Emergency Preparedness and Response: How CDC DRH Addresses Needs of Women and Newborns

By Wanda D. Barfield, MD, MPH, FAAP
Captain, U.S. Public Health Service Director, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion

At a Texas field medical station in the path of Hurricane Rita, effects of the disaster were already taking a toll. Young women were being treated for medical conditions such as depression and anxiety. Elderly people too sick to evacuate were being cared for by their daughters, sisters and nieces. Some pregnant women were being monitored while others were caring for their own families. As a medical epidemiologist and chief medical officer for Rapid Deployment Force of the U.S. Public Health Service, I was experiencing first-hand the challenges women face, particularly pregnant and postpartum women, when a disaster strikes.

Now 10 years later as director of the Centers for Disease Control and Prevention (CDC) Division of Reproductive Health (DRH), I oversee the division Emergency Preparedness and Response (EPR) activity that works with state and local health departments to meet the needs of pregnant and postpartum women and newborns.

DRH has responded to disasters for more than a decade, from the Sept. 11 attacks to the Ebola Virus outbreak in West Africa. Each disaster – whether it’s a natural disaster, pandemic infectious disease or man-made hazard – poses a challenge for vulnerable populations. We focus our efforts...
Feature CONT.
How DRH Addresses Needs

on maternal health needs, whether it is creating the formal collaborative pandemic flu plan with the CDC National Center for Birth Defects and Development Disabilities or helping public health partners in Illinois collect reproductive health data after a tornado outbreak.

Research has shown that pregnant women may have increased post-disaster medical risks such hypertension, anemia, preterm birth, and low birth weight infants. We would like to know more about how disasters uniquely affect women of reproductive age, particularly pregnant and postpartum women. Because pregnant women comprise a small proportion of the U.S. general population and require special post-disaster sampling approaches, surveillance is lacking among this population. DRH is actively involved in building scientific and emergency information on pregnant women and newborns for public health and health care professionals.

DRH emergency response and preparedness activities focus on developing materials for the health care audience as well as the public. For example, during the Pandemic H1N1 2009-2010 response, the DRH Maternal Health Team created nine maternal health guidance documents and addressed more than 4,600 maternal health inquiries. Additionally, as part of the Anthrax preparedness in 2012, DRH collaborated with the National Center for Emerging and Zoonotic Infectious Diseases to convene 77 national experts on anthrax and public health to guide the update of recommendations for pregnant and postpartum and lactating women exposed to the virus.

Examples of Emergency Preparedness Response Activities that Support Pregnant/Postpartum Women & Newborns

Disaster Response
- Compiled scientific evidence about disaster effects on pregnant women and birth outcomes through analyses and a systematic literature review. An article on Post-Disaster Reproductive Health Outcomes was published in the Maternal Child Health Journal in 2012.
- Created online tools such as factsheets and checklists on disasters and pregnant women for state and local health department use (www.cdc.gov/reproductivehealth/Emergency/index.htm).

Infectious Disease Response
- Published an American Journal of Obstetrics & Gynecology supplement in 2011 pertaining to lessons learned in the Pandemic H1N1 response.
- As part of its emergency response activities for Ebola, deployed 24 DRH staff members (10 to the field), created guidance for health providers in U.S. hospitals for Ebola issues related to maternal health, and addressed 80 Ebola inquiries related to maternal health and the pregnant/postpartum/lactating population.

Collaboration between agencies and state/local governments is a big part of disaster emergency response. To improve knowledge and collaboration, CDC is developing an online training (to be released in 2016) for maternal health professionals across the United States. This training course will help them plan for special needs of women and newborns before a disaster, improve the quality of emergency response during a disaster and identify important needs after a disaster.
Feature
Building Emergency Preparedness and Response Capacity in Reproductive Health

By Marianne E. Zotti, DrPH, MS, FAAN
Consultant, Emergency Preparedness and Response Activity, MANILA Consulting Group, Inc.

Hurricane Katrina in 2005 was a major disaster that forced the evacuation of New Orleans and affected large areas of other states, especially Mississippi, whose coastal areas received extensive damage as a result of being directly in the path of the storm and subsequent storm surge. Afterward, a small group of New Orleans women who were pregnant or postpartum at the time of the storm described their harrowing experiences when evacuating. Their poignant stories revealed heartbreaking losses of loved ones, a lack of resources for their families, threats to the safety of themselves and their children, an inability to provide health care for their children, and increased responsibilities for the care of other family members (to learn more, see the reference in the box). The stories of these women give us a partial picture of the types of ordeals that pregnant and postpartum women may experience after a major natural disaster.

The CDC DRH had been active in previous emergency responses, but Hurricane Katrina was a wake-up call. This hurricane and subsequent response revealed that in order to be fully prepared, we needed to know more about

- What health indicators should be measured for disaster-affected pregnant and postpartum women and infants

To facilitate more efficient post-emergency assessment for women of reproductive age, DRH collaborated with the University of North Carolina Center for Public Health Preparedness to create a ready-to-deploy toolkit with pilot-tested questionnaires (cphp.sph.unc.edu/reproductivehealth/) so that public health partners can quickly assess post-disaster reproductive needs and respond to them.

It often takes a decade after a major disaster for literature that answers critical questions to become available. DRH worked with local, state and federal partners to evaluate what works and what does not when assisting women of reproductive age during a disaster. Our work is still evolving, but we have developed an array of tools for a variety of disasters, including natural disasters, infectious disease outbreaks, and preparedness for an anthrax bioterrorism event. Information about these tools will be shared in the Jun. 16 webinar, but in case you would like to review them beforehand, you can find some of the tools on the DRH Emergency Preparedness and Response website: www.cdc.gov/reproductivehealth/Emergency/index.htm. Lastly, we are in the process of creating an online training for U.S. public health and health care professionals pertaining to reproductive health and disaster. This training is scheduled to be released in 2016.

We look forward to joining you for the June webinar!

Read the Stories of Some Pregnant and Postpartum Women Who Experienced Hurricane Katrina
Feature
Recovering from Disaster: Implementing the RHAD Toolkit to Improve MCH Services to Childbearing Women

By Mary Ellen Simpson, R.N., Ph.D.
Instructor of Community Health, Graham School of Nursing, Canton, Illinois

The Reproductive Health Assessment After Disasters (RHAD) toolkit was developed to assess the reproductive health needs among women aged 15-44 years who have been affected by natural and/or man-made disasters. RHAD is part of an initiative by the CDC, Division of Reproductive Health, for use by local and state health departments or other organizations that provide reproductive health services to U.S. disaster-affected women. A modified RHAD survey was implemented to assess the reproductive health risks and psychosocial effects of the Nov. 17, 2013 tornado of women residing in four central Illinois counties. MCH issues pertinent to pregnant women, postpartum women and infants, family planning, family stressors, risk behaviors, and gaps of services were assessed. Data collection was conducted by teams of trained volunteers of student nurses, alumni, faculty, and staff from partnering schools of nursing. The sample population was derived by superimposing National Weather Service (NWS) field reports and U.S. Census data. If a community population was greater than 900, a two-stage cluster sampling method with referral, adapted from the CDC Community Assessment for Public Health Emergency Response (CASPER), was used to identify households. Finding displaced families was a challenge. In partnership with maternal and child health (MCH) coordinators, extensive outreach efforts were employed to obtain questionnaires and locate displaced families who were eligible to participate. Tapping into self-organized social media accounts facilitated outreach to women eligible to participate who were relocated from the targeted blocks selected in the first or second stage of sampling and verified by the MCH coordinators. As a result, 37 percent of the sample consisted of women who had lost their homes due to the tornado.

Results showed that immediate post disaster MCH needs such as access to formula and prenatal care were adequately addressed. However four months after the event, 15 percent of the respondents expressed a desire for counseling to help their families cope with multiple stressors. Women reported children demonstrating regressive behaviors, panic during thunderstorms, and fear during monthly siren testing. Several women indicated they could not afford mental health services and asked if any of the post-disaster funding could be used for that purpose. Although mental health services were available immediately after the tornado, no services were available in the recovery phase. Trauma and stress resulting from a disaster are not unique to victims of tornadoes and are applicable in most emergency settings. State and local MCH leaders can address short and long term service gaps and help families to recover from an emergency situation.

The RHAD is a valuable tool to identify the unmet MCH needs during the recovery phase of a disaster. RHAD findings can inform state emergency planning and strengthen preparedness recommendations. Ultimately, the results support the development of evidence-based services to improve the health of disaster-affected women and their families.

The Reproductive Health Assessment after Disaster (RHAD) in Four Illinois Counties report can be accessed at www.grahamschoolofnursing.org.
Feature
Is Your State Prepared for the Unique Challenges of Protecting Pregnant and Postpartum Women During an Anthrax Incident?

By Valerie R. Johnson, MPH, CHES, and Dana Meaney-Delman, MD, MPH
National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention

Bacillus anthracis, the type of bacteria that causes anthrax, is one of the most likely agents to be used in a biological attack. If such an incident were to happen in the United States, state public health officials at all government levels would need to respond quickly. To help protect the health of pregnant and postpartum women, public health officials need to be aware of the unique challenges that would arise for this population during an anthrax incident:

• Antibiotics and vaccine must be given to everyone who has been exposed in order to prevent anthrax disease. All pregnant women (regardless of trimester) as well as postpartum and lactating women should receive a 60-day course of oral antibiotics as soon as possible and three doses of anthrax vaccine at zero, two, and four weeks postexposure. Antibiotic dosing is the same for pregnant, postpartum and lactating women as for nonpregnant adults. Ciprofloxacin is the preferred antimicrobial, and Amoxicillin may be used for susceptible strains.

• Pregnant and postpartum women experience normal physiologic changes that may make it more challenging to diagnose anthrax. Vitals signs (e.g., respiratory and heart rate) and laboratory values (e.g., white blood cell count) may differ during pregnancy. In addition, abnormal laboratory values and clinical findings observed in anthrax can mimic those of common obstetrical conditions, such as preeclampsia, HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome, fatty liver of pregnancy, and thrombotic thrombocytopenia purpura. Pregnancy complications such as preterm labor, fetal distress, or fetal loss may be observed and may be the first signs of anthrax infection or may indicate worsening health status. Therefore, the inclusion of epidemiologic and laboratory information, when available, and assessment of clinical signs are imperative when evaluating these patients.

• Inhalation anthrax can be deadly if it is not treated promptly with the correct antibiotics. Pregnant, postpartum and lactating women diagnosed with anthrax should receive a combination of intravenous antibiotics to treat anthrax. Because of concerns for transplacental transmission of anthrax in pregnant women, at least one of these intravenous antibiotics should cross the placenta. Antitoxin use would not differ from that for nonpregnant adults, and antitoxin dosing for infected pregnant, postpartum, and lactating women is the same as for nonpregnant adults.

• Critical and supportive care is important to meet the medical needs of mothers and their unborn babies. Pregnant women with anthrax should be hospitalized and might require obstetric monitoring. Given the severity of the infection, hospitals caring for these women must be equipped for possible emergency deliveries.

To help state health departments and other partners prepare for these challenges, CDC experts in anthrax and emergency preparedness developed resources that you can use in your pre-event planning and during an actual event. For example:

Pre-event


• A communications toolkit that provides health departments with strategies for delivering effective messages during an anthrax emergency.
Feature CONT.  
**Anthrax Incident**

### During an event

- Just-in-time training for clinicians, with special guidance for preventing, diagnosing and treating anthrax in pregnant and postpartum women.
- A text messaging program that states could use to provide critical messages to pregnant and postpartum women during an anthrax emergency: reminders to take their antibiotics or get their next shot of vaccine, ways they can text back to indicate if they are experiencing any side effects, and advice to help them recognize the symptoms of anthrax. These messages are free and will be available to health departments.
- An emergency CDC website that would be used only if an anthrax emergency occurred. The site includes critical information for people in and near the affected areas, including guidance for pregnant and postpartum women.
- Print materials and pictograms that health departments could use during an anthrax emergency to convey critical life-saving information to pregnant and postpartum women. These materials are available in English and Spanish and were tested with audiences, including English speakers with limited literacy. They will be available free of charge to health departments on a secure site managed by the CDC Strategic National Stockpile.

Public health officials have learned a lot from recent public health emergencies that can help us prepare for future events. These past events make a strong case for why we need to plan ways to protect pregnant and postpartum women during an anthrax incident. For a complete list of CDC prevention and treatment recommendations following exposure to anthrax, please visit the following websites:

- Special Considerations for Treating Anthrax in Pregnant and Postpartum Women: [wwwnc.cdc.gov/eid/article/20/2/13-0611_intro](wwwnc.cdc.gov/eid/article/20/2/13-0611_intro)
- CDC Expert Panel Meetings on Prevention and Treatment of Anthrax in Adults: [wwwnc.cdc.gov/eid/article/20/2/13-0687_intro](wwwnc.cdc.gov/eid/article/20/2/13-0687_intro)
- CDC Anthrax website, Guidance and Recommendations for Healthcare Providers: [www.cdc.gov/anthrax/healthcareproviders/index.html](www.cdc.gov/anthrax/healthcareproviders/index.html)

### Member to Member

We asked AMCHP Members: How is your Title V/MCH department incorporating reproductive emergency preparedness and response into its work?

**MISSISSIPPI**

By Juanita Graham, DNP, RN, FRSPH  
*Mississippi State Department of Health*

On Aug. 29, 2015, Mississippi (MS) will recognize the 10th anniversary of Hurricane Katrina. I use the term “recognize” because it will certainly be no celebration — merely an opportunity to remember lives lost and lessons learned through the single greatest natural disaster ever experienced by our state. Damages exceeding $125 billion encompassed all 82 Mississippi counties. A 30-foot storm surge wiped out 90 percent of the buildings along the MS Gulf Coast, 238 people died, and 67 went missing. Public health nurses from all over MS were deployed for the disaster response efforts. On Sept. 1, 2005, just two days post-storm, my nurse buddy and I abandoned my car and walked/climbed through nearly a mile of debris to get to the beach and see for ourselves the seemingly endless line of bare foundations where stately and historic coastal homes had stood just a few days before. Ten years later, many of those slabs remain bare.

Mississippians are no strangers to challenges. We employed our humor and strength to get us through the trying times to follow — well-illustrated by this photo I took of a Rolls Royce and fern pillar parked next to the FEMA trailer that replaced a once stately home. We have trudged along seeking partners and resources to rebuild. One partnership was sought with the CDC DRH to help assess the needs of the Gulf Coast maternal and child health population. We were delighted to help DRH pilot a survey tool designed for just that purpose.
Utilizing a group of nursing students from the University of Mississippi as data collectors, we interviewed more than 100 coastal women in waiting rooms of the six Coastal Family Health Center locations. The women were eager to tell their stories and many stood in line waiting to speak to a student, even after all of the small incentives had been disbursed. There were weaknesses and limitations to the pilot project but we did the best we could, given the sparse resources in the region. But, those weaknesses and limitations provided valuable insight as to what challenges a researcher might anticipate in a significant post-disaster setting.

As expected, many women described long waiting periods for appointments and low availability of services. Most notably, about 40 percent of the women said they usually got their family planning services at a hospital emergency room, certainly not the best setting for quality reproductive health care. Given the state history of high rates of infant mortality, that finding was a grave concern. As it turned out, MS recorded a statewide infant mortality rate (IMR) of 11.4 per 1,000 live births for the calendar year 2005, the highest rate during the 20-year span of 1994 to 2013. There are insufficient data to confirm any correlation between the high 2005 IMR and Hurricane Katrina. But, the limited findings derived through the DRH pilot study suggest that risks for infant and maternal health were present on the coast, long after that dreadful day of Aug. 29, 2005.

HAWAII

By Emily K. Roberson, PhD, MPH
Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) Program Coordinator

By Bryan Vidrine, MPH
Public Health Preparedness (PHP) Planner

By Judy K. Kern
Education and Training Coordinator, Acting PHP Branch Co-chief

The Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS), housed within the Hawaii State Department of Health (DOH), Family Health Services Division and funded by the CDC, is a population-based surveillance system designed to identify and monitor maternal experiences, attitudes, and behaviors from preconception, through pregnancy and into the postpartum period. Every three to five years, the survey that forms the basis of the program is revised through a collaborative process involving many local, state and national stakeholders. The revision process that will eventually result in the 2016-2020 version of the Hawaii PRAMS survey version began in earnest in 2014.

In late 2014, CDC introduced a new potential survey question to PRAMS states related to family and household disaster preparedness. Hawaii PRAMS contacted the Hawaii DOH Public Health Preparedness Branch (PHPB) to see if they had any interest in working with Hawaii PRAMS to add this question to the revised survey. PHPB was very interested, as MCH populations are often among the most vulnerable in disasters. Hawaii PRAMS and PHPB worked together to modify the disaster preparedness question slightly (with the CDC blessing) to make it more relevant to the unique needs of Hawaii as a geographically remote island state. The modified version of this question will appear in the Hawaii PRAMS 2016-2020 survey, and PHPB is providing funding support to the Hawaii PRAMS program in order to assist with data collection activities.

PHPB seeks to use this data to increase state capacity to ensure the needs of MCH populations are adequately addressed during emergencies or disasters and identify any gaps that may exist. In addition to collecting important new information about disaster preparedness among a high priority population in Hawaii, this experience also established a mutually beneficial new partnership between Hawaii PRAMS and PHPB that did not exist before.
Recognizing that pregnant women, infants and children are especially vulnerable during public health emergencies, the Allegheny County Health Department (ACHD) Emergency Preparedness, Bureau of Assessment, Statistics and Epidemiology (BASE) and MCH program staff launched an innovative collaboration. The ACHD MCH home visiting program offers prenatal, postpartum, and pediatric visits to promote healthy pregnancies and positive birth outcomes in at-risk populations. In order to deliver preparedness information to this population, the ACHD incorporated curriculum enhancements into its MCH home visiting program. Topics included making an emergency kit and plan, keeping extra food and water, infant safe sleep during an evacuation and awareness about infectious disease emergencies. The brief messages were designed to complement curriculum lessons, which home visitors use to develop visit plans for their clients. For example, a lesson on infant nutrition could include messaging about storing extra formula for emergency situations. Understanding that clients enter the program at different points, messages were repeated when topic areas recurred.

ACHD preparedness staff trained the home visitors to incorporate the enhancements into their lessons. The MCH preparedness initiative was well-received and supported by the home visitors. Three months after implementation, home visiting clients were asked to recall key preparedness topics. These questions were delivered as part of a routine client satisfaction survey. Fifty-two percent of the surveyed clients reported that preparedness information was addressed during a visit.

The project initiated conversation about emergency planning with a vulnerable population. The enhancements aligned well with essential home visiting lessons; thus, the structure of the curriculum was preserved. When developing preparedness goals for an at-risk population, access to resources must be considered. MCH home visitors, who work with the same clients throughout their enrollment, develop a unique perspective on a family’s ability to plan for an emergency, including needs and access to resources.

Get Involved

National MCH Workforce Development Center Coffee Talk Series – Check Out the Coffee Talk 2 Video!
This series will be hosted by the National MCH Workforce Development Center Change Management core on three pertinent topics benefiting the Title V workforce. The series will consist of three archived 20-minute videos for AMCHP members to access bi-monthly at their leisure. For the alternating months, AMCHP will host a Twitter chat on the content shared during the preceding month’s archived video. The topics and identified speakers for each video/Twitter chat are outlined below. Click here to learn more about each talk and to register!

Coffee Talk 1: Title V Transformation
Presenter: Lacy Fehrenbach, MPH, CPH, Director, Programs, AMCHP
Video Release: Mar. 2 – Click here to view the video

Coffee Talk 2: Getting to the Table
Presenter: Sharron Corle, MS, Associate Director, MCH Leadership Development & Capacity Building, AMCHP
Video Release: Apr. 1 – Click here to view the video
Twitter Chat: May 13 2-3 p.m. EST

Coffee Talk 3: Leading Change
Presenter: Karen Trienweiler, Director of Programs & Services, Prevention Services, Colorado Department of Public Health and Environment
Video Release: Jun. 1
Twitter Chat: Jul. 22 2-3 p.m. EST

Coffee Talk 4: Managing Change
Presenter: Brenda Jones, DHSc, RN, MSN, WHNP-BC, Deputy Director, Office of Women’s Health, Illinois Department of Public Health
Video Release: Aug. 1
Twitter Chat: Sept. 9 1-2 p.m. EST
Get Involved CONT.

Now Available: Application to Participate in the National MCH Workforce Development Center Training – Cohorts 3 and 4
The National MCH Workforce Development Center offers a range of trainings, tools and resources to strengthen MCH workforce capacity to lead through health transformation. The Center offers training in four key areas: access to care, quality improvement, systems integration and change management. State/territory Title V agencies/MCH programs and their partners will have the opportunity to gain knowledge, skills and tools in the four key areas and apply them to a current health transformation project of interest. The application for the final two cohorts is being released and is due simultaneously; states/territories are allowed to choose between Cohort 3 and Cohort 4 according to the timeline and training location that best fits their needs. Cohort 3 will run from July 2015-March 2016 and the training will be held in Denver or San Francisco. Cohort 4 will run from November 2015-June 2016 and training will be held in the Washington DC area. States and territories are strongly encouraged to apply to participate in Cohort 3 or 4, as current project funding ends in August 2016. Applications are available via the AMCHP Transformation Station website and the Center website. All applications must be received by Jun. 1 at 5 p.m. EST.

Announcing Call for Abstracts and Save-the-Date: ACEs Southeastern Summit
The Adverse Childhood Experiences Southeastern Summit 2015: Building Resilient, Interdisciplinary Workforces, Communities & Families will be held Sept. 24-26 in Asheville, North Carolina. This conference will focus on the impact of adverse childhood experiences (ACEs) on early childhood development, long-term health behaviors and health outcomes in adulthood. Interactive speaking sessions will showcase how providers in the community, both locally and regionally, including health, social and human service, education, mental health and law professionals incorporate practical tools and evidence-based programs into their work to identify these experiences early in a child’s life and give their families tools to prevent the intergenerational transmission of adverse experiences. Come to the beautiful Blue Ridge Mountains of Western North Carolina and speak or learn alongside the keynote speaker, Dr. Robert Anda, principal investigator of the landmark ACE study. To learn more about the summit, click here.

Special Issue Call for Papers: Postpartum Health and Wellness
The Maternal and Child Health Journal is soliciting manuscript submissions to be considered for an upcoming issue on the theme of postpartum health and wellness. This important period in the reproductive life continuum provides a critical link between prenatal care and women’s preventive health care as well as an essential opportunity to guide and support maternal role attainment, breastfeeding, mental health and healthy parenting. The Journal solicits manuscripts on any aspect of postpartum health and wellness, including policy briefs, original research, commentaries, perspectives in practice (clinical or public health), program development or implementation, program evaluation, and literature reviews. The deadline for submission is Oct. 15. For more information, click here.

AMCHP is collecting emerging, promising and best practices related to emergency preparedness and response!
Does your program address an MCH best practice? If so, consider sharing your program through Innovation Station, the AMCHP searchable database of emerging, promising and best practices in maternal and child health. Through this opportunity, you can:

- Share successes with your peers
- Enhance the MCH field
- Contribute to program replication
- Get expert feedback from the Review Panel
- Receive national recognition

The online submission process is simple and applications are accepted on a rolling basis. For more information, contact Ki’Yonna Jones at (202) 266-3056 or visit amchp.org/bestpractices.

You can also click here to refer an innovative MCH program that we should know about!
Disasters and Hurricane Katrina

- Large scale, weather-related disasters have become more frequent, and the impacts and losses from natural disasters have grown as populations have increased in vulnerable areas.\(^1,^2\)

- From 2000 through 2014 the United States (U.S.) averaged 60 major federally declared disasters per year. The highest number of disaster declarations (n=99) was registered in 2011.\(^3\)

- Hurricane Katrina was the most costly U.S. natural disaster, resulting in causing an estimate of $125 billion in overall damages and costs.\(^4\)
  - It is estimated that approximately **56,000 pregnant women and 75,000 infants** were directly affected by the hurricane.\(^5\)
  - It is estimated that at least **10,000 pregnant women** were among the total number of displaced people from the hurricane.\(^6\)

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2015 Association of Public Health Laboratories Annual Conference
May 18-21
Indianapolis, IN

CSTE Annual Conference
Jun. 14-18
Boston, MA

8th Biennial Childhood Obesity Conference
Jun. 29-Jul. 2
San Diego, CA

NACCHO Annual 2015
Jul. 7-9
Kansas City, MO

2015 CityMatCH Annual Urban MCH Leadership Conference
Sept. 27-30
Salt Lake City, UT

2015 ASTHO Annual Meeting
Sept. 29-Oct. 1
Salt Lake City, UT

AAP National Conference and Exhibition
Oct. 24-27
Washington, DC

2015 APHA Annual Meeting & Exposition
Oct. 31-Nov. 4
Chicago, IL

Want your event listed on the AMCHP MCH Events Calendar? It’s easy! Just complete our online submission form.

Calendar

AMCHP Events

2016 AMCHP Annual Conference
Jan. 23-26, 2016
Washington, DC

MCH Events

31st Pacific Rim International Conference on Disability and Diversity
May 18-19
Honolulu, HI

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