



PULSE

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

Emerging Issues in MCH

March/April 2016

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From the President

Collaboration

By Eileen Forlenza



Wow – what a fantastic annual conference this month in DC. Considering the collaborative effort required to reschedule from the original January date – I would indeed classify this conference as outstanding! Thank you to the AMCHP staff and all the members of the AMCHP family for your dedication and ongoing commitment to learn from each other. I am always amazed at the amount of learning that can happen in 3 short days! Since my message this month is about collaboration, I'd say the timing is perfect!

One of my favorite places to visit is the Lincoln Memorial, a beautiful monument that symbolizes leadership and social justice. I have often studied the work of Abraham Lincoln, and like many of you, consider him a hero in many ways.

In the midst of all the current political discourse, I am reminded of President Lincoln's plea to us during his Gettysburg Address in 1863. The history books tell us that he was exhausted and deeply concerned having just witnessed the ugliness of poverty, pain and powerlessness. He said, "...that this nation, under God, shall have a new birth of freedom—and that government of the people, by the people, for the people, shall not perish from the earth."

His reminder to us then and now, is that democracy is about people. More importantly, our government should reflect the people for whom it was designed, and give voice

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to people. This idea of providing a place at the table for all to be heard is at the core of our work at AMCHP as we are strongly committed to collaboration and partnership. From coffee cafés in local communities to elegant board rooms in urban downtown cities, people are working together to solve challenging problems by aligning resources. AMCHP's new strategic plan has a strong emphasis on alignment directly related to strong collaboration. Specifically, the goal area reads that "AMCHP will influence the alignment of resources at the federal and state levels to improve and increase support for maternal and child health. Objective #2 is "Increase the ability of programs to function at or towards the collaboration level."

Collaboration is anchored by mutual trust and commitment. As an MCH champion, you know firsthand that our ability to improve the lives of women and children is dependent on a collective effort over a long period of time. In public health, we often never see the fruits of our labor, but the partnerships we've developed are a testament to the value of collaboration. Communities are the benefactors of collaboration, which is an outcome we can all be proud of. I am excited to see and hear more about your collaborative efforts!

I hope you are enjoying the spring season and the symbolism of renewal that comes with this time of year.

All the best,
Eileen

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From the CEO

By Lori Tremmel Freeman, BS, MBA
Chief Executive Officer, AMCHP



This issue of Pulse is an inaugural theme focused on Emerging Issues. By definition, the word 'emerging' according to Merriam-Webster is "newly created or noticed and growing in strength or popularity: becoming widely known or established." Similarly, the word 'issue' means "something that people are talking about, thinking about, etc.: an important subject or topic."

I'm slightly surprised we've not had this theme in the past. Although it appears to be a period of calm in public health, most of us know that the reality is that public health emergencies and crises are occurring almost every day across the country and happening to our most vulnerable populations. The media (and sometimes even those on the front lines) can just have a short attention span as we move from one crisis to the next.

It wasn't even a year ago that AMCHP published a special edition of Pulse on Emergency Preparedness and Reproductive Health. At that time, the articles focused on things like natural disasters (Katrina was at the forefront), the Ebola outbreak, and Anthrax exposure and their impact on maternal and child health. As you read this issue of Pulse focused on Emerging Issues, you'll find that all of the topics meet the definitions above for emerging issues including the Zika virus, opioid abuse, and lead exposure articles. And, these are truly different issues than were in play a year ago today – at least in the public's eye.

With perhaps the exception of Zika, we know in our hearts that these are not modern nor are they emerging issues necessarily. They only meet this criteria because they have become 'noticed' and they are what we are now 'talking about.'

For example, abuse of prescription pain relievers by pregnant women which can result in a number of problems in newborns (e.g. neonatal abstinence syndrome), increased by almost 300 percent in the United States between 2000 and 2009 (CDC. Vital signs. <http://www.cdc.gov/vitalsigns/PrescriptionPainkillerOverdoses/index.html>). This increase was driven in part by the high rate of opioid

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prescriptions being given to pregnant women. In the United States, an estimated 14.4 percent of pregnant women are prescribed an opioid during their pregnancy. [Bateman, B.T. et al. Patterns of Opioid Utilization in Pregnancy in a Large Cohort of Commercial Insurance Beneficiaries in the United States. *Anesthesiology*. in press (2014)]. Data around NAS were beginning to trend 10 to 15 years ago!

In terms of lead poisoning, we all know and understand that childhood exposure to lead can have lifelong consequences and that there are significant differences in lead exposure by race/ethnicity and income indicating a persistent disparity. These disparities can be traced to differences in housing quality, environmental conditions, nutrition, and other factors. Even though the level of lead exposure in children tested today has declined over time, there are still far too many children with lead poisoning with many in vulnerable populations once again. In January 2012, the CDC changed its "blood lead level of concern" based on a growing number of scientific studies that show that even low blood lead levels can cause lifelong health effects. This new level is based on the population of children aged 1-5 years in the U.S. who are in the top 2.5% of children when tested for lead in their blood. Currently, that is 5 micrograms per deciliter of lead in blood. CDC's "blood lead level of concern" was previously 10 micrograms per deciliter. Although the Flint water crisis has certainly brought lead poisoning once again to the forefront of concerns – and created an 'emerging issue' as a result – we should all remember that every day pregnant mothers and children are exposed to lead poisoning across the country and that the overall impact is significant with devastating results that last forever for families.

So while emerging issues are with us – and they may be very familiar to those working the front lines of public health – they are often in the forefront of the public eye and that of Congress for the first time due to enhanced media attention. Nevertheless, we can absolutely seize an opportunity for maternal and child health to take advantage of the added attention and fight harder for public health funding and support for states in order for these issues that frequently require reprioritization of existing concerns.

Feature An Increasing Awareness of Maternal Mental Health



By Michelle Eglovitch, MPH
Program Associate, Women's & Infant Health, AMCHP



Carolyn McCoy, MPH
Senior Policy Manager, Health Reform Implementation, AMCHP

The mental and emotional wellbeing of expectant and new mothers, troubling rates of maternal depression and anxiety, as well as their effect on mothers, families, and communities, is a growing national concern. Maternal mental health encompasses mental health disorders during and after pregnancy, including mood/depression and anxiety disorders (collectively referred to as Perinatal Mood and Anxiety Disorders, or PMAD). 15 to 20 percent of women will experience depression during or after pregnancy, and up to 15 percent of women will develop anxiety during pregnancy or after childbirth¹. Untreated maternal depression and anxiety can have negative short-term consequences ranging from inability to self-care, to disruption of infant-child bonding². Long-term consequences of untreated maternal depression and anxiety involve negative mental health outcomes for the mother, and also may put strain on the family unit².

Nation-wide, research on maternal mental health screening and subsequent outcomes is limited, potentially due to lack of a universal screening protocol and variances by facility in procedure. However, research shows that recognition and treatment rates for depression specifically are lower in pregnant and postpartum women (14 percent) than in the general population (26 percent)³. For those providers who are screening for postpartum depression, they may be doing so with a tool that is not validated or through informal assessments, which are ineffective in identifying actual cases of depression⁴. Although rates of screening vary by facility and state, there is insufficient evidence that such screenings are universally translating into better patient

Feature CONT. Maternal Mental Health

outcomes⁵. Thus, not only is there missed opportunity in provider settings to screen for maternal mental health disorders, but lack of a universal knowledge base on what to do if a mother receives a positive screen.

Fortunately, renewed attention to maternal mental health has given way to several initiatives to address screening and treatment outcomes on the legislative, coverage, and care quality fronts. In July 2015, Representative Katherine Clark (D-MA) introduced the "Bringing Postpartum Depression Out of the Shadows Act." The bill seeks to improve access to maternal mental health services by creating a grant program to states for screening and treatment for maternal depression. Also in January 2016, the U.S. Preventive Services Task Force (USPSTF) released a revised recommendation for the screening of all adults, including pregnant and postpartum women. The USPSTF goes on to recommend that "Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up⁶." This guidance is especially important now that the health insurance plans sold through the health insurance Marketplace as part of the Affordable Care Act are required to cover all USPSTF preventive services with an A or B rating, with no cost sharing. Depression screening for adults has always been covered without cost sharing by these plans, however, the revision of the guidance and specification that pregnant and postpartum women should be screened universally, could lower barriers to screening for the patient and provider. Additionally, as of 2014, most

individual and small group health insurance plans, sold inside and outside of the Marketplace, are required to cover mental health and substance use disorder services. Plans serving the Medicaid expansion populations must also cover mental health and substance abuse disorder services. For non-expansion Medicaid populations, all state Medicaid programs for adults provide some mental health services and some offer substance use disorder services to beneficiaries, and Children's Health Insurance Program (CHIP) beneficiaries receive a full service array.

Also, as part of the ACA, most individual and small group health insurance plans must now cover a set of 10 essential services that includes prenatal and maternity care thus lowering the barrier for women to access the clinicians to provide the depression screening.

Young women of reproductive age have another avenue for coverage, with the ACA's requirement for all non-grandfathered health plans — employer-sponsored, as well as individual policies purchased in or out of the Marketplace — to allow dependents to remain on their parent's plan until the age of 26. Coverage is available regardless of an adult dependent's employment or marital status. This provision holds potential for ensuring that young adult women have continued access to coverage and care.

Finally, in January 2016, the [Council on Patient Safety in Women's Health Care](#) — a multidisciplinary collaboration with representation from all major health professional organizations serving women — released a maternal mental health safety bundle. The bundle includes sets of three to four action items for four focus areas that apply to various health professionals and facilities serving women prenatally and postpartum, and is accompanied by a listing of resources and Web links. Amongst other important features, the bundle seeks to rectify barriers to screening and treatment. For example, the bundle makes recommendations to facilitate relationships between healthcare providers to address lack of collaboration between different sources of maternal care.

Maternal depression and anxiety are significant medical issues for women, and may go unrecognized by patients, family members, caregivers, and healthcare providers. Recent initiatives to address maternal mental health are important, not only because they shed national light on such an imperative public health issue, but also because they call for further improvements in policy and procedures to better serve mothers. AMCHP and partners are actively working to address this issue and connect its members with resources and tools. The Alliance for Innovation

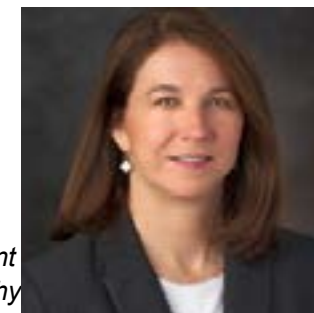
Feature CONT. Maternal Mental Health

on Maternal Health (AIM) is the 'implementation arm' of the Council, and partners with states and major hospital systems to implement maternity safety bundles across birth facilities. AIM's goal is to prevent 1,000 maternal deaths and 100,000 cases of severe maternal morbidity nationally by 2018. AMCHP and six other organizations are core partners on the initiative. Further, numerous state Title V agencies selected National Performance Measure #1: percent of women with a past year preventive medical visit, as a priority area. In draft state action plans, states positioned this measure as an opportunity to enhance access to services and supports for women across the lifespan, including access to mental health services postpartum (as well as zooming in on intimate partner violence and substance use). AMCHP also supports states in health reform implementation and can offer best practices and guidance on how Title V agencies can get involved in ensuring women have access to necessary coverage to receive screening and treatment. If your state has a specific technical assistance need pertaining to maternal mental health, please contact Michelle Eglovitch, Program Associate for Women's and Infant Health, at meglovitch@amchp.org.

1)The 2020 Mom Project. (2016). About Maternal Mental Health Disorders
2) New York State Department of Health. (2005). Understanding Maternal Depression, A Fact Sheet for Care Providers
3)Wisner, K. L., Sit, D. K., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., & Confer, A. L. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry*, 70(5): 490-498.
4)Gjerdingen, D. K., & Yawn, B. P. (2007). Postpartum depression screening: importance, methods, barriers, and recommendations for practice. *The Journal of the American Board of Family Medicine*, 20(3), 280-288.
5)Yawn, B. P., Olson, A. L., Bertram, S., Pace, W., Wollan, P., & Dietrich, A. J. (2012). Postpartum depression: screening, diagnosis, and management programs 2000 through 2010. *Depression Research and Treatment*, vol. 2012, Article ID 363964, 9 pages.
6)US Preventive Services Task Force. (2016). Screening for Depression in Adults: Recommendation Statement. *JAMA*, 315(4):380-387.

Feature Healthy Homes- Healthy Children: A Holistic Approach

By Ruth Ann Norton, *President and CEO of the Green & Healthy Homes Initiative*



The past few months have reawakened us to the continuing threat from lead poisoning. The horrifying scope of the crisis in Flint, Michigan, where the city water supply was contaminated with high levels of lead, has shocked the nation. Sadly, similar problems are confronting cities and communities across the country. It's a national emergency that demands an urgent response

focused on prevention of this avoidable problem.

The good news is that policymakers and advocates are refocused on the issue and looking for better approaches. In Maryland, where the Green & Healthy Homes Initiative's (GHHI) work first focused, decades of work has led to stronger policies that have reduced the number of children with elevated lead levels by 97 percent. Pediatricians, nurses and other healthcare providers played a vital role in educating parents, testing kids and helping authorities follow through with treatment and other interventions. We continue to push for reforms that will eliminate all lead poisoning in the state.

However, our work has expanded significantly in recent years. While preventing lead poisoning remains a key focus, we are now looking holistically at the entire home — to make sure children and families live in conditions that are healthy, safe, more affordable and environmentally sustainable over the long term.

Our efforts are gaining strength and financial support from diverse partners, including the federal government and national foundations, which are interested in new, smarter approaches that use resources more efficiently to prevent childhood health problems.

Public health officials and healthcare providers are also vital partners, increasingly recognizing the critical need to make sure children and families live in homes that are safe and healthy, free of hazards that contribute to health problems such as asthma. Seven million children in the United States suffer from asthma, and research shows that 40 percent of asthma episodes are attributable to home-based environmental health hazards such as mold or pests.

A child's asthma can cripple a family, especially those with lower incomes. Children end up in the hospital and miss school. Parents are often forced to miss work to care for children.

The enormous costs of treating asthma and other pediatric health problems are often borne by public and private health insurance programs, as well as hospitals and other providers. Too often we are only responding to the problem and wasting resources. Instead, we should be putting more resources into preventing these health problems, beginning with making homes healthier.

GHHI is utilizing our experience in Pay for Success to build out capitalization needed by state and local governments

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Feature CONT. Healthy Homes-Healthy Children

to help scale efforts in lead poisoning. GHHI also engages with its partners from major grants such as the federal Social Innovation Fund and the Robert Wood Johnson Foundation.

Programs in these cities are working with local healthcare organizations to advance and evaluate new models of funding home-based interventions that produce measurable outcomes such as reducing asthma-related hospitalizations, emergency department visits, healthcare costs – as well as missed school and work days. GHHI provides technical support to these cities as they explore viable models of care.

These interventions include addressing unsafe lead paint conditions, removing asthma triggers and fixing problems such as leaky plumbing that can lead to mold or other health risks. Our partners also work closely with the families to make sure they know how to keep the house healthy and prevent asthma attacks.

Over time, we will demonstrate that these interventions are cost-effective and should be part of ongoing preventive health spending by public agencies and others – akin to pediatric immunizations and physical exams.

Healthcare providers are key partners in our healthy-home work. In Grand Rapids, Michigan, for example, we are partnering with Health Net of West Michigan, the Asthma Network of West Michigan, the Healthy Homes Coalition of West Michigan and Spectrum Health. We are excited to work closely with those who best understand the home-based health issues that children and their families are facing.

We urge maternal and child health providers to get involved with these kinds of efforts and help us transform how we think about – and mitigate – the causes that contribute to pediatric health problems.

The stakes are enormous, and so are the rewards. Time after time, we hear the good news: our interventions are leading to dramatic health improvements for kids. The number of hospital visits drops, children do better in school and parents are able to work regularly and not be constantly worried about a recurrence that will disrupt the entire family.

The bottom line: smart investments in healthy homes foster healthy families and stronger communities.

Ruth Ann Norton is President and CEO of the Green & Healthy Homes Initiative. She has worked for more than 25 years to address lead poisoning issues and make homes safer, healthier and more sustainable.

Feature Congenital Syphilis on the Rise



By Michelle L. Allen,
*Maternal and Child Health
Director, Georgia Department
of Public Health*

William (Bill) Smith, Executive Director, National Coalition of STD Directors (NCSDD) and Senior Faculty Fellow, Robert Wood Johnson Center for Health Policy, University of New Mexico



For the first time in nearly a decade, all three commonly reported sexually transmitted infections (STIs) – chlamydia, gonorrhea, and syphilis – are on steep inclines. The resurgence of syphilis, in particular, has been quite significant with three straight years of double digits increases. No demographic has escaped these increases in syphilis, including women. As a result, we are also witnessing an increase of congenital syphilis which increased 38 percent between 2012 and 2014 according to data released by CDC. Four jurisdictions made note of the rising rates of syphilis related to maternal and child health (MCH) outcomes in their FY16 Title V MCH Block Grant Applications.

Congenital syphilis occurs when a pregnant woman passes the infection to her fetus during the pregnancy. The results of congenital syphilis can be quite severe. According to the CDC, up to 40 percent of babies born to women with untreated syphilis and who contract the infections may be stillborn births or die from the infection as a newborn www.cdc.gov/std/syphilis/stdfact-congenital-syphilis.htm.

Feature CONT. Congenital Syphilis

[cdc.gov/std/syphilis/stdfact-congenital-syphilis.htm](http://www.cdc.gov/std/syphilis/stdfact-congenital-syphilis.htm). Babies born with the infection can also have deformed bones, severe anemia, enlarged liver and spleen, meningitis, jaundice, and nerve problems, including blindness and deafness. Given the severity of congenital syphilis and the increasing number of cases seen across the country, we must do everything possible to prevent mother-to-child transmission.

We are authoring this article jointly because we believe that in the face of the steep increases in congenital syphilis cases in the United States, state, territorial, and local health department maternal and child health (MCH) programs and STD programs can work together to reverse the trend.

So what can be done?

1) Ensure that providers of care for pregnant women are following CDC guidelines that recommend pregnant women be screened for syphilis during their first prenatal visit and ideally, routinely as part of a routine prenatal panel, along with HIV and other infectious diseases. Additionally, the CDC recommends additional screening in the third trimester and at delivery for women who are at increased risk of syphilis; who live in areas with a high number of syphilis cases; and for women not tested or who had a positive syphilis test when initially screened.

2) Consider, based on case rates in your jurisdictions, policy changes to support additional screening beyond the CDC recommendations. For example, while most states have laws that require syphilis screening during the first trimester of pregnancy, several states have more added third trimester screening. From 2014-2015, Louisiana, Georgia, and Texas all added third trimester syphilis screening to state laws.

Health department programs should work closely with providers to ensure that all pregnant women who test positive for syphilis are treated without delay. Recent evidence suggests that nearly 70 percent of congenital syphilis cases in 2014 were actually among women who received some prenatal care while pregnant. Some of these women accessed care late in their pregnancy, receiving treatment for their syphilis less than 30 days before delivery, and therefore still count as a congenital case. Still, nearly 30 percent of all congenital syphilis

cases in 2014 were among pregnant women who tested positive, but received no treatment, and another 21 percent who received inadequate treatment. www.cdc.gov/mmwr/preview/mmwrhtml/mm6444a3.htm

A single case of congenital syphilis is one too many. Each is a sentinel event broadcasting a clarion call for all of us concerned about the reproductive and sexual health of pregnant women – as well as the health of their babies – to take action. Public health MCH and STD programs, working with providers and other partners, can create better outcomes and turn the tide on congenital syphilis.

Feature Emerging Technologies in Autism Treatment, Training, and Systems Building: Snapshots from Autism CARES Grantees

**By Cori Flyod, Program Associate,
Child & Adolescent Health, AMCHP**



**Ben Kaufman, MSW, Acting
Director of MCH Technical
Assistance, Association of University
Centers on Disabilities (AUCD)**



**Kate Taft, MPH, Senior Program
Manager, CYSHCN, AMCHP**



Through its implementation of the Autism CARES legislation, HRSA-MCHB funds grantees to improve autism spectrum disorder and other developmental disabilities (ASD/DD) service delivery and to enable all infants, children and adolescents who have, or are at risk for developing, ASD/DD to reach their full potential. This includes training future leaders to improve the health of children who have or are at risk of developing neurodevelopmental disabilities, improving state systems and access to health care and related services for children and youth with ASD/DD, and

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Snapshots from Autism CARES Grantees

national research networks and field-initiated research projects to advance the evidence base and best practices.

Technologies, such as telehealth, telemedicine and m-Health (also known as Mobile Health), can be used to address gaps in access and can also play a key role in expanding availability of service delivery, building systems, and workforce training. They are being used to address barriers related to shortages of specialists with ASD expertise, geographic and transportation barriers, as well as financial barriers experienced by families. This article highlights how some Autism CARES legislation grantees representing research, training, and state implementation stakeholders are using technology to improve ASD/DD autism education, early detection, and intervention.



Below are a couple of examples of how grantees are using telehealth and telementoring to increase local capacity for best-practice care and access to behavioral health services regional centers:

•Missouri - ECHO Autism for Professional and Workforce Development: Missouri's team began their Extension to Community Healthcare Outcomes Autism project (ECHO Autism) after identifying unmet needs for children with ASD/DD in Missouri (e.g. delayed identification, uncoordinated care, and limited access to proper ASD/DD-related services). They utilized the ECHO model, originally developed by the University of New Mexico, to educate primary care physicians (PCPs) and increase timely, community-based, and culturally competent care. The six-month training program consisted of 12 two-hour training clinics with two clinics per month. PCPs were trained using a multipoint videoconferencing mechanism that connected expert "Hubs" to PCP "Spokes". This system allowed PCPs to participate in case-based learning and be part of a comprehensive learning network. At the conclusion of the program, PCPs reported an increase in self-efficacy, compliance with AAP Autism Screening Guidelines, and high satisfaction with the training program overall. Missouri is now focused on expanding their pilot to multiple sites to continue future research and increase

access to healthcare for children with ASD/DD. For more information about ECHO Autism, [click here](#).

•Iowa – Increasing Access to Telehealth for Specialty Care: The Iowa Regional Autism Assistance Program (RAP) with Child Health Specialty Clinics (CHSC) at the University of Iowa has partnered with The University of Iowa Children's Hospital Autism Center (UI) to increase access to telehealth for specialty care. In March 2015, the UI's Autism Center received a four-year multi-state Autism telehealth research grant from the National Institute of Mental Health. This project offers families enrolled with RAP the opportunity to access behavioral health services through telehealth technology based on referrals from any of their 15 statewide CHSC Regional Centers. The applied behavior analysis (ABA) services offered through telehealth include functional behavior analysis, social communication training, and consultation to families to address challenging behaviors. Drs. Scott Lindgren and David Wacker, faculty members in the UI's Stead Family Department of Pediatrics, are the principal investigators for this study. Children in Iowa, Georgia, and Texas are participating in the project, which is a collaborative effort between UI, the Marcus Autism Center in Atlanta, and the University of Houston – Clear Lake. Dr. Lindgren also serves as a Psychology Technical Consultant with the CHSC HRSA ASD/DD state implementation grant; he continues to explore ways to utilize telehealth opportunities for diagnostics and other areas of ASD support for Iowa's underserved populations. CHSC and the UI's Autism Center work collaboratively on various public health infrastructure-building efforts and other projects to better serve CYSHCN in rural areas. These collaborations focus on family support, nutrition, and provider in-service training. For additional information, please contact [Peggy Swails](#) or visit [Children's Specialty Health Clinic](#), as well as the [University of Iowa's Children Hospital](#).

Access to expertise represents a barrier to the provision of high quality intervention for children with severe neurodevelopmental disabilities and their families who reside outside of metropolitan or densely-populated areas. Previous research has demonstrated the efficacy of telehealth as a service delivery mechanism to remotely coach parents in various interventions to improve communication and challenging behaviors among children with autism^{1, 2, 3}. Below are examples of efforts to provide parent coaching as an alternative to long waiting lists for services:

•Florida - Coaching Parents in Bilingual Households: iCan Chat – a project of the Mailman Center for Child

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Snapshots from Autism CARES Grantees

Development LEND program at the University of Miami (FL) – provided a model for coaching parents on the use of Augmentative Alternative Communication (AAC) in the parents' home language of English or Spanish. The goal of the intervention was to introduce the iPad as an AAC tool with a range of communication apps to children with minimal to no verbal speech (61% with an ASD diagnosis), while coaching the parents on the tool and strategies for use. The intervention was child focused (ages 2-12), using naturalistic strategies, while engaging the child in preferred activities. Participating parents expressed their concerns over AAC use and integration of their home language. Fifty-eight percent of parents preferred the option of having another language on the AAC device/app, citing that the bilingual option would provide the child the opportunity to communicate with non-English speaking family members.

On the other hand, 42% preferred the use of an English-only AAC device/app to facilitate communication at school and during therapy, thereby avoiding any extra burden the child would face trying to communicate in two languages. The intervention allowed parents to borrow the iPad for one month. During that time, 40% used AAC only at school / during therapy, while 60% used AAC across environments. Some of the parents reported not using AAC at home because they felt they had established nonverbal cues to communicate with their child. While parents reported many benefits of the iPad as an AAC tool (e.g. ease of portability, promotes literacy skills) and barriers (e.g. technology is too hard, distractions), the project concluded that there was a need for a better understanding of how to apply technology in culturally, linguistically, and developmentally appropriate ways for families from diverse cultural backgrounds. In addition, more education and research needs to be conducted regarding exposure to two languages in children with ASD who use AAC.

•Minnesota - Telemedicine for Early Communication Intervention: Minnesota LEND in collaboration with the University of Minnesota's special education program is examining the effectiveness of telehealth coaching with parents of children who have extremely limited conventional communicative repertoires who engage in socially maintained problem behavior. Parents receive several weekly sessions in which children working with their families are observed. During sessions, coaching is delivered to the parent implementing the intervention via speaker or ear bud; sessions are archived for subsequent analysis and also used as a tutorial to LEND Fellows

being taught to implement telemedicine coaching.

To date, the project has served 15 learners (diagnosed with either Rett syndrome or Autism Spectrum Disorder and who experience severe developmental delays) in the implementation of assessment and intervention in early communication skills as an alternative to challenging behavior. Study procedures consist of: (1) pre-assessment of technology and safety for the use of telehealth, (2) parent interview to identify contexts in which idiosyncratic potentially communicative behavior occurred, (3) structured descriptive assessment of contexts and routines identified from the interview, such as observing the child during snack time or when a difficult task was presented, (4) functional analysis if challenging behavior was occurring to identify the maintaining reinforcer and inform intervention (e.g. experimental manipulation of programmed consequences contingent on the challenging behavior), and (5) communication intervention through the use of functional communication training during the identified contexts/routines and the use of nonverbal, aided augmentative and alternative communication strategies. Thus far the project has generated experimental evidence that telehealth applications have been effective in establishing or supplementing live-delivered service with children having significant neurodevelopmental disabilities. Telemedicine application in the area of positive behavior support that involves early communication intervention may have important implications for families whose access to service is limited due to geographic location. Additionally, it may be useful in providing service to families who are on a wait list for in-home delivered service.

For more information about grantees, visit:

- [AUCD's Interdisciplinary Technical Assistance Center on Autism and Developmental Disabilities \(ITAC\)](#)
- [AMCHP's State Public Health Autism Resource Center \(SPHARC\)](#)
- [MCHB's ASD/DD webpage](#)

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Feature

Emerging Issues Committee Spotlight



By Ki'Yonna Jones, MPH
Program Manager, Workforce & Leadership Development, AMCHP

The Emerging Issues Committee uses the eyes, ears and experience of Title V professionals throughout the country to assist AMCHP in responding to emerging maternal and child health issues that impact its members.

The Committee defines an Emerging Issue as: An issue, positive or negative, which is not yet generally recognized, but which may have significant impact on Title V programs and the populations we serve. An emerging issue is associated with one of the following:

- Policy, social, economic, financial, institutional or technological developments that may cause changes in trends, Title V programs, and/or the health of Title V populations;
- New evidence or theory that suggests potentially large change in Title V programs and populations, but which is currently either not widely accepted, or is considered unproven; and
- Lack of adequate policy, action or leadership on an existing issue, which may become more significant or more urgent in the future.

An emerging issue is not necessarily an issue no one has heard of, or that comes as a shocking surprise.

Annually, the Committee conducts an Environmental Scan consisting of primary and secondary data from content experts, MCH/Title V Directors, AMCHP Committee members, AMCHP's member assessment, AMCHP's conference evaluation, TVIS, Title V Block Grant Applications, etc.

The most mentioned emerging issues to surface during the 2015-2016 scan fell under the general categories of: Life-course/Cross-cutting, Access to Care, Family Engagement and Developmental Screening. The Committee focused its

efforts on three specific topics that have been resonating with many states, families and MCH professionals: Trauma-informed care for children and families; the role of Title V funds in an era of healthcare financing transformation; and the use of innovative financing for developmental screenings.

The Committee will provide additional information and resources on these topics throughout the year. We are encouraging all thought leaders on these topics, who would like to present or contribute on future webinars or publications, to please contact Ki'Yonna Jones, Committee liaison at kjones@amchp.org.

Feature

Human Trafficking and Access to Health Care

By Atyya Chaudhry, MPP
Policy Analyst, Health Reform Implementation, AMCHP



Human trafficking takes many forms, ranging from forced prostitution to exploitation of laborers. Because of the various forms of human trafficking, anyone can be affected, including the populations primarily served by Title V programs: women, children, adolescents, and their families. The nature of human trafficking makes it difficult to monitor; victims may be trafficked internationally into the U.S. and vice versa, across state lines, or even locally. The National Human Trafficking Resource Center (NHTRC) operates a 24/7 toll-free national hotline in the United States and monitors the number of calls received. In 2015, they received 21,947 calls with 5,544 cases of human trafficking reported. According to the U.S. Department of State, an estimated 18-20,000 individuals are trafficked into the U.S. annually. The actual number of domestic and international victims in the U.S. may vary.

The Trafficking Victims Protection Act (TVPA) of 2000 made human trafficking a federal crime. The TVPA was legislated to prevent "severe" forms of human trafficking, protect victims in the U.S. and abroad, and prosecute offenders. "Severe" forms of human trafficking are defined as :

- Sex trafficking [i.e., the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting

Feature CONT.

Human Trafficking

of a person for the purpose of a commercial sex act] in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age; or

- The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

There are several initiatives to prevent and combat human trafficking at the federal level across departments and agencies, including interagency initiatives. Collaboration across departments is critical in identifying and aiding trafficked victims. Under the U.S. Department for Health and Human Services, the Administration of Children and Families (ACF) operates a newly created [Office on Trafficking in Persons](#) that administers an Anti-Trafficking in Persons Grant program. As of 2015, grants were awarded to grantees in all ten HHS regions. A full list of grantee information by state with contact information can be found [here](#).

While there is no one size fits all strategy to address human trafficking, in the past few years, access to health care has emerged as one strategy. Contact with a health care provider may often be the only time a trafficked victim is alone and in safe space. In a 2014 study on victims of sex trafficking, approximately 87.8 percent of victims indicated they had contact with some form of health care while being trafficked. In light of the role health care professionals can play as frontline responders, the American Medical Association released a [policy](#) encouraging members to raise awareness about the issue and the resources available. In addition, Futures without Violence has resources for providers and organizations to better understand and address this problem, [building a healthcare response](#) and the [role of the healthcare provider](#).

Title V programs are well positioned to increase access to health care through outreach, enrollment, and education about coverage options in Medicaid, the Children's Health Insurance Program (CHIP), the health insurance Marketplace, and local health care clinics. The well-woman visit, adolescent well-visit, and adequate insurance National Performance Measures (NPMs) are all tied to access to health care. Movement in these NPMs may positively impact the lives of trafficked victims. Title V

programs are also well positioned to work collaboratively across agencies and partners to increase awareness, understanding, and improve collective response. In Tennessee, for example, MCH staff collaborate with the Tennessee Bureau of Investigation and the Departments of Human Services, Children's Services, Intellectual and Developmental Disabilities, and Mental Health in a coordinated system of identification and service delivery for human trafficking victims. Addressing human trafficking at the state level is truly a cross-agency collaboration; there are several resources and grantees at the national, state, and local level that Title V programs can connect with to help address this issue that affects some of the most vulnerable MCH populations.

Feature

Responding to the MCH Side of the Opioid Epidemic

By Amy Haddad
Associate Director, Government Affairs, AMCHP



By now, too many of us have personally experienced the toll of the opioid epidemic in our community, our family or our circle of friends. Seventy-eight Americans die every day from an opioid overdose and one infant is born with neonatal abstinence syndrome (NAS) every 25 minutes. Many Title V programs are on the frontlines of efforts within their states to prevent, monitor and

address this crisis and we have asked three of them to share their experiences.

Tennessee – by Dr. Michael Warren, Assistant Commissioner, Division of Family Health and Wellness

In 2013, the Tennessee Department of Health made Neonatal Abstinence Syndrome (NAS) a reportable condition. Prior to that time, the Department obtained NAS incidence from hospital discharge data, but this data lagged 12-18 months behind, making program planning/evaluation difficult. The Department (led by Title V) created an online reporting system, allowing for real-time reporting of NAS cases. Surveillance reports are posted online weekly and can be found [here](#). In addition to providing real-time estimates of NAS incidence, the reports also provide information on the exposure source, allowing for targeted efforts at prevention. Tennessee also used Title V funds

MCH in Epidemiology CONT.

Childhood Lead Poisoning Prevention Program

Massachusetts uses its comprehensive universal screening data to conduct detailed surveillance of children's BLLs. The [Childhood Lead Poisoning Prevention Program](#) (CLPPP) database receives close to 250,000 blood test results annually. These data are used to create reports on screening and prevalence rates for each community in Massachusetts. The data are also used on the [Massachusetts Environmental Public Health Tracking Portal](#), where users can view maps and tables down to the census tract level to evaluate trends in BLLs across time and geography.



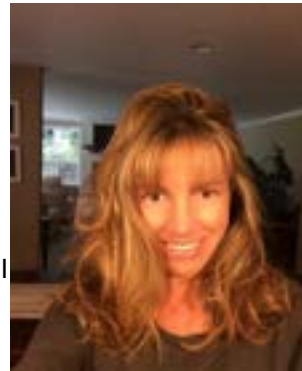
As part of its prevention strategies, Massachusetts has also used these data to develop predictive models of risk, enabling targeted outreach in high risk communities.

This high risk community algorithm incorporates five years of elevated BLL incidence data, the proportion of homes built prior to 1978, and the proportion of families having incomes below 200% of the poverty threshold to determine communities at higher risk for childhood lead poisoning. These communities are then targeted for more surveillance and prevention activities as well as educational and awareness campaigns, including information about tax credits and financial assistance for low-income homeowners for lead abatement costs.

The best way to eliminate childhood lead poisoning is to target it at its source. The availability of quality surveillance data and analytical capacity help Massachusetts meet that goal. The Massachusetts CLPPP supports a network of community partners who strive to reach the goal of creating a lead safe environment for all children. As current knowledge and recommendations surrounding the long-term harmful effects of low-level lead exposure are incorporated into policies and practices in all sectors of children's health, we will move closer to achieving this goal.

Real Life Story

Suffering in Silence: My Journey with Postpartum Depression



By Kristen Marshall, MS, CCC-SLP, Speech Language Pathologist

I wanted to have a baby so badly. After a few months of temperature charting and overall obsessing about getting pregnant, I was thrilled when those two pink lines showed up on the test.

I never thought much past sitting with my happy baby in the rocking chair and gazing at him adoringly.

I was completely delusional. Nothing I envisioned could be further from reality.

A week after being at home with the baby, I distinctly remember staring out the window, crying, and wondering "what did I do? Our lives are ruined". I became consumed with guilt because...what kind of mother has those kinds of thoughts? I remember looking out that same window and for the first time in my life thinking "I can't live like this. I want to die."

After a lifetime of dreaming about being a mom, I was miserable. With the guilt, came the shame. Although I had been sent home from the hospital with pamphlets about the "baby blues" and tips on how to handle them like, "sleep when the baby sleeps" and "get fresh air," what I was feeling was so beyond that. I believed there was something fundamentally wrong with me. There was no way I was going to admit to anybody how I was feeling. High anxiety and paranoia became a part of my life. I can remember walking the baby along the water when I was overcome with the idea that someone passing me was going to grab the baby from the stroller and toss him into the water. My body reacted to these thoughts as if this event was actually taking place. I became short of breath, started shaking, and tears rolled down my face as I steered away from the water.

Two years later, I was once again thrilled to see those two pink lines on the pregnancy test. After all, now I knew what to expect. It was going to be so much better this time! I

Real Life Story CONT.

Postpartum Depression

was an expert! Baby #2 came home and I vividly remember becoming furious during Listerine commercials. I was insanely jealous of those people about to go to bed with the knowledge that they were going to sleep all night long. When my second child was three weeks old, my concerned husband said to me "You have always been eager to take a shower at least once a day. When was the last time you showered?" Those words hit me hard. He was right. I needed help.

Babies # 3 and #4 were not part of the plan. My post-partum depression grew worse following each birth. After my fourth child was born, I was driving down the highway and trucks were flanking each side of me. The baby was in the back screaming and I remember thinking "These trucks could crush us and this will be all over. I won't have to feel this way anymore." I told my therapist and I ended up in "partial hospitalization." Post-partum depression landed me in a program with a van that took us all on supervised field trips on Tuesdays? What? Talk about reinforcing the erroneous belief that I was an atrocious human being.

Most of the people closest to me in my life still don't know the extent of the pain that took over. Through much trial and error, I found a doctor who worked with me to find the right combination of medications and counseling. However, I will never forget suffering in silence because I was not informed about the dark side of having babies. In retrospect, I wish that post-partum depression had been addressed right from the start. Mandatory education and research-based screening for new mothers, along with a strict protocol for follow-up, has the potential to change the parenting experience, including mother-baby bonding, and overall quality of life for many, providing light through the darkness.

A View from Washington

Emerging Issues Added to Public Health Appropriations Mix



By Brent Ewing, MHS
Director, Public Policy & Government Affairs Team, AMCHP

Every winter, AMCHP gears up our advocacy machine to be prepared to push for the highest possible appropriation for the Title V Maternal and Child Health Services Block Grant and other critical MCH programs. The release of the President's budget proposal, traditionally on the first Monday in February, marks the official opening of "Appropriations Season" in Washington. This is followed up by every advocate in town scrambling to make their pitch to all key policymakers before bills begin to be drafted.

This year, the President's budget included two new public health appropriations requests that have changed the landscape a bit for this scramble. The first is to address opioid and heroin abuse and the second is to support preparedness and response to the Zika virus. A third emerging issue has also surfaced on Capitol Hill in this cycle – responding to the lead poisoning crisis both in Flint, Michigan and possibly beyond.

Many Americans are learning the tragic new reality that there are now more deaths from drug overdoses than motor vehicle collisions. AMCHP is particularly concerned about the devastating impact caused by misuse of opiates during pregnancy, which often results in the drug withdrawal syndrome in newborns called neonatal abstinence syndrome (NAS). In 2012, an estimated 21,732 infants were born with NAS—equivalent to one baby suffering from opiate withdrawal born every 25 minutes. This Administration's proposed \$1.1 billion funding will boost efforts to help individuals with an opioid use disorder seek treatment, successfully complete treatment, and sustain recovery. We are joining with partners to call on Congress to find common ground to address this epidemic and strengthen both prevention and treatment efforts. Additional details on this proposed funding are available [here](#).

As this issue goes to press, AMCHP leaders are participating in the CDC Zika Action Plan (ZAP) Summit and working on cutting edge strategies to support both

A View from Washington CONT.

Public Health Appropriations Mix

preparedness and response. AMCHP therefore also strongly supports the Administration's proposed \$1.9 billion in emergency funding to enhance ongoing efforts to prepare for and respond to the Zika virus, a virus primarily spread by mosquitoes that has recently been linked to birth defects and other concerning health outcomes.

While the President's budget did not include any new proposed funding to address the lead poisoning crisis revealed in Flint, Michigan, AMCHP has recently supported efforts led by the National Safe and Healthy Housing Coalition asking Congress to support \$35 million for CDC's Childhood Lead Poisoning Prevention program, which would allow the program to expand its surveillance of childhood lead poisoning nationally and \$230 million for HUD's Office of Lead Hazard Control and Healthy Homes, including \$35 million for the Healthy Homes program and \$6 million for the Lead Technical Studies Grant Program. A copy of this sign on letter is available [here](#).

Even though the President asked for expedited consideration of the Zika funding in what is known as a supplemental request, Congress to date has not acted on any of the above requests. The biggest sticking point is the question of where the money will come from and if other programs should either be cut or have funds redirected to support these new efforts. AMCHP is joining with many others in the public health community to share the message that weakening one part of the public health system to (temporarily) bolster another is not wise.

These issues were further discussed at the 2016 AMCHP Annual Conference. If you were unable to attend, please stay tuned to the usual AMCHP channels for updates as this year's appropriations cycle unfolds.

Who's New

New MCH Directors

Texas

Natalie Furdek
Title V Director
Texas Department of State Health Services

NEW AMCHP STAFF

Michelle Eglovitch, MPH



Michelle Eglovitch is the Program Associate for Women's and Infant Health at AMCHP. In this role, Michelle provides support to all Women's and Infant Health team program activities. Prior to joining AMCHP, Michelle worked as a research assistant for a pregnancy research study at the Boston University School of Public Health. In this role, she

built foundational knowledge and awareness of critical issues in women's and infant health, including occupational, environmental, and dietary factors and exposures during pregnancy. In the summer of 2015, Michelle completed a practicum facilitating a community health assessment in Ladakh, India, where she collected and analyzed information on gender differentials in growth and development for children aged 0-5. Michelle recently earned a MPH in Maternal and Child Health from the Boston University School of Public Health. She received her bachelor's degree in Public Health, with a minor in Psychology, from the University of Rochester in 2013.

Jeanette Kowalik, PhD, MPH

Dr. Jeanette Kowalik joins AMCHP as the new Associate Director of Women's and Infant Health. She has over a decade of progressive public health experience in a variety of areas representing the life-course. Jeanette began her career as an intern at the University of Wisconsin (UW)-Milwaukee in healthcare administration. She obtained a Master of Public Health from the Northern Illinois University while maintaining full-time employment at the Milwaukee Health Department. Afterwards, Jeanette began her doctoral program in health sciences at UW-Milwaukee. Her initial focus was infant mortality disparities, but she soon realized there was a significant gap in the literature regarding recruitment and retention of the public health workforce. Jeanette completed her coursework while working full-time for the Wauwatosa Health Department and Boys & Girls Clubs of Greater



Who's New

Milwaukee. Jeanette completed her dissertation remotely as she served the city of Chicago as the Director of STI Surveillance. She served as UW-Madison's Director of Prevention and Campus Health Initiatives prior to her transition to AMCHP.



Mahlet Menwelet, MBA

Mahlet Menwelet is the Grants and Contracts Administrator on the Finance and Accounting team. In this role, Mahlet oversees all federal and foundations grants as well as contract management. She plays a key role in the planning, preparation, and review of the annual

organizational budget, implementing and managing grant reporting and compliance systems, and has future aspirations to develop and manage the fund acquisition process focusing on long term sustainability. Mahlet has over 10 years of business and financial management experience with corporate and nonprofit organizations. She holds an MBA degree in Finance, Accounting and International Business from Regis University and a BA in Economics from Colorado State University.

Get Involved

WSSDOM Series

AMCHP is pleased to present a new MCH Workforce Development Solutions Series Domain (WSSDOM). This new series will provide a platform for AMCHP members to learn more about successful workforce development solutions to address issues such as staffing, organizational design, accreditation, and work process re-design (e.g., due to health transformation), share innovations, and identify best practices. The MCH WSSDOM series consist of 45-minute live interactive webinars. The next topic is listed below:

- Resiliency: Tips and Tricks on How to Keep Staff Morale High

Success of an organization/department depends on the employees who work there. The morale among staff must be high to have outstanding staff performance. Sometimes when organizational changes occur, the morale can

decrease. Dr. Kris Risley, Clinical Assistant Professor at the University of Illinois at Chicago, will provide tips and tricks to keep staff morale high by using appreciative inquiry and positive questions to bring out the best of the organization/department/team on **May 12, 2016 from 1-2 pm EST**. Dr. Risley will also discuss the importance of emotional intelligence and the impact you have on your organization/department. [Click here](#) to register.

Strengthen the Evidence Base: Communities of Practice (CoP)

Come and join AMCHP's Strengthen the Evidence Base: Communities of Practice (CoP)! The CoPs are grouped by population domain including Child Health, Children and Youth with Special Health Care Needs (CYSHCN), Cross-cutting/Life-course, and Women's/Maternal Health. The purpose of the CoPs is to provide a space for peer sharing and learning, which could include topics ranging from Evidence Based Strategy Measures (ESM) development to implementation of your plan. As a participant, we encourage active contributions within the CoPs by responding to discussion questions, posting your own questions and resources, and engaging with other participants. To sign up, [click here](#). For questions or additional assistance, please contact Krista Granger at kgranger@amchp.org or Sarah Beth McLellan at smclellan@amchp.org.

Join AMCHP for the 2016 March for Babies Campaign

Once again, AMCHP is supporting our partners at the March of Dimes by raising funds and participating in the Maryland-National Capital Area March for Babies on May 7, 2016 at Nationals Park in Washington, DC! Last year, the AMCHP team raised over \$2,000 for stronger and healthier babies. [Click here](#) to support our team in reaching our 2016 fundraising goal of \$3,000.

Get Involved CONT.

Continuing Education for CME, CNE, CUE, CECH, and CPH

Continuing Education for the AMCHP Annual Conference 2016 is available through the CDC Training and Continuing Education Online system (CDC TCEO). Online evaluations must be completed by **May 16, 2016** to receive credit for continuing education or a certificate of completion. [Click here](#) for instructions on the evaluation process.

Maternal and Child Health Life Course Network Webinar

The Maternal and Child Health Life Course Research Network will host TADPOHLS: Enabling Integrative Longitudinal Studies of Positive Health on **May 9, 2016 from 5-6 pm EST** and feature Dr. Margaret Kern. Dr. Kern and her colleagues developed TADPOHLS (The Anatomy of Developmental Predictors of Healthy Lives Study), a database that categorizes items and constructs from 25 prospective longitudinal studies that have followed participants from adolescence into adulthood. This webinar will present the database and coding typology, and illustrate how the database can be used to integrate multiple studies at the item level to examine adolescent predictors of adult health outcomes. To register, [click here](#).

National Call for Applications

The National Center for Children's Vision and Eye Health at Prevent Blindness (NCCVEH) and the National Institute for Children's Health Quality (NICHQ) are issuing a call for applications to public health professionals, early educators, community vision programs, eye care professionals, primary health care provider groups, and family advocates to join the quality improvement collaborative, "Improving Children's Vision: Systems, Stakeholders & Support". The mission is to improve the systems supporting children's vision and eye health in a minimum of five carefully selected states. The results will be comprehensive and coordinated approaches to children's vision and eye health and a reduced prevalence of vision problems in hard-to-reach populations. All teams interested in participating must submit applications [online](#) by **Apr. 25, 2016 by 5 pm EST**.

Addressing Lead Exposure in Our Communities

The American Public Health Association (APHA) will host a webinar on **Apr. 26, 2016 from 1-2 pm EST**. This webinar will provide information about lead exposure, focus on community solutions to lead exposure, and provide tools for preventing lead exposure in the home. Healthy homes

interventions will be highlighted and there will be ample opportunity for discussion. One CPH continuing credit is available for individuals who register and attend the live webinar. To register, [click here](#).

Genetics and ASD Webinar

The Autism Intervention Research Network on Physical Health and the Autism Treatment Network will host a webinar on **Apr. 27, 2016 from 2-3 pm EST** to discuss genetics and Autism Spectrum Disorder (ASD). To register, [click here](#).

Playground Safety: Having Fun and Staying Safe

The National Program for Playground Safety (NAPPS) will host a webinar on **Apr. 27, 2016 from 3-4 pm EST** to highlight Playground Safety Week. NAPPS will share information related to advocating for SAFE (Supervision, Age Appropriate, Fall Surfacing, Equipment Maintenance) inclusive and high quality play areas that support child development and reduce unintentional childhood injuries. An overview of playground injuries will be shared, along with a description of the agencies and organizations that have issued recognized guidelines and standards that address safety. To register, [click here](#). Please note that space is limited for this webinar.

National MCH Epidemiology Awards

CityMatCH is now accepting nominations for the Maternal and Child Health Epidemiology Award to be recognized at the 2016 CityMatCH Leadership and MCH Epidemiology Conference. The purpose of the awards is to recognize individuals, teams, and leaders of institutions for making significant contributions to one or more aspects of epidemiology with the aim of improving health of women, children, and families, advancing public health knowledge through applied research, improving public health practice through effective use of data and epidemiology training in the field, and enhancing the political will to support practice and advance knowledge through effective use of data, epidemiology, and applied research. Various award categories are open and nominations will be accepted until **Apr. 30, 2016 at 11:59 pm PST**. For more information, [click here](#).

Secondary Use of Electronic Health Data for Child Health Research: Opportunities and Challenges Webinar

EnRICH (Research Innovations & Challenges) will be hosting a webinar on **May 5, 2016 from 1:30-2:30 pm EST**. The learning objectives for this webinar include understanding the types of data readily available in electronic health records (EHRs) that support child health research activities; recognizing the challenges with

Get Involved CONT.

with cleaning and organizing electronic health data before statistical analyses can be performed; and gaining a practical understanding of how researchers working with the American Academy of Pediatrics are using data from an EHR "supernetwork" to conduct cutting-edge research. To register, [click here](#).

Evidence to Prevent Childhood Obesity

Healthy Eating Research: Building Evidence to Prevent Childhood Obesity is a Robert Wood Johnson Foundation (RWJF) national program. The program supports research on environmental and policy strategies with strong potential to promote healthy eating among children to prevent childhood obesity, especially among groups at the highest risk for obesity: black, Latino, American Indian, Asian/Pacific Islander, and children who live in lower-income communities (urban, suburban, and/or rural). Findings are expected to advance RWJF's efforts to help all children achieve a healthy weight, promote health equity, and build a culture of health. This is a call for proposals that includes two types of awards aimed at providing advocates, decision-makers, and policymakers, with evidence to reverse the childhood obesity epidemic. These awards include Round 10 grants and RWJF's New Connections grants awarded through the Healthy Eating Research program. The first round of proposals will be accepted until **May 11, 2016 at 3 pm ET**. For additional deadline dates and more information, [click here](#).

2016 Breastfeeding Summit: Call for Abstracts

Reaching our Sisters Everywhere, Inc. (ROSE) is currently accepting abstract and poster applications for the 5th Annual Breastfeeding Summit, which will take place on Jul. 28 and 29th, 2016 in New Orleans, LA. Applications must be received by **May 16, 2016 by 5 pm EST** in order to be considered. All submissions should address breastfeeding, lactation issues, and concerns in vulnerable communities. To apply, [click here](#). Additional information on poster and abstracts requirements can be found [here](#).



AMCHP is seeking submissions of emerging, promising and best practices in maternal and child health from all states and territories on child health. Do you have a program that fits?

You'll have a chance to:

- 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) 266-3049 or visit [amchp.org/bestpractices](#).

Want to learn more new ways your Title V MCH program can build capacity to support ASD/DD? Check out AMCHP's new Autism Awareness infographic!

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Calendar

[YTH Live \(the youth+tech+health conference\)](#)

Apr. 24-26, 2016
San Francisco, CA

[Building a Healthier Future 2016 Summit](#)

May 18-20, 2016
Washington, DC

[CSTE Annual Conference](#)

Jun. 19-23, 2016
Anchorage, AK

[NACCHO Annual Conference](#)

Jul. 19-21, 2016
Phoenix, AZ

[ROSE 5th Annual Breastfeeding Summit](#)

Jul. 28-29, 2016
New Orleans, LA

[Public Health Informatics Conference](#)

Aug. 21-24, 2016
Atlanta, GA

[CityMatCH Leadership and MCH Epidemiology Conference](#)

Sept. 14-16, 2016
Philadelphia, PA

[Congenital Cytomegalovirus Public Health and Policy](#)

Conference
Sept. 25-27, 2016
Austin, TX

*Want your event listed on the AMCHP MCH
Events Calendar? It's easy! Just complete our
[online submission form](#).*

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