality improvement. In collaboration with the Council on Patient Safety in Women's Health Care, AIM – Maternal Health has developed bundles to address hemorrhage, hypertension in pregnancy, prevention of maternal venous thromboembolism and support of vaginal births.

The AIM – Maternal Health team is also excited to share a new bundle in the development stage: Reduction of Peripartum Racial Disparities. This bundle is unique, because it does not focus on a specific outcome or direct cause of maternal mortality and morbidity; rather, it concentrates on addressing health equity across the care continuum and opportunities presented during care processes to close disparities in maternal health outcomes. This work group is led by Elizabeth Howell, MD, MPP, from the Mount Sinai School of Medicine, and William Grobman, MD, MBA, from Northwestern University Feinberg School of Medicine.

It includes representative membership from the American Association of Family Practitioners, American College of Nurse Midwives, Association of Women's Health, Obstetric and Neonatal Nurses, Society for Obstetric Anesthesia and Perinatology, Society for Maternal/Fetal Medicine and AMCHP.

This exciting bundle will focus on strategies that include establishing systems to accurately document patients' self-identified race, ethnicity and preferred language; using patient-centered strategies; ensuring staff education on racial and ethnic disparities in maternal health outcomes, shared decision-making and implicit bias; and building a culture of equity at the facility-level to complement a culture of safety. Strategies will map back to the "four R's" – Readiness, Recognition, Response and Reporting and Systems Learning – utilized by all the existing bundles. The workgroup will refine the bundle and its supporting resources throughout the summer, with the hopes of publishing the bundle on the council's website by fall 2016. AMCHP is excited to partner with the AIM – Maternal Health project to assist its members and partners in the bundle's implementation and to embed it within overall strategies to reduce disparities in women's and infant health. For more information, view the [slide deck](#) presented at the 2016 ACOG-CDC Maternal Safety and Maternal Mortality meeting or contact Jeanne Mahoney at jmahoney@acog.org.

A View from Washington

By Brent Ewing, MHS

Director, Public Policy & Government Affairs Team; AMCHP



As we prepare this issue for press, we are on the verge of learning more about two critical MCH funding priorities: 1) the Senate's proposed funding level for the Title V MCH Block Grant and other important MCH priorities and 2) the potential resolution of differences between the Senate's \$1.1 billion Zika emergency supplemental and the House's \$662 million counter offer.

We expect to get details soon for a FY 2017 Labor, HHS, Education and Other Related Agencies Bill. Recall that this is the committee that initially proposed a \$25 million reduction to the Special Programs of Regional and National Significance (SPRANS) component of the MCH Block Grant last year. AMCHP played a criti-

cal role in leading opposition to that cut, and we were very pleased when the final FY 2016 package not only rejected the proposed cut but instead included a small \$1.2 million increase. [Editor's note: the Senate Appropriations Committee just approved a proposed FY 2017 Appropriations Bill recommending a \$3.5 million increase to the Title V MCH Block Grant – see AMCHP's Legislative Alert [here](#).]

We will watch closely as details are released to see if that success is sustained or if we will need to re-litigate last year's proposed cut. Stay tuned for a Legislative Alert from AMCHP as soon as we know more. Other issues we will follow in this draft bill include assessing whether additional resources will be proposed to address the opioid and lead poisoning crises.

Regarding Zika funding, AMCHP continues to play a lead role in a broad coalition of nearly 80 MCH and public health-related groups advocating the urgent need for Congress to resolve differences and promptly pass an emergency supplemental appropriation providing states and localities with the resources needed to prevent, contain and respond to the Zika virus.

AMCHP has sent [this letter](#) to Congressional leaders and has signed on to several other coalition efforts underscoring the urgent need for action. Congress appears to be aiming to finalize a package before recessing for the Fourth of July. We will continue to press for urgent action and recommend checking [AMCHP's Zika web page](#) for continuing updates.

Emerging Issues

Facilitating Access to Health Care for Justice-Involved Populations

By Atyya Chaudhry, MPP

Policy Analyst, Health Reform Implementation; AMCHP



The incarceration rate in the United States is one of the highest in the world. The majority of incarcerated individuals are adult males who are African-American or Hispanic, but the incarceration rate of female adults is on the rise. According to the [Sentencing Project](#), between 1980 and 2014 the number of incarcerated women increased by 700 percent. Additionally, more than 60 percent of

women in state prisons have a child under age 18. Justice-involved individuals have disproportionately higher rates of

chronic conditions, infectious diseases, mental health disorders and substance use disorders. Access to health care is especially important for justice-involved individuals who are transitioning back into their communities – the same communities where women, children and families reside. According to an [issue brief](#) by the U.S. Department of Health and Human Services (HHS), poor health and poor access to care after release are associated with higher rates of recidivism. Conversely, improved access to health care is associated with improved employment, housing and family support. Access to health care for justice-involved individuals re-entering the community can have a positive impact on both the individual and community, through improved health and well-being, lower recidivism and improved community safety.

The Medicaid program is critical for providing health care to the justice-involved population. In early May, HHS released guidance for state health officials on how to improve access to health care for justice-involved individuals. The letter provides guidance on how states can improve access to health care through Medicaid for individuals transitioning back into their communities, as well as clarification and guidance on many aspects of Medicaid coverage for justice-involved populations. This includes the distinction between inmates in public institutions versus those in home confinement or on parole or probation, as well as eligibility for Medicaid while incarcerated and Medicaid coverage in a different state. The [letter to state health officials](#) (SHO No. 16-007) also discusses dealing with Medicaid suspension upon incarceration and shares strategies to promote continuity of care in light of suspension of coverage. This [map](#) by Families USA provides a glimpse of Medicaid suspension or termination policies in the U.S.

Teen Pregnancy Initiatives Show Historic Outcomes

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



Our efforts are clearly paying off: May's opening of National Teen Pregnancy Prevention Month coincided with some encouraging news from the U.S. Centers for Disease Control. According to the CDC, the U.S. is yielding its lowest teen pregnancy rate of all time, a mere 25 years from its peak in 1991¹. The teen birth rate has fallen 40

percent over the past decade alone². In addition, the birth rates among black and Hispanic teens dropped by almost half between 2006 and 2014.

Although much is to be celebrated in regards to our successes with this public health and social issue, MCH advocates cannot become complacent. It is important to note that the reduction was not proportional among all populations within this age group, and there is more to be done to lower the disparity.

Teen pregnancy can certainly impact familial, educational and economic outcomes that extend well into adulthood and can become cyclical for their children as well. For adolescents themselves, early and unplanned parenthood can generate a number of health and social challenges. Teen mothers and fathers graduate from high school at lower rates than peers who do not give birth, and teen mothers are even less likely to go on to complete either a two- or four-year degree program. Given the fact that educational attainment is a strong indicator of financial viability, teen parents are more likely to experience poverty and dependence on public assistance than their peers³. Through the lens of the life course, we understand that children of adolescent parents also face significant challenges – including poorer educational, behavioral and health outcomes – that can extend well into their adult years.

For MCH advocates, improving the health equity of children and families has increasingly become a point of emphasis in supporting the needs of underserved populations, which include racial or ethnic minorities, those experiencing poverty and those who reside in urban and rural communities. Adolescents within these underserved populations are at an additional risk of becoming teenage parents. For instance, poverty is both a contributor to and outcome of teen pregnancy; black and Hispanic youth in particular are more likely to experience poverty than their white peers. Similarly, there are geographic patterns of states and characteristics of counties with the highest levels of teen birth rates. Data show that across the southern U.S. from New Mexico to Mississippi (the Sun Belt), the rates exceed 50 births per 1,000 teen girls⁴. Factors such as limited or no access to family-planning services and to evidence-based sexual and reproductive health education enable rates in some communities to remain higher than in other parts of the country.

While often referred to as a “winnable battle” by the CDC, preventing teen pregnancy among at-risk adolescents is a complex challenge that can be solved only through multifaceted approaches; there is simply no one strategy that will solve the problem. Title V agencies and partners can, and should, be strategic in collaborating across several efforts to combat much of the underlying causes of this inequality.

² [Teen birth rates fall nearly 50 percent among Hispanic and black teens, dropping national teen birth rate to an all-time low](#)

³ [Youth.gov Adverse Effects of Teen Pregnancy](#)

⁴ [The New Geography of Teen Mothers](#)

¹ [Teen birth rates fall nearly 50 percent among Hispanic and black teens, dropping national teen birth rate to an all-time low](#)

Contributing risk factors include substance abuse, mental health conditions and experiencing or being exposed to violence and trauma⁵. It is imperative that prevention efforts across the state, counties and local communities are both practical and sensitive to these factors. In addition, engaging youth to be part of these strategic efforts – not just as a participant of the interventions — is key to ensuring the programming is culturally relevant for adolescents. Prevention has proven to help curb teen birth rates thus far; however, intentional initiatives focused on those who continue to be disproportionately at risk can also help narrow the disparity of these rates.

To learn more about programming efforts focused on teen pregnancy, visit the Office of Adolescent Health's webpage.

⁵ [Co-Occurring Risks in Adolescence: Implications for Teen Pregnancy Prevention](#)

LGBT Bathroom Bills and Adolescent Health

By Michelle Eglovitch, MPH
Program Associate, Women's and Infant Health;
AMCHP



Although lesbian, gay, bisexual and transgender individuals experience more equality today than ever before, national-level policy needs to go further to address the negative physical, social and mental health outcomes of LGBT youth. LGBT youth are more likely than their straight peers to experience challenges such as violence and bully-

ing and are more likely to be depressed, have suicidal ideation and behaviors and to [attempt suicide](#). Research shows that transgender youth in particular are already at a high risk for self-harm behaviors: Forty-one percent of transgender individuals attempt suicide at some point in their lives, as compared with just 4.6 percent of the [overall population](#).

In 2015 and 2016, multiple state legislatures considered and/or passed bills restricting access of transgender people in gendered public spaces, such as public bathrooms and locker rooms. These bills are primarily meant to prevent transgender people from accessing spaces consistent with their gender identity, as they mandate that people must only enter facilities based on sex assigned at birth. (Gender identity is the personal conception of oneself as being male or female.) Although many of these bills aim to restrict access statewide, some bills are specific to public high schools and subsequently restrict access for transgender youth. Propo-

nents of such bills, colloquially known as “bathroom bills,” argue that the legislation is intended to protect the safety of women by preventing assaults from transgender populations or men who identify as heterosexual. However, there is no evidence that such assaults have occurred in the past at an elevated rate or pose a legitimate threat in the [future](#).

Even before this recent influx of bathroom bills, transgender youth have historically felt unsupported in accessing bathrooms and other public accommodation spaces. The [Gay Lesbian and Straight Education Network's 2013 National School Climate Survey](#) of LGBT middle and high school students found that over 63 percent of transgender youth avoided bathrooms at school and 52 percent avoided locker rooms because they felt unsafe, compared with less than 40 percent of their non-transgender, or cisgender, peers. (Cisgender is a term used to describe a person whose gender identity aligns with the sex assigned to them [at birth](#)). Research shows that discrimination against LGBT youth in a public accommodation setting contributes to negative physical and mental health outcomes, such as feeling sad, upset or frustrated as a result of how they were treated based on their gender identity or gender [expression](#).

Much of the physical and emotional harm that transgender youth experience comes in the form of bullying. The recent transformation of the Title V Maternal and Child Health Services Block Grant includes bullying as a National Performance Measure (NPM). NPM No. 9 is the percent of adolescents, ages 12 to 17, who are bullied or bully others. Emotional and behavioral problems experienced as a result of bullying may continue into adulthood and lead to long-term negative outcomes, including low self-esteem and self-worth, depression, anti-social behavior, vandalism and [substance use](#). LGBT allies, including the public health community, express concern that these bills have the potential to exacerbate the bullying and harassment that transgender youth already experience.

For transgender youth to thrive in their schools and communities, they need to feel socially, emotionally and physically safe and supported. A positive school climate has been associated with decreased depression, suicidal feelings, substance use and unexcused school absences among [LGBT students](#). The American Academy of Pediatrics released a statement opposing legislation that restricts transgender people's access to gendered spaces on these grounds:

“Pediatricians in [North Carolina](#) and across the country know what children need: they need the stability and support of nurturing adults, they need the acceptance and compassion of their peers and community and they need to feel safe where they live and where they learn.”

States that chose to focus on NPM No. 9 should consider the structures and systems they have in place to support all school-age children and adolescents within their

jurisdictions. A specific focus on LGBT youth in policies and procedures would be a part of addressing this measure. Schools with clear policies on LGBT-related bullying report higher rates of feeling safe at school and are less likely to report [harassment problems](#). (Model policies can be found [here](#)). In addition, schools and districts should consider providing training to school staff on being a supportive educator. LGBT students who report having many supportive staff members at their school are less likely to miss school because of feeling unsafe or uncomfortable, and they report feeling more connected to their [school community](#). (GLSEN's [Safe Space Kit](#) is one example of a resource geared toward educators.) If your state has proposed or implemented strategies to create inclusive school environments for LGBT youth, contact Michelle Eglovitch, program associate for Women's and Infant Health, at meglovitch@amchp.org to share your ideas.

Children's Mental Health and Parity

By Renée Speth

NAMI IA Children's Mental Health Committee

If you haven't found an organization that fits your needs, you can start one. That's what some Iowa parents did two years ago, when we founded the National Alliance on Mental Illness (NAMI) Iowa Children's Mental Health Committee. We are now leading the charge to reform health systems to meet the needs of children with mental health challenges.

As parents of children with mental health challenges in Iowa, we at NAMI Iowa Children's Mental Health Committee understand how a mental health crisis is perceived very differently from a physical health crisis. Parents have told us about the lack of appropriate and effective services for their children. Some families report waiting with their children in the emergency room for hours, and up to five days to secure a hospital bed, for a suicidal or violent teen. Parents tell us about long waiting lists for child psychiatrists (three to six months) because of a statewide lack of psychiatrists. Children in many rural communities travel hours for a psychiatric appointment. Families wait two years for Medicaid waivers, which pay for crucial services like therapies and respite. Behavioral challenges resulting from mental illness are often



referred to law enforcement by schools, forcing our children into the school-to-prison pipeline; this is especially true of our children of color. Our adopted children with high adverse childhood experience (ACE) scores face inadequate support at school, which impacts their capacity to learn. Many of our young people are sent to treatment facilities outside of Iowa, so parents must travel hours to visit their children. We consider these services to be medically necessary: they treat mental illnesses and save lives. Appropriate and adequate services can help children remain at home and in the community and keep them out of institutions and the criminal justice system. They can help prevent suicide or murder during a mental health crisis. It costs far less to provide life-saving programs for children than to care for adults who never received preventive care.

Parents have started two Facebook groups for family members in Iowa. The NAMI IA Casserole Club is named for the traditional form of hometown support given during a crisis – the humble casserole – and is an online support group that bands together during children's medical crises. The second group, Parents Creating Change, is an online advocacy network where parents can organize political action around children's mental health.

A comprehensive, pro-active, non-criminalizing, individualized mental health system was developed for adults a few years ago, but there is none for children. Last year we created the Coalition for a Children's Mental Health Redesign. The coalition was parent-led and involved 94 family members and professionals and 45 organizations from across Iowa (including hospitals, law enforcement and service providers). We published the ["Statewide Call for Action: A Strategic Plan for a Children's Mental Health Redesign in Iowa."](#) Our goals were to stop the criminalization of mental illness, build a statewide mental health system that includes an array of services, and be in full compliance with and enforce federal mandates (such as mental health parity laws, the Olmstead Act, Child Find, Early Periodic Screening Diagnosis and Treatment, and the Juvenile Justice and Delinquency Prevention Act).

The Iowa Department of Human Services then invited the coalition to help develop the Children's Mental Health and Well-Being Workgroup, using the Call for Action as a foundation. The co-chairs of the coalition served as representatives of NAMI Iowa Children's Mental Health Committee and the coalition. The DHS Workgroup consisted of professionals from a wide range of organizations across the state, including legislators. The [DHS Children's Mental Health and Well-Being Final Report](#) resulted in a bill to establish the first phase (a crisis system) of a comprehensive system.

Real Life Success Story Coalition Grows to Extend Life Expectancy in Missouri and Kansas

By Eva Creydt Schulte, MA, Diaconal Minister

President and CEO, Communities Creating Opportunity, Kansas City (Missouri and Kansas)



At Communities Creating Opportunity, (CCO) we believe that the only good economy is a moral one – one that puts families at the forefront of decision-making. How do we know whether our economy is moral or not? Simple: we judge the standard of living and length of lives lived. In Missouri, we are losing life expectancy in one-quarter of our counties. In fact, girls in our state no longer outlive their mothers.

This dramatic change occurred over 25 years after a series of public policy decisions that led to disinvestment, predation and the removal of pro-family support systems. In 1995, Missouri numbered 24th in life expectancy compared with other states. Now, Missouri ranks 36th, having been surpassed by eight states that are making different decisions and experiencing an aggregate of longer and more quality lives. Kansas lags even further behind.

This is a problem that 290 community leaders from the Midwest and across the country pondered during May's Moral Economy Summit. How could this happen? More importantly, what can we do to turn course so that everyone in the heartland has the opportunity to thrive?

Communities Creating Opportunity is a constituency-rooted and values-based organization committed to prioritizing human dignity in public life through community organizing, activating citizenship and building prophetic community and life expectancy campaigns. Four years ago we co-located with the Kansas City, Missouri, public health department. This decision solidified our conviction that public health prevention efforts and systemic change through organizing are two sides of the same coin. Now public health professionals and community organizers across our region come together to drive new breakthroughs for health equity and social justice. Last year, Kansas City's collective power building was awarded with the coveted Robert Wood Johnson Culture of Health Prize.

In 2014 we decided that together we would utilize the soon-to-be pre-released film "The Raising of America: Early Childhood and the Future of Our Nation" to challenge the status quo around early childhood education. The film was developed as a teaching tool to present the "social ecology" that children need along with scientific evidence to demonstrate how pro-family policies and investments in early learning lead to dramatically improved outcomes from infancy to age 3 that position young people for success throughout their entire lives.

Communities Creating Opportunity and the Missouri Public Health Department successfully used California Newsreel's earlier film "Unnatural Causes" with our leadership base to impel a new narrative about inequality in our nation. When we began we did not know the extent to which the next film, "Raising of America," would catalyze a movement in the heartland.

In early 2015, we publicly launched the Raising of America Coalition to show the film at a regional event recorded live by our local public television station. After the film showed, we facilitated a discussion between participants: the Kansas City-Missouri Mayor Sly James, medical doctors and the child advocacy organization Kansas Action for Children. Hundreds of people pledged to show the film with their constituency groups, including Children's Mercy Hospital, local religious congregations, city government and the Greater Kansas City Chamber of Commerce. And they did. CCO secured a pre-released DVD and through a simple memorandum of understanding, we coordinated across diverse sectors to ensure that those watching the film would do more than view a movie. As a result we have seen significant public policy progress, new innovations in workplace family support and a growing base of grassroots supporters and civic leaders who are committed to comprehensive universal pre-K campaigns.

Here's what's happening: Over 1,500 people saw the film before it was officially released last October. We developed a locally contextualized tool kit with the resources provided by [Raising of America](#) and support of the Black Community Fund of the Greater Kansas City Community Foundation. The coalition's primary focus is to recruit as many people to watch the film as possible. We are building a constituency base committed to seeking systemic solutions through 1) exciting broader cross-sector partnerships and 2) deepening organizational awareness of the intersectionality of issues impacting how a child starts off in our community. To date we have:

- trained dozens of facilitators, primarily from area public health departments and our community organizing teams
- gathered nearly 1,000 pledge cards from individuals who are committed to share their stories, host a

film viewing or build a voting or issue specific base of community leaders who drive a policy or programmatic breakthrough related to the film and – secured early education continuing education credit hours for providers who watch the film.

Most importantly, immediately after the mayor hosted his own viewing of “Raising of America,” he and the city manager pledged to advance a municipal ordinance, in coordination with the city council’s unanimous support, to adopt a six- to eight-week, full-pay parental paid leave policy for all 6,000 public employees. It is one of the more progressive ordinances in the nation, with growing momentum for replication in neighboring cities across Missouri and Kansas. Additionally, the Women’s Foundation launched a partnership on index measurement for how friendly a workplace is to women and families, called WhenWorkWorks.org.

We have a new moment for health equity and social justice that has the potential to break through our current life expectancy trajectory. Communities Creating Opportunity and our public health partners are committed to building the Raising of America coalition in Kansas City and beyond. Over the next year, CCO will work to build a voter base of 5,000 people — people who are committed to early childhood education breakthroughs and revenue investments to put families first. We are not far from achieving our goal of comprehensive, universal pre-K for 3- and 4-year-olds in Kansas City, Missouri; just a few more film viewings, an integrated voter engagement plan and the continued momentum of our cross-sector partnerships keep us away.

The Rubik’s Cube of bureaucracy we live in is depriving girls and boys of the full lives we want them to live. We have the tools to discover the pattern that will free families and children from the bondage of inequity, lack of quality education, inadequate health access and racialized disparities. We know the code to extend life expectancy in our communities. We have a plan. Now onward! Join us in building your own Raising of America coalition in your region.



Preschool students learn about food prep.

Building a Movement to Improve Low-Income Communities and the Lives of Their Residents:

An Update on the History and Focus of the Build Healthy Places Network

The Build Healthy Places Network expands on the work of the Healthy Communities Initiative and RWJF’s Commission to Build a Healthier America. It was founded in recognition that a national network connecting sectors and promoting and enabling cross-sector collaboration is critical for ensuring that all people have the opportunity to live healthy and rewarding lives.

Its work builds on the Healthy Communities Initiative, a multi-year effort led by the Federal Reserve Bank of San Francisco and the Robert Wood Johnson Foundation, to deepen cross-sector collaboration. This series of conferences at regional Federal Reserve Banks around the country bring leaders from multiple sectors together to examine the ways in which where people live, learn, work and play affect health. Over 20 Healthy Communities conferences have convened around the country since 2010. The work is guided by the 2014 recommendations of the RWJF Commission to Build a Healthier America, which called for action to “support and speed the integration of finance, health and community development to revitalize neighborhoods and improve health.”

The Problem: Sectors Working in Silos – The nearly one-fifth of Americans who live in low-income communities have fewer opportunities to achieve healthy and rewarding lives. Many of the root causes of poverty and poor health are the same, and the community development and health sectors have worked for decades to address these challenges. However, these two sectors have often worked separately, even when serving the same places and people.

As a result, challenges such as siloed work streams, underestimated value and impact of work, inefficient use of resources, policy roadblocks and unrecognized investment opportunities persist. Today we know that factors related to health, employment, education, housing and neighborhoods are linked. Place does matter, and in many cases your Zip code is more important than your genetic code in determining your health. We need coordinated action to build communities where all people can live healthy and rewarding lives.

The Build Healthy Places Network works to connect leaders and practitioners, provide capacity-building tools to make partnerships easier and curate examples of what

works to highlight cross-sector innovation and build the evidence base for collaboration.

By joining forces, the community developers and health professionals can have a more powerful impact in improving the health and opportunity of low-income neighborhoods.

“Letter from the President” continued from page 1

approach to the issue of social parity. Along with being featured prominently in our current strategic plan as core values, AMCHP keeps social justice and health equity at the core of our planning and decisions. As you will see throughout the pages of this month’s Pulse, AMCHP is involved with initiatives dealing with issues ranging from women and the criminal justice system to the support of young people fighting to address social justice issues in their local communities. I hope you will enjoy this issue and feel inspired by the great work our MCH partners and colleagues are doing across the country to further these goals.

Although social injustice is deeply rooted into the systems that shape our country, your AMCHP colleagues are just as deep in the trenches, fighting to create systemic change. I look forward to hearing from you about the challenges you’ve successfully faced on this journey. In the meantime, continue to link arms and cross this bridge together!

All the best,
Eileen

Gestational Diabetes: Consequences and Solutions

By Cynthia S. Shellhaas, MD, MPH



Gestational Diabetes (GDM) may impact as many as 9.2 percent of pregnant women, according to a 2014 report from the Centers for Disease Control and Prevention (CDC)¹. Because GDM is most commonly associated with immediate complications, the emphasis is often on managing the disease during pregnancy, but up to 70

percent of women with gestational diabetes will develop Type 2 diabetes mellitus (T2DM) in their lifetime. Both the ADA and ACOG recommend that women previously diagnosed with GDM are screened for pre-diabetes and diabetes at six to 12 weeks postpartum and regularly throughout their lives. Only half of women even undergo postpartum screening².

The Ohio Gestational Diabetes Postpartum Care Learning Collaborative was formed in January 2014 as a quality-improvement initiative and is sponsored by the Ohio Department of Health (ODH) and administered by the Ohio Colleges of Medicine Government Resource Center. Its primary objectives are to increase postpartum visit rates and postpartum T2DM screening rates in women with a history of GDM. Secondary objectives are to educate women on T2DM risk and risk-reduction methods. To achieve these goals, the project engages national experts and clinical practice sites throughout Ohio to participate in a QI initiative utilizing a modified version of the Institute for Healthcare Improvement (IHI) Model for Improvement.

Practice sites – which consist of teams of OB/GYNs, nurse practitioners, midwives, and diabetes educators – participate in monthly learning sessions to share best practices, complete PDSA (plan-do-study-act) cycles, collect data and receive rapid cycle feedback. Clinical sites participating in the collaboration are located in both rural and urban areas across Ohio and serve populations in which where over half of the people are covered by Medicaid. Many of these clinical sites are from one of the nine communities that comprise the Ohio Equity Institute (OEI) – a partnership between the Ohio Department of Health and the CityMatCH project – which focus on improving birth outcomes and reducing racial disparities in infant deaths. In addition, populations at high risk for diabetes (such as African-American, Hispanic and Appalachian) are a priority.

The first six months of the project were spent developing toolkits for providers and patients. Practice sites were trained on how to implement project resources, including provider and consumer toolkits. The consumer toolkit, which was created in English and Spanish and written at a fourth- to fifth-grade reading level, provides women with information on their GDM diagnosis, recommended nutrition, breastfeeding and the risk of T2DM. The provider toolkit includes information for educating patients on how to manage GDM as well as algorithms for screening and diagnosing GDM, and tools to improve care coordination between providers and office work flow.

To learn more about our project and gain access to the provider and consumer toolkits, visit our website, ohiogdm.com, which is scheduled to launch June 20.

¹ DeSisto CL, Kim SY, Sharma AJ. Prevalence Estimates of Gestational Diabetes Mellitus in the United States, Pregnancy Risk Assessment Monitoring System (PRAMS), 2007–2010. *Preventing Chronic Disease* 2014;11:130415.

² Tovar A, Chasan-Taber L, Eggleston E, Oken E. Postpartum screening for diabetes among women with a history of gestational diabetes mellitus. *Preventing Chronic Disease* 2011; 8: A124.

Revealing the Scope of Severe Maternal Morbidity in New York City



By Deborah L. Kaplan, DrPH, MPH, R-PA
Assistant Commissioner,
Bureau of Maternal, Infant and Reproductive Health, New York City Department of Health and Mental Hygiene



By Sang Hee Won, MPH
Project Director, Severe Maternal Morbidity Surveillance Project, Bureau of Maternal, Infant and Reproductive Health, New York City Of Department of Health and Mental Hygiene

The New York City Health Department, in partnership with the Fund for Public Health in New York, recently released a report titled “Severe Maternal Morbidity, New York City, 2008-2012,” which examines life-threatening complications during delivery. This report details findings of the city’s first-ever severe maternal morbidity (SMM) surveillance system based on the Centers for Disease Control and Prevention’s national maternal morbidity surveillance model. It explains how SMM cases are identified; describes the overall trends and leading indicators of SMM; examines SMM by maternal characteristics, place-based indicators and prenatal and delivery characteristics; and estimates direct medical costs associated with SMM. The report is available [here](#).

Key findings of this report include:

- SMM affects approximately 2,500 women each year in New York City.
- The rate of SMM in New York City increased 28.2 percent – up from 197.2 deaths per 10,000 deliveries in 2008 to 252.9 per 10,000 deliveries in 2012 – and was 1.6 times as high as the national estimate from 2008-2009.
- The leading indicators of SMM included blood transfusion, disseminated intravascular coagulation, hysterectomy, ventilation and adult respiratory distress syndrome.
- Women with an underlying chronic condition, such as hypertension, diabetes or heart disease, were three times as likely to have SMM as were women with no chronic conditions.

- There are stark demographic disparities.
- Black non-Latina women were three times as likely to have SMM as were white non-Latina women. Rates were also high among Puerto Rican and other Latina women compared with white non-Latina women.
- Black non-Latina women with at least a college degree had higher SMM rates than did women of other races/ethnicities who never graduated high school.
- SMM rates were highest among women living in high-poverty neighborhoods.

There are likely many contributors to the disparities in SMM, including a woman’s health prior to becoming pregnant, obesity, access to care and factors associated with poverty, including structural racism, inadequate housing, residential segregation and lower educational attainment. The chronic stress of racism also likely plays an important role. Showing these stark disparities through data is key to making injustice visible and reaffirms the Health Department’s commitment to improving maternal health and promoting health equity. These data will inform the agency’s efforts to address this public health concern. For more information, contact Sang Hee Won at swon1@health.nyc.gov.

This project was supported by a grant from Merck through its Merck for Mothers Program.

Medicaid Expansion: Through a Health Equity and Economic Justice Lens

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



Traditionally, Medicaid coverage has been limited to pregnant women, young children, and disabled and elderly adults. Through the Affordable Care Act (ACA), states have the option to expand Medicaid coverage to all adults with incomes at or below 138 percent of the federal poverty line (FPL). The federal government pays 100 percent of the cost of the expansion through 2016, dropping to 90 percent by 2020, and remaining at that level thereafter.

As of May 2016, 19 states have chosen not to ac-

cept federal funding to expand Medicaid coverage to very low-income adults. Nearly three million uninsured Americans in these states fall into the “coverage gap,” whereby their incomes are above current Medicaid eligibility levels for their states, but below the 100 percent FPL minimum to attain federal subsidies for Marketplace insurance coverage. Nearly [90 percent of those](#) in the coverage gap live in the South, and they are disproportionately people of color.

Racial and ethnic minority groups face longstanding and persistent disparities in access to health insurance coverage, resulting in greater barriers to care and poorer health outcomes than their white counterparts. When states choose to expand Medicaid, uninsured adults of color are often the largest beneficiary group. Gaining health coverage through Medicaid increases this population’s access to care and promotes greater health equity.

Many people in the coverage gap are parents with dependent children residing in their homes. [Studies](#) have demonstrated that providing health coverage to parents reduces children’s uninsurance rates as well. Indeed, the largest coverage increases for children have occurred in states that expanded Medicaid to low-income adults.

Many women of reproductive age fall into the coverage gap. Without health coverage, low-income women often forgo important preventive health services such as contraception, screenings for sexually transmitted infections, and other services.

Reducing disparities in the use of preconception and inter-conception care is advanced by expanded access to Medicaid. Prior to the ACA, many low-income women had little or no reliable access to health care before or between pregnancies. [Studies](#) have shown that lack of preconception and inter-conception care can significantly impact a woman’s health and the health of her future pregnancies and children. By basing Medicaid eligibility on income rather than pregnancy status, postpartum women who traditionally lost coverage two months after delivery can retain their coverage under the Medicaid expansion. This offers women an opportunity for on-going care that includes preventive and acute care services, as well as care they may need to manage chronic health conditions.

The mental health of parents affects the health and well-being of children. The prevalence of mental health and substance use disorders is high among uninsured adults. Studies have shown that more than half of all infants living in poverty have a [mother with depression](#). Along with its other benefits, Medicaid expansion [can dramatically improve access to treatment](#) for people with mental and substance use disorders, thereby improving health outcomes for themselves and their children.

By lessening the risk of crippling medical debt, the Medicaid expansion can reduce poverty and promote economic security for low-income families. By providing health

coverage that is not tied to employment, families have more flexibility to explore training and other educational options to improve their financial circumstances. And with insurance to cover health care costs, families have more money to pay for other goods and services, helping low-income communities to grow economically.

The Medicaid expansion offers states the opportunity to address persistent disparities and improve health equity. By removing financial barriers to health care for low-income adults and families, the Medicaid expansion will have a ripple effect that can positively impact people’s lives and the nation’s future.

Paid Family Leave and Health Equity



By Kate Taft, MPH
Senior Program Manager,
Children and Youth with Special Health Care Needs;
AMCHP



By Carolyn McCoy, MPH
Senior Policy Manager;
AMCHP

The ability for someone to take time away from work either for their own or a family member’s health needs should not put her/him at economic risk. This time off is especially important for parents at the time of birth or placement of a child into the family. For mothers after birth, it is a time of healing and bonding, and is critical to improving breastfeeding rates. Parents, and caretakers of children or spouses need the ability to care for loved ones without potential financial hardship or loss of job security.

According to a recent [study](#) by the Center for America Progress, in the United States, nearly 40 million workers (39 percent of the paid workforce) lack access to a single paid sick day. Those least likely to have access to these paid sick days are those who are in low-wage positions. The research goes on to highlight that hourly workers are significantly less likely to have access to paid sick days, flexible hours and flexible working locations than similar workers who are not hourly. Further, African-American and Latino workers are less likely than white workers to have ac-

cess to paid sick days. The Center for Economic and Policy Research [found](#) that workers lower educational attainment were also less likely to receive pay during leave as part of employer-provided benefits. They also have lower family incomes, and thus have fewer financial resources to draw upon during an unpaid leave event. This unequal access to paid time off exacerbates health disparities in our society. More than 2.5 million employees who are eligible for the Family and Medical Leave Act [do not take the leave](#) because they cannot afford the loss of pay. The United States is the [only rich nation that does not guarantee](#) workers any paid vacations, paid holidays, paid sick leave or paid maternity leave by federal law.

The National Partnership for Women and Families [highlights](#) that new mothers who receive job-protected paid leave are more likely to take at least the minimum six to eight weeks of leave recommended by physicians, their babies are more likely to be breastfed, and their children are more likely to be taken to the pediatrician for regular visits and immunizations. In addition to promoting better health and childhood development outcomes, paid leave can have economic and business benefits. An [analysis of states](#) with paid family and medical leave programs found that women in those states are less likely than women in other states to receive public assistance or food stamps following a child's birth, particularly when they use the paid leave programs. Additionally, paid leave programs can be an [affordable strategy](#) for businesses to support and retain workers when serious family and medical needs arise. In California, nearly 90percent of employers reported positive effects or no effects in terms of productivity, profitability, retention, and morale after the state's paid family leave statute was enacted. Small employers reported fewer problems than large firms (if any)¹.

There are opportunities to examine policies at the state and federal levels for improvement, and for maternal and child health professionals to promote pro-family policies and investments that lead to improved outcomes. As the maternal and child health "hubs" in each state and jurisdiction, Title V programs are well positioned to engage with stakeholders, including employees and businesses, to work toward a healthy start for children. State Title V MCH programs can provide education on how business and economic policies and programs can impact families and child health outcomes. State MCH programs can also provide data on the needs that affect families and children in their states and communities, as well as the opportunities to implement policies and programs that improve early childhood and family well-being.

¹ [Paid Leave Works in California, New Jersey and Rhode Island](#)

Member to Member Doula Care and Health Equity

How does doula support decrease health disparities and improve birth outcomes for women of color/minorities?

Rachel Abramson, RN, MS, IBCLC
Executive Director, HealthConnect One

The powerful impact doulas have on birth outcomes for both mother and baby has been well-documented in recent years, making this a pivotal moment for doulas and those of us who work with doulas. For doula support to decrease health disparities, however, special attention must be paid to who doulas are serving, where they are working, how they are building relationships with their clients and how their impact is sustained in communities of color.

While doulas are experienced women who support other women during childbirth, community-based doulas are experienced women who support other women specifically in their own communities throughout pregnancy, birth, breastfeeding and early parenting. Community-based doula programs have successfully served birthing families in communities of color and low-income communities around the country for over two decades. How these programs function, and the transformative effect these doulas have was detailed in a [federally funded study](#) in 2014, which describes high breastfeeding rates (87 percent at 6 weeks vs. 61 percent of a similar sample), low C-section rates (24 percent vs. 30 percent of a similar sample), and increased access to maternity and pediatric care. Additionally, community-based doula programs have demonstrated lower rates of prematurity and low birth weight, increased birth spacing, and more responsive parenting. Because these programs rely on peer-to-peer support, women from the communities being served are recruited, trained and hired – thus providing community and workforce development as well as improved birth outcomes.

[HealthConnect One](#) is the national leader in advancing respectful, community-based, peer-to-peer support for pregnancy, birth, breastfeeding and early parenting.

Naima Black, Doula, CLC
Coordinator, North Philadelphia Breastfeeding & Community Doula Program

It's all about relationships. For many decades, women of color have been under-represented in the world of birth

Data and Trends

By Christina Ratleff

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

Advancing Equity in Birth Outcomes

By Addressing the Social Determinants of Health

AMCHP Birth Outcomes Collaborative Spotlight On: 13 States in the Collaborative

This initiative builds upon the Infant Mortality CollN successes in HRSA Regions IV and VI and supports states in accelerating progress on infant mortality reduction activities, specifically those related to:

- Quality Improvement
- Health Equity
- Economic Analysis

The United States ranks #32 in infant mortality

Japan	2.3
Sweden	2.5
Spain	3.2
Germany	3.4
France	3.6
United Kingdom	4.2
Canada	4.9
United States	6.0

*among 36 other similarly developed nations
**infant deaths per 1,000 live births

2x Black infants die at twice the rate of white infants in the US

The Social Determinants of Health

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH).

Social and Economic Factors	40
Gene & Biology	10
Physical Environment	10
Health Behaviors	30
Clinical Care	10

40% of Health is driven by the SDOH

#1 CAUSE OF INFANT MORTALITY IS PRETERM BIRTH

Social/ Structural Determinants DRIVERS OF PRETERM BIRTH

14% vs. 9%

non-Hispanic White: 10
Hispanic: 13
African-American: 18

Education matters:
Women with up to a 12th grade education, w/no diploma have higher rates of preterm birth (14%) compared with women with a Bachelor's degree (9%)

Race matters:
African American women have a preterm birth rate of 18% compared to non-Hispanic White women who have a rate of 10%

Income matters:
Preterm Birth associated with Lower Maternal Income (proxy: insurance payer)

Medicaid	13
Private Insurance	10
Self-pay	11
Other	12

2014

The AMCHP Birth Outcomes Collaborative aims to advance equity in birth outcomes:

Spotlight On

- NORTH CAROLINA**
Training community leaders on structural racism and its impact on communities of color
- 3 States with Innovative Approaches**
- LOUISIANA**
Engaging business in health
- FLORIDA**
Mappings 'systems of care' to identify gaps in services

Sources:
National Vital Statistics System, CDC/NCHS
MacDermid, Public Health Rep. 2009 Sep-Oct; 124(5): 670-681
MacDermid, 2012
Determinants of Health Model based on framework developed by
Vetter AR, Ann NY Acad Sci 1999; 896: 201-93, and Nancy D. Jones
Y, Biostat J. JAMA 2006; 295(11): 1381-1383

workers. Thankfully this trend is changing with a growing community of midwives and doulas of color who are supporting their sisters with culturally and linguistically connected perinatal education, and support during pregnancy, childbirth and the postpartum period. Community doulas offer non-judgmental mentoring to families about their options in childbirth and infant feeding choices. They nurture mothers so mothers can nurture their babies. This movement is having positive impact in Philadelphia communities that face significant poverty and race-based barriers to equitable health care. Women are having fewer cesarean sections and breastfeeding rates are on the rise. Women are encouraged to become active participants in the health and wellness of their families. And many women who were supported by a community doula are now becoming trained themselves. Each one teach one!

Calendar

June is Men's Health Month! CDC's Division of Reproductive Health and the Office of Population Affairs released a Morbidity and Mortality Weekly Report: "[Male Attendance at Title X Family Planning Clinics – United States, 2003-2014.](#)"

[Nighttime Parenting and Infant Sleep in the 4th Trimester Webinar](#)

Tuesday, June 21, 2016, 12:30 p.m. EDT

[CDC's Public Health Grand Rounds: "Tracking Environmental Health Data for Public Health Decision Making"](#)

Tuesday, June 21, 2016, 1 p.m. EDT

[ASTHO ART Webinar – Role of State Health Agencies in Improving Assisted Reproductive Technology](#)

Tuesday, June 28, 2016 from 2 p.m. EST

**Want More AMCHP?
Get Social With Us!**

Who's New

AMCHP's Communications and Membership Team



Patrick Boyle is the associate director for communications and membership. Patrick received his bachelor's in communication arts from the University of Dayton and his master's in journalism from the Phillip Merrill College of Journalism at the University of Maryland. Patrick was editor of Youth Today for 13 years and has served as a reporter at The Watertown Daily Times, The

Washington Times and Law360, and as a communications director at the Forum for Youth Investment and the Automobile Club of New York.



Karissa Charles is our meetings and membership associate, focusing on member services (including Member Briefs) and AMCHP's Annual Conference. Karissa has worked with several nonprofits, including HCM Strategists, where she tracked congressional action on health issues, and as an intern at NARAL Pro-Choice Maryland, where she researched policies on the

reproductive health care of incarcerated women and girls. Karissa holds a Bachelor of Arts degree in political science from Howard University and is pursuing her master's of science in health promotion management at American University.



Kristen Taylor is the team's communications associate, focusing on external communications, including Pulse. Kristen has worked at a variety of media outlets, including the Dallas National Public Radio member station, an arts and entertainment magazine and a digital marketing agency. Kristen is a proud graduate of the University of Texas at Dallas, where she earned her

Bachelor of Arts in Emerging Media and Communications with a specialization in global communications.

AMCHP welcomes interns

Elise Aliotti joins the policy team. Elise received her bachelor's degree in political economy last month from the University of California at Berkeley. She comes to AMCHP through the Leonard D. Schaeffer Fellows program at Berkeley's School of Public Health. Elise hails from Monterey, California, and most recently worked as a research assistant at the School of Public Health, investigating the cost-effectiveness of DNA sequencing.

Lauren Barrison joins the epidemiology and evaluation team. She earned her bachelor's in international health from Georgetown University in 2014. She is now a second-year medical student at the Georgetown University School of Medicine and comes to AMCHP through the school's Population Health Scholar Track. Lauren most recently worked as a medical assistant supporting practitioners during in-office procedures such as colposcopies, IUD insertion/removals and endometrial biopsies.

Get Involved

Applications Open for the 2016 MCH Epi Pre-Conference Trainings

AMCHP and CityMatCH will offer four two-day training options Sept. 12-13 for those wishing to build their skills in the areas of Medicaid claims analysis, data communication, spatial thinking and evidence-based public health. A detailed description of each, including learning objectives and MCH leadership competencies addressed, is available through the [AMCHP website](#). To apply, click [here](#). The training application will remain open as long as slots are available until July 1.

Stay Informed About Adolescent and Young Adult Health

The Adolescent and Young Adult Health National Resource Center (AYAH Center), funded by HRSA's Maternal and Child Health Bureau (MCHB), has launched its June newsletter: Engaging Youth in Health Care Improvement Efforts! Learn more about current youth engagement initiatives, state strategies, and the Adolescent and Young Adult Health Collaborative Improvement and Innovation Network's (AYAH CoIIN) work related to youth engagement. To subscribe to the newsletter, please contact Karissa Charles at kcharles@amchp.org. To view the June issue, click [here](#).

Strengthen the Evidence Base: Communities of Practice (CoP)

Come and join AMCHP's Strengthen the Evidence Base: Communities of Practice (CoP)! The CoPs are grouped

by population domain, including Child Health, Children and Youth with Special Health Care Needs (CYSHCN), Cross-cutting/Life Course, and Women's/Maternal Health. The purpose of the CoPs is to provide a space for peer sharing and learning, which could include topics ranging from Evidence Based Strategy Measures development to implementation of your plan. We encourage participants to actively contribute to the CoPs by responding to discussion questions, posting your own questions and resources, and engaging with other participants. To sign up, click [here](#). For questions or additional assistance, please contact Krista Granger at kgranger@amchp.org or Sarah Beth McLellan at smclellan@amchp.org.

New Diversity Training Resource and Virtual Technical Assistance for MCH Training Program Grantees

On June 22, from 1:00-2:00 p.m. ET the Division of MCH Workforce Development will host a new MCH Training Diversity Resource webinar. This is designed to share strategies and resources, suggestions on how to use the resource, and upcoming virtual technical assistance office hours for grantees who have a special interest in sharing strategies they are implementing or discussing how to overcome barriers to implementation of diversity and health equity related strategies. To register, click [here](#).

The National CLAS Standards in Action

The U.S. Department of Health and Human Services Office of Minority Health will host a webinar on June 30, from 3:00-4:30 p.m. ET focusing on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). Participants will learn about how different organizations, including an integrated health care system, an academic medical center, and a public health department are implementing the National CLAS Standards. Presenters will share their successes, best practices and strategies, as well as challenges for meeting the needs of the individuals and communities they serve, regardless of cultural background or communication needs. To register, click [here](#).

The ACE Study: Implications for MCH Policy and Practice

Maternal and Child Health Journal is soliciting manuscript submissions based on the ACE (Adverse Childhood Experiences) Study, for an issue dedicated to enhancing knowledge of the study and its implications across the field. Topics of interest include: the aims and findings of the ACE Study; the implications of the study and use of its findings to shape MCH practice in clinical, program and policy settings; the importance of the study in relation to life course theory and social determinants of health; the strengths and limitations of the study as a basis for action to improve

MCH outcomes; adoption of a trauma-informed approach on an agency or communitywide basis; and the strengths and limitations of the study in relation to efforts to eliminate inequality in MCH health outcomes. Submissions received by July 1 will have a greater likelihood of acceptance. When submitting a manuscript, include a cover letter requesting that it be included in the thematic issue and select "ACE Special Issue" as manuscript type. For submissions and additional instructions, [click here](#).

2016 Summer Institute in Adolescent Health

The University of Minnesota School of Nursing will host a summer institute focusing on setting a healthy course for sexuality during the middle school years on July 25-27 and July 28 for graduate students. Participants will learn strategies for effectively engaging young teens and their families in conversations about values and behaviors toward healthy sexuality; talk with young people, health professionals, and educators who are committed to teaching about health and improving clinical and social services; and consider evidence-based approaches with diverse groups of teens. Participants will also gain skills for working across multiple cultures and contexts, and understand the acquisition and influence of gender norms during early adolescence. Please register by July 1 in order to receive early bird rates. For more information, click [here](#).

Society for Adolescent Health and Medicine Educational Presentation Submissions

The Society for Adolescent Health and Medicine (SAHM) 2017 Annual Meeting will take place in March 2017 in New Orleans. SAHM will begin accepting educational and scientific research presentations.

- The application period to submit an educational proposal will close on July 15 at 11:59 p.m. ET. Presentations should highlight the significance of adolescent health and medicine. Other key selection criteria include relevance of the conference theme, expertise of the proposed presenters, clarity of educational objectives, likelihood of proposed workshop methods to achieve educational objectives, and perceived relevance to our diverse, multidisciplinary and international meeting attendees. For additional information, click [here](#).
- Scientific Research Presentations include platform, poster, and poster symposia presentations. The application period will close on Aug. 22 at 11:59 p.m. ET. For more information, click [here](#).

Free MCH Summer Skills Institute

The National MCH Workforce Development Center is offering a free MCH Summer Skills Institute in August. You can choose either a three-day or five-day schedule to enhance

your skills and improve effectiveness. All activities will focus on advancing block grant strategies and outcomes in the health transformation environment. The institute will also include the rescheduled full-day session on Collective Impact in MCH. Save the dates of Aug. 22-26 and check out the National MCH Workforce Development Center's [website](#) or AMCHP's upcoming issues of Member Briefs/Pulse for registration details. For additional information, click [here](#).

Resources

[A New Way to Talk About the Social Determinants of Health](#): This resource from the Robert Wood Johnson Foundation provides resources and tools to create effective messaging around the social determinants of health to diverse stakeholder groups.

[The American Congress of Obstetricians and Gynecologists \(ACOG\)](#) serves as the premier professional membership organization dedicated to the improvement of women's health. The organization continues to produce practice guidelines and other educational material.

[The American Academy of Pediatrics Technical Report: Mediators and Adverse Effects of Child Poverty in the United States](#): The American Academy of Pediatrics (AAP) published a research-supported technical report that examines the mediators associated with the long-recognized adverse effects of child poverty on families. This technical report draws on research from a number of disciplines, including psychology, sociology, psychology, economics and epidemiology to describe the present state of knowledge regarding poverty's negative impact on children's health and development.

[The Association of Reproductive Health Professionals](#): This resource serves to bring together health care professionals across disciplines and specialties for evidence-based training and network building. A wide range of topics are discussed, including adolescent health and healthy pregnancy.

[Centers for Disease Control and Prevention: Severe Maternal Morbidity in the United States](#). According to the CDC, maternal morbidity includes physical and psychological conditions that result from or are aggravated pregnancy and have an adverse effect on a woman's health. The most severe complications of pregnancy, generally referred to as

severe maternal mortality (SMM), affect more than 50,000 women in the United States every year.

[Debunking the "Bathroom Bill" Myth](#): GLAAD (Gay & Lesbian Alliance Against Defamation) serves as a guide for health professionals and journalists covering stories related to LGBT nondiscrimination, in collaboration with a coalition of state and national LGBT advocacy organizations.

[Expanding Coverage Under the Affordable Care Act](#): The Expanding Coverage MAC Learning Collaborative is providing a forum for states and the Centers for Medicare & Medicaid (CMS) to translate the Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment standards and processes required by the Affordable Care Act into program design options. Products developed or used by the Collaborative include cost sharing, premiums and premium assistance, eligibility and verification, hospital presumptive eligibility, Medicaid and CHIP renewals, and single streamlined application guidance.

[Health Resources and Services Administration MCH Life Course Teaching Resources](#): The Life Course Model offers a strategic approach to minimize health disparities in infant and child health by addressing their deeper social and environmental root causes. Integrating the model across HRSA-supported maternal and child health training and research programs is an ongoing process. Resources available include integrating life course, meeting archives, discipline-specific materials, neurological and related disorders, and pediatric pulmonology.

[How Doula Care Can Advance the Goals of the Affordable Care Act](#): This resource explains how doula care meets all aims of the Affordable Care Act and explains how the widespread availability of doula care could significantly reduce cesarean rates, and increased access to community-based doula programs could reduce health disparities.

[Paid Parental Leave in the United States: What the Data Tells about Access, Usage, and Economic, and Health Benefits](#): This paper was prepared by the Institute for Women's Policy Research as a part of a series of Scholars' Papers sponsored by the U.S. Department of Labor Women's Bureau

[National Conference of State Legislatures](#): This resource provides information on California, New Jersey, and Rhode Island's policies for paid family leave. All three states fund their programs with employee-paid payroll taxes and are administered through their respective disability programs. [U.S. Department of Health and Human Services' Office of Adolescent Health: Trends in Teen Pregnancy and](#)

[Childbearing](#): This site is a collection of the statistics for teen pregnancy and variation in teen pregnancies across populations.

[National Partnership for Women and Families: Resources on Families and Paid Leave](#): The National Partnership for Women and Families provides various information on the Family and Medical Leave Act, paid leave and paid sick days.

[Mental Health Parity, United States Department of Labor](#): This resource provides all information related to the Mental Health Parity and Addiction Equity Act of 2008. Resources include Final Rule, fact sheets, publications and videos.

[Medicaid Expansion & Criminal Justice-Involved Populations: Opportunities for the Healthcare for the Homeless Community](#): The National Health Care for the Homeless Council designed a policy brief intended to outline the changes in Medicaid eligibility affecting the criminal justice population, summarize the process improvements being made to enrollment, provide a brief overview of the health status of the population, and recommend steps communities might take to maximize the opportunities afforded by the expansion of Medicaid.

[Raising of America](#): This is a multi-media, public engagement and education initiative translating recent scientific findings on the effects of children's environments at birth and throughout childhood on life-long health and well-being.

– [Raising of America: Activist Toolkit](#): This toolkit addresses important issues by acknowledging that paid family and medical leave is needed in order to help children thrive in the United States.

– [Tip Sheet: Guidance for Title V MCH Programs](#): This short guide was developed to provide state Title V MCH programs with information and resources to support use of the Raising of America documentary series.

[Robert Wood Johnson Social Determinants of Health](#): The Robert Wood Johnson Foundation

(RWJF) supports research and initiatives that are bringing forth new insights into the social and economic factors which most affect health, and empowering communities to take action.

[Substance Abuse and Mental Health Services Administration \(SAMSA\)](#) serves as a resource for the Caring for Every Child's Mental Health Campaign to raise awareness about the importance of children's mental health.

– [Increasing Access to Behavioral Health Services and](#)

[Support through Systems of Care](#): Originally published by the Substance Abuse and Mental Health Services Administration in honor of National Children’s Mental Health Awareness Day on May 5, 2016, this report illustrates how serving children and adolescents within a system of care increases access to behavioral health services and supports and improves outcomes.

– [Finding Help, Finding Hope](#): This archived video resource was recorded during SAMSA’s National Children’s Mental Health Awareness Day on May 5, 2016. This one hour video features youth and family leaders, educators, law enforcement officials, and behavioral health professionals discussing how communities can work together to improve access to behavioral health services and supports for children, youth and youth adults.

[Severe Maternal Morbidity, New York City, 2008-](#)

[2012, Final Report](#): This resource has been prepared by the New York City Health Department’s Bureau of Maternal, Infant, and Reproductive Health and Fund for Public Health in New York. This report details findings of the city’s first-ever surveillance of severe maternal morbidity (SMM), or life-threatening complications during delivery. It explains how SMM cases are identified; describes the overall trends and leading indicators of SMM; examines SMM by maternal characteristics, place-based indicators and prenatal and delivery characteristics; and estimates direct medical costs associated with SMM. The press release of the report can be found [here](#).

[Trauma-Informed Practice: A New Paradigm](#): This resource was created by Ruth Ann Shepard and presented during the AMCHP 2016 Annual Conference. This Powerpoint presentation focuses on the Life Course Perspective and the Biology of Trauma.

[WHO Recommendations for Prevention and Treatment of Pre-eclampsia and Eclampsia](#): This resource from the Agency for Healthcare Research and Quality (AHRQ) provides information to health professionals on pre-eclampsia, eclampsia, postpartum hypertension, labor in the presence of presence of pre-eclampsia, and HELLP (haemolysis, elevated liver enzymes, low platelet count) syndrome.

Board of Directors

Executive Committee

President (2016-2017)
Eileen Forlenza
Colorado

President-Elect (2016-2017)
Michael D. Warren MD, MPH, FAAP
Tennessee

Past President (2016-2017)
Sam B. Cooper III, LMSW-IPR
Texas

Secretary (2016-2018)
Susan Colburn
Alabama

Treasurer (2016-2018)
Valerie J. Ricker, MSN, MS
Maine

Board Members

Region II (Interim 2015-2017)
Marilyn Kacica, MD, MPH
New York

Region I (2016-2019)
Karin Downs, RN, MPH
Massachusetts

Region II (Interim 2015-2017)
Marilyn Kacica, MD, MPH
New York

Region III (Interim 2015-2017)
Mary Frances Kornak, MPH
Washington, DC

Region IV (2015-2018)
Kris-Tena Albers, CMN, MN
Florida

Region V (Interim 2016-2018)
OPEN

Region VI (2016-2019)
Susan Chacon, MSW, LISW
New Mexico

Region VII (Interim 2015-2017)
Heather Smith, MPH
Kansas

Region VIII (2015-2018)
Linda McElwain, RN
Wyoming

Region IX (2016-2019)
Mary Ellen Cunningham, MPA
Arizona

AMCHP Staff

Patrick Boyle, Associate Director, Communications

Karissa Charles, Membership Associate

Atyya Chaudhry, Policy Analyst, Health Reform Implementation

Stacy Collins, Associate Director, Health Reform Implementation

Linnard Corbin, Accounting/Office Assistant

Andria Cornell, Senior Program Manager, Women’s Health

Emily Eckert, Program Associate, Health Reform Implementation

Michelle Eglovitch, Program Associate, Women’s and Infant Health

Kidist Endale, Accounting Associate

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

Jennifer Farfalla, Analyst for Quality Improvement and Life Course, Women’s & Infant Health

Cori Floyd, Program Associate, Child & Adolescent Health

Krista Granger, Program Manager, Data and Assessment

Amy Haddad, Associate Director, Government Affairs

Alexandra Harris, Program Associate, Epidemiology and Evaluation

Michelle Jarvis, Specialist, Family Engagement and Leadership Development

Ki’Yonna Jones, Program Manager, Workforce & Leadership Development

Jeanette Kowalik, Associate Director, Women’s & Infant Health

Nora Lam, Senior Executive Assistant & Board Administrator

Carolyn McCoy, Senior Policy Manager

Sarah Beth McLellan, Senior Program Manager; CYSHCN

Mahlet Menwelet, Grants and Contracts Administrator

Megan Phillippi, Program Analyst, Women’s & Infant Health

Christina Rattleff, Senior Program Manager, Women’s & Infant Health

Caroline Stampfel, Director of Programs

Kate Taft, Senior Program Manager, CYSHCN

Kristen Taylor, Communications Associate

Jessica Teel, Senior Program Manager, Workforce & Leadership Development

Wendy Wen, Associate Director, Finance & Accounting

Iliana White, Senior Program Manager, Adolescent Health

Eliane Yashar, Program Analyst, Child and Adolescent Health



Association of Maternal & Child Health Programs
2030 M Street, NW, Suite 350
Washington, DC 20036
(202) 775-0436
www.amchp.org