



PULSE

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

Home Visiting/ Medical Home

November/ December 2013

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From the President

By Millie Jones, MPH



As the year comes to a close and I am approaching the end of year one of my two-year presidency, much energy is spinning in my head and it is not all “sugarplums.” 2013 has been a year of change and challenges: sequestration, state and federal budget constraints, health reform, defining the future of Title V, personnel changes, and, perhaps of greatest impact, unimaginable losses in some of our communities and of family, friends and colleagues.

But through it all maternal and child health (MCH) continues and **Magic Can Happen**. For many of us the budget challenges have stabilized, health reform moves forward, new staff are joining our teams, and we begin the healing process of our losses.

Earlier this fall, I attended the Association of State and Territorial Health Officials (ASTHO) affiliate meeting in the greatest land of Magic – Orlando. There I observed the little boy picture below. (*As I shared with many of you “I now see MCH in every situation.”*) This little boy, in that moment, seemed to epitomize all that we strive for each day in

our MCH work world. He was traveling with his family, wearing his crown of wizardry, topped off with the necessary wane. In that moment, he was calmly coloring in his book, talking with his family, completely oblivious and most comfortably in his hat. He appeared to be a happy child, surrounded by love and most importantly



From the President CONT.

claiming his mastery of his universe. Is this not what we strive for – every child safe, loved, happy and functioning to their full potential.

So, in the spirit of the holiday season, let us all recommit to go forward in 2014, attired in our own crown of wizardry and wane, and continue to make positive change happen with the conviction that **Magic Can Happen**.

Wishing you a happy and safe holiday season and see you all in January at our AMCHP Annual Conference!

From the CEO

by **Barbara Laur, MS**

We have been very busy here at AMCHP over the last several months. Our main priority is the upcoming January conference – we look forward to seeing you all in D.C. soon! AMCHP strives to make our conference the annual showcase event for MCH professionals. We recognize the difficulties you face in getting travel approved and taking time away from the office and family. That is why we are committed to providing you the best opportunities to learn with and from your peers; hear firsthand how what's happening in our nation's capital will affect the work you do and populations you serve; and leave you energized and inspired to be even stronger leaders. If you're not signed up yet, you can register through the following link: amchp.org/AMCHP14.



In other news:

- The AMCHP board and Title V Working Group have continued their effort to be part of the ongoing dialogue with Dr. Michael Lu about the future of Title V. Dr. Lu came to the November AMCHP board meeting to give us a preview of his presentation about the ideas that will be used to develop a new guidance for the block grant. Since then, a working group of AMCHP board and staff members have put their heads together to really dig into performance measures and offer our best thoughts to the process. In January, we will be working with Dr. Lu to host listening sessions so the full membership can share in the new vision.
- The AMCHP Search Committee has narrowed the field of candidates to take to the next round of interviews. They are still hoping to complete this process in December. If all goes smoothly, we will be able to introduce our new CEO to you at the conference.
- AMCHP held a second meeting of the children and youth with special health care needs (CYSHCN) standards of care work group to finalize and discuss translation and use of the standards. AMCHP will release the standards before the Annual Conference. We thank the brain trust of national CYSHCN experts who have informed this important project.

(continued on page 4)

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In Memoriam: Loretta “Deliana” Fuddy

One of my fondest memories of our friendship was the time she invited me to Hawaii to keynote the state’s annual public health meeting. I came in over a three day weekend as Monday was a holiday. Deliana spent her “day off” driving me around the entire island of Oahu! We had a great time; I will always remember her generosity, her quiet strong sense of purpose, her optimism and her lifelong commitment to public health work. Hawaii is today the #1 healthiest state in America, due to her leadership. Deliana was a great leader and a wonderful human being, greatly loved and admired. She will be sorely missed.

*-Maxine Hayes, MD, MPH
Washington State Health Officer
Former AMCHP President*

Loretta, fondly known as Deliana, was treasurer of the AMCHP board while I was president. She was an exceptional advocate and leader for families in Hawaii, her beloved home, and throughout the nation. She created so many wonderful programs and continued to speak for the disenfranchised always looking for opportunities to help. She will be remembered by many for her quiet yet effective persistence. We in the maternal and child health world mourn the loss of our friend and kindred spirit.

- Phyllis Sloyer, Former AMCHP President

"From my perspective in working with Deliana (Loretta) on the board, I felt the interest and needs of the Title V population and Title V was a solid core of who she was as a person and a professional. She had a gift in how she presented an issue and while being very strong in articulating her position, she did it in a way that was respectful and convincing. The people of Hawaii and members of AMCHP have lost a wonderful advocate and colleague."

*- Valerie Ricker, AMCHP Secretary
Assistant Director, Division of Population Health,
Maine Center for Disease Control & Prevention*

Deliana and I served on the AMCHP board for several years as members of the executive committee. She was a thoughtful, engaged member of AMCHP and I always marveled at her ability to manage east coast timed meetings with a Pacific Island body clock. Deliana leaves a legacy of public health policy and practice that will continue to benefit the health and well-being of mothers, youth and children for decades. My thoughts are with her family, friends and coworkers.

*- Millie Jones, AMCHP President
Family Health Clinical Consultant,
Division Of Public Health,
Wisconsin Department of
Health Services*

Hard to imagine the world without her. Thank you for sharing your passion for MCH & teaching us the meaning of true advocacy.

*- Melinda Sanders
Deputy Director, Division of
Community and Public Health,
Missouri Department of Health &
Senior Services*



Loretta and I worked together for three years in the Hawaii DOH and I learned so much from her! I was a freshly minted public health professional with a background in pediatrics and preventive medicine and she showed me the ropes of MCH. She brought passion and intellect together to improve the lives of countless mothers and children in Hawaii in the years I knew her... My heart goes out to her family and friends and the people of Hawaii have lost a great champion!

*- Lisa Simpson, MB, BCh, MPH, FAAP
President and CEO, AcademyHealth*

In lieu of flowers, please consider a donation to either the March of Dimes – Hawaii Chapter (www.marchofdimes.com/hawaii) or the Hawaii Humane Society (www.hawaiianhumane.org).

From the CEO CONT.

- Staff have been working closely with the University of North Carolina to prepare for the launch of the National MCH Workforce Development Center during a special post-AMCHP conference event.
- The AMCHP policy team is keeping up with developments on Capitol Hill and making sure that AMCHP is at the table to discuss and strategize about any important legislative measures related to maternal and child health.

I hope that you're watching the conference updates and are as excited as we are about our chance to get together in January. We look forward to seeing you then!

Feature MIECHV Helps States Increase Collaboration and Evidence- Based Practice Implementation

By Joan Wightkin, DrPH

Assistant Professor, Department of
Community and Behavioral Health,
Louisiana State University Health
Sciences Center



The May/June *Pulse* on evidence-based practice (EBP) included many valuable topics ranging from the integration of quality improvement and epidemiology; “promising” practices and the AMCHP *Innovation Station*; the Florida redesign of their Healthy Start Program toward a more research-informed and evidence-based intervention; and the Home Visiting Research Network informing home visiting policy and practice. Title V leaders faced with the difficult decisions for allocating limited Title V funds benefited from this information.

The federal *Patient Protection and Affordable Care Act* (ACA), signed into law in 2010, established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. At least 75 percent of the MIECHV funding must go to implement one of 13 evidence-based home visiting models and up to 25 percent may go to “promising approaches” that are rigorously evaluated.

Feature CONT.

MIECHV EBP Implementation

Title V leaders weighed variables, such as cost, existing investments and infrastructure, and politics, in order to decide which was the right model for the state. An underlying principle of Title V programs is to reach a large proportion of a state maternal and child population, focusing on the highest risk subpopulations. More costly models may be passed over unless the primary state consideration is the proven impact and cost benefit of the model. Long standing Title V interventions that receive Medicaid reimbursement may not be considered an evidence-based practice, yet provide needed support services to large numbers of low-income pregnant women and young children.

The beliefs of policymakers, agency partners, and consumers influence the uptake of or resistance to new programs that may be more costly than existing interventions. A new model may change the type of provider, requiring the difficult task of building a new infrastructure in state Title V programs for training, quality improvement, and reporting.

Building strong evaluation capacity has been a principle of Title V programs in the past decades, to ensure that all investments are worthy of public funding. MIECHV allows further growth of Title V program evaluation capacity and expertise.

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Feature CONT.

MIECHV EBP Implementation

The experience of two Title V programs, Louisiana and Michigan, illustrate the decision making and challenges involved in changing the direction of Title V investments amidst the backdrop of evidence-based practice and MIECHV.

Michigan

The Michigan Maternal and Infant Health Program (MIHP) began as a public health intervention providing population-based services to pregnant women and infants in the state. Eight years ago, MIHP began a redesign of the intervention as a shared partnership between the state Public Health and Medical Services (Medicaid) Administration. MIHP targets all Medicaid-eligible pregnant women and infants up to age one and is the largest program in the state providing support services to improve birth outcomes and promote maternal and infant health. Nurses and social workers assess the health and psychosocial needs of a pregnant woman, work with the client to develop a care plan, and refer her to needed health and social services.

Influenced by the MIECHV, the Michigan legislature passed Act 291 in 2012 requiring its state departments to restrict home visiting funding to programs that are evidence based or, “(h)ave data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women, infants, children, or their families...an active evaluation of each promising program, or there must be a demonstration of a plan and time line for that evaluation...(with a) projected time frame for transition from a promising program to an evidence-based program.”

MIHP is considered a promising practice and is undergoing an evaluation that has already shown positive outcomes for utilization of prenatal care and well-baby visits among MIHP participants. Additionally, Title V leaders have incorporated evidence-based practices and screening tools in their redesign of MIHP. The hope is to transition MIHP from a promising to an evidence-based practice.

Louisiana

In 1999, Louisiana Title V began to shift funding to implement the Nurse Family Partnership (NFP) Program, one of the evidence-based home visiting models approved for funding in MIECHV. Over the next decade, NFP funding sources were diversified and increased from an initial

\$1 million investment to more than \$12 million in 2010. Following the passage of the ACA, the NFP program was the intervention chosen for Louisiana MIECHV.

When Louisiana began NFP, there were few if any resources for clients in need of Infant Mental Health services, and the Title V program chose to add a mental health professional trained in Infant Mental Health to support the teams of nurse home visitors. In addition, each NFP nurse received 30 hours of training in Infant Mental Health. Louisiana was awarded a MIECHV Competitive Grant for promising practices, and some of the MIECHV funding is being dedicated to conducting an evaluation of the Infant Mental Health intervention.

Other examples of Louisiana Title V EBPs include having staff to support strong MCH epidemiology and evaluation capacity and to provide content expertise to ensure fidelity to other evidence-based interventions funded by MCH, such as breastfeeding promotion and teen pregnancy prevention. In addition to providing content expertise for MCH investments, Louisiana Title V staff provides expert consultation and training to agency partners, including the state child care and child protection agencies.

MIECHV has helped move Title V programs further toward EBP in states such as Michigan and Louisiana. In addition, MIECHV funding requirements have helped state child-serving agencies become more effective collaborators.

The Title V Early Childhood Comprehensive Systems initiatives in both Michigan and Louisiana evolved over the past decade into strong interdependent partnerships among state agencies, jointly developing policies and programs to build an early childhood system. MIECHV has taken that a step further in requiring agencies to plan, evaluate, and report together on indicators of comprehensive early childhood systems in these states.

The focus on evidence-based practice has helped Title V leaders be better stewards of government spending. Federal MIECHV policy has helped states remove the remaining “silos” that separate child-serving agencies and has created opportunities for states to succeed in reaching their shared goal of children being healthy and ready to learn by the time they start kindergarten.

Feature CONT. MIECHV Technical Assistance Coordinating Center



By Valeri Lane, Ph.D.
*Project Director, MIECHV
Technical Assistance
Coordinating Center, ZERO TO
THREE*

The legislation that makes the MIECHV program possible includes a provision for technical assistance to grantees in administering programs or activities conducted with grant funds. Through a contract with the Health Resources Services Administration (HRSA), the MIECHV Technical Assistance Coordinating Center (TACC) is one entity responsible for the delivery of this technical assistance (TA).

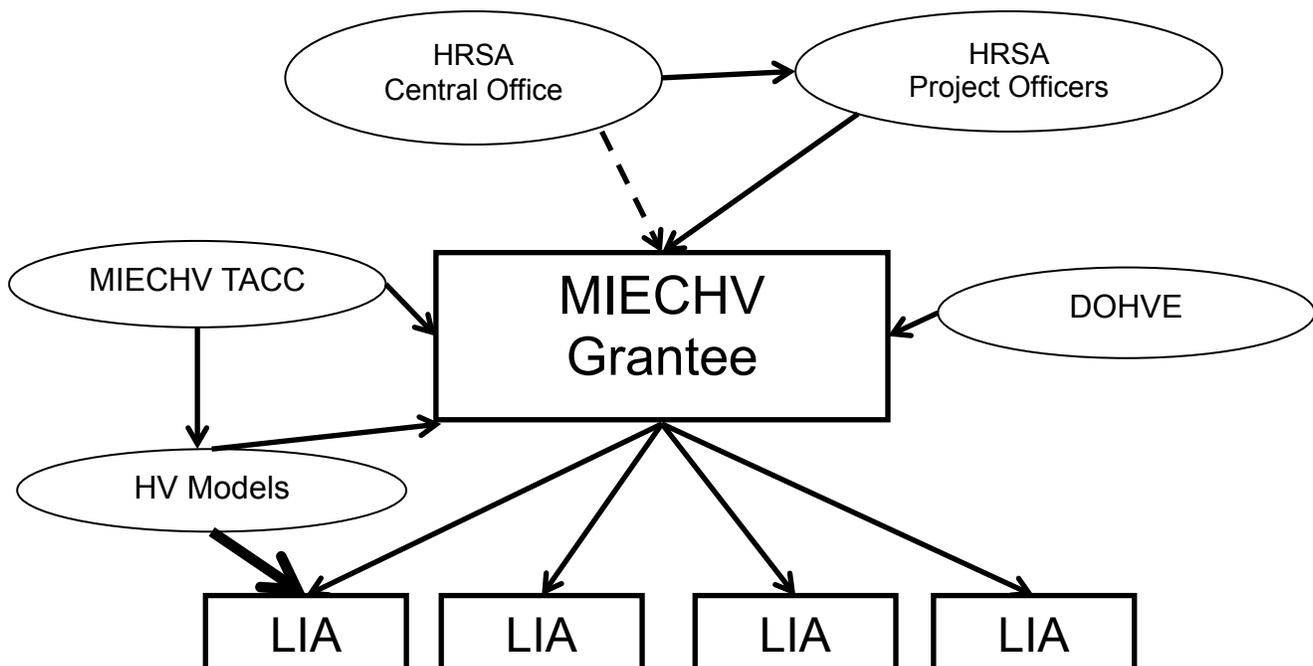
The TACC contract was awarded to ZERO TO THREE and is comprised of three additional partner organizations. The primary role of ZERO TO THREE is overall administration of the contract, delivery of TA to MIECHV grantees, oversight of subcontracts and continuous quality improvement. Three partner organizations make up the balance of the TACC via subcontracts. AMCHP assists with TA and offers linkages to state and jurisdiction Title V programs. Chapin Hall also assists with TA, and leads

TA to the evidence-based models and tasks related to grantee data. Walter R. McDonald and Associates (WRMA) leads the evaluation of TACC TA and the development and maintenance of a system to track data related to technical assistance.

By regulation, the TACC delivers TA to grantees funded through HRSA, specifically the MIECHV state lead and state grantee teams. As topics warrant, the target audience may include the MIECHV team's state partners such as Early Childhood Comprehensive Systems (ECCS) teams, professional development partners, and so on. It is important to note that the target audience is the state- and jurisdiction-level grantee teams, and not the actual home visiting programs or implementation sites.

The overall structure of TA to MIECHV grantees extends beyond the TACC to encompass additional TA support. For HRSA-funded grantees (state and jurisdiction), the TA structure is represented in Figure 1. In addition to the TACC, MIECHV grantees are supported by Design Options in Home Visiting Evaluation (DOHVE), and the evidence-based model developers. The program implementation sites (local implementing agencies or LIAs) are served by the grantee and the models. A somewhat parallel structure exists for Administration for Children and Families-funded tribal grantees.

Figure 1: The structure of TA and supports to State and Jurisdiction MIECHV grantees



Feature CONT.

MIECHV TACC

TA Methods

The TACC delivers multiple levels of TA, ranging from those intended to support many grantees to those that are specifically targeted to the unique needs of a single grantee.

Universal TA is intended to support all grantees. Topics addressed in universal TA are of broad interest and application across grantees. Examples of universal TA include webinars, the e-newsletter, and an online collaboration portal designed for grantee-driven cross-state and jurisdiction sharing and exchange. Archived webinars can be found on the MIECHV TACC website [here](#), and anyone interested in receiving the TACC e-newsletter can be added to the list by contacting [Lena Cunningham](#).

Regional forums also are intended to reach multiple grantees and cover topics of general interest, but have the added benefit of peer exchange. These annual two- to three-day on-site forums are planned with input from grantees in the region, the TACC, and the HRSA project officer. As the only TA option from the TACC that offers the opportunity for grantees to meet face-to-face, the regional forums offer an important venue for networking, peer sharing, and the opportunity to learn from the experiences of others.

The TACC also offers TA designed to support multiple grantees, but with a more specific focus, through *communities of practice*. Currently, the TACC facilitates communities of practice on professional development and centralized intake. Participating members join a monthly Web chat to learn from each other and exchange ideas and successes, and have the option to post and share materials through their respective rooms in the online portal. A community of practice on leadership transitions is newly emerging to support the needs of grantees that have experienced transitions in key personnel within their MIECHV state team.

In addition to communities of practice, recent similar requests from multiple grantees have led to the development of “*cohort TA*,” a natural venue for receiving TA and learning with peers. The primary topic that led to the development of this cohort is fiscal sustainability. Although the requests for TA came in independently from individual grantees, in this method, multiple grantees join on TA calls to receive TA and the benefits of peer exchange.

TA designed to meet the needs of a specific grantee can be delivered in two ways. *Targeted TA* is delivered remotely, in response to a specific request. TA delivery is accomplished through Web conferencing, phone or e-mail. The topic can be anything related to MIECHV infrastructure development or implementation. Current targeted TA requests vary broadly in focus. If the TACC TA specialists do not have the expertise on a particular topic, consultants are brought in to support grantee growth.

When circumstances and grantee need warrant, the TACC can deliver *intensive, on-site TA*, although funding for this method of TA is limited. This TA option is requested via HRSA central office or project officer when the need for TA is such that the other methods will not support progress. Intensive TA is sometimes delivered in conjunction with a HRSA site visit to a grantee.

TA Topics

As mentioned in the introduction, the TACC is just one of the entities responsible for delivering TA to MIECHV grantees. Determination of which TA project will respond to a TA request is largely framed by the topic of the TA needed. DOHVE is responsible for TA related to evaluation and research, MIECHV benchmark measurement, data systems, and continuous quality improvement plans. TA related to administration and implementation of the MIECHV grant falls to the TACC.

The topics of TACC TA vary widely, but can be clumped into four general categories: the development of state infrastructure to support MIECHV; system integration to support linkages of MIECHV with existing early childhood and health systems; implementation TA, including capacity building among local implementation sites; and a focus on program participants, such as family engagement.

Within those broad categories, the TACC works with grantees on a number of topics. Sample TA requests from the past year include:

- Fiscal sustainability
- Workforce development, including developing and implementing core competencies
- Developing an infrastructure for statewide continuous quality improvement
- Developing a system for screening and referral
- Ensuring fidelity across models
- Integration of MIECHV with ECCS

Feature CONT. MIECHV TACC

- Collective impact
- Implementation science
- Development of statewide home visiting coalitions
- Engagement and retention of culturally diverse populations
- Addressing homelessness within state and local systems

As MIECHV moves forward and grantee efforts emerge beyond the mode of starting up a complex program to a more sophisticated level of implementation, the TA needs of grantees will continue to evolve. The TACC will coordinate with TA partners to meet TA needs effectively and support the implementation of MIECHV across states and jurisdictions. For more information, contact [Valeri Lane](#), MIECHV TACC project director.

Feature Improving Access to Medical Home Programs for Hispanic Children with Special Health Care Needs by Utilizing Community Health Workers

By **Myra Rosen Reynoso, PhD**
National Center for Ease of Use of Community-Based Services



Data from the National Survey of Children with Special Health Care Needs (CSHCN) indicates that the reported prevalence rate of Hispanic children with special health care needs has risen from 8 percent to 11 percent over the past few years. In addition, recent parental reports indicate that only 32 percent of Hispanic CSHCN have medical homes, which is the model for delivering the highest quality of primary care that is accessible, comprehensive, family-centered and **culturally effective** (medicalhomeinfo.org).

For many underserved populations, one key component to increasing access to health care, achieving health equity, and promoting medical home access is community health workers (CHWs). Moving forward, learning from states that have succeeded in implementing successful models of CHWs to increase access to medical homes and reduce disparities for Hispanic CSHCN is imperative to reducing medical home disparity.

In November 2013, a national meeting was convened to address emerging CHW models. The National Center for Ease of Use of Community-Based Services convened the meeting, "High Expectations: Community Health Workers and Hispanic CSHCN." The meeting was held in partnership with the [Eunice Kennedy Shriver National Institute of Child Health and Human Development](#) and [The HSC Foundation](#). The HSC Foundation is dedicated to improving access to services for individuals who face social and health care barriers due to disability, chronic illness, or other circumstances that present unique needs. States represented at the meeting included Indiana, New York, North Carolina, Rhode Island and Washington, as well as the District of Columbia.

During the meeting, three key areas regarding CHWs were



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

Feature CONT.

Utilizing Community Health Workers

discussed regarding potential strategies to increase access to medical home programs for Hispanic CSHCN and their families:

1. Core Competencies of CHWs

There was consensus that CHWs assist families in accessing services as part of the medical home. The core competencies needed for this role include a basic understanding of the ways that having a child with a special health care needs affects a family. For CHWs who serve Hispanic populations, a special attention to cultural norms and cultural competency is crucial. The CHW also should have knowledge of insurance coverage, including coverage for CSHCN. Their work should help families build their general advocacy skills and assist in developing family leaders in the community. These professionals should be linked to medical homes and provided a formalized way to document visits and develop benchmarks of success.

2. Knowledge Medical Home Providers Need to Have About CHWs

Within a medical home program, there needs to be a clear definition of the role of the CHW with the recognition that many terms like navigator, promotora, liaison, and health worker are often times used interchangeably but may have different functional roles in each setting. There must be an established understanding of the value added by working closely with CHWs. The “value” may be in the form of reduced rates of cancelled appointments, compliance to treatment protocols, reduced emergency room visits, or

increased trust and communication between providers and families.

Additionally, providers should stay informed of the changes provided by the Affordable Care Act and possible funding mechanisms to either establish or expand different models of CHWs. Most importantly, providers should know that CHWs play a paramount role in fortifying linkages to the community and improving families’ access to essential services.

3. Knowledge Medical Home Providers Need to Better Serve Hispanic CSHCN

The Hispanic community has significant historical, political, economic, cultural, educational and linguistic variations. Providers should not assume that all parents want to speak in Spanish during a medical visit; however, qualified medical interpreters should be available for those that do want to interact in Spanish. An ecological approach should be considered when designing effective and sustainable medical home programs for Hispanic families with CSHCN.

For more information, including a video of the panel presentation, Health Insurance Access for Underserved Families, visit communitybasedservices.org.

Speakers at the meeting included:

Robert Hall

Associate Director, Federal Affairs, American Academy of Pediatrics

Kim Horn

Regional President, Mid-Atlantic States, Kaiser Foundation Health Plan

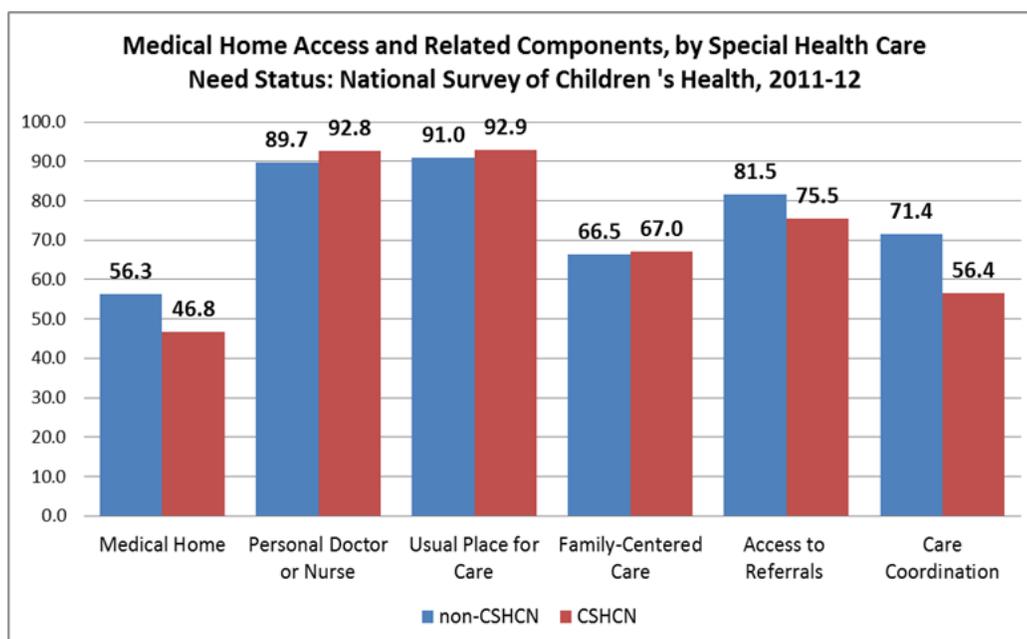
Diane Lewis

Executive Vice President, Alta Consulting Group, Inc.

Donna Cohen Ross

Senior Advisory, Office of External Affairs, Centers for Medicare & Medicare Services

Data source: Data for both 2005-2006 and 2009-2010 National Survey of Children with Special Health Care Needs. Accessed at the Data Resource Center for Child and Adolescent Health. Available at childhealthdata.org/browse/survey.



Feature

Medical Home and Health Information Technology

By Carolyn McCoy, MPH
Senior Policy Manager,
AMCHP



Title V programs play a key role in states as the locus for MCH activities. One of key activities within this role is working toward ensuring universal access to a medical home. States even report annually on the number of children and youth with special health care needs who have a medical home.

Within a medical home, one of the key functions is effective communication. Health information technology (HIT) is one tool to improve effective communication, measure quality of services delivered, and enhance coordination among providers. To this end, the [National Center for Medical Home Implementation](#) (NCMHI) created two useful guides with promising practices and resources for practitioners at all levels of implementation of HIT systems. The National Center for Medical Home Implementation is a cooperative agreement between the [Maternal and Child Health Bureau](#) (MCHB) and the [American Academy of Pediatrics](#). The mission of NCMHI is, “to work in cooperation with federal agencies, particularly the MCHB, and other partners and

stakeholders to ensure that all children and youth, including children with special needs, have access to a [medical home](#).”

The first [Spotlight on Child Health Issues: Health Information Technology & Medical Home](#) provides an in-depth review of various topics ranging from “What is HIT?” to “How does HIT Interact with Medical Home?” as well as providing promising practices for states.

The second tool, [Improving the Medical Home Through the Use of Health Information Technology](#), is a fact sheet for health care professionals that summarizes the key points of how HIT assists the medical home in delivering quality care by supporting information functions and effective communication.

Technology is not the end-all for a well-functioning medical home. However, as the health care world moves away from paper-based record keeping and into the virtual world and thus integration between community-based and clinical providers becomes more continuous, understanding the positive benefits of HIT is important for those in the field who are working hard every day to ensure access to medical homes for our MCH populations.

Want to learn more about medical homes, home visiting and early childhood?

Join us at the [2014 AMCHP Annual Conference](#)!

The Tuesday morning plenary session, *Working Together on Early Childhood Systems: Implementing a Multi-Sector Approach*, will be moderated by Dr. Cheri Pies, Principle Investigator of the Best Babies Zone Initiative at University of California Berkeley and features leading national experts including:

- Dr. David Willis Director of the HRSA-MCHB Division of Home Visiting and Early Childhood Systems
- Ms. Ellen Seidman from the Low Income Investment Fund/Urban Institute
- Dr. Michael McAfee from the Promise Neighborhoods Institute at PolicyLink

There are several other workshops and skills-building sessions on home visiting, early childhood, medical home, and other topics. We hope to see you there. [Register today!](#)

Feature

Integrating Home Visiting Programs and the Family Centered Medical Home to Improve Child and Family Health Outcomes

By Carolyn McCoy, MPH
*Senior Policy Manager,
AMCHP*

Veronica Helms, MPH
*Program Manager, Child &
Adolescent Health, AMCHP*



Recent discussions in the field of child and family health have focused on the intersection of home visiting (HV) programs and the family centered medical home (FCMH). Such systems integration initiatives have the potential to decrease redundancy and promote effective systems of care for MCH populations.

Title V programs play a crucial role in both HV and medical home programs. The ACA includes a provision authorizing the creation of the MIECHV program under a section of Title V and provides substantial funding to develop and implement evidence-based home visitation models. State MCH programs have a long history of utilizing home visiting strategies. Prior to passage of the ACA, nearly 40 states managed or financed home visiting programs. When considering the role of Title V and the FCMH, it is important to note that more than 35 state Medicaid and CHIP programs have taken steps to promote the medical home model; state Title V MCH programs are key partners in many of these efforts. State Title V MCH programs administer numerous public programs that are critical, natural access points for building and strengthening integrated service delivery systems, including medical home initiatives.



Home Visiting and the Family-Centered Medical Home: Synergistic Services to Promote Child Health

In response to the emergence of increased funding opportunities and the inclusion of both programs in the ACA, the American Academy of Pediatrics-Academic Pediatric Association (AAP-APA) Workgroup on the FCMH developed a comprehensive [policy brief](#) to provide guidance regarding strategies based on integrating care between the FCMH and HV.

When home care activities are systematically integrated with the FCMH, there is great potential to promote positive child health outcomes and reduce health disparities. Since both programs share similar goals, integrating HV and the FCMH seems like an obvious fit. In AAP policy brief, [Home Visiting and the Family-Centered Medical Home: Synergistic Services to Promote Child Health](#) by Sara Toomey and Tina Cheng, the authors discuss synergistic collaborations between the FCMH and HV and discuss strategies to evaluate coordination. Article highlights are briefly summarized below.

What are the Contributions of HV Programs and FCMHs to the Health of Children? Research suggests that both home visiting program and the FCMH model have been successful in promoting the health of children and their families.

HV Programs

HV programs provide culturally relevant, ongoing service delivery to support children and families in their own homes. Data indicates that high-intensity HV programs for young children have resulted in better child and family outcomes, including improved social skills, reduced children maltreatment, and improved parenting skills. Research also suggests that HV by health care providers has led to enhanced provider-family relationships, including enhanced trust (Toomey and Cheng, 2012).

The FCMH

Although variant in structure and approach, the FCMH provides “comprehensive, coordinated, family-centered primary care that facilitates partnerships between patients, families, clinicians, and community resources and services” (Toomey et al., 2012). By focusing on the delivery of optimal health care services, the FCMH attempts to maximize health outcomes and coordinate care across

Feature CONT. Integrating Home Visiting

various providers and venues. Research suggests the FCMH can decrease barriers, improve family satisfaction, and improve child and family outcomes.

Coordination and communication between HV programs and the FCMH can be challenging. However greater integration between HV programs and FCHMs could simultaneously enhance HV program effectiveness and help reinforce guidance given by primary care providers (Toomey and Cheng, 2012).

How Can HV Programs and the FCMH Best Serve Families and Children?

Addressing the health and complex psychosocial needs of families requires a range of support services, many of which are maximized in a home setting. HV programs developed within a FCMH framework can provide effective care at both the individual patient and population levels. Partnership between HV and the FCMH can provide advantageous benefits that align with the Title V program mission, including:

- “Assisting families in care coordination
- Facilitating referrals to community resources (e.g., early intervention), medical evaluations (e.g., audiology) and community supports (e.g., parenting groups, nutrition services)
- Identifying community needs that are important in managing population health
- Assisting transition across multiple settings, (e.g., early intervention, health care, education)”

Source: (Toomey et al., 2012)

For a full list of program coordination benefits, please read the [full AAP policy brief](#).

Conclusion

As outlined above, integration of HV and the FCMH has the potential to promote sustainable health outcomes for children and their families. Moving forward, Title V programs and key partners must take advantage of emerging funding opportunities in this space and continue to explore strategies to integrate HV and the FCMH.

Feature Medical Home Access among Children with Special Health Care Needs: Findings from the 2011-12 National Survey of Children’s Health

By Reem M. Ghandour, DrPH, MPA
Michael D. Kogan, PhD
Jessica J. Jones, MPH
*Office of Epidemiology and Research,
Maternal and Child Health Bureau,
Health Resources and Services
Administration*



For two decades, the American Academy of Pediatrics (AAP), MCHB at HRSA, service providers, policymakers, and advocates have championed the medical home model to improve the delivery of children’s health care. This model is characterized by the *compassionate* delivery of easily-*accessible, comprehensive, continuous, culturally effective, coordinated* medical services in *partnership* with patients and families. Research has shown that children fare best with respect to the accessibility, timeliness and quality of health care when provided in such a setting. Medical home access for children with and without special health care needs is monitored by MCHB through the [National Survey of Children’s Health](#) (NSCH) and the [National Survey of Children with Special Health Care Needs](#).

According to the most recent data from the 2011-12 NSCH, 54.4 percent of children were reported to receive care in a medical home. However, rates of medical home access varied by special health care need status, with less than half (46.8 percent) of CSHCN reported to have a medical home compared to 56.3 percent of children without such needs. These rates reflect parent-report of five measurable components of medical home: personal health care provider; usual source of sick and well care; receipt of family-centered care; referrals for doctors or health services if needed; and receipt of care coordination

Feature CONT.

CSHCN Medical Home Access

if more than one service was used in the past year.¹ In 2011-12, CSHCN were slightly more likely to have a personal health care provider or usual place for sick and routine care (approximately 93 percent) compared to 89.7 percent and 91.0 percent, respectively, of children without such needs. In contrast, sizable disparities were observed for both receipt of needed referrals and care coordination. Compared to 18.5 percent of children without special health care needs, nearly one-quarter (24.5 percent) of CSHCN reported having difficulties getting needed referrals and nearly half (43.6 percent) reported not receiving effective care coordination compared to 28.6 percent of children without such needs who also used more than one health care service in the past year. Disparities in the receipt of care coordination were more pronounced when parents' perceived need was considered regardless of the number of services used: nearly one-third of CSHCN lacked care coordination compared to less than 10 percent of children without special health care needs. No significant differences were observed for the receipt of family-centered care by special needs status.

Among CSHCN, medical home access varied by geographic location ranging from more than 60 percent to less than 40 percent. Regional differences also were observed with the highest overall rate of medical home access among CSHCN observed in [Public Health](#) Region VII (55.5 percent) while the lowest was observed in Region IX (36.8 percent).

Receipt of care in a medical home is a critical measure of health care quality for all children and CSHCN, in particular, as evidenced by its inclusion among the nation's 10-year goals for improving the health of all Americans, [Healthy People 2020](#), and ongoing inclusion in the MCHB Core Outcomes for CSHCN. These latest data indicate that disparities among children by special health care need status have changed little since 2007 when 49.8 percent of CSHCN and 59.4 percent of children without such needs, respectively, had medical home access. Recent estimates for individual components of medical home suggest that this disparity is driven largely by differences in referral access and receipt of care coordination. Disparities in the latter should be of particular interest to program managers, policymakers, and service providers. Research suggests that care coordination may hold the capacity to impact multiple outcomes among CSHCN ranging from access to care to family burden to patient and provider satisfaction.

Ongoing surveillance of medical home access overall, and receipt of specific components at the state and national level, is critical to understanding opportunities to improve systems of care for U.S. children and CSHCN. National, regional and state-level data for medical home and related components are available at childhealthdata.org.

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<sup>1</sup> More information on the measurement of medical home and these components is available at: [childhealthdata.org/browse/medicalhome](http://childhealthdata.org/browse/medicalhome).

## Feature

### Supporting Maternal and Child Health by Involving Fathers on Home Visits

By Haji Shearer  
*Director of the Fatherhood Initiative, The Children's Trust*



What do fathers have to do with maternal and child health? A lot! According to research, infant and child mortality, duration of breastfeeding, and many other classic MCH indicators, are significantly impacted by the involvement of a child's father. So why aren't we discussing father involvement more in the field of maternal and child health?

A study published in 2010 by the University of South Florida showed that more babies survive when fathers are involved, "The neonatal mortality rate of infants born to women with absent fathers (of the infant) is nearly four times that of their counterparts with involved fathers."<sup>1</sup>

Additionally, "Women with absent fathers have a higher prevalence of maternal obstetric complications, are less likely to get adequate prenatal care, and more likely to smoke." The authors concluded, "Our study suggests that significant proportion of infant mortality could be prevented if fathers were to become more involved."

## Feature CONT. Involving Fathers

Less infant mortality, that's good news. More mothers breastfeeding also is good news. A paper published in 2000 by the American Academy of Pediatrics featured a survey with bottle-feeding mothers in which the single most important factor contributing to bottle-feeding was "baby's father's feelings."

This paper also referenced another study that investigated mothers' perception of the fathers' attitudes toward breastfeeding and discovered that, "Generally, fathers had more positive attitudes than their partners expected." More reasons to get dads involved and actually talk with them and moms about breastfeeding.

MCH professionals are charged with involving fathers. The HRSA maternal and child health mission requires the field to employ, "an integrated view of families, their health, and well-being over the lifespan and across generations." It has never been possible to fulfill this mission without including fathers, but now more than ever it's impossible to execute this charge and ignore or minimize the active role that many dads play in the lives of their children and the mothers of their children.

Although the percentage of children who grow up in father absent homes has tripled since 1960, the traditional roles of fathers and mothers have become more flexible and today's dads are doing tasks that were once reserved for moms and vice versa. According to the American Psychological Association position paper on The Changing Role of the Modern Father, "Today's fathers have started to take on roles vastly different from fathers of previous generations."<sup>2</sup>

I work for the Children's Trust, the leading family support organization in Massachusetts. We administer Healthy Families Massachusetts (HFM), a state-wide, evidence-based, newborn home visiting program that supports young, first-time parents. We are committed to working with both parents because there is overwhelming evidence that children do better in almost every important outcome measure when both parents are involved in their lives.

Studies compiled by the U.S. Administration for Children and Families show responsible father involvement increases a child's school readiness and behavior; cognitive, motor, and verbal development; security, confidence, and attachment; and the ability to make wise life choices.<sup>3</sup>

Not every child will have a dad involved and many great moms raise fabulous children without a father present. Our program reaches out to fathers to give a child every possible advantage that he or she can have. A possible reason why MCH professionals don't discuss father involvement more is we are still operating within a model of gender roles and social structure that has radically changed in the last 50 years.

Home visiting programs can play a critical role in encouraging this positive social change. HFM has promoted the importance of father involvement on home visits since our program began in 1998. We ask referrals for contact information on fathers. We ask mothers to invite dad to visits and if there are safety reasons why dad cannot be involved we work with mom to create a plan to keep her and baby safe. Supervisors ask about the status of fathers in each family on an ongoing basis and we provide technical assistance for programs to help overcome obstacles they face in engaging fathers.

People pay attention to what is measured, so we have kept data on the number of fathers who participate since our program began. In FY 2013, this focus resulted in more than 6,800 home visits with the baby's father present. We include biological and non-biological fathers in our data to honor the blended family formations we often encounter. That's a lot of opportunities to support maternal and child health.

*Interested in learning more? Haji Shearer will present at the AMCHP Annual Conference at a skills-building training entitled "Building Family Strengths By Engaging Fathers on Home Visits" on Saturday, Jan. 25 from 12-3 p.m.*

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1 <http://www.jointcenter.org/hpi/sites/all/files/Alio%20AP.%20Mbah%20AK.%20Kornosky%20JL%20et%20al.%20Assessing%20the%20Impact%20of%20Paternal%20Involvement%20on%20Racial%20and%20Ethnic%20Disparities%20in%20Infant%20Mortality%20Rates.pdf>

2 <http://www.apa.org/pi/families/resources/changing-father.aspx>

3 <http://www.headstartresourcecenter.org/fatherhood/Resources/root/data/Building%20Blocks/HSBCombo4.1.pdf>

Feature

Promoting the National Home Visiting Research Agenda

An Update from the Home Visiting Research Network

By **Kay M. Gonsalves, MSPH**
Home Visiting Research Network
Coordinator, Department
of Population, Family and
Reproductive Health, Johns
Hopkins Bloomberg School of
Public Health



This is a very exciting time to work in the field of home visiting research. The ACA invests an unprecedented \$1.5 billion in home visiting through grants to states, territories and tribal organizations. Most of this funding is dedicated to the development or expansion of services. However, a portion of this funding is designated for home visiting research to strengthen the role of home visiting as part of the system of services for expectant families and families with young children. Part of the ACA investment has been the establishment of a national Home Visiting Research Network (HVRN). Funded by the HRSA Maternal and Child Health Bureau, HVRN seeks to create a strong infrastructure for home visiting research to inform policy and practice.

One way in which HVRN is building this infrastructure is by the creation and promotion of a national stakeholder-

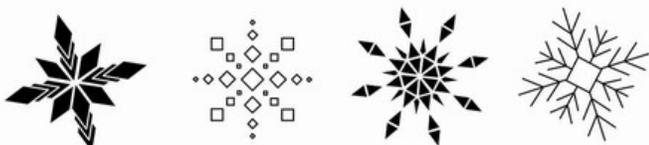
driven home visiting research agenda. The agenda calls for research to address 10 priorities:

1. Strengthen and broaden home visiting effectiveness
2. Identify core elements of home visiting
3. Promote successful adoption of home visiting innovations
4. Promote successful adaptation of home visiting innovations
5. Promote fidelity in implementing home visiting innovations
6. Build a stable, competent home visiting workforce
7. Promote family engagement in home visiting
8. Promote home visiting coordination with other services for families
9. Promote the sustainment of effective home visiting
10. Build home visiting research infrastructure

HVRN is currently promoting research to advance this agenda in two major ways. The first way is by the development of the Home Visiting Applied Research Collaborative (HARC), a national practice-based research network of local home visiting program sites. HARC will support collaborative research that addresses the 10 research priorities. 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 and coordinators of local home visiting networks. Member programs choose the studies in which they would like to participate and will be among the first to know results and their implications for policy and practice. E-mail [Kay Gonsalves](mailto:Kay.Gonsalves@jhu.edu) if you are interested in joining.

The second way to advance the research agenda is to provide consultation to promising early career researchers on the design of studies addressing these research priorities. The Early Career Home Visiting Research Scholar Program will provide scholars the opportunity to attend the Pew Charitable Trust Fourth National Summit on Quality in Home Visiting in Washington, DC and to receive consultation from HVRN leaders in designing a study addressing one or more of the national home visiting research agenda priorities. The HVRN is primarily interested in short-term studies that would be appropriate to conduct in collaboration with HARC. Applications have already been accepted for this year, but please visit hvrn.org to learn more.

**As the year draws to an end,
AMCHP sends our best wishes for
a happy and healthy 2014 for all
women, children, and families!**



Feature Pregnancy Medical Homes

By **Carolyn McCoy, MPH**
Senior Policy Manager, AMCHP

North Carolina, one of the leading states in implementation of pregnancy medical home defines services provided in a pregnancy medical home as managed care services to provide obstetric care to pregnant Medicaid beneficiaries with the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care. The pregnancy medical home is kept abreast of missed appointments, specialist visits and emergency department visits. This model of care is not yet widespread in the United States but there are efforts underway to implement and test the effectiveness this model of care.

As highlighted in the AMCHP [Forging a Comprehensive Initiative to Improve Birth Outcomes and Reduce Infant Mortality: Policy and Program Options for State Planning](#), the **North Carolina** pregnancy medical home model aims to improve birth outcomes among the Medicaid population. The pregnancy medical home provides evidence-based, high-quality maternity care to Medicaid patients and focuses care management resources on those women at highest risk. In the medical home model, quality-improvement goals are aligned with cost-savings goals, keeping more babies out of neonatal intensive care using and avoiding associated expenses. Pregnancy care management is a key intervention of the medical home model. Pregnancy care managers, trained social workers and nurses, provide care management services for pregnant and postpartum women with specific risk criteria. The services are provided based on need and risk stratification. The pregnancy medical home incentives to providers include increased rate of reimbursement for the global fee for vaginal deliveries to equal that of a c-section global fee, incentive payment for risk screening, incentive payment for a postpartum visit, and no prior authorization required for OB ultrasounds. In turn, providers have a set of requirements as well, including appropriate use of 17P with their patients, completion of screenings, and attention to c-section rates and induction of labor before 39 weeks. This new model is based on the Community Care of North Carolina system of regional networks of providers, clinics and partners across the state.

In addition to state-led initiatives, a new effort by the Centers for Medicare and Medicaid Services (CMS), [Strong](#)

[Start for Mothers and Newborns](#) seeks to test enhanced prenatal care interventions. The four-year initiative is for women enrolled in Medicaid or Children's Health Insurance Program (CHIP) coverage who are at risk for having a preterm birth, improve the health outcomes of pregnant women and newborns, and decrease the anticipated total cost of medical care during pregnancy, delivery and over the first year of life for children born to mothers in Medicaid or CHIP. There [are 27 sites](#) that received funding for this initiative.

Title V MCH programs can offer a range of leadership and support through outreach and education to women, through an advisory role, contributions of data or quality metrics, coordination between stakeholders and others.

View from Washington Reauthorizing MIECHV



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

As 2013 winds down, we at AMCHP are looking over the MCH policy horizon to determine our 2014 federal policy agenda. In addition to the expected budget battles and need to continue defining a vital role for Title V MCH programs in an

ACA environment, one of the anticipated centerpieces for next year's agenda will be advocating for congressional reauthorization of the MIECHV program. We've even begun laying the groundwork this year and are working with a strong coalition to ensure broad support in 2014.

By way of background, most programs created by Congress are authorized for five years, which allows future Congress's the opportunity to regularly review each program's performance, assess its value, and determine if the level of funding is appropriate. The current five-year MIECHV authorization will expire on Sept. 30, 2014 which means that absent congressional action, no new funds would be available for the program in FY 2015.

View from Washington CONT.

Now in the old days, most program reauthorizations happened with relatively little drama and were generally close to on time. However, in recent years, the increasingly partisan Congress has missed deadlines and become less amenable to the compromises essential to legislative progress. That observation is not exactly a news flash, but assessing the landscape that will impact MIECHV reauthorization, there are a couple additional elements that add even more complexity to an already nuanced situation.

First, the MIECHV program was created with a mandatory rather than discretionary appropriation, which means that as long as the authorization is in effect the funding is automatically available at the beginning of each fiscal year. This is generally a really good thing as it insulates the program from the vast uncertainties that have accompanied the discretionary appropriations process, which has become badly broken in recent years. However, one key difference is that congressional appropriators can – and often do – provide funds to programs whose discretionary (as opposed to mandatory) authorization has expired. Our best understanding is that Congress would not have this option with an expired mandatory program.

Second, MIECHV was created as part of the ACA. Again it is not exactly breaking news to report that the ACA doesn't enjoy broad bipartisan support. One of the main challenges to our work now is making the case that supporting young families who are voluntarily seeking assistance to build healthier, stronger families and communities should not be seen as partisan regardless of how the program was enacted.

Finally, perhaps the biggest hurdle MIECHV needs to overcome is the fiscal tab. Extending the current authorization even at its existing level – which we know will only reach a small portion of the eligible population – for five years is a \$2 billion (with a B) proposition. As you all are painfully aware, the 2013 sequestration has taken nearly \$1 billion from MCH programs operated by CDC, HRSA, NIH, and USDA's WIC. In a nutshell, the MCH community is struggling mightily with how we advocate for increased resources for programs with demonstrated needs in the face of indiscriminate cuts to all the programs we care about. We are essentially operating in a potential zero sum environment and need to balance priorities more carefully than ever before.

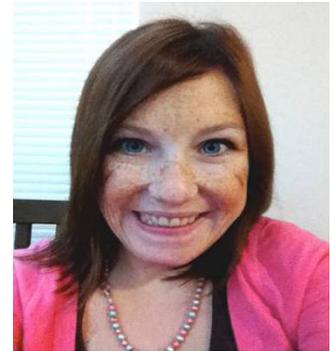
AMCHP is taking a leading role to address each of these challenges head on and is working as part of a larger coalition of stakeholders including advocates and the home visiting models themselves to make the case to Congress that the vital investment in MIECHV needs to continue and be expanded. We will likely be calling on you in 2014 to share the successes your state is making in expanding home visiting services and convincing policymakers that this investment needs to continue and grow.

All best wishes for a great 2014!

Real Life Story What is a Medical Home?

By Mallory Cyr
*MPH Candidate, Boston
University School of Public
Health*

Medical home is a buzzword heard frequently in the world of MCH. The reality, however, is that many people do not have a full understanding of what a “medical home” really is.



Once you throw more words into the alphabet soup, like health home, ACO, HMO (and the list goes on), good luck keeping track of what anyone is talking about! This muddled framework of what the ideal health care system is supposed to look like can be especially frustrating for youth, families, or the average consumer trying to gauge the quality of care they really have.

Most of my medical home education came from my work with the National Center on Health Care Transition (Got Transition?), through the Center for Medical Home Improvement. I had the privilege and honor to be mentored by two of the top medical home experts in the country who shared in the genuine belief that no matter what it's termed as, health care needs to be about quality, and needs to be about the person, not just the diagnosis.

In my “other life,” I am a graduate student at Boston University School of Public Health concentrating in

Real Life Story CONT.

Maternal Child Health, and a LEND (Leadership in Neurodevelopmental Disabilities) fellow through UMass Medical School. In both of these settings, we were taught about the “patient centered medical home,” and read the works of my former employers. I was surprised at the lack of knowledge people had about these topics. Didn’t everyone know what a medical home was all about? Doesn’t everyone eat, sleep and breathe MCH like I do?

No. They don’t. It was then I began to realize how much I take for granted the knowledge and experience that I have gained as a consumer within the system – as much of a double edged sword as it may be.

So what is a medical home REALLY? As an everyday “consumer,” how can you tell if you have one? Well, let me start with what it is not. It’s not a building. It is not one person. It is not a home of people who require a lot of medical care and supplies.

In my experience, a medical home is: consistently receiving care that makes you feel like a person, not a number. It is talking to a provider and instead of leaving the room and feeling like you just can’t do it anymore, breathing a sigh of relief.

It is having a provider who says “let me follow up on that for you,” and they DO. It is knowing that when you arrive at the lab to have blood drawn, the proper orders will be there without YOU having to hunt them down. A medical home is having conversations about your goals, your fears and knowing who you can contact in an emergency (and that number connects to an actual person....not a recorded menu of options).

I know this sounds all fine and good, and I can hear all the providers screaming “BUT WE DON’T HAVE TIME FOR THAT! HOW CAN WE BILL FOR IT ALL?” Take a deep breath. Medical home is a team-based approach, with the right people involved, and the providers who really achieve it, somehow find the time. It is not held in the hands of one provider, so they can check a box for their practice quality improvement measures.

A true medical home takes time, patience and care. But with the right people, policy and shared vision – it is an outcome that can be achieved.

Success Story

Research to Improve the Nurse-Family Partnership in Community Practice: The Nurse Family Partnership Contraceptive Study

By Alan Melnick, MD, MPH and Marni Storey-Kuyl, RN, MS
Clark County (WA) Public Health

Unintended and short interval pregnancies are associated with adverse health effects for women, children and families.¹⁻⁷ Increasing access to effective contraceptives could prevent unintended pregnancy and, if provided soon after delivery, could reduce short-interval unintended pregnancy.⁸

Unfortunately, many women at high risk for unintended pregnancy face difficulties receiving contraceptive services from publicly funded family planning programs. Cost, inadequate access to childcare and transportation, time of available services, and geographic location can inhibit a woman’s ability to obtain and use contraceptives.^{8, 9, 10, 11, 12} Waiting times at clinics, delays in obtaining appointments, fear of side effects, the belief that clinics offer less personalized and lower quality care, and the pelvic exam requirement lead to reduced effective contraceptive use.^{8, 12}

Our research team, including members from Oregon Health and Science University and the University of Colorado, has worked collaboratively with the NFP Program and several local health departments in the state of Washington to study whether it is possible to eliminate these barriers and increase effective contraceptive use by dispensing hormonal contraceptives during nurse home visits. The NFP is a voluntary nurse home visiting program found in randomized clinical trials to improve pregnancy outcomes, child health and development, and parent economic self-sufficiency. Nurses visit homes of low-income women, including adolescents, during their first pregnancy and throughout their child’s first two years of life. Although studies have shown that the NFP has reduced unintended



Success Story CONT.

pregnancy and increased spacing, populations the NFP serves still experience high rates of unintended pregnancy and short pregnancy intervals.^{13,14,15,16,17}

Our study was a randomized clinical trial of adding a contraceptive dispensing component to the NFP program at three local health departments. We designed the study to determine whether NFP clients who received contraceptives from nurses during home visits had fewer gaps in effective contraceptive coverage and fewer unintended pregnancies compared to women receiving the usual NFP care. Women were eligible for participation in the study if they were NFP clients, less than 33 weeks pregnant, English or Spanish speaking and interested in participating.

Usual NFP care included education and counseling focused on pregnancy planning and contraceptive use, with referrals to clinical settings for contraception. Participants in the enhanced intervention group received the same services, but during home visits following delivery, the nurses also offered women their choice of up to a 12-month supply of hormonal contraceptives, including oral contraceptives, vaginal rings, contraceptive patches or a depot medroxyprogesterone injection at no cost. The nurses followed clinical protocols, approved by their health department medical director.

For both study groups, blinded research staff conducted phone surveys at enrollment and at three-month intervals three months after delivery and continuing until 12 to 24 months following delivery. The surveys gathered data related to gaps in effective contraceptive use, specifically days without contraceptive use (gap days) and repeat pregnancy, and factors that could influence the rates and timing of subsequent pregnancy, such as pregnancy intention, perceived barriers to contraceptive use, and self-efficacy related to contraceptive use.

Preliminary results are promising. The mean age at enrollment for the 337 participants was 19.0 (range 14.3 – 42.8). Women in the enhanced group had fewer contraceptive gap days up to 15 months postpartum ($p < 0.001$). However, by 18-months postpartum, the enhanced care group had more gaps, and beyond 18 months, there was no difference between groups.

Based on these early results, we believe that giving NFP

nurses the ability to dispense contraceptives during home visits can improve contraceptive use for up to 15-months postpartum. This is significant, because increasing spacing of subsequent pregnancies improves birth outcomes, child health outcomes and the mothers' opportunities for economic self-sufficiency. The findings after 15 months might be due to changes in pregnancy intention or other moderating variables such as domestic partner/family influence and perceived barriers to continued effective contraceptive use. Our next steps include exploring potential moderating and mediating variables such as race, ethnicity, income, education, perceived barriers, contraceptive use self-efficacy and pregnancy intention.

If further analysis confirms our findings, we intend to work with other sites to add hormonal contraceptive dispensing to the NFP model. Considering that the NFP program reaches more than 26,000 participants in hundreds of sites, the potential health impact of the intervention is significant.¹⁷

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Success Story CONT.

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Member to Member

We asked members the following question: What is the relationship of Title V and your state Medicaid department in coordinating and funding home visiting services?

Stephanie Trusty, BSN
Nurse Clinician, Iowa Department of Public Health



In Iowa we have 21 local Title V Maternal Health agencies selected through a competitive bid process and contracted by the Iowa Department of Public Health (IDPH) to provide services to pregnant and postpartum women in all 99 counties. Through the request for proposal process, local Title V agencies received state and federal Title V funds and are designated by Iowa Medicaid as a "Maternal Health Center." The Medicaid provider designation allows the Title V agency the ability to bill Medicaid for nursing home visits and other MH services provided to Medicaid eligible women enrolled in the Title V

Member to Member CONT.

Maternal Health Program.

The nursing home visit is provided by a registered nurse and includes nursing assessment of the mom and infant and also includes health education, care coordination and oral health services. The nursing home visit is a timed code and must provide at least 31 minutes of face-to-face time in the client's home. Local maternal health agencies can bill 10 visits in 200 days for each client in the maternal health program.

The Medicaid revenue typically doubles the amount of funding the local maternal health agency has to provide preventive health services and helps makes the Title V MH program sustainable. The Medicaid revenue the agency receives must be reinvested in the Maternal Health Program.

IDPH has an interagency agreement with Iowa Medicaid Enterprise (IME) that clarifies our responsibilities for oversight of the Maternal Health services provided to Medicaid eligible women. IDPH has a long standing collaborative relationship with our Medicaid partners. IDPH and IME staff meet on a monthly basis to discuss any barriers to care for Medicaid members and quality improvement strategies. For more information, view the [Iowa Medicaid Maternal Health Center Provider Manual](#).

Michael D. Warren, MD, MPH, FAAP
Director, Division of Family Health and Wellness, Tennessee Department of Health



The Tennessee Department of Health (TDH) is the recipient of the MIECHV funds for Tennessee. MIECHV funds have been used to expand the availability of evidence-based home visiting programs in the most at-risk counties in Tennessee. Additionally, the MIECHV program has prompted us to explore opportunities for further developing our early childhood infrastructure, which includes a spectrum of services for children and families. Our state Medicaid program, TennCare, is a vital partner in this arena. TennCare funds a statewide targeted case-management program, Help Us Grow Successfully

Member to Member CONT.

(HUGS), which is administered by TDH and works in concert with the MIECHV-funded programs as well as other state-funded home visiting programs. MIECHV funding also has been used to build on an existing Medicaid-funded outreach initiative (TENnderCare) to create the “Welcome Baby” program. The parents of every new baby born in Tennessee receive a “Welcome Baby” packet with a letter from the First Lady and important information about early childhood priorities; families at medium and high risk for infant death (as determined from the birth certificate) receive a phone or home visit, respectively. Our goal has been to maximize all the available funding sources to create a system of services of varying intensity that enables us to provide the right service for the right family at the right time. The funding from Medicaid allows us to have a more robust spectrum of services available for Tennessee children and families.

Lauri Kalanges, MD, MPH

Acting Director, Office of Family Health Services, Deputy Director, Office of Family Health Services, Virginia Department of Health



The Virginia Title V program at Virginia Department of Health has been collaborating with the state Medicaid office, Department of Medical Assistance Services (DMAS), to provide home visiting for at-risk pregnant women and high-risk infants in the agency’s local health departments. In Virginia, this home visiting program, called Baby Care, has served high-risk pregnant women and infants up to age two for more than 25 years. Both agencies have a designated staff member who is named in a memorandum of agreement. Collaboration occurs across several home visiting efforts by both agencies including the statewide implementation of Behavioral Health Risk Screening for pregnant and parenting women, representation on the Virginia Home Visiting Consortium, and launch of the Virginia Infant Mortality Strategic Plan. The Title V MCH Services Block Grant funds the infrastructure by supporting staff salaries in local health departments to provide Baby Care home visiting services. DMAS reimburses health departments for Baby Care services that partially support the staff salaries and program operations.

The purpose of the Baby Care Program is to improve birth outcomes, reduce infant mortality and morbidity, ensure provision of comprehensive services to pregnant women and infants up to age two, and assist pregnant women and caretakers of infants in receiving wrap-around services that affect their well-being and that of their families.

The Baby Care program includes two key components:

- Case management through home visits for at-risk pregnant women and high-risk infants up to age two by a registered nurse or social worker
- Expanded prenatal services for pregnant women including patient education classes (including tobacco cessation), nutritional services, homemaker services and substance abuse treatment services by an approved provider

Who’s New

NEW TITLE V/MCH DIRECTORS

WASHINGTON

Janna Bardi, MPH
 Director, Office of Healthy Communities
 Washington State Department of Health

NEW TITLE V DIRECTORS

NEW JERSEY

Lori Garg, MD, MPH
 MCH Director
 New Jersey Department of Health

WEST VIRGINIA

Christina Mullins
 Director, Office of Maternal, Child and Family Health
 West Virginia Bureau for Public Health

Who's New CONT.

NEW MCH DIRECTORS

SOUTH CAROLINA

Beth De Santis, RN, MSN, WHNP
Director, Maternal & Child Health Bureau
South Carolina Department of Health &
Environmental Control

NEW CYSHCN DIRECTORS

INDIANA

Shirley I. Payne, MPH
Director, Children's Special Health Care Services Division
Indiana State Department of Health

Get Involved

AMCHP New Director Mentor Program Now Accepting Applications!

The AMCHP New Director/Mentor Program is accepting applications – if you know of a new MCH, CYSHCN or Title V director (someone who has been in their role for three years or less) encourage them to apply! And, we are always looking for great mentors, so if you are a seasoned MCH professional, we strongly encourage you to share your knowledge and information with new directors. The deadline for applications is Jan. 3. All application materials can be located [here](#) on the workforce development pages or contact AMCHP staff [Jessica Teel](#).

2014-2016 Act Early State Systems Grants Request for Applications

Through funding from the Centers for Disease Control and Prevention (CDC) National Center for Birth Defects and Developmental Disabilities, AMCHP will facilitate a competitive award process of up to \$20,000 over two years, to seven state teams led by either the Title V program or a member of the Association of University Centers on Disabilities network, to support the collaboration of Act Early Regional Summit Project teams and to further activities. These funds are designed to be a catalyst for collaboration with stakeholders, as well as for implementing specific activities outlined in Act Early State Plans. AMCHP will provide ongoing technical assistance, disseminate resource materials and link grantees to other states and experts in autism spectrum disorders. For more information

and to apply, [click here](#). Applications are due Jan. 10, 2014. For additional questions, contact Michelle Jarvis at mjarvis@amchp.org or (202) 775-1472, or Alma Reyes at areyes@amchp.org or (202) 775-1474.

WKCF Community Leadership Network

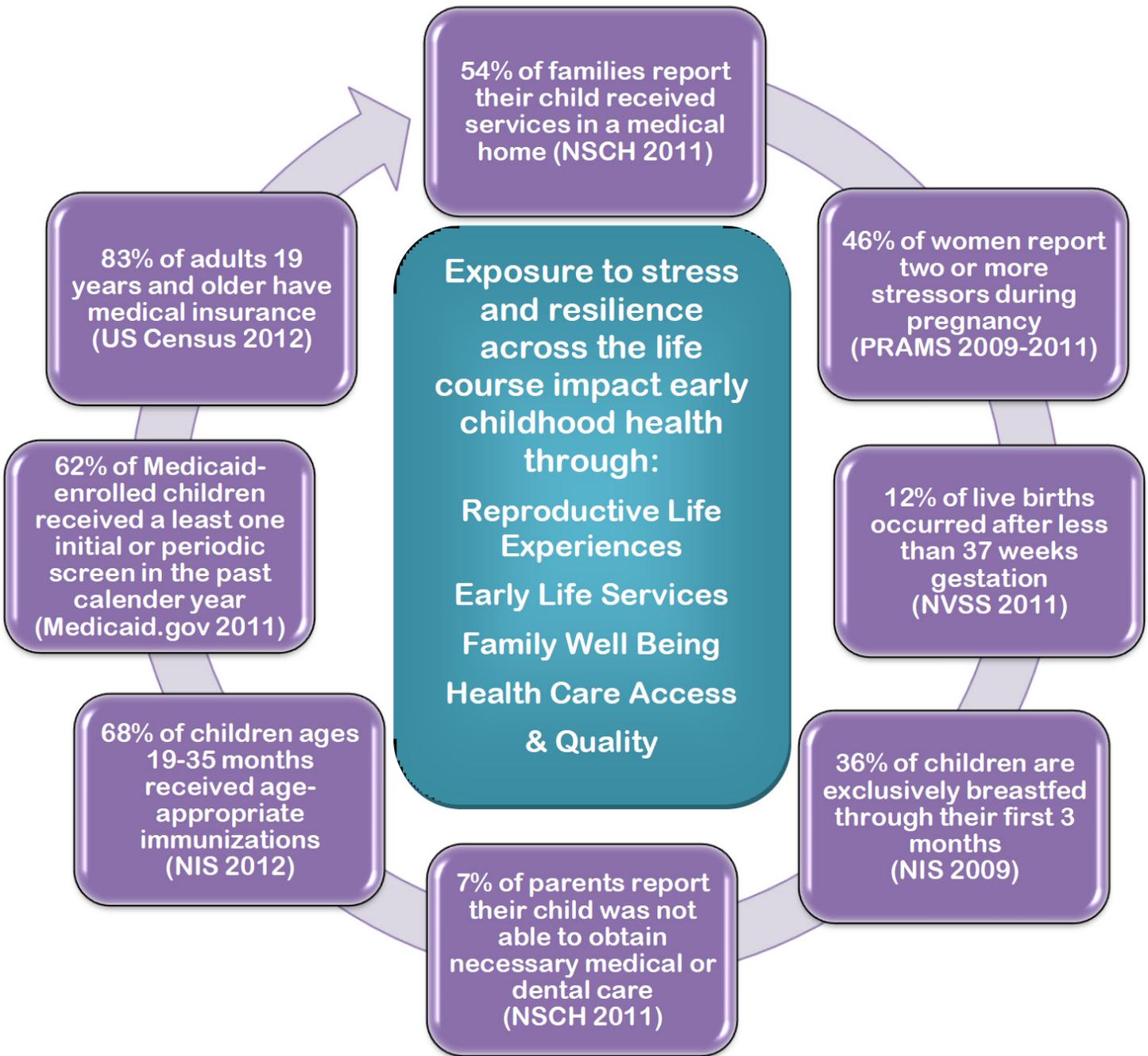
The WK Kellogg Foundation (WKCF) announced a new program, committed to leadership development, the WKCF Community Leadership Development Fellowship. This program targets individuals who can be transformative agents of social change in their communities, in order to help vulnerable children and their families achieve optimal health and well-being, academic achievement and financial security. The fellowship will support both emerging and existing leaders and will help form new, self-sustaining networks in the foundation's four U.S. priority places – Michigan, Mississippi, New Mexico and New Orleans. A national cohort also will be included. Applications will be accepted through Jan. 14. Each selected fellow will spend three years polishing leadership skills and sharing their experiences with a cohort of developing leaders. For more information on this opportunity and to apply, [click here](#).

Webinar Series: Leading in Changing Times

In working to improve the lives of women, children and families, leadership is an essential role for MCH programs. Leaders must have a vision, take initiative, influence people, solve problems and take responsibility in order to make things happen. Whether or not they have a formal title, everyone is engaged in the process of leadership. Likewise, everyone can develop their leadership effectiveness. The Leading in Changing Times Series is an initiative launched by AMCHP as part of our larger efforts to support a diverse, effective and competent workforce in state and territorial MCH programs. The year-long, three-part series of webinars blends principles of key leadership theory with real-world stories from senior-level MCH leaders. The second conversation of this series is scheduled for Jan. 15 at 1:30 p.m. EST titled, Leading Change: The Challenge of Change. Presenter Valerie Ricker, assistant director, Population Health Division at the Maine Center for Disease Control and Prevention with more than 30 years of MCH experience and currently serving on the AMCHP board as secretary, will provide an overview of the key concept, leadership and change, followed by her personal experience in combining MCH with other programs into one department. For more information and to register, [click here](#).

Data and Trends

A Life Course Context for Early Childhood Health



Resources

[AAP National Center for Medical Home Implementation](#)

– The American Academy of Pediatrics (AAP) developed the medical home model for delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including children and youth with special health care needs.

[American Academy of Home Care Physicians \(AAHCP\)](#)

– The mission of AAHCP is to promote the art, science and practice of medicine in the home, by serving the needs of thousands of physicians and related professionals and agencies interested in improving care of patients in the home.

[CMHI Medical Home Index](#)

– The Center for Medical Home Improvement (CMHI) Medical Home Index (MHI) self-assessment and classification resource is designed to translate medical home indicators, including accessibility, family-centered, comprehensiveness and coordination, into observable processes of care within any office setting. This tool helps provides a means in which to measure and quantify the degree of “medical homeness” of a primary care practice.

[Healthy Families American Home Visiting for Child Well-Being](#)

– Healthy Families America is a home visiting program model designed to work with overburdened families at-risk for child abuse, neglect and other adverse childhood experiences. The program offers voluntary services for three to five years after the birth of the baby to families with histories of trauma, partner violence, mental health issues and substance abuse issues.

[Home Visiting and the Family-Centered Medical Home: Synergistic Services to Promote Child Health](#)

– This brief by the American Academy of Pediatrics and the Academic Pediatric Association workgroup on the family centered medical home (FCMH) reviews the synergistic contributions of home visiting programs and the FCMH, and discusses how to evaluate their coordination.

[Home Visiting Applied Research Collaborative](#)

– The Home Visiting Applied Research Collaborative (HARC) is an exciting, new practice-based research network devoted to conducting collaborative studies with home

visiting programs. It is part of the Home Visiting Research Network, which is funded by the U.S. Health Resources and Services Administration Maternal and Child Health Bureau.

[HRSA Family/Patient Medical Home Program](#)

– The Health Resources and Services Administration (HRSA) Family/Patient Centered Medical Home Program assists in the implementation of family/patient centered medical home models at the practice and system levels to guarantee that all children, particularly those with special health care needs, have access to comprehensive health care that is family-centered, coordinated and compassionate.

[HRSA Health IT for Children Toolkit](#)

– This resource is a compilation of health IT information targeted at the health care needs of children, ranging from pediatric electronic medical records to children’s health insurance coverage. It also discusses opportunities to link other systems that serve children, including Head Start, schools and foster care.

[Jefferson Medical College Department of Family & Community Medicine](#)

– The department’s Home Visit Program, established in 1981, is an urban, physician-based, home visit program that delivers care to homebound patients. The program also offers its students an educational opportunity to visit and provide medical care to patients in their home environment.

[Johns Hopkins Home Visiting Research Network](#)

– The Home Visiting Research Network at Johns Hopkins Children’s Center works to improve the lives of mothers, infants and children by strengthening home visiting service models, innovative research methods, translating research into policy and practice and supporting the professional development of the next generation of home visiting researchers.

[MCH Library at Georgetown University Home Visiting Resource Brief](#)

– This resource brief offers high quality resources and reports on data, toolkits, policy and research aimed at comprehensive and high quality home visiting/medical home programs.

[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

Resources CONT.

families.

- [Every Child Deserves a Medical Home](#) – The AAP Medical Home channel houses a compilation of videos developed by the National Center for Medical Home Implementation. A five-minute introductory video provides an overview of “Every Child Deserves a Medical Home” and is followed by several short feature narratives presented by pediatricians, other healthcare providers, and families who – in their own words – describe what “medical home” means to them. These videos discuss the key constructs in evaluating a medical home, including team-based care, coordination, and quality improvement.
- [Medical Home](#) – “Medical Home” was initially presented as a session at the 2013 AMCHP Annual Conference. Included are two presentations of about 41 minutes in length each. The session introduction provides a thoughtful presentation from the perspective of a state CYSHCN director about how the concepts of “medical home” provide the backdrop for a major paradigm shift in orientation of Title V CYSHCN programming. The video is close captioned and slides are posted for downloading. (Part 1: Parent Professional Partnerships in Medical Homes and Health Reform; Part 2: Transition, Families and Youth-Essential in the Medical Home)

[MIECHV](#) – The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program facilitates collaboration and partnership at the federal, state and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

[National Center on Medical Home Implementation](#) – Works to ensure that all children, including children with special needs, have access to a medical home by enhancing by providing resources, tools, technical assistance and support.

[National Coordinating Center for the Genetic Service Collaboratives](#) – The National Coordinating Center brings quality genetic and newborn screening services to local communities and connects public health, primary care, Medical Home, specialists and consumers.

[Nurse-Family Partnership](#) – The Nurse-Family Partnership (NFP) is an evidence-based, community health home visiting program for first-time, low-income mothers and

babies. With over 30 years of randomized controlled-trial research, NFP provides clients with the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children and become more economically self-sufficient, through ongoing home visits from registered nurses.

[Ounce of Prevention Fund](#) – The Ounce of Prevention Fund advocates for home visiting as a means to prepare young, inexperienced parents to excel as their baby’s first teacher, as research has shown that such programs increase children’s literacy and high school graduation rates. Home visiting programs also have shown to increase positive birth outcomes for children and decrease rates of child abuse and neglect.

[Patient-Centered Primary Care Collaborative](#) – PCPCC is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. The collaborative achieves its mission through the work of five stakeholder centers, led by experts and thought leaders dedicated to transforming the U.S. health care system through delivery reform, payment reform, patient engagement and employee benefit redesign.

[Safety Net Medical Home](#) – The Safety Net Medical home aims to make the primary care practice the hub of all relevant activity and improve quality the care coordination of communities, labs, specialists and hospitals. Priorities of the initiative include linking patients with community resources to facilitate referrals and respond to social service needs, integration of behavioral health and specialty care into care delivery through co-location or referral agreements, tracking and support of patients when they obtain services outside a practice, follow-up with patients within a few days of an emergency room visit or hospital discharge, and communication of test results and care plans to patients/families.

[Zero to Three Home Visiting Community Planning Tool](#) – This resources provides guidance and tools to help ensure the successful implementation of quality home visiting programs in communities. The comprehensive list of resources covers public engagement, how to best match the needs of a community, family recruitment and engagement, professional development, collaboration, evaluation, and more.

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Calendar

AMCHP Events

[AMCHP 2014](#)

Jan. 25-28
Washington, DC

MCH Events

[Family USA's Health Action 2014](#)

Jan. 23-25
Washington, DC

[National Summit on Quality Home Visiting](#)

Jan. 29-30, 2014
Washington, DC

[AcademyHealth 2014 National Child Health Policy](#)

Conference
Feb. 5
Washington, DC

[Racial Justice or Just Us? in Birth and Breastfeeding](#)

Mar. 4-6
Washington, DC

[15th Annual NHSA Spring Conference](#)

Mar. 29-31, 2014
Washington, DC

[2014 Preparedness Summit](#)

Apr. 1-4, 2014
Atlanta, GA

[CityMatCH Leadership & MCH Epidemiology Conference](#)

Sept. 17-19, 2014
Phoenix, AZ

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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THE ROAD AHEAD:
Challenges, changes & opportunities for Maternal and Child Health

2014 amchp annual conference
jan. 25-28
washington, dc
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