From the President

Leadership
By Nan Streeter, MS, RN

A leader is a person that leads, directs, commands or guides. When I think of a leader, I think of a person with a vision, a person with the ability to share that vision with others and guide them to making the vision a reality. A leader is someone who shares the “glory” for the outcome with those that helped.

As MCH leaders, whether a Title V Director, a MCH or CSHCN Director, family or youth representative leaders, we all have a great deal of responsibility to ensure that those we serve or advocate for — mothers, families, children and youth, including those with special health care needs — have access to needed services. With today’s climate of political uncertainty and financial disaster, the challenge to us as leaders becomes huge. We all know about having to do more with less, but now we face deeper budget cuts, loss of staff or positions.

So, how do we cope with all these challenges? How do we continue to lead when faced with overwhelming odds? We continue doing our best to “make lemonade out of lemons.” Obviously we can’t make as much lemonade as before, but we can still make lemonade.

When you don’t have enough lemonade to go around, you have to make hard and fast decisions, some of which are not ones that are comfortable or popular.
Nonetheless, a leader is not always one who makes things comfortable or does what is popular, but rather has the responsibility and the obligation to make those sometimes unpopular hard decisions.

Now more than ever, mothers, children and youth, especially those with special health care needs, and families need us to step up and speak up for those who may not have a voice, or may not be able to speak up. We have to do what we can with what we have. Easy? No, of course not.

As President of AMCHP, I encourage each and every leader to step back and ask yourself: how you are doing as a leader? Can you do more? I ask you to consider demonstrating your leadership for mothers and children by volunteering to play a leadership role with AMCHP. You can do this by speaking up to your Senators, Congressmen and women, to your state leaders, about the important needs of mothers and children in your state, cities and in the nation. While you may not be able to do this as a government staff member, you certainly can as an individual. You also can participate in AMCHP committee work, or better yet, by serving as an AMCHP Board member!

Before next year’s conference, all delegate members of AMCHP will have an opportunity to vote for six Board of Director positions: family representative member, two at-large members, two Regional Directors (Regions IV and VIII) and President-elect of the Board of Directors. Yes, I know that being a Board member entails time, energy and work, but the rewards are so great. Board members have an opportunity to work with peer leaders on national issues, to learn what issues exist in other parts of the country that may be similar to those they face, to dialogue with federal and national leaders on maternal and child health needs, to participate at another leadership level, national, and to work together with other leaders across the country on promoting the importance of meeting the needs of mothers and children.

I urge you to step up and demonstrate your leadership by getting involved in efforts to promote the health (including mental health) and wellness for mothers, children and youth, including those with special health care needs, and families so that your voice can be heard for those who cannot or are not able. We are up to the challenge, aren't we? Because we ARE leaders!
By Mike R. Fraser, PhD

With just a few weeks left before the presidential election, it is fitting that our October issue of Pulse focuses on the topic of leadership. This campaign season has brought the leadership issue to the forefront of many people’s minds. What makes a good leader? Who would be the best leader for our country? Why would this person be a better leader than the other person?

Answering these questions is beyond the scope of this column, and beyond the allowable limits of AMCHP’s tax-exempt status which requires me to be passionately non-partisan. So, let me leave it at this: leadership is about creating a vision of the future and motivating people to take responsibility for that future as if it was their own. An effective leader has a vision of the future and encourages people to work toward that vision together. We’ve all experienced that kind of leadership and known good leaders who do just that. In just a few short weeks, the United States will decide which candidate will be our next leader and which vision of the future we’ll share in developing. These are exciting times indeed.

Although the presidential campaigns have spurred lots of talk about leadership in Washington, there has always been talk about leadership in maternal and child health (MCH). Competencies are developed around it. Strategic plans include it. Institutes are founded, and funded, for it. Careers are dedicated to developing it. Leadership is everywhere in MCH, and thankfully so.

For us to effectively improve the health of women, children, fathers and families in the United States we need good leaders – individuals who can create a shared vision of the future and get us all to take responsibility for that vision as if it were our own. That MCH is cognizant of this fact is due to our enlightened leaders – individuals who know that our success rests on creating a vision and getting the support to make that vision a reality.

Recently I had one of those strange weeks when everything seemed to come together with some kind of cosmic serendipity – and in this case it was a week full of leadership. Within five days I had been part of a gathering of MCH leaders at the annual CityMatCH conference in Albuquerque, met with a group of MCH leaders in Santa Fe working hard to improve the health of women in children in New Mexico, met with a group of family leaders developing a leadership program to encourage family leadership in Delaware, visited in Washington with Dr. Julie Gerberding who leads the Centers for Disease Control and Prevention (CDC), and capped the week off at a meeting in New York City with Mrs. Sarah Brown, the First Lady of the United Kingdom, who was at the United Nations leading an effort to reduce maternal mortality and improve maternal health worldwide. What a week! It was a whirlwind of MCH leadership in all its glory and with all its diversity.

All of these gatherings were focused on getting individuals to take responsibility for a shared vision of the future. At CityMatCH that vision was about being effective MCH leaders within our organizations and agencies and being part of a network of committed MCH professionals working day in and day out to improve the health of women and children in states and communities nationwide. In Santa Fe that vision was about supporting efforts to improve the health of women and children in new and creative ways given budget shortfalls, political challenges, and the reality of working within state governmental systems.

In Delaware the vision was about getting families more involved in the work of Title V and engaged throughout the state to assure families were viewed as partners in improving the health of all children, including children with special health care needs. In Washington the vision was about leading an agency through change and transition and creating a shared vision of what CDC can and should be as a leading public health institution.
From the CEO CONT.

On Leadership

minute worldwide, and developing joint projects to bring awareness to the issue and energy to a solution. At all these events diverse local, state, federal and international leaders shared their visions of what we could be, asked us to dedicate ourselves to that vision, and invited us to work together to obtain those visions.

It was a week full of MCH leadership, and a week full of MCH leaders. In a few short days I had been from New Mexico to New York with a few stops in between and taken part in developing visions of the future with some of our best and brightest MCH leaders. All had clear visions of where we should be going together. All invited me to be part of that vision, and asked for AMCHP’s help in moving their visions forward with the resources, time, talent and treasure of our organization and its members.

My experience during those five days showed that leadership is not about one’s title, education, position or perceived authority. Leadership is knowing where you want to go and motivating people to go there with you because they believe in the vision you have created. Genuine, authentic leadership is not about ego or power, it is about creating a common purpose and a shared path to carry out that purpose.

As MCH leaders we have so many opportunities to lead because our vision for the future is so clear: healthy children, healthy families, living in healthy communities. What will you do to get others to share that vision, and how will you do it? My hope is that this issue of Pulse helps you think through how you may continue your journey as an MCH leader and bring others along with you.

Get Involved

AMCHP Women’s Health Information Series Call

The next Women’s Health Information Series call, “Women and IPV, Substance Abuse, and Mental Health: The Need for an Integrated Response,” will be held on Thursday, October 23 from 3 to 4:30 p.m. (EST). Please register here to receive the call-in number and passcode. For additional information, please contact Brynn Rubinstein or call (202) 775-0436.

Sign the Petition for Preemies

AMCHP has joined families across America and the March of Dimes by signing on to the 2008 Petition for Preemies. As an alliance partner, we’re creating awareness of Prematurity Awareness Month this November and the growing problem of preterm birth. Please direct your colleagues and constituents to sign the petition here. With your help, we can increase support for prematurity-related research and maternal and infant health.

Help AMCHP Recognize Our Maternal and Child Health Leaders

AMCHP is currently soliciting nominations for the Vince Hutchins Leadership Award and the John C. MacQueen Lecture Award. Both awards will be presented at the 2009 Annual Conference in Washington, D.C., February 22-25. Submissions are due by October 31, 2008.

The Vince Hutchins Leadership Award recognizes outstanding individuals, living or deceased, whose work has contributed to significant societal changes that have resulted in improvements in the health of American families and their various members. Last year’s award was presented to Dr. Peter van Dyck of the Maternal and Child Health Bureau.

Dr. Peter van Dyck, winner of the 2008 Vince Hutchins Leadership Award.
The John C. MacQueen Lecture Award for Innovation in the Field of Maternal and Child Health is an annual lectureship award honoring one of its most distinguished members, John C. MacQueen, the former director of the Iowa Child Health Specialty Clinics, the state's program for Children with Special Health Care Needs (CSHCN). Last year’s awardee was Dr. Vic Sidel.

The criteria for the MacQueen Lecture award are:

1. the awardee is a contributor to the field of MCH;
2. the awardee is an advocate on behalf of the MCH community;
3. the awardee focuses their work on/around the establishment and maintenance of healthy communities; and
4. the awardee can deliver a dynamic/inspirational lecture to the MCH community.

To submit a nomination for consideration please e-mail the AMCHP Governance Committee, c/o Nora Lam, Executive Assistant at AMCHP. Please include the following information:

1. the award for which you are submitting a nomination;
2. your name and contact information;
3. the name and contact information of the nominee; and
4. a brief summary of why you think the nominee meets the criteria established for the award.

If you have any questions about AMCHP’s awards, the selection process or would like additional information, please contact Annette Phelps, Governance Committee chairperson or Michael Fraser at AMCHP.

Submit Your Best Practice Today

AMCHP is seeking submissions of best practices in maternal and child health from around the country. Whether it’s an effective campaign to promote breastfeeding, an outstanding nurse-family partnership, or a proven early intervention program for young children, get the word out about your best practice. AMCHP defines “best practices” as a continuum of practices, programs and policies ranging from promising to evidence-based to science-based. A best practice could focus on the health of women, adolescents, young children, families, or children with special health care needs.

1) Click here to download a PDF of the submission form.
2) When you are ready to submit, click here to start the survey.

To be considered for a Best Practice Award at the AMCHP annual conference, please submit by November 21, 2008. For more information on submitting best practices, please contact Darlisha Williams or call (202) 775-0436.
The State of Connecticut, Department of Public Health, Family Health Section (FHS) receives over $30 million in state and federal funding for a wide variety of programs including, but not limited to CHCs, SBHCs, family planning, intimate partner violence, rape prevention education, case management for pregnant women, CYSHCN and others. With the diversity of programs, lack of a strategic plan and decreased funding, it is easy to become distracted (lose sight of what is important), and dilute existing resources (trying to do too much with the same amount or less funding).

In September, the FHS management staff worked with a consultant to begin to develop a strategic plan to:

1. develop priorities for the Section;
2. realign programs with allocated resources;
3. allow staff to better focus their energy; and
4. ensure effective use of available resources.

As Jim Collins suggests in his book, Good to Great, you have to get the right people on the bus (or in this instance programs in FHS), and get the wrong people off the bus (remove programs from FHS that are not a good fit), and get the right people in the right seats (put the right programs in the right units within FHS), before you drive it.

Looking for the opportunities. Several years ago I found myself in a no-win situation. My state’s legislature was moving a large program I was supervising to a different state agency. The program and subsequent move was volatile, involving lawsuits, public hearings, scrutiny and nasty politics. About two months into the controversy, I remember thinking there was no way I could come through this unscathed.

To say that every crisis presents an opportunity is so cliché, but true. In the aftermath of losing a well funded, well staffed, well known program, in a state with a hiring freeze, with a somewhat tattered reputation, I had an “opportunity” to remake the office of special healthcare needs in my state, establish a system to address all the Title V assurances, and build a voice for parent/professional partnerships. First, I fell in love with this great guy (my second son) and took an extended leave. When I came back, I embraced the opportunity to build a system of accountability that really met the needs of families raising children with special needs. I am real proud of the system in Rhode Island and thankful for the “opportunities,” no matter how stressful the presentation was.

MCH is broad in scope and the Block Grant provides us with great latitude in determining areas for investment. With this flexibility, however, comes the responsibility to assure results. For states heavily focused on direct and enabling services, client counts can serve as process measures documenting “the number of people touched by MCH.” And yet, I wonder just how much these gap-filling services (many in existence for some 20+ years) have improved MCH across all populations. With the advent of the MCH performance indicators, I feel that states have been charged to improve population-based indicators of maternal child health. In order to do so in Colorado, we are moving further down the MCH pyramid, investing in population-based and infrastructure (systems) building efforts. In changing our approach, we have been challenged with the need to define the outcomes of our work, without much formal guidance.

In Colorado, we are addressing this challenge by determining key focus areas for MCH efforts. Instead of being involved in a number of activities “an inch deep,” we are critically evaluating our current work to determine what should be continued, what should be reconfigured or transitioned to other partners, and what should be
Member to Member CONT.

What is the biggest leadership challenge?

discontinued. In addition, we are determining if our role is as a lead, partner or monitor. Ultimately, we are looking at investing in fewer areas with greater depth (“a mile deep”) and emphasizing implementation and evaluation at least as much as assessment and planning. Effective interventions tied to a well-crafted evaluation plan are critical in achieving tangible MCH outcomes.

“What are we getting?” is not easily answered, but in the long run there is probably no more important question.

Feature

Thoughts on Leadership

By Peter C. van Dyck, MD, MPH

As the nation moves forward into this millennium — carrying some of the unresolved problems of its maternal and child population — this population will face current as well as new challenges. The Maternal and Child Health/Title V program and its many partners need to review their past history and approaches, modify these approaches for the new period, reaffirm their purpose and provide the leadership required.

In the current MCHB Strategic Plan, which is currently being reviewed and updated, and is the first to include a separate goal for leadership, the first goal is to “Provide National Leadership for Maternal and Child Health.” Key strategies are the broad cross-cutting approaches the MCHB uses in order to reach its strategic goals. The five leadership strategies are:

1. to create a shared vision and goals for MCH;
2. to forge strong, collaborative, sustainable MCH partnerships both within and beyond the health sector;
3. to strengthen the MCH knowledge base and support scholarship within the MCH community;
4. to promote family leadership in MCH service delivery, evaluation and program/policy development; and
5. to provide both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide.

The following principles for MCHB leadership roles and responsibilities guide the work of the Bureau in the implementation of its service program and its strategic plan:

- leadership, performance and accountability form the basis for the MCHB approach to doing business in a positive, can-do way;
- effective leadership requires collaborative partnership as well as excellent communication among key stakeholders;
- in accordance with the Government Performance Results Act, and as part of its leadership role, MCHB maintains high expectations for performance and holds itself and its grantees accountable;
- evaluation is an essential tool for program management allowing sound decisions about future allocations of resources; and
- promoting a respectful, supportive work environment is key to successful performance.

Even as we go through lean times and face unique challenges, I think the staff of MCHB have exhibited what I call attributes of good leadership: creativeness, innovation, confidence, sureness of conviction, strategic thinking, flexibility, wiseness and what I call, “don’t get stuck” — find a way to get it done. Together, with our grantees and our partners, we are making progress. Napoleon Bonaparte said, “A leader is a dealer in hope.” Let us all embrace the attributes of good leadership in an environment of hope and lead this nation in our strong sense of mission to improve the physical and mental health, safety and well-being of the maternal and child health population.
If you are within the ‘sound’ of my words, hear me clearly: your obligation to lead well is non-negotiable. “Leadership” may not be in your job title or you may not feel very potent in the course of your daily grind inside bureaucratic, hierarchical organizations, or in highly politicized times. But you don’t get to opt-out. Not never. Not now.

Leadership is not anointed. It is an art and craft to be practiced with intention over time. So the question is: how shall we lead, together? Seven kinds of leaders must unite to fulfill the enduring social contract that is bedrock to the MCH field:

1. **Values-Driven Leaders**, grounded in equity and fairness, whose practice is anchored in our core public health philosophy: social justice.

2. **Ethical Leaders**, who set the highest ethical standards for themselves and for others, and who hold themselves and others accountable for both means and ends.

3. **Servant Leaders**, whose service embodies an array of core characteristics: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to human growth and building community.

4. **Collaborative Leaders**, who create and sustain mutually beneficial, well-defined relationships among individuals and organizations to achieve results that would not have occurred as well or at all if they had not worked well together.

5. **Systems Leaders**, who see so much more than the sum of parts; who skillfully combine creativity to generate ideas, analytic intelligence to evaluate them, practical intelligence to implement ideas and persuade others of their worth; who wisdom helps harness the power of diverse interests and aligns all contributions for the greatest good.

6. **Transformational Leaders**, who transcend the routine reciprocity of giving and getting, who embrace a common mission, set a clear shared vision, and execute with mastery the process of complex change for the greater good…over the long run.

7. **Ecological Leaders**, who expect, invite, promote and sustain a culture and infrastructure of learning in their public health organizations; and who are committed to the ongoing development and synthesis of leadership skills and competencies throughout their careers, in response to an ever changing environment.

MCH is the urgent perfect part of public health to model and manifest “Mighty Seven Leadership” in intentional, strategic ways. MCH practitioners and the institutions through which we serve are stewards of the public’s health, grounded in social justice, ethical in the conduct of our work, and accountable for what happens as a result. We must be systems thinkers, navigators of complexity, masters of collaboration, architects of transformation, and advocates for sustainable change.

I call upon each of us to dedicate time for leadership development, to renew ourselves and grow others at the beginning, middle and slow sunsets of our careers. Make a plan. Find learning partners. Build skills. Read and reflect.

And please, no whining. If you think you are too busy to learn, you are too busy to lead well. Women and children, fathers and families everywhere are counting on you and me to do the best for them. If we truly invested in our own best MCH leadership, imagine how together we could be an unstoppable mighty force for change.
The MCH community has shown great interest in and commitment to developing leadership capacity and “grooming” the next generation of public health leaders. The publication in 2007 of the MCH Leadership Competencies by the Maternal and Child Health Bureau provided a tool for understanding the competencies required of MCH leaders and integrating them into job descriptions and professional development plans. Many resources exist to help programs provide leadership training, but barriers to accessing these resources remain for many MCH professionals, most notably limited resources (in terms of both staff time and money).

The MCH Leadership Skills Development Series (MCHLDS) was created by the Women’s and Children’s Health Policy Center as an alternative or supplement to existing training programs and institutes. The series comprises a set of web-based modules intended for use by groups of colleagues as stand-alone instruments or as part of other professional development activities. By providing the modules free of charge over the web, we hope to reach a broad spectrum of MCH professionals, at all organizational levels, who otherwise might not have an opportunity to focus on leadership development. Additionally, in recognition that leadership development is an evolutionary, ongoing process, the modular format provides access to targeted training tools for professionals who have received other kinds of leadership training but wish to reinforce or enhance their skills periodically throughout their careers.

Four modules currently are available, and two are in development:

Module 1: Tapping Into Your Leadership Potential
Module 2: Creating Clarity and Shared Vision
Module 3: Building and Supporting Teams
Module 4: Managing Conflict Effectively
Module 5: Organizational Change (available late 2008)
Module 6: Mentoring and Developing People (available mid-2009)

Each module makes use of multiple formats combining individual reflection and group activities (e.g., video lectures and interviews with MCH leaders, self-assessment and planning tools, role plays, discussion questions, and other collaborative activities). Case studies are integrated into the modules to translate broad concepts into practice and illustrate their application in real-life MCH scenarios. Initial feedback from “the field” indicates that MCH programs are adapting the modules for a variety of settings and uses. In recent examples, LEND trainees have used the MCHLDS to enhance their conflict resolution and negotiation skills. Healthy Start nurses have adapted the modules to focus on infant mortality and the dynamics of coalitions; and other leadership training programs have integrated MCHLDS videos and discussion questions into their own training workshops.

The MCHLDS provides a free, user-directed mechanism to enhance and sustain leadership skills and competencies in MCH staff. In conjunction with the MCH Leadership Competencies, the MCHLDS can help identify areas for organizational and individual growth and provide opportunities for teams of colleagues to build their personal and collaborative capacities.

“My colleague and I are providing these modules to our Healthy Start Registered Nurse leaders. The group is having fun and learning about leadership and dynamics of coalitions. These modules have provided the structure to adapt to many audiences.”
—Kathleen Moline, BSN, MA
Division of Women’s and Infants’ Health
Virginia Department of Health
Some Things Never Change: The Persistent Need for Leadership Preparation in MCH

By Donna J. Petersen, ScD, MHS
Director, Maternal and Child Health Leadership Skills Training Institute

I’ve had the distinct pleasure of being affiliated with the MCHB-sponsored Maternal and Child Health Leadership Skills Training Institute since 1990 and through this stellar program have had the honor of contributing to the leadership development of over 2,000 dedicated MCH professionals. I’ve also provided leadership training to graduate students in MCH programs and have participated in numerous conversations about leadership development for our field. Through all this I have come to understand one universal truth: we will never be done with leadership training and we can never relax our vigilance in assuring that every MCH professional has an opportunity to be schooled in the lessons of leadership, history, advocacy, communication, negotiation, championship, human rights and social justice.

It has been profoundly humbling to me to meet people from all over the world who find themselves in the MCH field and who are compelled to enhance their ability to act on behalf of this most important of vulnerable populations — women, children and families — who depend on a variety of community and public institutions for their safety and security in order that they may fully develop into productive and healthy adults. This is no small task for these people who come to a field that is chronically under-resourced, under-powered, poorly understood and a victim of its own politicization. But happily, these people learn through the leadership training that we and others provide that MCH is grounded in a profoundly powerful history, led by prescient champions who believed that it was every child’s birthright to be healthy and whole and that it was our responsibility as a society to assure this right. They left us a legacy that we must now shape into our own; leadership training helps us connect to that powerful past and realize our responsibility to assert our own future.

Leaders need skill and passion and both can be harnessed through training. In leadership training, we extol the virtues of leadership actions to everyone in an MCH organization regardless of position and we bring everyone under our collective leadership mantle, encouraging them to practice these leadership skills toward achieving local and universal goals. Many of our leadership training topics withstand the test of time, other content must be adapted to the changing environment. In either case, new leaders enter our field every day, just as new families enter our communities and hope that our leadership will be apparent to them. Our leadership training must be apparent to the new professionals that enter our field so that those new families' hopes do not go unheeded. We pride ourselves on our ability to assess needs, set priorities and intervene toward resolution of public health challenges.

This is one challenge that must always remain a priority, for the need is ever-present and the intervention at hand. However organized, however delivered, we owe it to ourselves, our forbearers and our constituents to assure that leadership training remains available. If not organized, if not delivered, we must still seek opportunities to mentor, to coach, to teach and to support our leaders. It is within each of us to lead and to leave a legacy of leadership.

AMCHP Adolescent Health Leadership Development Initiative

By Sharron Corle
Associate Director for Adolescent Health, AMCHP

Dr. Steve Edwards
President and Chief Executive Officer, Edwards Educational Services

Guided by the belief that leadership is key to improving maternal and child health (MCH) outcomes, that leadership is needed throughout the organization, and that leadership can be improved and developed by learning and experience, in 2008 AMCHP, working in collaboration with Edwards Educational Services, launched a pilot leadership development initiative for State Adolescent Health Coordinators. The initiative is
Feature cont.
AMCHP Adolescent Health Leadership

a one year pilot project working with Title V programs in five states. A key component of the initiative is the application of the 12 MCH Leadership Competencies through organized training, collaborative meetings and virtual support. Over the next year, AMCHP hopes the Adolescent Health Leadership Development participants will achieve the following outcomes:

- Gain a greater understanding of the 12 MCH Leadership Competencies and how they can be applied in multiple arenas;
- Be able to apply the 12 MCH Leadership Competencies in a day-to-day professional environment;
- Develop a learning collaborative who will learn and grow together in the application of these competencies;
- Learn leadership skills that will enhance career growth and opportunities, and become embedded in professional practice, creating sustainability over time; and
- Have a repertoire of skills that can be shared with others to distribute leadership throughout the organization.

Predicated on the belief that leadership development programs should use real organizational issues to provide challenges, feedback and support — the adolescent health leadership development initiative sought to integrate learning and application by creating a 12 module curriculum that provides an overview of MCH leadership skills and the requirement of a professional activity, based on real-world program needs, to demonstrate competency of the skill. On-going support through an interactive wiki, video conferencing, emails and phone calls provides participants guidance in their leadership development journey.

In the spring of 2009, the pilot group will come back together to evaluate the experience, discuss challenges, celebrate successes, communicate ideas to improve the initiative and discuss thoughts on bringing the concept of leadership development for State Adolescent Health Coordinators to other states. Look for more information on the initiative in 2009.

Feature cont.
Family Leadership in Action

By Rachel Rodriguez, Aleja-Laura Larson
Missi Barank, Family Voices

Family Voices is a national nonprofit organization that aims to achieve family-centered care for all children and youth with special health care needs and disabilities. Through our national network of family leaders, we provide families tools to make informed decisions, advocate for improved public and private policies, build partnerships among professionals and families, and serve as a trusted resource on health care. Family leadership is the essence of Family Voices. Family Voices was built — and continues to grow — by the determined efforts of a remarkable community of family and youth leaders and friends. Family to family communication of knowledge, resources, and support is fundamental to our work.

Aleja-Laura Larson

As a parent with a child with special health care needs it has become my passion to become an advocate for our daughter, Gracie and for other children with special health care needs. The beauty of leadership is it can take so many forms and it challenges each and every one of us to use our talents and share them with others!

Our journey began June of 2005 with the birth of Gracie, our second daughter. Woven within Gracie was an extra chromosome: the diagnosis Down syndrome. Gracie has been blessed with truly extraordinary traits including unconditional love, strength, innocence, the simplicity of childhood, and the ability to smile with her whole body! It is those extras within Gracie’s little body that have fueled my passion of leadership and advocacy which will allow Gracie and other children to have the life and opportunities they are entitled to. With leadership, awareness is born and through awareness our society will become more tolerant of those less able than ourselves.

I challenge parents to become leaders and take advantage of any leadership opportunities that may come their way. Start small and think BIG! My journey began with becoming active in our local Down syndrome support group which led to family networking, which led to...
strong physician relations, which led to education via the Internet and establishing a blog for Gracie, which led to becoming the chair of our state ICC Committee. Parent Leadership not only heals the soul, but it creates a network of advocacy, and lifelong friendships.

The opportunities of leadership are endless and together as one big family alliance we can pave a brighter future for our children. Challenge yourself and challenge the parents around you! It does the heart good!

Missi Baranko
My name is Missi Baranko and I am the proud mom of four daughters. Our oldest daughter, Tashina, was born with a brain disorder called Schizencephaly. At the time of her diagnosis I was a stay at home mom who had little experience with disabilities. Luckily, I was blessed to have her involved with our Early Intervention Program at an early age. Early Intervention helped to teach me that my husband and I know what is best for our daughter. We had to make a lot of tough decisions in those early years which is probably where I learned a lot about the most important type of leadership: leading for my child.

When Tashina was about three years old, one of the staff members at the Early Intervention Program asked me if I would be interested in being on our Regional Interagency Coordinating Council (RICC). I didn't really know what it was or what it meant, but in the past I had participated on other committees for other things and had enjoyed it so I agreed to be on this one.

I went to the first meeting and was intrigued by this group of professionals who were working on improving Early Intervention Services in our region. This was obviously something I was very interested in since Early Intervention had been such an asset for us. I was especially interested in making sure that the public knew about the program so more families could access it.

Within a year or so I was asked to be the coordinator for the RICC. I was quite nervous about coordinating it because I didn’t feel that I really understood the lingo yet, but I agreed and am still doing it today. I remember thinking, “fake it until you make it,” as I sat at meetings trying to figure things out. Eventually I picked things up and was given more opportunities to increase my leadership skills. I was often asked to co-present with Early Intervention staff about the benefits of Early Intervention. I also had opportunities to go to conferences related to Early Intervention. One of those conferences happened to be the Office of Special Education Programs conference (OSEP). Again, I wasn’t really sure at the time what it meant, but it was in Washington DC so that sounded exciting.

When I look back I realize going to the OSEP conference was really my largest stepping stone for leadership. I had the opportunity to meet other parents there who were in similar situations and some were also coordinators of their RICC's. I also found out about a program in our state, called the Experienced Parent Program. This was a program that our region could access. It would allow a parent to be paid to work in the Early Intervention system. This parent would provide other parents emotional support and assist families in finding resources and information. When I got back home I eagerly dug in to find out what we needed to do to get that program in our region. After about seven months we had it up and running and I was lucky enough to be the parent to do the job.

Working in the Experienced Parent Program in our region has continued to provide me with opportunities both career related and personally. I have been able to attend multiple parent leadership conferences as well as other conferences related to children and youth with special health care needs (CYSHCN). I have met many other parents and families in my state and across the nation who have contributed to my leadership both locally and statewide. I have had the opportunity to present at a handful of conferences on what it is like to raise a child with special health care needs. This has helped
to give me the confidence to continuing presenting on a wide array of issues.

About a year ago I was also asked to be a family consultant for Family Voices of North Dakota. This position allowed me to continue working on bettering the lives for families raising CYSHCN. Recently Family Voices of North Dakota held a Family Leadership Institute. I was able to be part of the planning committee and was a presenter at the Institute. It is amazing to see how the circle is now complete and I am now a leader for those families who are just beginning to learn about parent leadership. I hope to continue my journey on becoming a better parent leader as it is something that gives so much back to those who do it!

Developing MCH Leaders

By Laura Kavanagh, MPP
Training Branch Chief, Division of Research, Training and Education, MCHB

“An MCH Leader inspires and brings people together to achieve sustainable results to improve the lives of the MCH population.”

Why Leadership?
The field of MCH has a rich history of leadership. From its very beginning, committed leaders tackled an ambitious agenda for MCH with few resources, determined to assure that approaches were based on the best science available. As MCH professionals you are part of this legacy—to inspire others, to build partnerships, to be accountable for sustainable results, and ultimately to improve lives.

Today MCHB remains committed to developing and sustaining MCH leadership. Innovative approaches and partnerships continue to require tireless leaders who are devoted to MCH. Leadership is the first goal in MCHB’s strategic plan and leadership development is a defining theme for our MCH Training Program, whose mission is

1 Adapted from: George, B. (2006, October 30). Truly authentic leadership. U.S. News & World Report, 52

Why Focus on MCH Leadership Development?
At the Federal level, we face many of the same issues that you face in the states. Within the federal MCHB workforce, approximately 1/3 of all staff and over 2/3 of senior staff are eligible to retire in the next five years. Recruitment and succession planning are critical concerns for all of us. We need to continuously develop the staff that we have and recruit those who will be taking our places as MCH leaders.

What tools do we have available to us?
In order to tackle the leadership development challenges facing us, MCHB has invested in a wide variety of initiatives.

Graduate Education—One important way that MCHB contributes to MCH leadership development is by supporting graduate education programs in schools of public health and clinical leadership training programs in MCH throughout the U.S. Detailed information about these programs is available here.

Lifelong Learning—The Maternal and Child Health Leadership Skills Training Institute offers continuing education and training to increase leadership skills for Title V staff. Learn more.

In addition to the MCH Leadership Skills Training Institute, MCHB supports 2 MCH Certificate Programs, targeted to practicing MCH professionals at the University of Arizona College of Public Health, and the University of Hawaii.

MCHB has also invested in continuing education and distance learning programs on topics as diverse as leadership and legacy, maternal mental health, and engaging families in evidence based research. We have also developed websites such as the MCH Timeline.

MCH Leadership Competencies
Do you need resources to develop a job description for an MCH leader, or competency areas for staff
Feature CONT.

Developing MCH Leaders

development efforts in your agency? The MCH Leadership Competencies are a good starting point. The site defines MCH competencies in 12 areas and provides information about how others are using them.

Innovations

MCH Directors from the Pacific Basin, in collaboration with Dr. Wendy Adam from Baylor College of Medicine, have used the MCH Leadership Competencies to craft a leadership development program.

AMCHP is also using the MCH Leadership competencies for Board development and a leadership development program for State Adolescent Health Coordinators.

Contact us with your ideas

Let us know what tools you’d like to see for leadership development in your state. Please contact Laura Kavanagh.

“Leaders aren’t born they are made. And they are made just like anything else, through hard work. And that’s the price we’ll have to pay to achieve that goal.”

—Vince Lombardi

Supporting Leadership at the Local Level

By Kathleen Brandert, MPH, CHES
Senior Coordinator, CityMatCH

Patrick Simpson, Executive Director of CityMatCH, recently stated in his “State of Urban MCH Address” at the 2008 CityMatCH Conference (Albuquerque, NM, September 20-23), “…The graying of our workforce isn’t a future problem anymore. It is here and it is real…Consider data from the most recent CityMatCH Membership Assessment: 35% of our member respondents indicated that they would retire in the next 5 years. All but a quarter plan to retire in the next 10.”

In 2007, CityMatCH received new funding – from HRSA MCHB’s MCH Training Branch – to create and implement CityLeaders: a leadership training program designed to build capacity in the emerging and mid-level leaders who will fill the spots of those on the road to retirement.

Two major components of leadership training encompass this experience. First, the MCH Leadership Competencies version 2.0, provides the backdrop for the CityLeaders skills-building curriculum. Trainings are tailored to each cohort of CityLeaders and are provided through onsite conference workshops, teleconferences, webinars, and self-instructional resource materials. The second critical component of the CityLeaders program is the Mentor/Mentee relationship. Each CityLeader is paired with a seasoned, senior leader in urban maternal and child health. This Mentor shares their experiences, challenges the emerging and mid-level leaders to think differently, and provides an intergenerational exchange of ideas and strategies.

Fourteen CityLeaders and seven Mentors participated in Year One of the program (August 2007 – February 2008). The second cohort – 10 CityLeaders and 10 Mentors – kicked off the program at the annual CityMatCH Conference in September 2008.

Though this program is a beginning, more must be done to ensure a qualified, competent urban maternal and child health workforce long into the future.
Every politician loves babies, right? Take this standard election season photo-op and add an avalanche of evidence on the economic benefits of investing early in the health and education of children, and you might think it would translate into making children a higher priority in federal policymaking. Instead, it is quite clear that we often have a leadership deficit that consistently leaves children out when it comes time to decide federal budget priorities.

To illustrate this point, a recent report by the nonpartisan advocacy group First Focus shows that while federal expenditures have grown over the past four and a half decades, the share of domestic spending focused on children has fallen 22 percent since 1960. Furthermore, their report estimates that the children’s slice of gross domestic product will decline from 2.6 percent in fiscal year 2007 to 2.2 percent by fiscal year 2018.

How can this be? The explanation we often hear on our visits on Capitol Hill is that policymakers “of course support the MCH Block Grant” and would even like to support an increase, but unfortunately there is just no new money to go around. That’s understandable — but frustrating when we consider that some health programs have done well.

The two most notable examples of this in recent years are the National Institutes of Health (NIH) and the Community Health Center (CHC) program. Both of these programs have seen their budgets double over the past decade — while the MCH Block Grant has been reduced by over $60 millions since 2003. But rather than see their success as competition, I argue that we can look to the growth of both NIH and CHC’s as inspiration and learn some leadership lessons from their success.

Three important components of their success include:

1. a clear demonstration of unmet need and a viable solution to address it;
2. a large and active network of grass-root advocates; and
3. committed Congressional champions who make the program a priority in their appropriations requests.

On the first point, advocates for these programs have shown that even in times of war and budget deficits, those who do a good job of demonstrating unmet needs and showing a credible solution to meet them can receive the resources they need. MCH programs certainly have the data to show unmet needs. On almost every visit we make to Capitol Hill, we try to highlight these key facts:

- Improvements in reducing infant mortality have stalled as preterm and low birth weight births have increased. The United States currently ranks 29th in infant mortality rates in international comparisons.
- Racial and ethnic disparities persist across several indicators, with the black infant mortality rate double the rate for whites.
- Maternal mortality rates have not improved in recent decades.
- Childhood obesity is a national epidemic, with some age groups experiencing a three fold obesity rate increase in rates over the past two decades.
- Teen pregnancy rates recently rose for the first time in 14 years.

We also share proof that the MCH Block Grant offers a credible solution to meet these needs. This is evident in the program’s recent recognition with the highest rating possible on the White House Office of Management & Budget's Performance Assessment Rating Tool (PART), where the MCH Block Grant is one of only 19 percent of all federal programs to earn the rating of “effective.”

When it comes to grassroots support, however, we...
Help Wanted: MCH Champions

know we have a long way to go. Our programs lack the ready made network of clinics or labs that both the CHC program and NIH have. Members of Congress can visit these sites and see first hand the work that is being done to help their constituents. We need to think creatively about how to show policymakers the work that Title V is supporting.

Over the past year we have had some success in reaching out to important friends and partners of MCH programs in key states, and we’ve also added over 4,000 MCH professionals and advocates to our database. These partners now receive regular updates on the work their state MCH programs are doing on behalf of women, children and families. Our hope is that these friends will be better empowered to help us tell the story of how Title V MCH funds make a difference in the lives of families where they live and will answer our call when we ask for help weighing in during key decision points in the federal appropriations process. We need all the help we can get sharing these stories with policymakers. We did receive some feedback from Hill staff that they heard more about Title V this year than they have in a while. We need to build on that momentum.

The third factor that many successful programs have but is largely missing for the MCH Block Grant is a vocal group of Congressional champions who understand these programs and make sure that they are not overlooked when appropriations decisions are made. Here too we made some progress this past year when an opportunity arose to work with Senator Chris Dodd (D-Connecticut) in support of a budget amendment he offered to recommend full funding of $850 million for the MCH Block Grant. Sen. Dodd gave a speech on the Senate floor where he acknowledged that “The MCH program is critical to the health and well-being of millions of families across this country, including some of the most vulnerable members of our society. Years of funding cuts and level funding have stretched maternal and child health programs to their limits… Now it’s time for us to ensure that the money will be there to continue the success of these vital programs.”

While the Dodd amendment passed, it unfortunately did not convince members of the Appropriations Committees to significantly change their proposals for funding MCH in fiscal year 2009. While his leadership was a tremendous step forward, it also underscored the need for us to garner additional MCH champions — preferably on the Appropriations Committees — so that we know we have advocates in the room when the tough funding decisions are made. In the coming year, we will continue to work all three of these advocacy strategies, and look to build upon the momentum begun this year. With a continued drumbeat about unmet MCH needs, an expanded grassroots network, and additional work to cultivate more MCH champions on Capitol Hill, we will increase our chances for success for the families we advocate for.

In Memoriam

Remembering an MCH Leader: Dr. Allan Rosenfield

AMCHP is saddened to share that Allan Rosenfield, MD, Dean Emeritus of Columbia University’s Mailman School of Public Health, died on October 12 from Amyotrophic Lateral Sclerosis, better known as Lou Gehrig’s disease. Dr. Rosenfield’s work made major contributions to maternal and child health efforts and will forever inspire us to do the same. Dr. Rosenfield has spent his career fighting for the health and well-being of the most vulnerable populations at home and abroad, especially women. Dr. Rosenfield is well known for his work on women’s reproductive health and human rights, innovative family planning studies, strategies to address the tragedy of maternal deaths in poor countries, and the HIV/AIDS pandemic, both domestically and globally. He pioneered work on the role of non-medical personnel to prescribe contraceptives, avert maternal mortality and morbidity from pregnancy-related complications, and the treatment and care of HIV-infected women and children in resource-poor settings. He was at the forefront in calling attention to women’s health as more than a just an add-on to child health. In lieu of flowers, donations are welcome to the Allan Rosenfield Fund at the Mailman School of Public Health. Please send donations to 722 West 168th St, New York, NY 10032.
Data and Trends

Distribution of Title V Leadership

The following chart reflects preliminary data analysis of the distribution of leadership experience for state MCH and CYSHCN directors from the AMCHP Workforce Development Survey. Stay tuned for additional survey results in the coming weeks.

Figure 4: Distribution of Title V Leadership Experience (N=41 for CYSHCN, N=49 for MCH)

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<thead>
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<td>Percent</td>
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AMCHP Joins International Leadership Groups to Promote Maternal and Child Health in the United States and around the World

In September, AMCHP joined the White Ribbon Alliance for Safe Motherhood, an international coalition of individuals and organizations formed to promote increased public awareness of the need to make pregnancy and childbirth safe for all women and newborns in the developing, as well as, developed countries. AMCHP looks forward to being a part of this important group and advancing our shared goals both in the United State and around the world.

AMCHP has applied to join the World Health Organization’s Partnership for MCH

The Partnership for Maternal, Newborn and Child Health works internationally to improve the health of women and children and promote healthy MCH policies. The Partnership is a global health partnership launched in September 2005 and joins the maternal, newborn and child health (MNCH) communities into an alliance of almost 260 members to ensure that all women, infants and children not only remain healthy, but thrive.
AMCHP’s **New Director Mentor Program** offers a bridge for new MCH professionals to connect with seasoned MCH professionals who are willing to share their knowledge about what state Title V programs actually do. AMCHP assists new directors by providing technical assistance with program activities, network opportunities to learn from their peers, and access to resources on MCH and MCH leadership.

**Leading State Maternal and Child Health Programs: A Guide for Senior Managers**

This manual is a resource for new Title V, MCH and CSHCN Directors. It is organized into chapters dedicated to “the big picture,” or the theoretical framework of maternal and child health, and “the ABC’s,” which delve into the day-to-day operational aspects of MCH programs.

**CityMatCH CityLeaders Program**

CityLeaders is a training program for emerging MCH leaders that serves as an introduction to the core MCH Leadership Competencies. It is targeted to emerging and mid-level urban MCH leaders. CityLeaders are matched with a seasoned urban maternal and child health leader in the field for a mentor/mentee relationship lasting the duration of the program.

The **MCH Leadership Skills Training Institute** offers continuing education and training to increase leadership skills for key management personnel in State Title V Maternal and Child Health and Children with Special Health Care Needs programs in the United States. The curriculum are: Planning, Implementing and Evaluating Programs and Systems.

The **MCH Skills Leadership Development Series** brings leadership concepts to life in an MCH context, and allows participants to conduct training sessions based on individual time frames. It is a set of training modules designed for use in small groups. Each module offers a mix of presentation and exploration in different learning formats.

The **MCH Leadership Competencies** are intended for use by MCH leaders to develop key competency areas and to assist with staff development. The site defines MCH leadership competencies in 12 areas and provides information about how others are using the competencies.

The **Public Health Leadership Institute (PHLI)** convenes new leaders and new public health partners who together will confront the new challenges in public health. The goal is to support the public health leaders who will help lead the change in the public health system for years to come. PHLI is based at the University of North Carolina Gillings School of Global Public Health.

Please see Laura Kavanagh’s feature article, *Developing MCH Leaders* for additional resources on MCH Leadership supported by MCHB.
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