From the President
By Eileen Forlenza
President of the Board, AMCHP

Stephanie pulled up to her son’s school just in time for recess, so she decided to simply watch for a while. Alec never saw his mom, because she stayed in the car, watching and crying. For the entire recess period, Alec walked the perimeter of the playground. No one played, laughed, skipped or clapped with him. He did not appear to be unhappy – he was just alone. He was not being bullied – he was just isolated. He wasn’t bothering anyone – he was just disengaged. Simply put, he was not included. Period.

Within weeks, Stephanie developed a facilitated recess program to assure that all children had access to team building, shared goals and social integration. She engaged the school nurse, physical education team, psychologist, principal, school board and of course, the kids. Some of these community partners had never worked together, but instinctively Stephanie knew they all had a shared goal for the school and the kids. Anchored by their vision of positive outcomes for children, the team created an integrated approach to wellness, including social-emotional health, that really worked! Alec soon had plenty of friends, increased activity and heightened self-esteem. He was on track for a great school year. While Stephanie was motivated by her own son’s situation, her dedication to quality and inclusion improved the lives of hundreds of children.

I am certain you see yourself reflected in Stephanie’s story – dedicated, inspired and equipped to make a difference. For MCH professionals, there are other components of Stephanie’s approach that we know are critical:

1. Families often create innovative solutions because their perspectives are from a different view.
2. Convening non-traditional partners leads to trust building.
3. The solution was not clinically-based; it was com-

Continued on page 11
From the CEO
By Lori Freeman, MBA
Chief Executive Officer, AMCHP

This issue of Pulse centers on the theme of quality improvement (QI) – an idea that I truly embrace and appreciate.

Quality improvement is one of those concepts that we’ve all been exposed to throughout our lives but sometimes never recognized.

As a young mother-to-be, I remember learning of our pregnancy and immediately launching into a very personal QI effort to be the healthiest I could be while carrying our twin children. I solicited the support of my husband, Dan (aka “meathead”), to help me and be the best possible positive outcome for our babies. We created our own personal at-home QI culture. We researched and read everything we possibly could about having a good pregnancy and learning to be new parents (aka “planning”).

My OB/GYN worked with us to ensure we closely monitored the health of the babies and were progressing toward a successful delivery (aka “measurability”). After the babies were born, we kept up the personal QI culture in our house. Because we were new parents, we developed and tested many, many processes and routines (from feeding prep to napping schedules to bedtime routines to planning regular date nights), and often kept revisiting these “systems” – tweaking them, improving them and repeating the cycle. Over the years, the continuous quality improvement culture in our home has remained, and we’ve tried to instill this same mindset in our everyday lives, both personally and professionally.

During my own career, I recall having been exposed as a younger professional to QI concepts in a number of different roles. At the Association for the Advancement of Medical Instrumentation, a core focal point of my work was the development of national and international standards for the use of medical devices. In this realm, QI concepts were used frequently related to quality assurance and equipment safety; we viewed product development through a lens of human factors to ensure ease and quality use of medical instrumentation by anyone touching the equipment, from biomedical engineers to health care providers, patients and caregivers. While at the International Test and Evaluation Association, I actively employed Six Sigma in my work related to assessing effectiveness, reliability, interoperability and safety of technology-based military systems and products throughout their life cycle. Six Sigma is a data-driven QI approach for eliminating defects in a process.

Six Sigma is applied to manufacturing, transactional processes, product development and customer service – to name a few applications. One of the many things I liked about Six Sigma was that, as systems improvement occurred, so did the morale of those working within those systems.

It was not until I reached the National Association of County and City Health Officials (NACCHO) that I experienced how QI could be truly intentional within a nonprofit at the highest management levels. This brilliant approach was spearheaded under the leadership of Bobbi Restronk, NACCHO’s executive director, and led by Grace Gorenclo, a professionally-trained QI expert. NACCHO already had a long history supporting QI with its members, mostly as the public health department accreditation process was being developed and launched. The organization embraced QI so fully that it invested in QI internally to help evolve and improve many of its management processes, product offerings and, at times, entire department structures. In the time I spent at NACCHO, I was involved in at least four intensive QI processes that moved the organization toward greater efficiencies; improved process and under-standing and increased staff morale, engagement and accountability. By the time I departed NACCHO for AMCHP in 2014, I was a self-declared QI advocate and remain so.

I learned so much about QI from my colleagues and friend, Grace Gorenclo; her teachings will always stay with me. Grace taught me that there was never one way you had to approach QI. She made sure I understood and could appreciate that not everything was a good candidate for a quality improvement process merely because it represented a challenge or problem to be solved. Sometimes, you have to step back and consider quality planning for the future. And she always taught me that failure was a valid result from QI and nothing to be ashamed of because, after all, QI is continuous.

In this issue of Pulse, you’ll learn how QI is being utilized in various ways across maternal and child health to improve outcomes. You’ll also gain some insight into how we are working at AMCHP to create our own internal QI culture. Please enjoy your reading!

Sarah McKasson, MPH
Colorado School of Public Health

Finding the Root Cause to Improve Timeliness in Newborn Screening

By Yvonne Kellar-Guenther, PhD
Colorado School of Public Health, NewSTEPs 360

Sikha Singh, MHS, PMP
Association of Public Health Laboratories, NewSTEPs

Marci Sontag, PhD
Colorado School of Public Health, NewSTEPs 360

Sarah McKasson, MPH
Colorado School of Public Health

NewSTEPs 360, a collaboration between the Colorado School of Public Health and the Association of Public Health Laboratories, supports improvements in timeliness of pre-analytic, analytic and post-analytic components of newborn screening (NBS) programs across the U.S. through continuous quality improvement (CQI) initiatives. The CQI approach has benefited many health agencies and organizations by promoting impactful and sustainable change in health care systems.

In June 2016, NewSTEPs 360 – in partnership with the Cystic Fibrosis (CF) Foundation – convened NBS program staff (laboratory and follow-up) and clinicians to identify barriers and solutions to assure timely newborn screening for cystic fibrosis. Participants agreed on the 5 Whys approach, conducting root cause analyses and applying this methodology within their multidisciplinary teams to identify underlying barriers to meeting the NBS timeliness recommendations issued by The Advisory Committee on Heritable Disorders in Newborns and Children. The overarching goal of the meeting was to equip NBS programs with tools to improve timeliness in newborn screening for all infants, as well as to identify specific solutions for improving timeliness in CF newborn screening. CF clinicians were engaged to provide aspects of process with the understanding that identification of solutions to improve the overarching system would also benefit newborns identified with CF.

In small groups, teams discussed the barriers and proposed solutions. Facilitators prompted discussions to identify root causes. For example, one barrier discussed was that midwives have a lower percentage of specimens collected in the recommended time frame (prior to 48 hours of life) than do hospitals. This barrier was not the “root cause,” though, it was the “problem statement. As a result, the facilitator walked the group through the 5 Whys approach to identify the true root cause. After three Whys, the group identified the root cause. (See Figure 1.)

Through a facilitated discussion, the group identified challenges in locating midwives as the root cause and discussed solutions to reaching midwives. These included finding professional midwifery groups and working with nurse practitioners to assist in outreach efforts to find other midwives in their state.

Another group discussed the challenge of increasing operating hours of the newborn screening laboratory to include weekends. Challenges identified included lack of dedicated funding, limited technical support on weekends and staffing shortages for weekend shifts. Using the 5 Whys approach, the group explored the staffing shortage challenge, and a root cause was determined to be a shift in ex-
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that we lose the ability to view it with a critical eye. Quality improvement (QI) methods and tools provide a lens from which to view and transform systems. These methodologies provide the plan for how to go about improving the systems that surround maternal and child health (MCH) populations, from assessing the current system to identifying and testing changes. QI tools provide the ability to implement each prescribed step in the methodology, or can be used as individual, standalone instruments to solve a specific problem.

Below are examples from the National Maternal and Child Health Workforce Development Center (WDC) that capture the essence of using standalone QI tools to move stakeholder groups towards improving systems that serve and improve the health and well-being of MCH populations.

Creating a Shared Vision and Understanding
A key component of improving a system is to create a shared understanding of the system among stakeholders. A process flow diagram provides visible documentation of how a system works. It is used to highlight gaps and variation among current systems or to document the “ideal” system for the future.

By engaging with the WDC, state Title V MCH and CYSHCN programs and their partners created process flow diagrams documenting various systems, including care coordination, screening and referral. Hawaii’s Title V program used a process flow diagram drafted during a developmental screening and surveillance efforts across the state. The team conducted on-site observations with six stakeholder agencies, created process flow diagrams for each agency’s process and shared the diagrams at an in-person meeting with 35 stakeholders. Stakeholders reviewed the diagrams; identified duplication and variation across agencies; and identified standard forms, communication techniques, and educational materials needed to standardize the process.

Georgia’s Title V program used a process flow diagram to create an “ideal” child health referral process. During an in-person meeting, approximately 100 child health program staff members worked in teams to draw their ideal process. Then the WDC team worked to respond to feedback from the teams by breaking the diagrams into one process flow diagram that represented the ideal system. The diagram created a common vision among staff and provided an opportunity to discuss roles, responsibilities and resources needed to successfully implement the new referral process.

Identifying Priorities
Identifying common priorities can create buy-in and help move a group to act more quickly. An impact matrix provides criteria to prioritize changes based on their: 1) impact on overall goals and 2) difficulty to implement. States that engaged with the WDC found the impact matrix valuable, as it provided focus to overall project objectives and goals and created space for ongoing discussions with partners by providing opportunities for diverse perspectives.

Colorado’s Title V program used the impact matrix to identify and prioritize over 40 programmatic and cross-agency policy and system changes to improve care coordination for CYSHCN. During an in-person meeting, stakeholders ranked each change and identified the “quick wins” (high impact and easy to implement) and “major projects” (high impact and somewhat difficult/difficult to implement). The team placed the “quick wins” in an action plan and incorporated the “major projects” in the state CYSHCN systems integration plan.

Creating Small Rapid Change
Maintaining engagement and momentum is challenging. Often, stakeholders agree on a list of changes, but “analysis paralysis” sets in as they try to anticipate all the “what ifs” of each change. The Plan-Do-Study-Act (PDSA) cycle can help build confidence in a change as it allows a group to quickly try the change on a small scale, make observations and take action based on what was learned.

One WDC state Title V team used the PDSA cycle to test a data-sharing memorandum of understanding (MOU) with a stakeholder group. The team drafted a MOU and shared it with two stakeholders for feedback. Based on that feedback, the MOU was adapted and shared with three new stakeholders, who provided additional suggestions for improvement. Over the course of a few weeks, the team adapted the MOU and shared the final version with the larger stakeholder group.

Another state Title V team aimed to reduce duplication in the referral intake process. After reviewing the intake forms, the team learned that two different forms captured eligible information. These were combined into one new form. The team used a PDCA cycle to test the new form with three clients from a pilot site organization. Clients were pleased with less paperwork; however, eligibility staff noted that several additional questions were needed to fully process clients. Based on feedback, the form was modified, and plans were made to test it with five additional clients. Testing the form provided an opportunity for the team to learn on a small scale rather than make the change in a single big step, reducing the chance of failure on a large scale.

Using QI tools can help improve the systems of care for MCH populations by establishing a shared vision and understanding among stakeholders, identifying common priorities and creating opportunities to rapidly test changes on a small scale. For example, about QI, visit the QI Step by Step Guide or Transformation Station on AMCHP’s homepage.

*Population Health Improvement Partners is a national lead-

er in building community and organizational capacity to im-
prove and sustain population health.

**National Maternal and Child Health Workforce Develop-
ment Center offers state and territorial Title V programs train-
ing, collaborative learning, coaching and consultation in health transformation.

Quality Improvement Resources for Public Health and Title V
By Jennifer Farfalla, MPH
Analyst for Quality Improvement and Life Course, AMCHP
Taking on quality improvement (QI) projects can feel in-
hibiting due to all of the tools, methods and skills there are to learn. However, a host of QI re-
sources and training opportu-
ities are geared toward state and local health departments – and even specifically toward Title V programs. Through our work with our members as well as our own internal QI journey, we at AMCHP identified a number of these resources.

QI Consultation for Title V Programs
The National Maternal and Child Health Workforce Development Center (the Center) at the University of North Carolina at Chapel Hill offers Title V programs free consultation and services related to health care reform. The center features four core areas in which it provides services: health transformation, workforce management, workforce transformation and quality improvement. The quality improvement core is staffed by a mix of AMCHP staff and QI experts from the Population Health Improvement Partners. The center is unique in that its services are concentrated on preparing the Title V workforce in particular to today’s complex and changing environment. Because quality improvement is one of its four core areas, the Center offers targeted coaching and consultation on quality improvement within health departments and Title V Request a consultation here.

As a practice partner of the Center, AMCHP’s houses Transformation Station, a web-based repository of resources related to health transformation. The quality improvement resources on Transformation Station can be accessed here.

QI Training for State and Local Health Departments
Population Health Improvement Partners (Improve-
Quality improvement (QI) can be a loaded term, and operationalizing it within Title V efforts can seem intimidating. But efforts to improve the quality of health care for adolescents and young adults at one New Mexico clinic show how making small, incremental steps—a core characteristic of QI—can build a foundation for generating improvements to be scaled and spread. First, some background: New Mexico has a long history of serving youth through its network of school-based health centers (SBHCs). The state Office of School and Adolescent Health (OSAH) in the Department of Health guides policy development on school and adolescent health issues and is involved in workforce development and training for those providing services to youth. In addition, OSAH has a close working partnership with Envision New Mexico, a child health care quality initiative based at the University of New Mexico Department of Pediatrics.

For over a decade, the SBHCs across the state took part in QI initiatives focused on preventative services, including one that examined the quality of comprehensive well-exams in the clinics. Rates of receipt of the well-visits in SBHCs were compared with other statewide measures, and medical record reviews were conducted to verify quality indicators within those visits. SBHCs are viable access points for health care among youth, and the adolescent well-visit was found to be the main reason students access services at the centers. Fast forward to 2015, when New Mexico was one of five states selected to participate in the Adolescent and Young Adult Health (AYAH) Collaborative (CoIIN) led by a multidisciplinary team of Title V leaders, youth advocates and leaders, Envision New Mexico staff, providers, community partners, the CoIIN team selected El Centro Family Health to help replicate the quality and successful strategies employed in the SBHCs at El Centro’s other clinics. El Centro is a federally qualified health center that serves eight counties and operates nine SBHCs as well as other community sites.

With OSAH’s help, Yolanda Montoya-Cordova, the former director of OSAH, said El Centro was selected because it had been part of previous QI initiatives and was an early adopter of QI in its SBHCs. In addition, El Centro’s leadership, including its medical director, was willing to try to test the successses found in the SBHCs at El Centro’s other clinics.

The AYAH CoIIN efforts will continue to bring new changes, but this early stage of small achievements can be a small step, but it can influence more significant and broader improvements for AYA patients to be made across the EL Centro Family Health system—and, it is hoped, across other systems in the state.

Insights on Public Health Accreditation
Having recently been awarded accredita-
tion status by the Public Health Accredita-
tion Board, what would you want to share with another MCH or CYSHCN program going through the process? How will your program benefit from accreditation?

The Arkansas Experience
Bradley Planey, MS, MA
Branch Chief, Family Health Branch, Arkansas Depart-
ment of Health

In Arkansas, individuals from all the major programs and support services in the agency were invited to participate in the work in the approach. Also, this QI effort—as well as others that may come along—will require a shift in focus among providers and youth to better understand the power of prevention. This milestone with the CoIIN might seem like a small step, but it can influence more significant and broader improvements for AYA patients to be made across the EL Centro Family Health system—and, it is hoped, across other systems in the state.

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AMCHP Quality Improvement 101, which allows participants to apply the QI methods and tools they’re learning to projects at their health departments. Staff learn to use tools such as the fishbone diagram, impact matrix, aim statements, process mapping and value stream mapping. The more advanced training program trains staff who have a QI skills base to become leaders for continuous quality improvement within their organizations. Staff learn how to lead the QI processes and tools from QI 101 and get experience facilitating a Kaizen Event. Visit the Population Improvement Partners here.

Examples of QI in Public Health Practice
A resource called the Public Health Quality Improvement Exchange (PHQIX) provides examples of QI in applied public health that you can study without having to leave your office. PHQIX is funded by the Robert Wood Johnson Foundation and created by RTI International. It is an online database of QI efforts conducted by state and local public health departments. You can filter to explore QI initiatives specific to MCH programs at the state and local level. When you click on an initiative, you can learn about the project and useful resources. For example, how many full-time employees a QI team had or what type of QI training the organization gave its staff. PHQIX can be accessed here.

Good luck on your QI projects! For additional support con-
tact AMCHP’s internal QI advisor, Jennifer Farfalla, at jfar-
falla@amchp.org.
AMCHP’s Internal Quality Improvement Efforts
By Jennifer Farfalla, MPH
Analyst for Quality Improvement and Life Course, AMCHP

AMCHP, like many of its members, is on its own quality improvement (QI) journey. Over the past three years, we have taken steps to increase our capacity to perform internal QI projects, offer external QI technical assistance and create a culture of continuous quality improvement (CQI) within our organization. CQI is a process of creating an environment where an organization’s staff and leadership are able to identify inefficiencies in their work and propose and implement solutions to those inefficiencies.

In December 2013, AMCHP staff members employed QI tools such as measuring our activities on an operational dashboard, but these tools were limited to use by a few staff members. In order to ensure staff were trained in basic QI tools and methods, AMCHP enrolled staff in Population Health Improvement Partnership’s QI 101 program. Staff applied these skills to three QI projects that aim to improve the services we offer our members. The QI project topics were (1) improving our identification of emerging issues in maternal and child health (MCH), (2) improving our recruitment of MCH best practices and submissions to our repository of best practices, Innovation Station, and (3) improving our virtual engagement, specifically webinar practices. AMCHP staff applied QI tools to analyze root causes of problems in these topic areas, prioritize our change ideas, test and measure changes, and sustain our change ideas with coaching from Improvement Partners staff. Improvements that came out of these projects included an AMCHP webinar toolkit, a technical assistance (TA) tracker designed to enable trend analysis of TA requests to help identify MCH emerging issues and a new Best Practices Ambassador program.

In order to keep the momentum going after the completion of our three QI projects, AMCHP’s analyst for quality improvement (who is a staff member) enrolled in Improve- ment Partners’ more advanced QI Advisor training program to build internal capacity to coach QI methods. As a part of the program, AMCHP created an A3, which is a two-page report on problem solving originally developed by Toyota and later adapted for use by other organizations, including hospitals and health organizations, to improve processes. AMCHP’s A3 consists of five sections: (1) Current performance, gaps and targets, (2) reflection on last year’s activities and results, (3) rationale for this year’s activities, (4) this year’s ac- tion plan, (5) follow-up and unresolved issues. Our A3 uses data, charts, visualizations and text to communicate a clear picture of ACHP’s history with QI, our current state and plan for the future and possible challenges that may arise.

Two main activities that came out of our COI A3 plan were a survey of AMCHP staff on our current culture and capacity for CQI, and the formation of a QI council that will lead QI activities in the future. Our QI survey was performed in January 2016 and showed areas where AMCHP is already doing well with CQI and its opportunities for improvement. AMCHP’s QI council, created in May 2016, convened its first meeting in June 2016. The council is in the process of creating a charter documenting a vision for QI at AMCHP and how the QI council will operate to help us fulfill that vision. We aim to create a few quick QI wins at AMCHP, including starting another QI project in 2016.

While AMCHP’s QI work created a number of posi- tive tools and changes, challenges to this work still exist. First, staff time is always a limited resource. Although a QI project creates several time-saving changes, we have to in- vest staff time to bring about these changes. However, all of our QI projects include metrics to measure the increased efficiency of our work and member services, which will show us if our staff time on these activities is warranted. Second, change is not always easy to implement, and we do not want to overwhelm our staff with changes. We will address this challenge through careful planning with tools like our A3 and feedback from our staff-driven QI council. While change can be challenging, we are also seeing the benefits of data-driven, mindful improve- ments and look forward to our future QI activities.

Applying Quality Improvement Measurement to Population Health Initiatives
By Greg Randolph MD, MPH
President and CEO, Popula- tion Health Improvement Partners; Professor of Pe- diatrics and Public Health, University of North Carolina at Chapel Hill

Measurement is a fundamental aspect of quality improvement (QI). Some fear that this measurement process will be exceedingly different than in a typical QI project, or even impossible. However, I have good news: the same prin- ciples apply; they just require minor adaptations, mostly in the number of measures needed and the related feasibility issues.

At the beginning of any improvement initiative, it is critical for leaders of the initiative team to set measurable goals that address the question, “What are we trying to accomplish?” Once these goals are established, the team can begin to develop a set of QI metrics that answer another key question: “Are the changes we’re making leading to improvement and moving us toward achieving our goals?”

A cornerstone of improvement science is the con- cept of a system. All systems tend to be complex and dy- namic. It’s not surprising, that when dealing with the health of a maternal and child population, complexity and the dy- namic nature are even greater. Thus measuring the impact of improvement at the population level must take this complexi- ty into consideration, and more measures (e.g., five to 10 measures) might be needed than in typical QI efforts. There will never be a “silver bullet” measure that can ac- curately reflect improvement in a complex system, so we need to think of a set of measures, including outcome, process and “balancing” measures.

Outcome measures address how policies and serv- ices affect the health, functional status and satisfaction of the people served. In other words, they measure the end results (at least, indi- ed by the experience of the population and its members). Pro- cess measures address how and what services and policies are provided (i.e., what programs and public health officials do). Balancing measures address potential unintended con- sequences to the system as it is changed (i.e., what could go wrong).

Outcome measures are very important for all stake- holders, especially initiative leaders, who want to know the ultimate reach of the initiative and its impact (or return on investment). Using a set of measures, including outcome, process and “balancing” measures, is an important part of any quality improvement initiatives’ measure set. Unfortunately, out- come measures are often slow to change (e.g., MCH data- sets like PRAMS, BRFFS and YRBS are primarily outcomes), so inclusion of one or more process measures is required so the team can understand the effects of the improvement ef- fort quickly and is able to assess whether the changes they are making are resulting in improvement. In addition, at the end of the initiative, the process measures can help demon- strate that the intended changes were indeed implemented. Finally, any time that changes are made to a system, there can be unintended, adverse consequences. We don’t want to improve one aspect of a system at the expense of an- other, as this could lead to less or no overall improvement, or even worse, it could harm. Ideally the team can identify several possible things that could go wrong early in the planning stage, such as decreasing client satisfaction with the time spent with Women, Infants and Children (WIC) staff when...
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PULSES

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Pathway to Quality Improvement

By John E. Safer, AMCHP President

It is often best to use existing data sources when possible. In addition to the above MCH data sources, various partners and stakeholders, community or state health assessments, Community Commons and other local, state and national resources can be vital. However, due to the need for both process and balancing measures, teams will often need to collect some of their own data. Feasibility and cost are key issues but can be mitigated by using some of these strategies:

- Sampling strategies are key, so consider using small sample sizes (e.g., 20 to 40 observations) collected frequently (e.g., monthly or quarterly) and/or representative convenience samples.
- Simple data collection instruments and methods, like check sheets and very brief surveys, can help minimize data collection costs and can be effective.
- Leveraging technology can also help (e.g., email surveys or scannable forms).

Finally, due to the dynamic nature of complex systems and the need to track progress, the best way to analyze data for improvement is to report your data graphically in run charts.

Other Considerations

In this era of health transformation and a strong focus on value, we should consider economic impact measures (sometimes referred to as “ROI” for “return on investment”) as outcomes as well. Measuring economic impact is consistent with the “triple aim” of better quality services, better health outcomes and lower costs. As part of this process, process, parent partners (veteran caregivers of children and youth with special health care needs) are included as equal partners on the QI team. They work in pediatric practices to provide follow-up and resources to families and to provide input as part of the QI process.

As a part of a Health Resources and Services Administration-funded grant for state autism spectrum disorders and other developmental disabilities implementation, the Parents’ Place of Maryland and Maryland’s Title V Children and Youth with Special Health Care Needs program are implementing a “Screening and Beyond” quality improvement (QI) learning collaboration with pediatric practices across the state. The goal is to reduce barriers to screening, referral and diagnostic services and to increase access to medical homes that coordinate care with pediatric specialists. As part of this process, parent partners (veteran caregivers of children and youth with special health care needs) are included as equal partners on the QI team. They work in pediatric practices to provide follow-up and resources to families and to provide input as part of the QI process.

In this article, two parent partners share their experiences as Medical Home Parent Partners and demonstrate the value of including parents in these projects. Dianna Speir works in a smaller rural practice and Shannon Svikhart works in two larger urban practices.

What was most challenging?

Speir: Some of the office staff in my practice didn’t see the value in having a parent partner right away. There was a shift in the office culture over time.

Svikhart: One doctor became overzealous, skipping protocols, pulling me into exams rooms without proper consent and referral – I definitely needed to rein that in.

What did you gain or value through your participation?

Speir: It feels good to help families in such a meaningful way. I wish there had been a parent partner available in the early years of my child’s diagnosis – someone to provide the type of support that we offer.

Svikhart: At the beginning of this project, I spoke with my practices about the potential benefit of this model. As it turns out, the impact of this enhanced care has been far greater than any of us anticipated.

What value do you think parent partners can add to similar QI work?

Speir: We help improve outcomes for the children when we support the family. Parent partners offer families time – time to listen, time to process, time to vent, time to strategize, time to make a plan. The families we work with are often shocked that someone is there to help them.

Svikhart: We offer the QI team firsthand knowledge of what it’s like to have this type of family [with a child with special health care needs, including ASD/ID]. We’ve walked that walk, and we can help these families in ways no one else can. We approach it from a different angle, knowing how challenging it can be. It’s as if they’re stranded on a little island, and we’re rowing out to let them know they’re not alone.

To learn more about Maryland’s project, click here.

“Letter from the President” continued from page 4

Mummy-based.

Quality improvement starts with a belief that services and programs can be better.

In this era of health care reform, we have an opportunity to commit to improving the quality of our services and programs in a manner that is innovative and inclusive. Across the country, state Title V agencies are uniquely qualified to build from their strengths as “systems builders” to illuminate not only the gaps and barriers to present solutions that work. The biggest gap in the implementation of the Affordable Care Act is the alignment of health outcomes which are not solely dependent on clinical interventions; there are opportunities to address wellness on the playground. If payment incentives were designed to honor non-clinical “health care” I am certain we would have a generation of healthier people. Like Stephanie, sometimes we as MCH professionals have to come out from the parking lot and step in as innovative providers.

As the president of AMCHP, I want to inspire a shared vision that we can improve our programs and services by integrating systems of care. Stating the problem is part of solving the problem. Sustaining vertical, competitive and disconnected systems is not supporting the best outcomes for kids, youth and families. As a parent of a young adult who requires 24/7 care, I have been involved in myriad quality improvement initiatives for over 20 years. In 2007 when I testified in our state for legislation to support the medical home model, I proclaimed, “Medical home” is a verb, not a noun! I often reflected that it doesn’t matter where we receive our care, but rather that the actions taken to assure the care is excellent and relevant.

Sadly, I am afraid that our nation’s well-intentioned efforts to integrate systems through the medical home movement only segregated specialists more deeply as a “place based” approach triumphed. Creating integrated services and systems of care is indeed a step in the right direction, and I am hopeful that recent investments and initiatives will garner outstanding results.
Quality improvement (QI) is a priority at the Bureau of Family Health (BFH): It’s an integral component of the CoIN initiatives, Title V and the general move toward the state’s public health accreditation. Although QI activities have been occurring within the bureau for a number of years, the BFH created a Quality ImprovementCoordinating Team (QICT) as the first step of many in formalizing QI. The QICT used many tools to introduce and demystify the principles of QI for the general staff. It illustrated examples of projects employing QI principles and promoted the concept of small wins. Using real-life examples proved to be effective, as it increased awareness of QI at work within the bureau. During QICT meetings, BFH teams can share their QI efforts, discuss strategies and develop ways to foster smoother, well-informed processes. The bureau’s Data to Action Team (epidemiology team) spearheads many QI projects, focusing on improved efficiencies in data collection and management that impact data quality, including:

- Streamlining data collection for child death reviews: In accordance with state legislation, Louisiana reviews records for all unexpected (non-medical) deaths for children under age 15. This data informs prevention strategies and data analyses. Data abstraction is time-consuming due to the number of variables included in the Child Death Review case registry. Certain variables are not needed for the specific death being reviewed, such as birth weight for a 7-year-old who died in a motor vehicle crash. The mortality epidemiologist created a data algorithm outlining variables that are needed for certain cases to refine data abstraction. The goal is to increase the quality of the essential data while reducing time wasted on collecting unnecessary data.

Improving Quality of Birth Certificate Data: Birth certificate data are regularly examined for missing and/or under-reported data that is outside a predetermined acceptable range. The Louisiana Center for Vital Statistics Quality Manager uses a quality report with each birthing hospital to improve reporting procedures. Accurate birth records are essential to birth outcomes surveillance.

Gaining operational efficiencies for Pregnancy Risk Assessment Monitoring System (PRAMS): Data from PRAMS are used to inform program development, policy and resource allocation. A threshold response rate of 65 percent is required for generalizability of results. Louisiana’s response rate had not exceeded 60 percent since 2004 — due in part to an inability to reach mothers with inaccurate or missing contact information and materials not clearly communicating the benefit of participation. Contact information was improved by electronically linking data sources (such as WIC and Newborn Screening records) to identify alternate addresses and phone information; this eliminated time-consuming manual searches, which had interfered with time for phone interviews. Through iterative prototype design, the new materials were released in 2015. The combination of these efforts led to an increase in the unweighted response rates from 57 percent in 2014 to 67 percent in 2015.

With a designated QICT leading the way, QI is becoming a regular part of operations at BFH. While the approach to how QI is conducted across programs is evolving, the momentum and enthusiasm for this process is thriving. It is becoming increasingly important to integrate QI into all the work done at BFH in order to create a culture of quality improvement.

An Epidemiological Focus on Quality Improvement
By Sumrita Bindra
Maternal & Child Health Epidemiologist, Bureau of Family Health, Louisiana Department of Health

Cara Bergo
Mortality Surveillance Epidemiologist, Bureau of Family Health, Louisiana Department of Health

Jane Herwehe
Epidemiology Supervisor, Bureau of Family Health, Louisiana Department of Health

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Engaging Families: A Challenge that Must be Met
By AMCHP Staff

Engaging families in Title V programs is more important than ever – which is why AMCHP just published a survey and series of case studies about family engagement in those programs. The Title V Block Grant now requires programs to document family and consumer participation, which are key to helping to improve service quality. That’s one reason AMCHP conducted a nationwide survey about family engagement policies and practices in Title V maternal and child health and children and youth with special health care needs programs, with funding from the Lucile Packard Foundation for Children’s Health and the U.S. Maternal and Child Health Bureau.

Although almost all Title V and CYSHCN survey respondents said they seek family input, their responses also show that programs struggle with the nuts and bolts of meaningfully employing, compensating and engaging families. The survey findings and case studies provide a snapshot of strategies to support meaningful family engagement, effective and innovative practices, and areas for improvement. Among the survey findings:

- Title V programs embrace a broad definition of family, ranging from program participant to immediate and extended family, as well as youth/young adults.
- Most Title V programs report some form of family participation, such as reviewing block grant applications and writing sections of block grants.
- Most Title V programs employ family members.
- More than three-fourths of programs report providing staff development and training about family engagement.
- Programs use a broad range of engagement strategies, including creating a process for improving family engagement and employing a family leader on staff.
- Most Title V programs use contracts to operationalize family engagement and leverage the expertise of family organizations.
- The key challenges reported are recruiting representation across geographic areas or from remote areas.
- The survey report, Sustaining and Diversifying Family Engagement in Title V MCH and CYSHCN Programs, is published in a series of easy-to-digest briefs that detail the results in specific areas:
  - Creating a Culture of Family Engagement
  - Levels of Family Engagement
  - Roles of Family Staff/Consultants
  - Family Members Employed as Staff
  - Sustaining and Diversifying Family Engagement
  - Evaluating Family Engagement

The case studies provide examples of engaging families and diverse populations in five states. See all the reports here.

Member to Member
How does your state incorporate family and consumer engagement into your quality improvement efforts?

Sarah Cox
Principal Planner, Children and Youth with Special Health Needs, Minnesota Department of Health

Sarah Mapellentz, JD, MPH
Family-Professional Partnerships Coordinator, Children and Youth with Special Health Needs, Minnesota Department of Health

The Title V Children and Youth with Special Health Needs (CYSHN) Program, within the Minnesota Department of Health, recognizes and actively relies upon the keen expertise of family organizations. Our program’s 2013-2016 Strategic Plan, developed in collaboration with families of children with special health needs, provides a framework upon which all of our quality and systems improvement efforts are based.

A key vision element within the strategic plan is increasing family-professional partnerships and shared decision-making at all levels of the system. One way of increasing our partnership with families was through the development of the CYSHN Parent Workgroup, which serves as an advisory resource for the MDH CYSHN Program. The Parent Workgroup consists of eight parents from diverse backgrounds who provide insight on program activities. Because we see these parents and caregivers as vital partners in our quality and systems improvement work, we provide financial reimbursement for their time and contributions, child care cost coverage and mileage for travel.

Roles of Family Staff/Consultants

Family Members Employed as Staff

Family Members

Sustaining and Diversifying Family Engagement

Evaluating Family Engagement

A View from Washington: What is the Sound of Failure?
By Brent Ewig, MHS
Director, Public Policy & Government Affairs, AMCHP

WASHINGTON – You know that President Obama requested $1.9 billion in emergency supplemental funding back in February. After some initial signs of bi-partisan cooperation on a package providing $1.1 billion, efforts in mid-summer broke down over the inclusion of family planning restrictions and envi-
Ronamental regulatory changes included in a bill that passed the House largely on a party-line vote. The Senate has since failed twice to muster the 60 votes needed to move forward. Congress is now on recess until early September—meaning that even if members are able to find common ground, any additional funds appropriated this year would likely not reach the front lines of Zika until autumn. In many ways, Congress’s inaction has guaranteed that states and localities are on their own and that the window for robust primary prevention this summer is nearly slammed shut. With the Centers for Disease Control and Prevention monitoring over 800 pregnant women with Zika virus infection in the United States and territories, it is likely just a matter of time that the focus will necessarily shift from education and prevention to intensive care coordination.

So where do we go from here? AMCHP continues to work with a broad coalition of leading MCH groups to urge Congress to be ready to pass a robust package as soon as it returns in September. Unfortunately, the staff we are meeting with on Capitol Hill report that no negotiations are underway, as both sides seem deeply entrenched in their positions. Our hope is that the confirmed local transmission of the virus reported last week in Florida will create a new urgency to act and will bring all parties to the table to find a path forward.

Zika virus is testing our public health systems in new ways, partly because new information about the virus is discovered on a weekly basis. But whether we are talking about hurricanes, floods, influenza, MERS, SARS or Ebola, we have learned to expect the unexpected. The need for a strong yet flexible public health system could not be clearer, and yet in this summer of discontent Congress is failing to provide even a modicum of support. We will continue to work to change that and keep our candles lit.

Who’s New at AMCHP

Dr. Cheryl Clark joined AMCHP as the associate director for epidemiology and evaluation. Dr. Clark received her bachelor’s in health information management administration from the University of Wisconsin and her MPH from the University of South Florida, with a concentration in public health education. She received her Doctor of Public Health (DrPH) in Epidemiology and Biostatistics from Florida A & M University. She has extensive work experience as an epidemiologist, data/ research consultant, evaluator and health informatics consultant. She has worked as a maternal and child health epidemiologist for 16 years and the past six years at a Sr. MCH Epidemiologist capacity.

Who’s New in MCH

Linda Cavitt
Deputy Director for Programs, Adult and Family Services
Oklahoma Department of Human Services

Lacy Fehrenbach
Director, Office of Healthy Communities
Washington State Department of Health, Prevention and Community Health Division

Rachel Jew
Title V CYSHCN Director, Purchased Health Services Unit
Texas Department of State Health Services

Sara Morgan
Administrator, Lifespan Health Services (MCH Director)
Nebraska Department of Health and Human Services

Andrea Palmer
Chief, Division of Maternal, Child and Family Health Services
Illinois Department of Public Health

Calendar

AMCHP 2017 Annual Conference
March 4-7, 2017
Kansas City, Mo.

Women’s Health Info Series Webinar: Understanding the New CDC Contraception Guidelines
Aug. 25, 2016

20th National Conference on Child Abuse and Neglect
Aug. 31-Sept. 2, 2016
Washington, D.C.

CityMatCH Leadership and MCH Epidemiology Conference
Sept. 14-16, 2016

2016 Infant Health Policy Summit
Sept. 15, 2016
Washington, D.C.

Congenital Cytomegalovirus Public Health and Policy Conference
Sept. 25-27, 2016
Austin, Texas

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Collaborative Improvement and Innovation Networks in the MCH Landscape

Compiled by AMCHP Staff

Collaborative Improvement and Innovation Networks (CoIINs) or CoIIN-like approaches to develop common aims, use and share evidence-based strategies, and use shared metrics and real-time data in order to improve maternal and child health outcomes.

CoIINs supported by the U.S. Health Resources and Services Administration (HRSA) address a range of topics across the life course, including maternal health, infant mortality, newborn screening, home visiting, child health and safety, school-based health, children and youth with special health care needs, adolescent and young adult health, healthy weight and oral health. Below is a quick overview of the current HRSA-supported CoIINs and CoIIN-like projects, along with related Title V National Performance Measures (NPMs).

<table>
<thead>
<tr>
<th>CoIIN</th>
<th>Participation</th>
<th>Contact</th>
<th>Related NPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents and Young Adult Health (AYAH)</td>
<td>State teams composed of: state Title V leadership, state adolescent health coordinator, state Medicaid agency, major health plan(s), state chapters of national professional membership associations, youth/young adult consumers.</td>
<td>Trina Anglin, <a href="mailto:tanglin@hrsa.gov">tanglin@hrsa.gov</a> <a href="http://www.amchp.org/programsandtopics/Age-RelatedHealth/Pages/default.aspx">http://www.amchp.org/programsandtopics/Age-RelatedHealth/Pages/default.aspx</a></td>
<td>10</td>
</tr>
<tr>
<td>Children's Healthy Weight</td>
<td>TBD</td>
<td>Meredith Morrissette, <a href="mailto:mmorrissette@hrsa.gov">mmorrissette@hrsa.gov</a></td>
<td>4, 8</td>
</tr>
<tr>
<td>Pediatric Obesity Mini CoIIN</td>
<td>Phase 1: Alaska, Louisiana, Ohio, Wisconsin Phase 2: Alaska, Louisiana, Ohio, North Dakota, California, Oregon</td>
<td>Meredith Morrissette, <a href="mailto:mmorrissette@hrsa.gov">mmorrissette@hrsa.gov</a> <a href="http://asphn.org/resource_read.php?resource_id=661">http://asphn.org/resource_read.php?resource_id=661</a></td>
<td>8</td>
</tr>
<tr>
<td>Early Childhood Comprehensive Systems (ECCS)</td>
<td>ECCS Impact Grantees</td>
<td>Sandy Sheehy, <a href="mailto:ssheehy@hrsa.gov">ssheehy@hrsa.gov</a></td>
<td>1, 6</td>
</tr>
<tr>
<td>Emergency Medical Services for Children (EMSC)</td>
<td>State teams composed of state EMS medical directors, trauma system managers, EMSC state program managers, family representatives and key stakeholders. States: Connecticut, District of Columbia, Florida, Kansas, Kentucky, Michigan, New Mexico, New York, Okla., Pennsylvania, South Carolina, Texas</td>
<td>Therese Morrison-Quinata, <a href="mailto:TMorrison-Quinata@hrsa.gov">TMorrison-Quinata@hrsa.gov</a></td>
<td>7</td>
</tr>
<tr>
<td>Healthy Start</td>
<td>Level 3 Healthy Start Programs: Alabama, Arizona, California, District of Columbia, Florida, Indiana, Louisiana, Massachusetts, Maryland, Michigan, North Carolina, New Jersey, New Mexico, New York, Ohio, Pennsylvania, and Texas (local sites, not states represented).</td>
<td>CDR Makeva Rhoden, <a href="mailto:mrhoden@hrsa.gov">mrhoden@hrsa.gov</a> <a href="http://healthystartepic.org/healthy-start/hs-coiin/">http://healthystartepic.org/healthy-start/hs-coiin/</a></td>
<td>1, 3, 4, 6</td>
</tr>
<tr>
<td>Home Visiting</td>
<td>MIECHV grantees supporting over 30 local implementing agency teams. States: Arkansas, Florida, Georgia, Indiana, Michigan, New Jersey, Ohio, Pennsylvania, Rhode Island, South Carolina, Virginia, Wisconsin</td>
<td>CDR Monique Fountian Hanna, <a href="mailto:MFountain@hrsa.gov">MFountain@hrsa.gov</a> <a href="http://hv-coiin.edc.org">http://hv-coiin.edc.org</a></td>
<td>1, 4, 6</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>State MCH program directors or designee-led teams States: 58 states and jurisdictions</td>
<td>Vanessa Lee, <a href="mailto:vlee1@hrsa.gov">vlee1@hrsa.gov</a> Website: <a href="http://www.nichq.org/childrens-health/infant-health/coiin-to-reduce-infant-mortality">http://www.nichq.org/childrens-health/infant-health/coiin-to-reduce-infant-mortality</a></td>
<td>1, 2, 3, 5, 10, 14</td>
</tr>
<tr>
<td>Newborn Screening</td>
<td>State newborn screening programs and hospitals: Arizona, California, Co.-Wyo., Hawaii, Iowa, Michigan, Minnesota, Montana, Nebraska, New YorkMAC (Delaware, Maryland, New Jersey, New York, Virginia), Oklahoma, Puerto Rico, Tennessee, Texas, Wisconsin</td>
<td>Debi Sarkar, <a href="mailto:dsarkar@hrsa.gov">dsarkar@hrsa.gov</a> Website: <a href="https://www.newsteps.org/newsteps-360">https://www.newsteps.org/newsteps-360</a></td>
<td>NOM 12</td>
</tr>
<tr>
<td>School-Based Health Services / Comprehensive Mental Health Systems</td>
<td>Teams of school-based health centers and school mental health systems in separate CoIINs.</td>
<td>Trina Anglin, <a href="mailto:tanglin@hrsa.gov">tanglin@hrsa.gov</a></td>
<td>10</td>
</tr>
</tbody>
</table>
Resources

Learn About Epi Support Services
Through support from the Centers for Disease Control and Prevention’s Division of Reproductive Health, AMCHP created EpiSupport Services (ESS). ESS is a structured way for AMCHP to provide epidemiology support and connections to peer epidemiologists and field experts who can provide insight on applied MCH epidemiology issues. To submit a request or to learn more, click here.

Give Feedback on Preconception Health Indicators
The Centers for Disease Control and Prevention, in partnership with AMCHP, will hold a meeting on the preconception health indicators at the 2016 MCH Epi Conference in Philadelphia on Sept. 14 from 12:15-1:15 p.m. ET. The objective is to receive feedback on the recommended preconception health indicators and to describe the prioritization process. We are interested in receiving responses from state and territorial staff, particularly MCH epidemiologists, MCH directors and Title X directors, so consider attending to share your perspective. Please register by Aug. 15. Registered attendees will be asked to complete a pre-assessment regarding the core preconception care indicators four weeks prior to the meeting. There are no ongoing commitments or requirements afterwards. Please keep in mind that all attendees must be a registered participant of the CityMatCH Conference. To register for the conference, click here. For additional information, please contact Jennifer Farfala at jfarfala@amchp.org.

Equity in MCH is Focus of Next Learning Network Call
CityMatCH will host the third and final call for the 2016 Learning Network Series on Aug. 17 at 2 p.m. ET. This call will focus on taking the equity lead in our institutions. Join CityMatCH and more than 100 of your colleagues for a call that aims to keep professionals informed and thinking critically about maternal and child health issues. To access the call, please dial 866-740-1260 and use passcode 5529500. For more information, click here.

Preventing Bullying Through Science, Policy, and Practice
The Centers for Disease Control and Prevention (CDC) will present a new installment of Public Health Grand Rounds on Aug. 19 from 1:00-2:00 p.m. ET. The presentation will discuss current prevalence and health strategies to prevent official bullying syndrome. For non-CDC staff, a live external webcast will be available via the Webcast Links section of the CDC website.

Prepare Adolescents with Asthma and Allergies for Transitions to Independent Living
Join the American Academy of Pediatrics for a free webinar on Sept. 1 from 1:00-2:00 p.m. ET to educate practitioners about adolescent transitions from their medical homes. The webinar will include practical tips to use immediately, with an emphasis on transitioning adolescents with asthma and allergies to independent living. To register, click here.

Ask-a-Collaborator
CityMatCH would like to know what your health department is doing to engage adolescents and young adults in preventative health care services. How is your health department incorporating positive youth development and engagement activities? To share events with others in the USBC network, please post them to the NBM16 Calendar.

On Aug 18 from 2:00-3:00 p.m. ET and Aug 23 from 8:00-9:00 p.m. ET, USBC will host virtual town hall meetings. Organizations and individuals are invited to share written comments on priority action areas and associated implementation strategies for the next five years. The written comments, hosted on separate channels for each sector of the SGCTA, will be open all month, allowing for continuous feedback. Volunteers will review and compile the comments into a report with recommendations for USBC and its network. The report will also be delivered to the Surgeon General and the federal Interagency Breastfeeding Work Group. To register for the Aug. 18 meeting, click here. To register for the Aug. 23 meeting, click here.

CityMatCH would like to know what your health department is doing to engage adolescents and young adults in preventative health care services. How is your health department incorporating positive youth development and engagement activities? To share events with others in the USBC network, please post them to the NBM16 Calendar.
strategies into this work? Please send any information on programs and strategies to Erin Schneider.

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Caroline Stampfel, Director of Programs

Kate Taft, Senior Program Manager, CYSHCN
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