Taking Action with Evidence: Implementation Roadmap
National Performance Measure #11, Medical Home

For Assistance:
Please contact Temi Makinde
tmakinde@amchp.org
Brief Notes about Technology

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Active Participation = 😊

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December 21, 2015
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December 21, 2015
Brief Notes about Technology

• Today’s webinar will be recorded

• The recording will be available on the AMCHP website at www.amchp.org

• Please complete the survey to be emailed at the conclusion of the webinar
Practice Poll

• What do you enjoy most about the season?
  – Baking
  – Gift giving
  – Gift receiving
  – Time with family
  – The weather
  – AMCHP Conference is around the corner!
Objectives

- Describe efforts to date by MCHB and partners in compiling the knowledge base of evidence pertaining to NPM #11
- Identify resources and partners from which to select existing evidence-based strategies based on state/territory’s Title V needs assessment findings of the NPM
- Evaluate potential strategies through the lens of current issues and opportunities related to the NPM
- Share feedback with MCHB and its partners on additional technical assistance needed to identify evidence based strategies and subsequently, define measures
Featuring

**Moderators:** Sarah Beth McLellan and Caroline Stampfel, AMCHP

- **Debra Waldron, MD, MPH,** Director, Division of Services for Children with Special Health Needs, MCHB
- **Cynthia Minkovitz, MD, MPP,** Professor, Johns Hopkins Bloomberg School of Public Health
- **Jean C Willard, MPH,** Program Manager, Division of Child and Community Health, University of Iowa
- **Christina Boothby, MPA,** Manager, National Center for Medical Home Implementation, AAP
- **Alex Kuznetsov, RD,** Program Manager, National Center for Medical Home Implementation, AAP
Welcome & Opening Remarks

Debra Waldron, MD, MPH
Director
Division of Services for Children with Special Health Needs
Maternal & Child Health Bureau
Health Resources & Services Administration
U.S. Department of Health & Human Services

DWaldron@hrsa.gov
STRENGTHEN THE EVIDENCE BASE FOR MCH PROGRAMS

Cynthia Minkovitz, MD, MPP
December 16, 2015

A collaborative activity of the Women’s and Children’s Health Policy Center at Johns Hopkins University, the Health Resources and Services Administration, Welch Medical Library at Johns Hopkins University, and the Association of Maternal and Child Health Programs.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC28257, MCH Advanced Education Policy, $1.65 M. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Goal

- To provide support and resources to assist State Title V Maternal and Child Health (MCH) programs in developing evidence-based or evidence-informed State Action Plans and in responding to the National Outcomes Measures, National Performance Measures, State Performance Measures and state-initiated Structural/Process Measures.
6 Objectives

1) Convene a Team of MCH Experts
2) Provide reports, including critical reviews of the evidence of effectiveness of strategies to address National and State Performance Measures
3) Provide technical assistance to State Title V MCH programs
4) Develop web-based supports and resources for State Title V programs
5) Establish an online platform for sharing best practices via a “Community of Practice”
6) Maintain and enhance an MCH digital library
Environmental Scans

- Compilations of strategies to advance performance for each of the 15 National Performance Measures (NPMs)

- Environmental Scans include:
  - **Reviews and Compilations**: identifies existing compilations for strategies that intend to improve performance for each measure; these include both scholarly reviews and compilations that have been produced by key organizations in the field
  - **Frameworks & Landmark Initiatives**: includes conceptual models underlying strategy implementation, these may or may not be explicitly highlighted in the Reviews and Compilations section; landmark initiatives include seminal programs/policies related to each NPM
  - **Data Sources**: indicates sources (e.g. PubMed), as well as criteria (search terms, publication date), and link to search strategy; also selected organizational websites
  - **Inclusion & Exclusion Criteria**: denotes types of studies, setting, populations of interest that were included in our search, and exclusion criteria
Strengthen the Evidence for MCH Programs: 
Environmental Scan of Strategies

National Performance Measure (NPM) #11: Medical Home

Percent of children with and without special health care needs having a medical home

Introduction

This environmental scan identifies collections of strategies to advance performance for NPM #11, Medical Home. The information provided in this document focuses on strategies to achieve the NPM, not on the content of care or specified health outcomes. Please note that the quality of the evidence in this compilation has not been evaluated, and that data sources describing a single strategy, rather than a collection of strategies, have been excluded.

This compilation includes the following sections:

- **Reviews and Compilations:** Identifies existing compilations for strategies that intend to improve performance for each measure
- **Frameworks and Landmark Initiatives:** Frameworks include conceptual models underlying strategy implementation; Landmark Initiatives include seminal programs/policies related to the NPM
- **Data Sources:** Indicates sources, search criteria, links to search strategy and selected organizational websites
- **Inclusion and Exclusion Criteria:** Denotes types of studies, setting, populations of interest and exclusion criteria

Technical assistance for State Title V MCH programs related to using evidence to inform State Action Plans, selection of strategies, and development of evidence-based or evidence-informed Strategy Measures may be requested at [http://www.semch.org/technical-assistance.html](http://www.semch.org/technical-assistance.html)

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| Frameworks and Landmark Initiatives | ........................................................................ | 7 |
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| Inclusion and Exclusion Criteria | ........................................................................ | 15 |

Strengthen the Evidence Base for MCH Programs is a collaborative initiative of the Women’s and Children’s Health Policy Center at Johns Hopkins University, AMCHP, and Welch Medical Library. This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC29297, MCH Advanced Education Policy, $1.65 M. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
<table>
<thead>
<tr>
<th>Review/Compilation</th>
<th>Summary</th>
<th>Web Link</th>
</tr>
</thead>
</table>
| Peikes et al. (2011). The Patient-Centered Medical Home: Strategies to Put Patients at the Center of Primary Care. Agency for Healthcare Research and Quality. [Target: C,H] | • Outlines how decisionmakers can encourage a Patient-Centered Medical Home (PCMH) model of care that is truly patient-centered  
• Strategies to put patients at the center of PCMH  
  • Require practices to actively demonstrate patient and family engagement  
  • Utilize payment strategies  
  • Provide practices with technical assistance  
  • Ensure meaningful use of IT  
  • Collect patient input at every stage in the design and implementation of the PCMH  
  • Proactively support additional research on patient-engagement strategies | [Target: C,H] | https://pcmh.ahrq.gov/sites/default/files/attachments/Strategies%20to%20Put%20Patients%20at%20the%20Center%20of%20Primary%20Care.pdf |

| AMCHP Innovation Station [Target: D,E,G] | • Pediatric Practice Enhancement Project (PPEP)  
  • Location: Rhode Island  
  • Statewide project developed in 2003 with 3 objectives:  
  • Reduce the number of families with CYSHCN reporting system barriers  
  • Provide all CYSHCN with access to a “Medical Home” by 2010  
  • Implement a system that is both accessible and navigable, to improve health outcomes  
Highlights from the Review for NPM #11

• Reviews and Compilations include:
  • 3 compilations of strategies
  • 3 organizational websites

• Frameworks and Landmark Initiatives include:
  • 7 resources with recommended approaches for implementing medical home programs
  • 5 organizational websites describing influential programs and policies
  • 2 policy statements from the American Academy of Pediatrics
  • 1 document with national standards for systems of care for CYSHCN
  • 1 consensus document on key characteristics of the medical home
Examples of Strategies for NPM #11

• States
  • Use payment strategies (e.g. incentivize/compensate practices)
  • Support practices with technical assistance and other tools (e.g. training on care coordination & transition planning)

• Organizations
  • Conduct outreach to families on availability and benefits of the medical home

• Health Care Practices and Providers
  • Engage patients in quality improvement efforts (e.g. surveys, creation of patient/family advisory councils)
Technical Assistance

- Complement ongoing HRSA investments and expertise among discretionary grantees

- *Strengthen the Evidence* team focused on TA related to evidence to inform strategies to achieve progress on state identified priorities
  - Varying levels of TA intensity
  - Recognize continuum of available evidence
  - Individual vs. groupings of states depending on needs

- Types of TA requests
  - Identifying possible strategies
  - Evaluating a selected strategy
  - Providing evidence relating to specific strategies
  - Adapting strategies for a specific population
  - Developing evidence-based or evidence-informed strategy measures

- Sample activities: In-depth evidence reviews, connect states with MCH consultants, work collaboratively to provide communities of practice
Evidence-based or –Informed Strategy Measures (ESMs)

• “…the measures by which states will directly measure their impact on the NPMs.”
• Align with selected NPMs and strategies proposed to enhance performance on the NPMs
• Assess evidence-based or –informed practices that impact individual population-based NPMs.

Characteristics of ESMs

• Relate to the selected strategy and are in the pathway to achieving a National Performance Measure (NPM) or a State Performance Measure (SPM)

• Link to an objective the State hopes to accomplish by tracking the measure
Selection Criteria for ESMs

• **Measurable**
  • reliable and valid
  • data available or planned over time to track progress
  • may be a percentage, rate, ratio or number, or an indicator of achievement of an activity (e.g. development of standards or guidelines)

• **Meaningful**
  • Related to the NPM and state priority objective
  • Incorporates stakeholder input for feedback/buy-in
  • State specific
Contact Us

• Technical Assistance Requests
  
  http://www.semch.org/technical-assistance.html

• Project Coordinator, Stephanie Garcia
  
  sgarci22@jhu.edu

THANK YOU!!!

www.semch.org

http://mchlibrary.jhmi.edu/
OPPORTUNITIES AND EXAMPLES IN THE TITLE V FIELD
Current and Future State Efforts

47 states and jurisdictions selected NPM #11

- Engaging/integrating families in shared decision making
- Improving care coordination efforts to achieve medical home
- Partnering and collaborating with various stakeholders
- Linking pediatric medical homes to dental homes and behavioral health services
- Providing education and training to partners, specifically providers
- Ensuring culturally appropriate services are available
AMCHP Resources:
National Standards for Systems of Care for CYSHCN
Innovation Station Spotlight:
Rhode Island Pediatric Practice Enhancement Project

Objectives:

1. To reduce the proportion of people with disabilities and families with CYSHCN reporting system barriers
2. To implement a system of care that provides all CYSHCN with access to a medical home
3. To improve health outcomes by creating a system of quality services for CYSHCN that is accessible to families
Development of Iowa’s Strategies for NPM #11

Percent of children with and without special health care needs having a medical home

University of Iowa Division of Child and Community Health  
Child Health Specialty Clinics—Iowa’s Title V program for CYSHCN

Jean Willard, MPH  
Program Manager, Policy and Measurement

Assuring a system of care for Iowa’s children and youth with special health care needs
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families report having a comprehensive, universal plan of care</td>
<td>In collaboration with family representatives, develop a universal plan of care template that can be used by multiple systems and programs.</td>
</tr>
<tr>
<td></td>
<td>Disseminate plan of care template and provide training for families of CYSHCN.</td>
</tr>
<tr>
<td>Primary care practices use the plan of care to share information and coordinate care with specialists and the entire care team</td>
<td>Give trainings for providers and staff to assure that families receive coordinated, family-centered care that is documented in their universal plan of care. Also provide information on how to refer CYSHCN to relevant care coordinators and other resources in their communities.</td>
</tr>
<tr>
<td>Primary care providers provide preventive health assessments to CYSHCN, in accordance with Bright Futures.</td>
<td>Offer instruction to PCPs and their staff on Bright Futures services and how to bill for screenings and assessments.</td>
</tr>
<tr>
<td>Health care and community providers have information about and provide referrals for CYSHCN to home and community-based supports.</td>
<td>Provide information and education to PCPs, pediatric specialists, community providers, and health plans on community resources for referral as needed.</td>
</tr>
<tr>
<td></td>
<td>Participate as LEND faculty to inform new interdisciplinary professionals of the needs of CYSHCN and system of care principles.</td>
</tr>
<tr>
<td>Primary care providers use shared decision making principles</td>
<td>Develop tool for shared decision-making that increases provider knowledge of positive family-professional interactions. Make tool available through web portal.</td>
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<td></td>
<td>Work with public and private health plans to incentivize delivery of Bright Futures services.</td>
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<tr>
<td></td>
<td>Continue to collaborate with Iowa’s 1st Five Healthy Mental Development Initiative.</td>
</tr>
</tbody>
</table>
Iowa’s CYSHCN approach:

1. Include family input *always* and *at all levels*
2. Use the Systems Standards
3. Provide Training
4. Leverage other projects
Iowa’s CYSHCN approach

1. Include family input always and *at all levels*

- Family-Navigator Network (paid staff)
- Family trainings
- Volunteer Family Advisory Council
Iowa’s CYSHCN approach

2. Use the Systems Standards

Standards for Systems of Care for Children and Youth with Special Health Care Needs

A Product of the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project

Use the Systems Standards

1. That’s why they exist
2. The standards are evidence-based or evidence-informed.
3. They come with references that can inform ESM development
Use the Systems Standards

MEDICAL HOME
CYSHCN will receive family-centered, coordinated, ongoing comprehensive care within a medical home.

- Overall Medical Home System Standards
- Pediatric Preventive & Primary Care
- Care Coordination
- Pediatric Specialty Care
Iowa CYSHCN Focus: Joint Plan of Care
(Medical Home Care Coordination section, item #3)

A plan of care is jointly developed and shared among the primary care provider and/or the specialist serving as the principal coordinating physician, and the CYSHCN and their family, and implemented jointly by the child, their family and the appropriate members of the health care team.
Iowa’s CYSHCN approach: 3. Provide Training

Health care providers

– Practice transformation activities.
  • Offer CMEs, CEUs
– Outreach to LEND and other health professions training programs

Families

– Advocacy,
– Self-advocacy,
– Family leadership
Iowa’s CYSHCN approach: 4. Leverage other projects

- Action plan draft has words like
  - In collaboration with
  - Participate
  - Work with

- All of our strategies tie into existing projects

- We continue to focus on these areas when looking at additional funding sources. These are our priority areas
Leveraging other projects: Care Coordination and Shared Plans of Care

Current Title V Medical Home strategies focus primarily on areas that are major components of other projects, e.g.,

- Pediatric Integrated Health Homes
  - Care coordination
  - Plans of care
  - Family support

- 1st Five
  - Practice transformation, developmental screening
  - Care coordination (IDPH)

- Systems Integration Project D70 funding
  - Shared Plans of Care

- Autism
  - Care coordination
  - Family support
Leveraging other projects: Pediatric Integrated Health Homes Driver Diagram

Outcomes

Primary Drivers

Secondary Drivers

Assuring a system of care for Iowa’s children and youth with special health care needs
# Iowa’s Pediatric Integrated Health Home Program Driver Diagram and Change Package

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>To build a System of Care in Iowa than includes community-based services and supports to meet the challenges of children and youth with serious mental health needs and their families.</td>
<td>Family-Driven &amp; Youth-Guided Care</td>
<td>Individual: Assure that children, youth, and families have an active role in all decision making and service planning. Provider: Improve families’ service experience through increased family engagement. Community: Engage child-serving systems to work together to build support networks on behalf of children and families. State: Include family-driven principles in the development of policies and procedures governing the care for children and youth in Iowa.</td>
</tr>
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<td></td>
<td>Comprehensive Coordinated Care</td>
<td>Individual: Complete individualized, comprehensive care coordination plans for all children and families. Provider: Ensure coordination between all services and establish protocols for all transitions. Community: Develop a broad array of comprehensive services to meet all medical and non-medical needs of children and youth. State: Create awareness and support the use of evidence-based treatment practices in services.</td>
</tr>
<tr>
<td></td>
<td>Engaged Leadership</td>
<td>Individual: Communicate effectively with staff, stakeholders, and community members about PIHHP program activities. Provider: Create a positive environment for change transformation. Community: Integrate System of Care values and principles throughout the community. State: Advocate and encourage the adoption of the PIHHP program throughout Iowa.</td>
</tr>
<tr>
<td></td>
<td>Community Partnerships</td>
<td>Individual: Identify new and existing natural and informal supports for families. Provider: Develop community partnerships that include families to provide guidance for ongoing agency activities. Community: Participate in community education activities to promote population health. State: Develop statewide partnerships to ensure that community-based mental health services are available to all Iowa children and youth.</td>
</tr>
<tr>
<td></td>
<td>Health Promotion</td>
<td>Individual: Assure that all children and youth are receiving comprehensive health care in addition to mental health services. Provider: Develop outreach strategies to engage primary care providers in integrated health care delivery practices. Community: Mobilize community resources to meet the needs of families. State: Promote efforts to educate Iowans about the social and economic factors that influence families’ health.</td>
</tr>
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<td></td>
<td>Data-Driven Infrastructure</td>
<td>Individual: Use validated functional assessment tools to monitor child and youth progress and outcomes. Provider: Establish a sustainable Quality Improvement structure. Community: Utilize quantitative and qualitative data to identify ongoing community needs. State: Utilize all data points to inform program planning and system development.</td>
</tr>
<tr>
<td></td>
<td>Health Information Technology</td>
<td>Individual: Integrate new technologies into service delivery. Provider: Develop and utilize an interoperable patient registry or Electronic Medical Record and other forms of e-health. Community: Create awareness of e-health technology. State: Develop of statewide health information exchange system.</td>
</tr>
<tr>
<td></td>
<td>Advocacy &amp; Policy</td>
<td>Individual: Empower families to be champions for their children. Provider: Teach leadership and advocacy strategies to staff. Community: Use community-based engagement strategies to develop community commitment to the PIHHP model. State: Champion family voice in the development of statewide policies.</td>
</tr>
<tr>
<td></td>
<td>Professional Development</td>
<td>Individual: Provide access to accredited continuing education opportunities for families and staff. Provider: Actively participate and build capacity by increasing competencies around integrated health. Community: Include ongoing educational sessions as part of community stakeholder meetings. State: Develop opportunities to increase the capacity to provide services for children with mental health needs.</td>
</tr>
<tr>
<td></td>
<td>Use of Resources</td>
<td>Individual: Teach families to navigate the service system in order to minimize the duplication of services. Provider: Track and analyze agency operations.</td>
</tr>
</tbody>
</table>

[University of Iowa Center for Child Health Improvement & Innovation](https://www.uiowa.edu/cechii)
Assuring a system of care for Iowa’s children and youth
with special health care needs

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Assuring a system of care for Iowa’s children and youth
with special health care needs
Medical Home
National Performance Measure #11:
Resources, Tools and Strategies

Christina Boothby, MPA
Alex Kuznetsov, RD
National Center for Medical Home Implementation

December 16, 2015

The National Center for Medical Home Implementation is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U43MC09134. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
What We Do

Work to ensure that all children and youth have a medical home

Collaborate with federal, state, and other agencies/stakeholders

Adapt and respond to new and emerging issues in health care, public policy, and technology
Who We Serve

- Title V Programs
- Other MCHB Grantees
- Pediatric clinicians
- Parents, Caregivers, Families
- Federal and State Agencies
- Non-Profit Organizations
- Education/Academia
- Community-based Organizations
- ... and many others!
Emerging Medical Home Themes

- Systems integration
- Population health
- Behavioral/mental health and primary care integration
- Medical home recognition and certification programs
- Evidence-based and evidence-informed implementation models
Models and Strategies for Medical Home Implementation

- NCMHI Promising Practices
- AMCHP Innovation Station
- CHIPRA Quality Demonstration Grants
- D70 implementation grants
- AAP chapter medical home initiatives
- Health Homes: Integration of primary care and behavioral health
- National and state recognition and certification standards
NCMHI Priorities

- Technical assistance and support for Title V programs
- Disparities in access to medical home
- Evidence-based and evidence-informed implementation strategies and models
- Family-centered care and care coordination
- Cross-system collaboration and alignment
Medical Home Education

- www.medicalhomeinfo.org
- Building Your Medical Home Online Resource Guide
- Resource Tutorials
- Annual Webinar Series
Shared Decision Making and Family Engagement

- “How-To” videos and webinars
- Quality improvement project change packets
- Online Resource Guide
- Parent Partner and Advisory Group Member job descriptions
- Family Care Notebook
- Fact sheet and AMCHP 2016 conference workshop
  - Engaging culturally and linguistically diverse populations in Block Grant activities
Care Coordination

- AAP Policy Statement
- Webinar Series
- Sample care plans, job descriptions, co-management agreement forms
- National Center for Care Coordination Technical Assistance
  - Pediatric Care Coordination Curriculum
  - Care Coordination Measurement Tool
State-Based Resources

- Poster session: 2016 AMCHP Conference
- State Pages
- State At-a-Glance Table
- State Profiles
- Pediatric SIM Initiatives
- Connections to partners in state:
  - AAP Chapters
  - Medicaid
  - F2F HICs
  - D70 States
  - CHIPRA Practices
Contact Us

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www.medicalhomeinfo.org
www.pediatricmedhome.org

Additional Resources:
NICHQ: www.nichq.org
IPFCC: www.ipfcc.org
Questions?

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Poll

• Do you think you can apply any of the strategies or resources presented to your state action plans?
  – Yes
  – No
  – Unsure
Q&A

• Mute your line by using the mute function on your phone or by using *6 to mute/un-mute

• **Raise your hand.** Using the icon at the top of your screen (example shown right)

• You can type your questions into the **chat box** (shown right)
AMCHP Innovation Station

- Online searchable database of cutting edge, emerging, promising, and best practices in MCH
  - New features and search functions!
- One-stop shop → Learn, Act, Share and Request Technical Assistance
AMCHP Communities of Practice

• In partnership with Johns Hopkins, AMCHP will host four Communities of Practice around the MCH Population Domains:
  – Child Health
  – Children and Youth with Special Health Needs (CYSHCN)
  – Cross-cutting / Life Course
  – Women’s / Maternal Health

• Purpose is to provide a space for peer sharing of:
  – Strategies related to the NPMs within the domain
  – Development of ESMs for strategies
  – Issues for group discussion and/or expert consultation
  – Updates on new resources and materials related to the development of ESMs
AMCHP Communities of Practice

• Who will benefit from joining:
  – State Title V staff engaged in the state action plan & developing ESMs

• Participant Involvement:
  – Participation in online discussion boards, interact with peers
  – Identify topics that require further TA
  – CoPs are participant-driven

• To learn more, visit our Communities of Practice Page:
  [http://www.amchp.org/AboutTitleV/Resources/Pages/MCHPopulationCommunitiesofPractice.aspx](http://www.amchp.org/AboutTitleV/Resources/Pages/MCHPopulationCommunitiesofPractice.aspx)

• To sign up, go directly to our Registration Page:
  [https://www.surveymonkey.com/r/CoP_MCHPop_Reg](https://www.surveymonkey.com/r/CoP_MCHPop_Reg)

• Questions? Contact Caroline Stampfel at [cstampfel@amchp.org](mailto:cstampfel@amchp.org)
# Implementation Roadmap

## Webinar Schedule

<table>
<thead>
<tr>
<th>NPM #</th>
<th>Date of Webinar</th>
<th>Link to Archived Webinar</th>
<th>Link to Registration</th>
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<tbody>
<tr>
<td>#8; Physical Activity</td>
<td>10/29/2015</td>
<td>[<a href="http://www.amchp.org/Calendar/Webinars/Pages/">http://www.amchp.org/Calendar/Webinars/Pages/</a> ArchivedNPMWebinars.asp](<a href="http://www.amchp.org/Calendar/Webinars/Pages/">http://www.amchp.org/Calendar/Webinars/Pages/</a> ArchivedNPMWebinars.asp)</td>
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<td>#4; Breastfeeding</td>
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<td>12/7/2015</td>
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<td>#11; Medical Home</td>
<td>12/16/2015 (4:00PM ET)</td>
<td>Link will be available shortly following the webinar.</td>
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<td>#13; Oral Health</td>
<td>1/7/2016 (4:00PM ET)</td>
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<td>#5; Safe Sleep</td>
<td>1/14/2016 (4:00PM ET)</td>
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<td>#14; Smoking</td>
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