



PULSE

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

September/October 2016

Table of Contents

- 1 From the President of the Board
- 2 The Raising of America
- 3 The Affordable Care Act and Community Benefit
- 4 The Value of Community Partnerships in Outreach and Enrollment
- 5 Innovative Initiatives to Engage Communities in Colorado
- 6 Republican and Democratic Visions for Health Care in 2017
- 7 West Virginia Engaging School-Based Youth Coalitions in Program Development
- 8 First Person: A Family Representative Visits the Hill
- 9 A View From Washington
- 9 Black Mamas Matter: Centering Human Rights and Racial Justice in Maternal Health
- 11 Success Story: Accelerating Successful Youth Engagement in Wyoming
- 12 Focus Groups in Action: Iowa's Progress
- 13 Calendar
- 14 Get Involved
- 15 Member to Member
- 15 Who's New in MCH
- 16 AMCHP Board of Directors and Staff
- 17 Standards of Quality Youth-Centered Care
- 18 3 Ways SPHARC Can Improve Your State's ASD/DD Program

The Community Engagement Issue Issue

From the President

By Eileen Forlenza

President of the Board, AMCHP



Families of children who have been marginalized have a rich history in our country of changing the conversation in many fields. Civic engagement is the bedrock of our democracy and the cornerstone of our Constitution. But while community engagement is not novel, what is new is the emergence of community engagement as a public

health priority. The shared interests and priorities of community and health leaders present an opportunity to partner and put the "public" back into public health.

Communities are developing innovative solutions to assure the health, safety and well-being of their members because they have unique insight regarding their resources, politics, history, culture, power and authority. Community members are dedicated to finding solutions because they are inextricably connected to the outcome. It's not a job or an assignment; it's their life. Like a baby swaddled by a blanket, the community's experience and deep culture are to be honored while being protected.

The Centers for Disease Control and Prevention's [Essential Services of Public Health](#) guidelines provide the framework for effective community engagement. Essential Service No. 4 states that public health systems should "mobilize community partnerships to identify and solve health problems." Of all the essential services of public health, this is the only one that specifically calls out partnership; it guides us to build trust and cultural respect.

Indeed, the public health workforce can and should be partners in these conversations. For years, public health leaders have been talking about the value of embedding the voice of the community in programmatic design, implementation and evaluation. I have had the privilege of working in Colorado and across the country to support public health teams in their community engagement activities. Going from

value to action requires several steps toward readiness. I encourage you to consider the following:

1. We must shift from *servicing* the community to *partnering* with the community.
2. Our budget is our policy statement.
3. We must take time to understand and honor culture; it is the heartbeat of all communities.
4. The community experience is the horizontal thread across vertical systems.
5. Lived experience held by individuals is a valuable credential and should be honored.
6. Community engagement leads to health equity.

Communities know what they need – the answers are in the people. It is our job as public health professionals to be invited to the conversation as partners. Careful consideration must be made to build trust with the community, so that we are not sidetracked by the call of our ego to “fix the problem” but rather to solve challenges together.

As you might know, I came to the public health workforce as a community leader, advocating on behalf of families who have children with special health care needs. Throughout my public health career, I have been awe-struck by the dedication of my colleagues who care deeply about population health and are committed to women, children and youth. I have

seen over and over again how the MCH workforce “gets it” when it comes to community engagement, and so I thank you for your tireless efforts. I am excited to see how much further we can go as new resources become available and members of the community join us in our work!

In light of the upcoming national election, community engagement is ultimately about democracy. I’ll leave you with the words of President Abraham Lincoln: “... and that government of the people, by the people, for the people, shall not perish from the earth.”

Let’s link arms and cross the bridge together.

Warmly,
Eileen

“Communities know what they need – the answers are in the people.”

The Raising of America: Learn how strong community and public health partnerships benefit our youngest children, and their families



The Raising of America is the first national, fully integrated media/public engagement project that aims to reframe the way Americans look at early child health and development. In the year since its release, the Raising of America documentary and resources have been used by hundreds of organizations to spark new conversations and change through community engagement. On Sept. 21, AMCHP and partners in the Centers for Disease Control and Prevention’s Division of Violence Prevention, the National Association of County and City Health Officials and the Healthy Heartlands Collaborative hosted a webinar that highlighted how state and local communities have used the series to build strategic partnerships and implement policy, systems and environmental changes to improve child health and development.

The webinar featured examples from Kansas City, Mo., about how community and public health organizations worked together to engage over 1,600 individuals in a “Raising of Kansas City” agenda that supports comprehensive early learning education solutions from a racial equity and families-first framework. As a result of those efforts, Kansas City created a six- to eight-week paid parental leave option for all 6,000 city employees.

Colorado shared how the state’s Early Childhood Partnership provides the space and conditions for diverse partners to come together, identify common results, share best practices, implement strategies and track progress in child and family well-being and in systems performance improvement. The statewide partnership supported communities in their efforts to help parents contribute to the workforce while build strong relationships with their children. In Boulder County, this work included providing four weeks of paid family leave for all county employees and creating “infants in the office” policies for county employees.

The webinar recording and resources are posted at www.amchp.org/earlyintervention. To learn more about Raising of America, visit www.raisingofamerica.org.

The Affordable Care Act and Community Benefit

By **Atyya Chaudhry**
Senior Program Manager
Health Reform Implementation, AMCHP



Keeping communities healthy and strong is one goal of the Patient Protection and Affordable Care Act (ACA). The various reforms and provisions – such as increasing access to affordable healthcare, expanding home visiting programs and providing support for breastfeeding – collectively work to improve the health and well-being of the individuals and families that form communities.

One ACA provision focused on community engagement is the requirement for 501(c)(3) nonprofit hospital organizations to conduct community health needs assessments in order to maintain their tax-exempt status. This provision requires nonprofit hospitals to partner with public and community health programs to conduct community health needs assessments (CHNA) and develop strategies to address the identified needs. This provision enhances community engagement and community collaborations to make health improvements.

The CHNA is completed every three years. Nonprofit hospitals are required to document their CHNA process in a report, which must contain the following information:¹

Definition of a community. Hospitals have the flexibility to define their communities. The definition is not permitted to purposefully exclude minorities, low-income and medically underserved populations.

Assessment of community needs. Hospitals are required to assess and prioritize the health needs of the community. Hospitals have flexibility in applying criteria to assess and prioritize these needs and are required to take community input into account in prioritizing those needs.

Broad representation of community interests. Hospitals are required to solicit input from the following:

- Individuals with expert knowledge in public health
- Federal, state, local, tribal or regional health departments or agencies with knowledge/expertise in health needs of the community

- Leaders, members or representatives of medically underserved, low-income and minority populations in the community

Proper documentation of the CHNA. Aside from the elements above, the report must include:

- An explanation of the how the community was determined
- A description of the methodology used to conduct CHNA
- A description of how the broad interests of the community were taken into account
- A prioritized description of community health needs and the criteria applied to determine the significance of the needs
- A description of resources to potentially address the needs identified through CHNA

Collaboration on reports. A hospital facility is allowed to conduct a CHNA in collaboration with other organizations, which can include public health or other departments at the state or local level. A facility that collaborates with a governmental public health department in conducting the CHNA may produce a joint CHNA report.

Public availability of CHNA report. A hospital facility must post the report on the facility’s or hospital organization’s website.

In addition, a hospital facility is required to identify an implementation strategy for each significant health need identified in the CHNA. The implementation strategy must:

- Describe how the facility will address the significant health need, potential impact of the actions and evaluation of the impact. Hospital facilities are permitted to collaborate with other organizations on implementation strategies.
- Identify the health needs that the hospital does *not* aim to address and explain why.

The CHNA process is a clear example of the ACA’s commitment to improving healthcare starting with the community. Given the flexibility of the CHNA process and the requirement to engage health officials, there is an opportunity for collaboration and coordination with Title V programs in the needs assessment and implementation strategies. An example of how a Title V program in Kansas engaged with this process can be found [here](#).

(Endnotes)
1 Association of Maternal and Child Health Programs (AMCHP). (2015, March). *Community Benefit & Title V*. Retrieved from: http://www.amchp.org/Transformation-Station/Documents/CHNA%20Formatted_March%2715_FINAL.pdf

The Value of Community Partnerships in Outreach and Enrollment

By Emily Eckert

Program Analyst - Health Reform Implementation, AMCHP



With open enrollment in the Health Insurance Marketplace [Marketplace] beginning on Nov. 1, Title V agencies have a unique role to play in connecting uninsured women, children and families to the Marketplace and other coverage options. One of the primary functions Title V staff can serve is coordinating with community partners to get people connected to coverage and care.

Although the Affordable Care Act (ACA) is a national law, successful implementation of the law has required the strong support of state and local advocates. Given the varying laws and policies that existed among the states prior to passage of the ACA, the law has played out differently in each state. As such, outreach and enrollment strategies that work in one state may not be as fruitful in another.

A number of national groups – including Community Catalyst, Families USA and Enroll America – have gathered and shared best practices in outreach and enrollment for states to adopt and adapt for their unique needs. Among these best practices are strategies for closing the information gap and expanding health literacy, investing in outreach, using various forms of technology, easing the enrollment experience by providing one-on-one assistance and establishing statewide and community-level relationships to partner on outreach and enrollment-related activities. Perhaps the most vital of these practices for the Title V community is establishing these critical partnerships.

Community partnerships are essential for maximizing Marketplace enrollment for maternal and child health (MCH) populations. Some of the more common partners Title V agencies engage with include local health departments, [federally-qualified health centers](#) (FQHCs), schools, hospitals and consumer advocacy groups.

One example of engagement with a traditional partner comes from Connecticut, where Title V works with school-based health centers throughout the state to conduct outreach and enrollment for the Marketplace as well as for the Children's Health Insurance Program (CHIP). It is important to note that many of these community-based entities, often FQHCs or consumer advocacy groups, may be receiving [Navigator grants](#) from the Centers for Medicare and Medic-

aid Services to conduct their outreach and enrollment work. However, in order to reach the most vulnerable women, children and families, it is critical for Title V agencies to think outside the box when establishing community partnerships.

Some less traditional partners for Title V to consider engaging in support of open enrollment include faith groups, homeless shelters, tribal councils, multicultural community centers, LGBTQ advocates and social service agencies or nonprofits that work with justice-involved individuals. Such partnerships are working in many states. For example, Washington partners with a statewide consumer advocacy group in which 90 percent of the outreach and enrollment staff are bilingual, in order to meet the language and cultural needs of its population. In Montana, the Department of Health and Human Services' Women's and Men's Health Section collaborates with the Montana Primary Care Association and the state's Navigator grantees to provide specialized trainings on coverage options for justice-involved individuals. These efforts demonstrate a commitment from Title V agencies to assist hard-to-reach populations as they try to navigate the health care system.

In the transformation of the Title V MCH Block Grant, Dr. Michael Lu, associate administrator of maternal and child health at the Health Resources and Services Administration, emphasized the importance of access to coverage and care through the development of National Performance Measure No. 15: the percent of children age 0 through 17 who are adequately insured. There are [15 jurisdictions](#) focusing on this measure in their block grants. Even if a state hasn't selected the measure, Title V agencies can engage in partnerships to promote outreach and enrollment in the Marketplace, Medicaid and CHIP. (Note: Eligible individuals can enroll in Medicaid and CHIP year-round.)

AMCHP's Health Reform Implementation (HRI) team has a number of useful resources for Title V staff related to the ACA, including the [Outreach and Enrollment Fact Sheet](#) and [Coverage Chart](#). For more information about how specific NPMs relate to the act, please see AMCHP's ACA [Crosswalk](#). For specific questions about open enrollment, which ends Jan. 31, please contact AMCHP's health reform implementation team at eeckert@amchp.org.

Innovative Initiatives to Engage Communities is Colorado

By Anne-Marie Braga, MSSW, LCSW

Population and Community Health Manager - Children, Youth and Families Branch, Colorado Department of Public Health and Environment



I'm not going to lie: Community engagement is tough. It can be inconvenient and uncomfortable at times – especially when engaging a new community that is very different than your own. However, community engagement is necessary to improve the health and well-being of maternal and child health (MCH) populations. And

here in Colorado, we have seen the benefits time and time again. This is why our Title V MCH program has formally adopted community engagement as a core, fundamental principle that is woven into each of our state priority needs. Engaging the community creates the dedicated space and time for all of us to ensure that the communities most affected by our MCH work are effectively engaged.

Many strategies and systems have been put in place to ensure meaningful, effective community engagement. Colorado's MCH program continues to invest in the Family Leadership Training Institute to ensure that family leaders – and to some extent youth leaders – are trained and ready to partner with community and state leaders to improve the health and well-being of the MCH population. To ensure these family leaders can identify and take advantage of opportunities to lend their expertise, Colorado created the [Family Leadership Registry](#), developed under the leadership of our Family and Community Engagement Specialist and current AMCHP president, Eileen Forlenza. This online system, modeled after LinkedIn, matches trained family leaders with opportunities on various boards and projects at the state and local levels. All members of the Family Leadership Training Institute are given a basic profile in the registry, which is enhanced when the family leaders add their areas of interest from a list of MCH priority areas and topics that were identified by the family leaders themselves. In addition, organizational partners are invited to submit leadership opportunities for family leaders, allowing those leaders to be matched to appropriate opportunities, assuring the family/community perspective is embedded in the work of participating organizations.

In 2015, the MCH program funded a comprehensive study to determine current practices and barriers regarding

family engagement within state agencies. As a result of this study, Forlenza created (and continues to lead) Colorado's Interagency Family Engagement Coalition. This group is composed of family leaders and state agencies who work together to change policies and practices across government entities; for example, developing community engagement policies for state agencies requiring them to set expectations and processes to effectively engage the communities they serve.

Our youth and young adult team has effectively hired and integrated youth into the workplace to serve as content experts in youth and young adult culture. This team also serves as a mechanism for capturing the needs, insights and interests of young people statewide. Institutionalizing the practice of hiring youth in term-limited positions ensures that programs, practices and policies that are meaningful and relevant to youth and young adults across the state are in place to affect health outcomes. This youth advisor model is being replicated by local public health agencies, community organizations and other state agencies. As a result of the expansion of the model, two learning communities, one for youth advisors and another for their adult supervisors, have been established. The youth advisor model supports youth employees in growing their ability to lead and provides opportunities for adult employees to enhance their skills as mentors and address issues in creative ways.

In addition to the youth advisor model, our MCH program continues to support the [Youth Partnership for Health](#) (YPH), our department's youth advisory board. This group of diverse youth and young adults provides guidance and feedback to programs and initiatives seeking to improve youth health and well-being. YPH has been meeting since 2000, and its results include a variety of policy and practice changes that affect programs addressing positive youth development, such as substance use, safe driving, sexual health, bullying, mental health and suicide. Finally, another strategy we identified as necessary to increase effective community engagement is providing one-on-one coaching opportunities for Colorado MCH program staff. Over the past several years, we conducted learning communities to provide space for groups of staff members to learn about the importance of community engagement. MCH staff are encouraged to ask questions of coaches such as: Where do you find community members? How do you get community members to come to your meeting? Do I have to pay community members? What if they don't come back? This was a great start to get the conversation going, but to keep it going we identified experienced staff to serve as MCH coaches. They are responsible for reaching out to and providing specific coaching for each MCH priority team lead. This ensures that staff get what they need in order to effectively engage the communities most in need. While this approach is new, we have already received positive feedback from the staff.

Republican and Democratic Visions for Health Care in 2017

Implications for MCH Populations

By Elise Aliotti

Policy Intern - AMCHP



In anticipation of the upcoming presidential election and change in administration, the Republican and Democratic parties have released their blueprints for improving the nation's health care system. The Democratic plan would expand the Affordable Care Act, while the Republican plan would scale it back. The two party platforms express differing visions for the country, and each would

have lasting effects on maternal and child health services.

The Republican Plan

Republican leaders' plan, "A Better Way," outlines the party's recommendations to improve health care delivery, payment and coverage by changing the ACA. Its proposals include removing the requirement for insurers to cover essential health benefits and repealing the health care law's individual mandate. The plan retains the provision allowing children to stay on their parents' insurance plans until age 26 as well as the ban on lifetime coverage limits.

The Republican plan allows states to choose from two options for their Medicaid programs: a block grant or a per capita allotment approach. States that have not expanded Medicaid would no longer have the option to do so. Each state would be allowed to determine which subsets of its population would be eligible for Medicaid coverage and which services would be covered, although coverage for certain vulnerable populations would remain. States would also be permitted to impose work or education requirements on adult enrollees and use wait lists or premiums for people who want coverage but do not fall into the category of people for whom coverage is mandated.

The plan would no longer require insurers to meet

minimum coverage requirements, which could lead to underinsurance for individuals and families who purchase less expensive plans that have limited benefits. Without minimum coverage requirements, insurance companies could opt out of covering certain preventive care measures for mothers and children.

The GOP plan proposes a one-time opportunity for people to obtain insurance in the individual market with a guarantee of coverage regardless of pre-existing conditions. If an individual does not enroll in coverage during this open enrollment period, insurers could determine eligibility and premium costs based on the individual's pre-existing conditions.

The Children's Health Insurance Program (CHIP) would also undergo changes. The Republican plan would eliminate the ACA's enhanced 23 percent federal match for CHIP, returning to a match rate in the traditional range of 65 percent to 85 percent.

The Democratic Plan

The Democratic Party platform, released in July, does not call for as many significant changes, focusing instead on expanding the reach of the ACA. The platform promotes the adoption of the ACA's Medicaid expansion in all states and recommends allowing individuals and families to purchase health insurance on the ACA health exchanges regardless of their immigration status.

The Democratic plan reaffirms the provisions within the ACA that ensure women have access to preventative care and contraception with

no copayment or coinsurance. The platform includes measures to improve treatment for mental illness and substance abuse, including school-based prevention programs for adolescents. In addition, the platform pushes for autism screening in early childhood and requiring insurance companies to cover autism treatment services. Another provision would double funding for federally-qualified community health centers and provide workforce training to improve quality of care and access to care.



West Virginia Engaging School-Based Youth Coalitions in Program Development

By Patty McGrew

Director - Office of Maternal, Child and Family Health's Adolescent Health Initiative, West Virginia Department of Health and Human Resources



The West Virginia Adolescent Health Initiative (AHI) began in 1988 with a state project director and a team of eight teen pregnancy prevention specialists. Extensive research into the concept of positive youth development steered the program toward a more holistic approach in 1993. Today, the AHI still funds a dedicated network of eight regional adolescent health coordina-

tors (AHCs) who engage individuals, organizations and the community to address negative health impacts and create a supportive environment in which adolescents can thrive.

The transformation of the Title V Maternal and Child Health Services Block Grant (aka MCH 3.0) in 2015 brought about more changes for the AHI program with the implementation of specific, strategic focal areas. Some, like improving the rate of adolescent well-visits, were new territory for AHI. Data about well-visits were limited. Program staff decided the best way to learn what barriers existed or what services were needed by West Virginia youth and their parents was to ask them.

Throughout the 2016 fiscal year, the AHI focused on obtaining statewide input from youth and parents to guide program efforts in order to increase adolescent well-visits and decrease bullying (particularly cyberbullying). Adoles-

cent and parent survey tools were developed based on feedback from four youth test groups. Surveys were distributed during community-based focus groups across the state, where the regional AHCs discussed the surveys with participants, obtained feedback, provided information and answered participant questions. Focus groups were conducted at schools, churches, housing authorities, malls, various youth groups (Students Against Destructive Decisions (SADD), Gay-Straight Alliance Clubs, Boys and Girls Clubs, etc.) and even professional meetings – basically, anywhere there was a captive audience. The survey tools were also made available online via Survey Monkey and distributed via social media, newsletters and email.

The number of responses exceeded expectations. In total, 1,450 parents and 3,131 youth responded to the surveys. When asked what would help with the problem of bullying, 53 percent of youth responded, "If more teens knew how to stop a bullying situation without getting into a fight or becoming a target themselves." Fifty-two percent responded, "If more teens had a trusted adult they could be open and honest with," and 46 percent responded, "If [their] community or society in general realized true bullying is a problem and not just part of growing up." Many youth expressed frustration with adults not listening to them or taking them seriously. Comments included:

"Adults seem to think that bullying is only as bad as it was when they were kids, but it is way worse."

"It would be nice if parents, adults and teachers would take bullying seriously. It isn't a joke. We know the difference between friends kidding and actually being bullied. STOP treating us like we don't!"

"I have been bullied a lot – face to face and on social media. I talked to a lot of adults [who] did not help me. I even wanted to die it was so bad."

Not surprisingly, when asked what form of bullying was the biggest or most common problem, 54 percent of youth identified social (also called relational) as the biggest problem versus verbal (36 percent) or physical (10 percent). Parents differed slightly identifying verbal (46 percent) as the greatest, with social (42 percent) closely behind.

On the well-visit surveys, parents expressed confusion about adolescent well-visits versus an annual sports physical: "I thought my son had a well-visit, but I learned today that's not what it was." Both youth and parents also listed affordability as a barrier (16 percent for both groups). Also high among the parents' concerns were convenience, namely office hours, missed time from work/school and travel time. Most youth (58 percent) stated they did not feel it was important to go to the doctor when they weren't sick. Youth offered (sometimes humorous) suggestions for in-



Members of the West Virginia Adolescent Health Initiative.

creasing awareness on the importance of well-visits:

“How about a health event [with] famous people there like dirt bike riders!”

Youth were very vocal about the “awkwardness” of visiting a “baby doctor” and how uncomfortable they felt:

“In the waiting room, do not let it just be quiet and awkward [with] everybody staring at each other.”

“I would like the doctor a lot better if the office had Wi-Fi and less little kids’ shows.”

“How about snacks and comfortable chairs – like bean bag chairs!”

“I’d go if I wasn’t afraid to see my weight.”



Snacks, “grown-up” shows, Wi-Fi and a noisier atmosphere were a few suggestions from youth on how to improve doctors’ offices.

Parents spoke highly of School Based Health Centers and said more were needed. Parents and youth stated transportation was a barrier, particularly in rural areas. Both parents and youth expressed confidentiality concerns: Youth did not want parents in the exam room, and parents were concerned about staff (particularly in small communities) revealing health information to friends and neighbors.

The data has not only guided the program but also the work of our partners. The well-child data has been shared at state and regional meetings and presented at the West Virginia Department of Education’s annual Kid Strong Conference. These conversations have paved the way for many projects and opportunities in the coming year. Most notably, data from the bullying surveys will be used by SADD Chapters across West Virginia to develop a media campaign. The campaign will launch at the annual state conference in November and will continue throughout the year. However, finding a famous dirt bike rider has proven to be a bit more challenging.

First Person: A Family Representative Visits the Hill

By Tiffany Earnhardt
Parent Advocate - North Carolina



I could never truly explain the feelings that I felt during my visits with my members of Congress. I had always thought that my voice never counted, and that no one would ever hear what I had to say or even care if they did hear me. That changed when I joined the Hill Visit during the 2016 AMCHP Annual Conference. I was so nervous: I had never spoken with a member of Congress or Congressional staffer before and honestly did not know what I had gotten myself into. Prior to my meeting, I had a great visit with someone from AMCHP who gave me some pointers, and from there I went to my first meeting in a senator’s office.

I was greeted with respect, as though I was one of them. While I waited for the senator’s staffer to greet me, I was so scared that I felt sick to my stomach. A gentleman walked over and asked if I was Tiffany. I responded with hesitation in my voice; I was scared to even speak and afraid of using the wrong words. We walked into a conference room, and we sat next to each other. He listened intently to what I had to say, and he even gave me feedback. He expressed to me how nice it was to meet one of the senator’s constituents – a family member who is actually touched by the laws Congress enacts. While I thought he was just being nice, I left the meeting feeling energized and overwhelmed with emotions. I never knew what would come of that meeting or if he would respond if I got back in touch, but this staffer and I still speak on a regular basis. He has helped me realize that what I have to say is important and can make a difference.

This is an experience I believe everyone should have. Our elected leaders do care about what we have to say, and they love to hear from families.

Advocacy has changed my life. I have gone from being a scared younger lady with two children with special health care needs to learning that I have a voice and that what I have to say matters. If you ever have a chance, please take the time and speak to your members of Congress – whether through emails, in person or phone calls – because they truly care about what we have to say, and want to know what is working and what’s not. Our elected officials will never know how we feel unless we speak with them. Knowing that I have changed in so many ways from just one experience, I can only imagine how it could make others feel as well!

A View From Washington

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



Faithful readers may recall that my last column reflected the deep frustration I have shared regarding Congress’ failure to respond in a timely manner to the request for emergency supplemental funds to address the Zika virus. It is a great relief to again share the news that Congress [recently passed](#) a \$1.1. billion Zika package.

Clearly, the immediate imperative for MCH leaders is to help deploy these resources in the most efficient and expeditious manner to protect mothers and babies from the Zika virus. As this work unfolds, MCH leaders need to help drive a dialogue with the broader public health community and policymakers to examine two critical questions: 1) Why did the Congress take nearly seven months to act on an emergency request made in February to respond to a virus that potentially attacks babies’ brains? 2) What can we do to assure minimal delays in funding any future public health emergencies?

To the former, it’s fair to fully examine all factors – including whether we, as MCH advocates, communicated the urgency of the situation effectively and to ask what else we could have done to make our case. To the latter, it’s encouraging that discussions have begun to revive the concept of a Federal Emergency Management Agency-like public health emergency fund that would be available immediately when certain conditions are met. The Association of State and Territorial Health Officials has begun to take a leadership role in pushing for such a fund, and we hope to join efforts in the next Congress to establish such an emergency fund.

Speaking of the next Congress, we at AMCHP are excited to be finalizing a 100-day agenda of policy steps the next president and Congress could take to improve the health of women, children and families, including those with special health care needs. Our plan is to release this agenda shortly after the election, and we look forward to a window of



Black Mamas Matter: Centering Human Rights and Racial Justice in Maternal Health

By Pilar Herrero
Human Rights Fellow - Center for Reproductive Rights

By Katrina Anderson
Interim Director - U.S. Human Rights and Foreign Policy, Center for Reproductive Rights

In June 2016, the Center for Reproductive Rights (the Center) released a new resource on maternal health called Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care. The toolkit is part of a broader effort — by the Center, [SisterSong Women of Color Reproductive Justice Collective](#) and a growing network of partners — to use the human rights framework to eliminate profound racial disparities in U.S. maternal mortality.

Bridging local and international dialogues

While most other countries have substantially reduced maternal deaths over the past two decades, the U.S. has become the only developed country with a rising maternal mortality ratio. Despite all the money and technology that flows through our health care system, women in the U.S. are still losing their lives during pregnancy, childbirth and postpartum. Racial inequality is driving many of these poor maternal health outcomes. Black women are three to four times more likely to suffer maternal mortality than are White women, and they are twice as likely to suffer severe maternal morbidity. These are not just public health issues; U.S. maternal health has become a human rights crisis of global concern.

In 2014, the Center partnered with SisterSong to elevate concerns about U.S. maternal health at the international level. Along with the National Latina Institute for Reproductive Health, these organizations submitted a joint report to the [Committee on the Elimination of Racial Discrimination](#) (CERD). (CERD is a body of independent human rights experts who monitor implementation of a human rights treaty aimed at ending racial discrimination. The U.S. has ratified the treaty and has agreed to incorporate its content into domestic law). The report presented data on maternal health disparities, and included insights from the experiences of Black women in the U.S. In preparing for the report, SisterSong hosted storytelling circles with Black women in

Mississippi and Georgia, documenting their experiences with sexual, reproductive and maternal health. Those stories provided CERD with crucial context about the barriers to health that southern Black women face – before, during and after pregnancy.

After completing its review of the U.S., CERD recognized the rising maternal mortality ratio as the human rights crisis that it is. [The committee called on the U.S. government](#) to step up its efforts to eliminate racial disparities and specifically recommended improving data collection and accountability mechanisms, such as maternal mortality review boards. Since then, the United Nations Human Rights Council and two other independent human rights expert groups have urged the U.S. to take action that ensures equality and nondiscrimination in maternal health and survival.

Facilitating cross-sectoral collaboration

Recognizing that maternal health is a complex and multifaceted issue, the Center and SisterSong followed up on the CERD report by co-hosting a [multi-sector convening](#) of maternal health experts in 2015. During this convening, public health professionals, researchers, service providers, policy experts and reproductive justice advocates identified their major challenges as well as innovative strategies for improving Black maternal health. Among the many ideas generated, participants identified a need for advocacy tools that would inform, engage and empower new leadership.

Providing advocacy tools

Working closely with the convening participants and other leaders on Black maternal health, the Center developed a set of materials that will support the work of state maternal health advocates as they mobilize their communities and communicate with state policy leaders. [The Black Mamas Matter toolkit, released in June 2016](#), takes a human rights-based approach to maternal health, identifying the rights of pregnant and birthing women and the corresponding role of government to ensure safe and respectful maternal health care for all. It emphasizes the need to address root causes of health disparities and to ensure the participation of marginalized communities in decisions that will affect their health. In an effort to center effort on those most affected by poor maternal health, the resources highlight issues of particular concern to Black women living in the South.

The toolkit includes: (1) a human rights brief on maternal health; (2) a summary of maternal health research; (3) an overview of policy solutions proposed by multi-sector stakeholders; (4) talking points for state and national advocates; and (5) a list of resources for those working on maternal health in the U.S. All of these materials can be found at [BlackMamasMatter.org](#).

Encouraging community engagement

Good maternal health outcomes depend on the full realization of human rights, within and beyond our health system. For Black women, multiple and intersecting forms of discrimination – on the basis of race, gender and often socioeconomic status – create obstacles to achieving the highest attainable standard of health. A human rights-based approach provides a framework for ensuring that all of our efforts to improve maternal health outcomes promote access and quality, but also accountability, dignity, nondiscrimination, autonomy, empowerment, participation and equality.

As the Black Mamas Matter network continues to grow, its [members are using the human rights framework](#) to highlight the leadership of Black women, to ensure the inclusion of marginalized voices and to generate community-oriented responses to the problem of poor maternal health. Ultimately, Black Mamas Matter is demonstrating that Black women have solutions. What these leaders need most right now are platforms for sharing ideas and access to the funding, partnerships, technical resources and institutional supports that will make their solutions sustainable. State health agencies are well positioned to play a powerful role in nurturing these community leaders and the community-based solutions they generate.



Participants of the 2015 Black Mamas Matter convening gather outside the SisterSong Motherhouse in Atlanta, Ga.

State health agencies can also strengthen partnerships with the communities they serve by: (1) recognizing the thought leadership that exists in those spaces; (2) building meaningful collaborations with community members who are most impacted by poor maternal health outcomes; and (3) incorporating the human rights framework into health agencies' own work. For example, as maternal mortality review processes continue to generate new findings, state agencies must ensure that Black women and their communities have meaningful opportunities to participate in the translation of data into policies and programs, including implementation and monitoring of any recommendations.

The view and opinions expressed in this article and the related toolkit belong to the Center for Reproductive Rights and do not reflect the view of the Association of Maternal & Child Health Programs.

Success Story: Accelerating Successful Youth Engagement in Wyoming

By Elliane Yashar

Program Analyst - Child and Adolescent Health, AMCHP



Youth are frequently described as leaders of the next generation or as the future leaders of our country, but why should they have to wait to become adults in order to take on important leadership roles? Adolescents and young adults have important ideas to contribute around positive social change and are certainly capable of serving as influencers in their communities. They just need the

opportunity for their voices to be heard.

How can such opportunities be provided? Although we may be fully aware of the numerous benefits around youth engagement, it can be challenging to start implementing programs and activities when we are dealing with budget cuts, staffing shortages and other impending priorities. Shelly Montgomery-Barth, manager of the Adolescent Health Program at the Wyoming Department of Health (WDH), has helpful experience and insight in effectively jumpstarting engagement programming for youth with limited support and resources.

Prior to her joining the WDH three years ago, there was no Adolescent Health Program in place – let alone a sustainable youth engagement program. As a new employee in a newly formed department, Montgomery-Barth began building the program by reaching out to experts in the field to see what had worked well. Her first step was working with a group of adults from statewide nonprofit and government organizations committed to adolescent health and to serving youth in Wyoming. Soon she was able to launch the Wyoming Adolescent Health Partnership (WAHP) through the newly developed Adolescent Health Program. The purpose of the WAHP is twofold: 1) to provide trained adult partners with opportunities to work with adolescents and young adults; and 2) to develop a state strategic plan for adolescent health addressing shared risk and protective factors across diverse programs and organizations.

Part of the WAHP includes a team composed of six compensated adolescents and young adults, ages 16-22, who will act as a statewide youth health council after receiving training in public health advocacy. The youth health

council will work directly with a young adult hired part-time as a youth liaison who oversees compensation, food for meetings, transportation and coordination of the council. In order to create a part-time position, Montgomery-Barth reached out to her partners in the Wyoming Division of State Parks, and together they share a seasonal position dedicated to youth engagement.

Once the youth council is fully established this October, its initial goal is to determine a name, mission and vision. From there, the council will work to advise the public health division programs about how to reach and connect with youth across the state. Montgomery-Barth's vision is that by the end of the fiscal year, all programs that target adolescents will have received input from the youth council.

"We're extremely excited about that and the work that can go forth from there," she says.

The goal is not only to engage a cohesive team of qualified and motivated adolescents for the council but to try to ensure the group is representative of diverse populations. Montgomery-Barth developed the idea for a "Self-Introduction" section in the job application to provide an opportunity for the youth to showcase their varying talents and diverse backgrounds.

"We wanted a lot of diversity, and you can't just necessarily have check-boxes for diversity," she says. "We really wanted the youth to be able to say what they have to bring to the table." Instead of the generic personal statement essay question format, the youth submit their responses to this question in the form of a work of art, a video or a written piece. Montgomery-Barth emphasizes the importance of including youth with varied abilities, and this response format allows youth to showcase these talents.

Trying to implement new programs from scratch with limited resources can seem like an overwhelming and somewhat daunting task, but sometimes the hardest part is just getting started.

"You don't have to start big, just start," Montgomery-Barth advises. "If you don't know what to do for youth right now, just ask them! Find where you can get in touch with youth, even if it's just having conversations with your co-workers' kids or going to the local Boys & Girls Club, just start talking to youth. It's that easy to start."

Montgomery-Barth's hard work in developing engaging youth programming in Wyoming is an inspiring example of how substantial progress can be accomplished within a short period of time. Sometimes all it takes is a clear vision and the willingness to take small steps to reach the ultimate goal.

Focus Groups in Action: Iowa's Progress

By Addie Rasmusson, MA

Community Health Consultant - Iowa Department of Public Health

By Cori Floyd

Program Associate, Child and Adolescent Health - AMCHP

Adolescence is a crucial time for preventive interventions, because it's a period of significant physical, behavioral and emotional growth. How can public health professionals better engage young people and families to identify opportunities to change the perception of available services?

As part of the Adolescent and Young Adult Health Collaborative Innovation and Improvement Network (AYAH CollIN), the Iowa Department of Public Health focuses on strategies to encourage more adolescents to receive well-visits. In the spring of 2016, Iowa conducted focus groups with adolescents and parents of adolescents to identify levels of awareness about the existence of adolescent well-visits and their content, as well as barriers to and motivators for a well-visit. Two focus groups of parents with adolescent-aged children averaging 15 years of age (n=16) and two focus groups of youth averaging 17 years of age (n=23) were completed in Iowa. These groups presented a wealth of information that the Iowa team plans to share and incorporate in their quality improvement work.

Parents highlighted that they took their adolescents to the doctor only for specific reasons, including the flu, broken bones, physicals for sports or camp, and chronic illnesses. They did not seem to be aware of the differences between a sports physical, an immunization visit or an adolescent well-visit. Parents also expressed value in establishing a relationship with providers through well-visits; however, the adolescent groups did not express that same perspective. The only notable benefit of the well-visit mentioned by adolescents is knowing whether or not they are healthy.

Each group also shared what they believed providers should talk about during the well-visit (Figure 1). Interestingly, youth most valued discussion around violence prevention, substance abuse and eating disorders, while parents valued conversations around bullying, school performance, puberty and sexually transmitted diseases. These differences can have notable impact on the well-visit experience. Using the focus groups' results can prove valuable when structuring the well-visit experience to meet the needs of both young people and their parents.

With regards to barriers, all the focus groups shared enlightening information on what hindered adolescents from receiving a well-visit. Adolescents identified being scared to go to the doctor and being too shy to discuss certain things with a provider. They also expressed concern with confidentiality and being honest about whether they are having sex, using drugs or drinking alcohol. Additionally, parents identified barriers such as not understanding how the visit is covered by insurance (i.e., co-pays) and scheduling with a provider, especially for those living in rural areas that have to account for significant driving time.

So with all of this information in mind, how is the Iowa team planning to move forward? Each focus group pro-

vided useful recommendations about how to advertise and incorporate the adolescent well-visit into their communities (Table 1).

The Iowa AYAH CollIN team plans to use each focus group's feedback and recommendations to develop key messaging under a larger communications plan that caters to the community's needs and concerns. The team will also distribute the focus groups' results to health care providers across the state to help providers improve adolescent and parent interactions and identify strategies to encourage repeat visits.

Strategies such as these that engage the community are valuable tools public health professionals can use to tackle population health issues, identify potential solutions and foster valuable partnerships with community members.

Table 1

Adolescents

- Want to see the benefits of a well-visit.
- Want to see messages emphasizing not to be embarrassed or afraid to be honest about their health with their doctor.

Both Adolescents and Parents

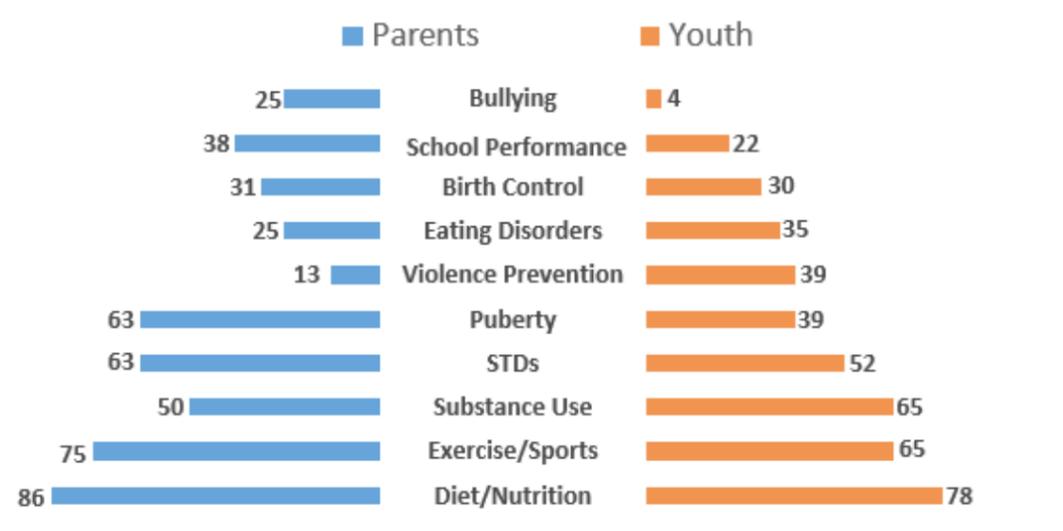
- Believe that confidentiality should be respected and left up to the adolescent and his/her family.
- Prefer to see the same health care provider each time in order to build rapport and allow the provider to know what the family prefers as far as sharing information between the parent, adolescent and provider.

Parents

- Want more education what a well-visit is and what it entails.
- Suggest making adolescent well-visits a school requirement or providing information about it in the school registration packets as a reminder.
- Suggest that the health care provider's office schedule the next appointment automatically when the adolescent is there, just as the dentist's office would.
- Shared that they did not go for well-visits annually themselves. Educating parents about the importance of well-visits and encouraging them to go could transfer to their adolescents.

Figure 1: What should health care providers discuss with teens?

Percent of youth and parents who responded 'yes' it should be discussed



Calendar

[AMCHP 2017 Annual Conference](#)

March 4-7, 2017
Kansas City, Mo.

[Adverse Childhood Experiences Awareness to Action 2016 Conference](#)

Oct. 19-21, 2016
San Francisco, Calif.

[2016 Northeast Epidemiology Conference](#)

Oct. 20-21, 2016
Saratoga Springs, N.Y.

[American Public Health Association 2016 Annual Meeting and Expo](#)

Oct. 29-Nov. 2, 2016
Denver, Colo.

[National Federation of Families for Children's Mental Health Annual Conference](#)

Nov. 10-13, 2016
Phoenix, Ariz.

[Healthy Teen Network 2016 Conference](#)

Nov. 16-18, 2016
Las Vegas, Nev.

[Association of University Centers on Disabilities 2016 Conference](#)

Dec. 4-7, 2016
Washington, D.C.

[Zero to Three Annual Conference 2016](#)

Dec. 7-9, 2016
New Orleans, La.

[University of Michigan's 24th Annual Primary Health Care of Women Conference](#)

Dec. 15-16, 2016
Ann Arbor, Mich.

[15th Annual Family Voices of California Health Summit & Legislative Day](#)

Feb. 27, 2017
Sacramento, Calif.

Get Involved



Become a Member of the 2017 Leadership Lab!

AMCHP is requesting applications for participation in the 2017 Leadership Lab! The Leadership Lab is built upon peer-to-peer collaboration. Participants will spend 10 months (January through October 2017) engaging in self-directed learning modules, creating an individual development plan, participating in quarterly webinars and much more. Applicants are able to tailor their learning by applying to participate in one of the following Cohorts: Family Leaders, New Directors, Next Generation MCH/CYSHCN Leaders or the Epi-Net P2P. Applications are open from Tuesday, Sept. 20 and are due by [Friday, Oct. 21, 2016 at 8:00 p.m. ET](#). Take advantage of this wonderful opportunity to sharpen and build upon your skills, share best practices and strategies and enrich the MCH workforce. Please visit us on our [website](#) for additional information.

Present Your Research at the 2017 AMCHP Annual Conference

The AMCHP Annual Conference is the ideal venue to present your ideas, research, innovative programming, best practices and effective outreach strategies. We invite you to [submit a proposal](#) for the 2017 AMCHP Annual Conference (March 4-7) in Kansas City, Mo. The deadline for submissions is Oct. 20 at 11:59 p.m. ET. You will receive notification of the status of your submission by Dec. 1. If you have questions about the session proposal submission process, contact Corey Siembieda at csiembieda@conferencemanagers.com or (703) 964-1240, ext. 200. For more information, please visit the [2017 AMCHP Annual Conference homepage](#).

Maximizing Insurance Enrollment in MCH

In partnership with Family Voices, AMCHP is hosting a webinar series to help maternal and child health advocates better prepare for the upcoming open enrollment period. The series, "Maximizing Insurance Enrollment in Maternal and Child Health," will feature presentations from the Maternal and Child Health Bureau, the Center for Consumer Information and Insurance Oversight, Enroll America, state Title V agencies and health insurance navigators from the family leader community. The next installments in the series are listed below:

- [Strategies to Enroll Hard-to-Reach Populations](#) - Oct. 25 from 2:00-3:30 p.m. ET
- [Strategies to Address Challenging Enrollment Situations](#) - Nov. 9 from 3:00-4:30 p.m. ET

For more information, please contact Maria Isabel Frangen-

berg at mfrangenberg@familyvoices.org or Emily Eckert at eckert@amchp.org. Follow the conversation on Twitter using #EnrollMCH, and be sure to tweet at [@FamilyVoices](#) and [@DC_AMCHP](#).



Promoting Health for Women Living with a Disability

October is Breast Cancer Awareness Month and is a perfect time to learn more about the importance of reducing barriers to health promotion for women living with a disability. Join the Association of University Centers on Disabilities for a [webinar](#) on Oct.

19 from 2:30-3:30 p.m. ET to gain more knowledge on the resources offered by the Food and Drug Administration's Office of Women's Health, the Friends of the National Center on Birth Defects and Developmental Disabilities and the American Association on Health Disabilities.



Apply Your Research in Epidemiology to MCH!

The Health Resources and Services Administration's Maternal and Child Health Bureau is accepting summer proposal project submissions for the upcoming [2017 Graduate Student Epidemiology Program](#). This program offers graduate students a unique opportunity to apply their classroom skills to real-world data projects, as well as offering state and local agencies valuable technical assistance as they work to enhance their information systems capacity. State or local health departments and tribal epidemiology centers are eligible to propose a project until Nov. 11. The application for graduate students will open on Jan. 2, 2017. Eligible students must be currently enrolled in an accredited U.S. school of public health, successfully completed coursework in epidemiology, biostatistics and health administration, as well as specializing in the study of maternal and child health. For additional information, please contact Julia Fantacone at gsep@altarum.org.

For more information, please contact Julia Fantacone at gsep@altarum.org.



Domestic Violence and Children

The Childhood Domestic Violence Association will host a [webinar](#) on Oct. 20 from 12:00-1:00 p.m. ET. The presentation will discuss the effects of children witnessing domestic violence.

Member to Member

Why is it important to engage community partners in developmental screening?

Janis Gonzales

Bureau Chief/Medical Director/Title V Director - Family Health Bureau, New Mexico Department of Health

As many as one in four children aged 0 to 5 is at moderate or high risk for developmental, behavioral or social delays. Proper administration and scoring of developmental screening tools contribute to improved health outcomes for young children by ensuring early identification of delays. This, in turn, leads to timely referrals to Early Intervention programs, which enhance development and provide support to the child and family.

Engaging community partners in the promotion of monitoring, screening and referral helps to increase awareness and ensure that more children with developmental and/or behavioral delays and disorders are identified, leading to appropriate intervention and treatment services. Engaging community partners also helps to identify shared measures, facilitate collaboration and reduce duplication across sectors. Community partners bring a wealth of information and expertise that assist with moving toward the goals of building a universal screening system and helping families successfully connect with support services.

Gina Robinson

Program Administrator - Client and Clinical Care Program Office, Colorado Department of Health Care Policy and Financing

Screening for delays is only the beginning of the story. Ensuring that children receive the necessary referral and access to services is key to changing the direction of a child's development. Even among those who are screened and recommended for services, only two-thirds are evaluated to determine if they qualify for Early Intervention Colorado services. The Children's Hospital of Philadelphia Policy Lab notes that while screening is important, it must also be supported by a coordinated, diverse number of services that include referral, evaluation and service delivery" (2012 SERIES: An Integrated approach to supporting child development). In order to ensure equal opportunities for children to succeed, all children should be screened, referred early when concerns exist and connected to services as appropriate.

Cross-agency collaboration is needed to achieve the goal of linking children to needed services. The development of robust, coordinated systems will improve efficiencies in our systems and ensure that children receive the care they need when they need it. Each partner is a key link, bringing its knowledge and expertise to the table to build a strong and well-coordinated system for developmental monitoring, screening, referral and connecting children to supportive services. In this way, the community ensures that more children and families reach the services and resources they need.

Who's New at AMCHP



Nisa Hussain is the Program Associate for the Workforce and Leadership Development Team. Hussain brings valuable experience in program coordination, committee management, digital education material development and working with focus groups, as well as collecting qualitative and quantitative data. During her internship at the National Center for Health Research, Hussain's responsibilities spanned from writing health blog posts and editing newsletters to managing website content. She graduated from the University of Maryland, College Park with a B.S. in Community Health. At AMCHP, she focuses on supporting event management for the National MCH Workforce Development Center, staff liaising the WDC Advisory Committee, maintaining the workforce development web pages, and advancing other leadership development efforts and initiatives.

AMCHP Staff

Patrick Boyle, Associate Director, Communications and Membership

Karissa Charles, Membership Associate

Atyya Chaudhry, Senior Program Manager, Health Reform Implementation

Cheryl Clark, Associate Director, Epidemiology and Evaluation

Stacy Collins, Associate Director, Health Reform Implementation

Linnard Corbin, Accounting/Office Assistant

Andria Cornell, Senior Program Manager, Women's Health

Emily Eckert, Program Analyst, Health Reform Implementation

Michelle Eglovitch, Program Analyst, Women's and Infant Health

Kidist Endale, Accounting Associate

Brent Ewig, Director of Public Policy and Government Affairs

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

Lori Tremmel Freeman, Chief Executive Officer

Cori Floyd, Program Associate, Child and Adolescent Health

Krista Granger, Program Manager, Data and Assessment

Amy Haddad, Associate Director, Government Affairs

Nisa Hussain, Program Associate, Workforce and Leadership Development

Michelle Jarvis, Specialist, Family Engagement and Leadership Development

Ki'Yonna Jones, Senior Program Manager, Workforce and Leadership Development

Jeanette Kowalik, Associate Director, Women's and Infant Health

Nora Lam, Senior Executive Assistant and Board Administrator

Sarah Beth McLellan, Senior Program Manager, CYSHCN

Christina Ratleff, Senior Program Manager, Women's and Infant Health

Caroline Stampfel, Director of Programs

Kate Taft, Associate Director, Child and Adolescent Health

Kristen Taylor, Communications Associate

Wendy Wen, Associate Director, Finance and Accounting

Iliana White, Senior Program Manager, Adolescent Health

Elliane Yashar, Program Analyst, Child and Adolescent Health

AMCHP Board of Directors

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

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)

Belinda Pettiford
Raleigh, North Carolina

Region V (Interim 2016-2018)

Shirley Payne, MPH
Indiana

Region VI (2016-2019)

Susan Chacon, MSW, LISW
New Mexico

Region VII (Interim 2015-2017)

Heather Smith, MPH
Kansas

Region IX (2016-2019)

Mary Ellen Cunningham, MPA
Arizona

Region X (2016-2019)

Cate Wilcox, MPH
Oregon

Director-at-Large (2015-2018)

Rodney Farley
Arkansas

Director-at-Large

Donna M. Johnson
Georgia

Family Representative (2015-2018)

Donna Macan Yadrich, MPA, CCRP
Kansas

Interim Family Representative (2016-2017)

Gina Pola-Money, A.S. Social Sciences, Mo.M.
Utah

Standards of Quality Youth-Centered Care

By **Elliane Yashar**

Program Analyst, Child and Adolescent Health - AMCHP

Standards of Quality Youth-Centered Care

Adolescents' Participation
Youth are involved in the planning, monitoring and evaluation of health services.

Adolescents' Health Literacy
Systems are implemented to ensure adolescents are knowledgeable about their health and how to access and obtain health services.

Community Support
Parents, guardians, and other community members recognize the value of adolescent health services.

Appropriate Package of Clinical Services
The health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfills the needs of adolescents.

Providers' Competencies
Providers demonstrate the technical competence required to provide effective health services to adolescents (e.g. confidentiality, respect, and non-discrimination).

Facility Characteristics
The health facility has convenient operating hours and an adolescent-friendly environment that maintains privacy and confidentiality.

Equity and Non-Discrimination
Adolescents are provided quality services regardless of income, age, sex, marital status, education, race/ethnicity, sexual orientation, or other characteristics.

Data and Quality Improvement
Data and service utilization and quality of care is collected, analyzed, and used to support quality improvement.

3 Ways SPHARC Can Improve Your State's ASD/DD Program

By Cori Floyd

Program Associate, Child and Adolescent Health - AMCHP

3 WAYS

★ **The State Public Health Autism Resource Center (SPHARC)**

Can help improve your state's Autism Spectrum Disorder and/or Developmental Disabilities (ASD/DD) program.

Click on graphics for more!

SPHARC
State Public Health Autism Resource Center is a comprehensive web-based resource center for state programs, including Title V.

»»

OUR AIM
is to help increase state capacity to implement systems of care for children and youth with ASD/DD.

Here are three ways we can help **YOU** to improve your state's ASD/DD program.

1

Resource Development

Find resources developed by SPHARC and state grantees using the search engine!

Title V MCH National Performance Measure 6 Developmental Screening Tools

Publications

State Profiles of ASD/DD programs and grantees

Title V Action Planning

Roles for State Title V Programs in Building ASD/DD Systems of Care

State Autism Grantee Spotlight Interactive Map

Case Examples on Using CYSHCN Standards and SPHARC Tools

Environmental Scan: State Strategies and Initiatives

National Landscape: Developmental and Autism Screening Programs and Initiatives

Children and Youth with Special Health Care Needs

91% of responding state implementation and planning grantees said they applied one or more concepts learned from SPHARC.

2

Technical Assistance

SPHARC has supported 30 HRSA State Autism Systems Grantees, including 12 Title V Programs!

SPHARC Webinars that feature topic area experts

One-on-One calls with SPHARC staff that focus on your state's area of need

Learning Modules around six critical indicators for CYSHCN

3

Peer Learning

See resources from past Peer-to-Peer Exchanges on topics like....

⚡ Addressing Gaps in ASD/DD Diagnosis

⚡ Considering Culture

⚡ Screening and Beyond

Site Visits that delve into one another's programs, successes, and lessons learned

Peer-to-Peer Exchange for states to learn from each other on a specific topic

Learning Community that facilitates collective problem solving, sharing, and replication of best practices

THE BOTTOM LINE

★

SPHARC is a great resource for you and your state.

We are here to SERVE!

✋

For more information, go to www.amchp.org/SPHARC.

AMCHP's State Public Health Autism Resource Center is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U01MC1069 - Partnership for State Leadership Cooperative Agreement. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS