

Health Care Reform 2009: *No Time for Complacency*



By Patrick Simpson, MPH, Executive Director

Let there be no doubt – we are in the midst of a defining moment in our Nation’s history – the winds of change have begun this year. Now is the time for Health Care Reform in the United States – to begin to assure that everyone, particularly children, and those most vulnerable, has access to affordable, effective health care. What will reform look like? What will it mean for urban mothers, children and families?

Mark Del Monte, JD, from the American Academy of Pediatrics, **Brent Ewig, MPH**, of the Association of Maternal and Child Health Programs, and **Neal Halfon, MD, MPH**, of the UCLA Center for Healthier Children, Families & Communities came together in January to share professional insights on the evolution of health care reform to an MCHB grantees’ group. Each expressed their unique point of view.

This rich discussion seemed timely for our CityMatCH members, so we invited them to describe key aspects of the current health care system they believe must change, what transformations can be anticipated in the coming year, and potential impacts for urban MCH populations. In a final question, CityMatCH asked these experts to counsel urban maternal and child health leaders to be well-positioned and proactive as health care reform efforts unfold.

After the interviews had been completed, we shared the transcripts with our Executive Committee of the CityMatCH Board of Directors. This small, yet diverse group represents some of the best minds currently working “in the trenches” of urban MCH; they graciously offered their own thoughtful interpretations and observations. We begin this article with selected comments from the three experts and culminate in a fusion of Executive Committee commentary.

Mark Del Monte: Access, benefits and quality health care are the three main categories for improvement through health care reform.

Access: Health care reform provides an opportunity to guarantee access to coverage for *all* children. With the Children’s Health Insurance Program (CHIP) reauthorized, approximately five million uninsured children remain in the US. Covering these children is within our grasp. Congress is considering several options to cover uninsured populations including an additional public program, subsidized private programs or a mix of both. A key issue is workforce.

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Brent Ewig: The cost of the current system is unsustainable; the outcomes we get do not match the investments we make; and the current system excludes too many. We can at least expect a national debate on health reform.

At best we can expect legislation passed this year that expands coverage, controls cost, improves quality, and hopefully begins a transformation toward a system that values and invests in prevention.

An expansion of affordable coverage will be a necessary and essential first step to improving the health of all urban mothers, children and families.

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Meet the Experts

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Neal Halfon: The first aspect of the current health care system that must change is the logic model. The system must be *less* about diagnosing and treating disease of individuals once they are symptomatic, and *more* about optimizing the health of all. To achieve that, there must be a greater focus on optimizing health development, through better, more systematic and strategic prevention, health promotion and developmental optimization; utilizing approaches that integrate individual, population and community strategies; and organizing health services into systems that integrate services across sectors and across the life span.

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CityView: “Purple Tickets” & Pluck

by Magda G. Peck, ScD, CityMatCH Founder & Senior Advisor



It has been awhile since I wrote about David or Sam. For more than a decade, their boyhood tales tracked the CityMatCH lifecourse trajectory, or so it seemed to me as someone raising both. When tender boy stories became more complicated adolescent mysteries, the linked lessons learned became hard to render and harder to tell. Now they are both old enough to marry and vote, so I was surprised when this one popped up a few weeks ago in the midst of national transitions.

In my mind's eye, here is what I saw: we were standing together near the base of the Capitol on a bright chilly January day at high noon, surrounded by passionate people of all hues and hometowns, listening to a new President articulate his vision for America.

Two engraved “purple” tickets from Senator Ben Nelson made that dream come true – almost. His congratulatory e-mail warned of overwhelming lines, winter weather and too few toilets, but

David and I were game. Worst case scenario, we'd walk the five miles from his freshman dorm at American University, queue up at the Purple Gate before 8:00 am as instructed, and take a front row stand to history. Aretha Franklin and Yo Yo Ma would keep us company. Being with so many others would keep us warm.

You have likely heard by now how bleak it was that day, how bitter the blustery winds. How thousands of “Purple” ticketholders were told by police to wait in an underground tunnel beneath the Mall before proceeding to our designated gate two blocks away. How no one seemed to know why the line barely moved for hours, and how word spread just after 11:00 am – as we finally reached the mouth of the tunnel – that security at the Purple Gate had been shut down.

Burrowing deeper into his hoodie, David had held it together in the tunnel until it turned sour and senseless. Most tunnel folks faded away angry or spent, but he insisted we press on with other undaunted believers. Waving our Purple tickets, we chanted “Open the gates! Let us in!” and somehow, after another long while, but just in time, they did. As we dashed toward the Capitol after clearing security, we heard him say, “...so help me God.” Cannons fired, and two million – and two – people roared for change.

In the end, it felt more monumental than celebratory. And bottom line: it was a lot of hard work to grab a first hand glimpse of history. But looking back, Inauguration 2009 mirrored the complex state of the nation – euphoric but anxious, playful but overwhelmed. And it rendered lessons learned that may help us navigate the stark years ahead in our ongoing work for the wellbeing of all women, children and families.

First, a potent mix of persistence and “pluck” can pay off. We have always brought passion to our work; it is a

longstanding hallmark of MCH – necessary

but insufficient. And we can be a tenacious lot.

It's “pluck” that's needed now – courage in the face of danger. So no whining, no fear, press on. There is too much at stake.

Second, *be prepared to exercise democracy*. Operative word: exercise, as in expecting to do regularly the hardest work. Think sweat; obstacle courses; marathons. With the worsening economic crisis and eroding public sector capacity, promoting and protecting maternal and child health may have never been as hard as it is going to get. Time to be or get in better collective shape, and we best stick together to see it through.

And last, *it is not just about us and it is not only about now*. On a too humid August day in the mid-60's, I pouted next to my father at the base of the Lincoln Memorial. Hot, impatient and preteen, I didn't get it all, but I can still remember feeling swept up in a wave of hope as Dr. King's words shimmied across an endless sea of people at the March on Washington.

A passionate, plucky young man stood now at my side after just a wrinkle in time. Taking into his heart the wondrous words of his President, David leaned in closer to find some warmth. He wrapped his arms around me to block the cold wind from my back, and rested his chin on my head. I do not know what leading challenges the Nation will be facing a generation from now, but I am betting that there is a good chance that David will return to D.C. from time to time to speak truth to power. And maybe one day his kids will flank him on the Mall, listening with millions of others to hear what their best leaders have come to tell them about justice and freedom and change.

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BUILDING ECONOMIC SECURITY TODAY: INTEGRATING THE LIFE COURSE PERSPECTIVE INTO A LOCAL MCH PROGRAM

CHERI PIES AND PADMINI PARTHASARATHY

Contra Costa Health Services – Family Maternal and Child Health Programs

In an era of global financial instability, will traditional public health strategies have the ability to fully respond to the unique problems facing families? Each day, the media is filled with stories about stock market crashes, big business bailouts, layoffs, unemployment and public anxiety. Looking even closer to home, we see many families in crisis. When family finances are in turmoil, health services are delayed, well-being suffers and health outcomes may be impacted.

One CityMatCH member health department has come up with an innovative approach to this situation – Contra Costa County (CA) Health Services' Family Maternal and Child Health (FMCH) Programs has developed a new project – Building Economic Security Today (BEST). BEST was developed to address disparities in birth and other health outcomes that have persisted for decades, regardless of the state of the economy.

BEST is an asset development project that utilizes innovative strategies to reduce disparities and inequities in health outcomes for this and future generations of low-income Contra Costa families by improving their financial security and stability. BEST will help families maximize their income for daily living, and preserve and increase their financial assets. Improving families' financial status will increase their access to health care, offer opportunities to live in safer and healthier neighborhoods, increase their food security, and enhance other protective social and environmental factors. Furthermore, research shows that children learn about how to manage money from their parents, and providing financial education to this generation's parents could increase financial stability in the next.

What led the FMCH program to create BEST? Lu and colleagues' *12-Point Plan to Reduce the Black-White Gap in Birth Outcomes*¹ provided a road map to guide their work. The plan helped them recognize that FMCH's focus must be on the social determinants of health outlined therein – specifically reducing poverty and supporting working mothers and families – for they know that wealth, or lack thereof, is a strong predictor of health and well-being, and that there is also a “social gradient” to this effect.

Groundwork for BEST dates back to 2005, when the FMCH program launched a 15-year Life Course Initiative in an effort to reduce disparities in birth outcomes and change the health of the next generation in Contra Costa County.

BEST is intended to achieve a variety of outcomes for staff, clients, and the local system, including increased staff knowledge and skills in asset development; increased client knowledge of, ability to adopt, and actual adoption of asset development strategies; and the creation of protocols, documentation systems, and community partnerships that will enhance the local health and human service system for clients. These outcomes are all intermediate markers of success on the path to improving FMCH's clients' financial stability, and by the next generation, improving health outcomes for women, children and families.

In its first year, BEST will train staff from FMCH's home visiting programs, as well as staff from the Women, Infants, and Children (WIC) Program, to integrate asset development activities, particularly financial education, into their services for pregnant and parenting women. BEST will offer 1) one-on-one support to families in home visiting programs, 2) financial education classes for WIC clients, and 3) asset development educational materials and referrals for all clients.

In October 2008, staff from 40 FMCH Programs attended an introductory training on Family Economic Success, which focused on building relationships with clients to address the difficulty of discussing financial issues. In January 2009, these same staff received follow-up training on 1) identifying families' underlying financial issues; and 2) helping clients identify and take their “first steps to success” on financial issues, such as applying for public benefits for which they are eligible, repairing



credit, opening a bank account, obtaining their Earned Income Tax Credit, or utilizing a low-cost prepaid debit card.

FMCH Programs' community partners in the development of BEST include the Contra Costa Family Economic Security Partnership, a public, private and nonprofit collaboration dedicated to increasing the income and building the assets of low-income families and individuals living in Contra Costa County, and Community Financial Resources, a non-profit organization dedicated to empowering low-income and financially marginalized people through education and low-cost banking and payment tools, such as a prepaid debit card.

Traditional public health responses to the economic downturn are essential. Yet, programs such as Contra Costa's BEST raise interesting questions. For example, does training staff on financial issues take away from time spent on more traditional public health roles and activities? Or, does it provide a service urgently needed now, that can have impact on the public's health down the road? Will the protocols, documentation systems, and community partnerships created through BEST serve to further enhance the local health and human services system? While it is too soon to know the answers unequivocally, we applaud the innovation of programs such as BEST, which attempt to address entrenched public health issues in new ways, using strategies that seem to show promise. Only time – and effective evaluation – will tell.



For more information, contact Padmini Parthasarathy, Life Course Initiative Coordinator, via E-mail at pparthas@hsd.cccounty.us or by phone: (925) 313-6178.

Footnotes:

1. Lu MC, Kotelchuck M, Hogan V, Jones L, Jones CA, Halfon N. Closing the Black-white gap in Birth outcomes: A Life-course approach. Accepted for publication in *Ethnicity and Disease*. 2009.

Mark Del Monte

This is a generational opportunity – so let's make the most of it!

Access to care hinges on having a sufficient and well-trained workforce to provide for the primary care and subspecialty health care needs of children and adolescents.

Investments in the education and training of a pediatric workforce, including subspecialties and surgical specialties are extremely important, for access without service providers will not enhance health outcomes.

Finally, we must reduce or eliminate barriers to getting coverage – the default for children should be enrollment. Similar to Medicare, where adults are automatically enrolled at age 65 unless they choose to opt out or have private coverage, all children should be automatically covered. The current system where children ricochet from under-insurance to a public program to no insurance and back simply must end.

Benefits: The American Academy of Pediatrics is focused on ensuring that children and adolescents get needed health care benefits when they need them. Benefits designed for adults are not sufficient to cover the developmental and preventive care needs of children. Benefits provided under the Medicaid standard (EPSDT) are an appropriate place to start so that children and adolescents get medically necessary and developmentally appropriate care. We must keep community-based prevention and treatment a priority and strengthen systems of care at the community level.

Quality and Delivery System Reform: Think about the way health care is currently delivered in the US. We have a very fragmented system with different providers and payors in multiple silos and lack effective care coordination across providers and systems. Quality improvement and delivery system reform is the third pillar of health care reform. AAP considers having a medical home for all children and adolescents, a concept pioneered by the AAP in the 1960's, as an essential component of a reformed health care system, providing a locus of care around families, maximizing available health information technology, with ongoing quality improvement efforts.

The President has been entirely clear that he would like to sign a health care reform bill in August 2009. Most people, including Congress, work best on deadlines, yet this is a huge effort that could impact upwards of 15 percent of the Gross Domestic Product (GDP) of the United States. The Senate and House are both working quickly and diligently with the Senate likely to move first. Grassroots involvement to articulate the needs of families and children is essential at every step of the process going forward.

Given the lessons of health care reform in the 1990's, we can anticipate this legislative effort will have key differences. The process will be led by Congress – not the White House. The White House has provided a framework and given priorities but Congress will draft the bills. The process will be more transparent, with more time to review and debate the various bills. Congress will likely avoid efforts that create uncertainty for people who are satisfied with their coverage and provider. Care will be taken to not “upset the apple cart” for those people who are happy with what they currently have.

Regarding how possible changes will impact the urban MCH population, we have articulated what we think ought to be in health care reform for the populations we care about. It is up to us to ensure this happens. We are all responsible for assuring children and families' issues are addressed. For vulnerable MCH populations, the tough news is that the overwhelming emphasis in Washington will be on adults. With millions of baby boomers approaching retirement and tens of millions of uninsured adults – keeping the focus on children and families will require hard work.

CityMatCH members must understand the framework for reform developed by Congress and fit our agenda within that framework. Speak their language! Get smart about what is going on in the Capitol and get in the room. Stay close to national organizations with the ear of key decision makers and visit your Senators and House members at home. Legislation is being introduced; once this happens, the critical phase of grassroots advocacy will be essential. Achieving health care reform legislation that meets the needs of our constituencies will not be easy. Member-by-member advocacy, state-by-state, and district-by-district will be necessary to tell lawmakers what's good in the bills and what needs fixing. *This is a generational opportunity – so let's make the most of it!*

Brent Ewig

However, now is the time to advocate that coverage by itself (alone) is necessary but insufficient to significantly move the needle on population health measures. In order to have the most positive impact on urban MCH populations, we need to articulate a vision for how prevention and public health approaches can be incorporated and strengthened as part of any health reform legislation.

CityMatCH urban health department members can articulate current unmet needs and highlight the effectiveness of current programs and policies. I think we are on the cusp of an “evidence-based” revolution in health policy, and especially in an era of trillion dollar deficits, we will need to justify every penny we are requesting and demonstrate how together we use MCH funding to make a difference in our communities.

Neal Halfon

The second aspect that must change is moving prevention and health promotion from the periphery of the health system, a central and core role. In tandem we also need to improve how prevention and health promotion services are organized at the individual, community and population level.

This will require considerable support for the development of innovative ways of organizing, delivering, integrating and paying for these services. Federal policy makers should consider establishing a national community prevention resource center that would make the tools that states and communities need more available. The Federal government should consider supporting the development of a National Prevention Innovation Network that could utilize collaborative innovation to catalyze rapid development, scaling and spread

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of effective community and population-based interventions.

Financing is the third key aspect – We need greater flexibility in how we finance health services. We need the ability to invest in long-term health capital of individuals and populations. Other countries are using health trusts or wellness funds to address population health funding over longer time frames. Innovations in finance to serve the many new functions that the health system needs to achieve are essential.

In the coming year, a health reform agenda will emerge. The big question is what will be the MCH components of that agenda? Right now, the focus is cost and access. How these changes will impact the urban MCH population just depends – if health reform is mostly about health insurance expansion, then more folks will be covered. Unless we make MCH a central component of health reform, there might not be much impact.

CityMatCH urban health department members must ensure that MCH is part of the health reform agenda. Make prevention part of health reform – not just as a public health issue – but as a central tenet of a reformed health system. Prevention needs to start at the beginning: before children are conceived, during gestation and across the entire child span.

“Are we willing to invest to make significant change?”

~ CityMatCH Executive Committee Response ~



The Executive Committee first shared general comments and subsequently responded directly to the question about how urban MCH can be prepared and proactive. A synthesis of their comments follows below and continues onto page six.

“Access seems to lie at the center of every debate,” said **Mary Balluff**, and she suggests that access should be viewed as a two-pronged issue: first, getting children into the existing systems to receive care, and second, assuring that the care children really need is readily available. Access also reflects values: “Do we value children and their needs enough to invest the resources to provide the service at a level to meet the need?”

Furthermore, said **Balluff**, financing care and return on investment are closely-linked issues. Ewig’s response meshed with Del Monte’s thoughts about the impact of quality on return on investment. Current system design reflects the principle of managing illness instead of supporting health. Until we invest in promoting health and recognize that we may have to allocate fewer dollars to managing illness and end of life, no substantial change in outcomes can be expected. Until health is seen within the greater spectrum and connected to economic, educational and social fabric, solutions will be small and short-lived.

Cynthia Harding thought that Del Monte’s cluster of access, benefits and quality, effectively highlights what urban MCH hopes to achieve from potentially dramatic policy change in the United States. Harding said that health care reform must be approached broadly if we are to impact health outcomes in this country.

If we focus only on the clinical side of health care reform, we will have missed our greatest opportunity to engage the medical establishment and others in greater efforts at health promotion and disease prevention. Public Health professionals

have long made the case that investing in prevention will have the greatest impact on curtailing treatment costs. If we expect true reform, we must be willing to invest accordingly. **Carolyn Slack** concurred and pointed out that while reform may focus on the health care system with its historical emphasis on sick care, much of MCH health care is primarily well care - prevention and health promotion - we must advocate for well care.

Halfon’s discussion of reconsidering how we fund health reform was refreshing to **Harding**. Because reaping the return on investments from preventive efforts often takes ten years or more, we must change our thinking and invest with a long-term vision. The tools and mechanisms for funding health care reform must be as innovative as the strategies. Overwhelming agreement exists within the public health community that the current system needs major restructuring to best promote the health of all Americans, said **Zenobia Harris**. It is too costly and does not produce acceptable outcomes, in part due to the focus on treatment of disease rather than prevention, and excludes too many of our citizens.

Ewig’s advice to MCH professionals to highlight our role in improving the health of communities and to be ready to justify the investment in MCH services is echoed in the remarks of the other experts, said **Harding**. We need to be accountable for the Federal dollars we receive, to explain how those dollars were used, how many mothers, babies and families we served, and also what larger impact we had in preventing future health problems, reducing the incidence of chronic diseases,

and describing how these efforts have provided cost savings to the health care and human services system as a whole.

CityMatCH Executive Committee Respondents

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“What Can CityMatCH Urban Health Department Members Do to Be Well-Positioned and Proactive?”

~Final Executive Committee Responses to Health Care Reform Interviews ~

Five Urban MCH Strategies (Harding):

We must constantly re-invent ourselves and our programs to meet the changing landscape of funding opportunities and the changing face of the communities we will serve. We must:

1. **Speak loudly and boldly – Advocate for the MCH populations we serve.** Be eloquent in making the case for how the dollars spent in MCH programs and policies become the framework for good health for the entire population and generations to come.
2. **Make the case for investing early in prevention and health promotion** and how this will save future treatment and health infrastructure costs. MCH gives the biggest return on investment.
3. **Become even more creative** – In a time of diminishing resources, state and local budget cuts, be more careful and more creative in how our MCH dollars are spent and more intelligent in leveraging resources to increase the level and quality of services provided.
4. **Collaborate effectively and seek out new opportunities.** Seek out new partners and fortify relationships with traditional partners who can make the case for our populations and services even more effectively than we can.
5. **Focus on policy.** Take advantage of this new era in American politics to elevate the voices of women, children and families in Washington, and at State and local discussions. Get to know your local senators, congressional representatives and state representatives. Introduce yourself as the local MCAH expert and position yourself to be their counsel and resource. Said Harding, *“This is no time for complacency!”*

Create a Voice

Balluff recommends that CityMatCH create a voice speaking beyond the needs and gaps in the current system, asking for substantial change. **Balluff** said, *“This is not the time to move the deck chairs around, rather the opportunity*

to raise the expectation that health is the cornerstone of our system. We have become complacent that evidence-based means doing the same thing that someone else has demonstrated has some effect; (i.e., letting others determine success). We must look beyond initial results to ask what would make it even better so that we can accomplish health.”

Educate and Inform

Ann Salyer-Caldwell realizes that this is the critical time to educate and inform broadly about the “life-course perspective” and begin key conversations around health care and public health. **Carol Synkewecz** stated that MCH must reexamine, show results, and create local systems of care, not just fill the gaps, and must be a part of all reform discussions and solutions nationally and locally. **Balluff** concurred that, as DelMonte suggests, CityMatCH must assure our voice is not only heard but respected and repeated. Use the science we know and our own experience to create plausible models that will improve lives. Be willing to act upon our convictions and demonstrate solutions as well as the sacrifices we are willing to make. **Harris** proposes that this moment in time provides the public health community an exceptional opportunity to mentor, teach, articulate, demonstrate and advocate in multiple leadership roles.

Advocate For A Women’s Health Agenda across the Life-Course

Deb Hendricks suggests we broaden the definition of MCH within health care and advocate for a women’s health agenda at all levels of government and for the integration of MCH across the public health spectrum, an idea that meshes well with Neal Halfon’s life-course model. CityMatCH members and the organization could help to frame at a local level how integration might occur, focusing on partnerships, services and policies in an effort to inform the health care reform discussion.

Create Consensus Principles for MCH

Slack anticipates that health care reform plans and ideas will be complex, and most health professionals will lack

time to thoroughly study proposals. We must assure we are connected with local, state and national advocacy organizations to stay abreast and use these avenues for our thoughts and ideas. Organizations like CityMatCH and AMCHP could create consensus principles for MCH in health care reform and promote a consistent national message. We should invite Federal House or Senate members to our health departments, illustrate the work we do, the needs we see and share the consensus principles. Hearing these same principles throughout the country could percolate them into the overall discussion.

Position Ourselves Effectively

Harris says we must be loudly vocal about developing inexpensive local systems of sustainable care. We must position ourselves to serve as active leaders of, advisers to and members of local, state and national groups working on this issue.

We must develop and sharpen our advocacy skills and arm ourselves with current information (evidence) which makes the case for changing the status quo of our system. We must advocate for and strategically position ourselves to participate in the active identification and removal of the last vestiges of inequality in the distribution of, utilization of and access to health care and promotion in our current system.

We must seize this opportunity to serve as mentors and “truth tellers” for the up and coming generation of public health workers, sharing our visions and hopes for maternal, child and adolescent health and American health overall.

Now it is your turn. CityMatCH would like to hear from you. *What can urban health departments do to be well-positioned and proactive in this era of unfolding health care reform?*

E-mail or phone with your ideas to **Maureen Fitzgerald**, Coordinator, Policy & Communications at mfitzger@unmc.edu or (402) 561-7514.



Improving the Health of Children and Adolescents in Foster Care: Opportunities for Urban MCH

By Lisa Pilnik, Esq., American Bar Association Center on Children and the Law¹

In 2007, 783,000 American children spent at least part of the year in foster care.²

These children came from a variety of backgrounds and have a range of outcomes.

40% of children in care were white, 32% were black, and 19% were Hispanic; the remainder belonged to other ethnic groups or their ethnicity was unknown.³

▲ The average age of these children was 10 years old, and there were slightly more boys than girls.⁴

▲ In 2005, 27% of children were admitted into foster care from primary urban areas, 34% from secondary urban areas, and 39% from non-urban areas.⁵

▲ Children from primary urban communities have longer median stays in foster care and are more likely to be placed in a group care setting.⁶

In addition to the abuse or neglect that led to their placement in out of home care, these children often enter the system with unmet health needs.⁷ Once they are in foster care, almost all children are eligible for Medicaid, but states report a shortage of providers who accept Medicaid.⁸ The American Academy of Pediatrics has said that “children and adolescents in foster care have a higher prevalence of physical, developmental, dental and behavioral health conditions than any other group of children.”⁹ In one study of children in care, 60% had at least one chronic health problem, and 25% had three or more; another study found psychiatric disorders in 40 to 60 percent of children in care, and discovered that these children were using mental health services “at a rate 15 to 20 times higher” than other children.¹⁰

Federal Requirements and State Progress

Federal law requires that states make “reasonable efforts” to keep families together by preventing placement in foster care when possible, and by enabling children and adolescents to return home safely (e.g., by providing appropriate services) when they are in foster care.¹¹ The law and related regulations stress, however, that the health, safety and well-being of the child are paramount when serving families and making decisions about reasonable efforts.¹² Well-being for children in foster care includes physical, mental, and emotional health.

The federal Department of Health and Human Services is also required to monitor



states’ progress in ensuring child safety and administering their child welfare programs.¹³ These assessments, known as Child and Family Services Reviews, revealed that states are not providing adequate services to children and families, particularly in the area of mental health.¹⁴ One of the outcome measures asked whether children received services to meet their physical and mental health needs: only *one state* achieved substantial conformity on that measure.¹⁵ Common challenges identified included: a shortage of providers willing to accept Medicaid; a lack of mental health services; inconsistent provision of preventive and/or dental services; and inconsistent provision of physical and mental health assessments.¹⁶

In 2008, a new law, the Fostering Connections to Success and Increasing Adoptions Act of 2008, was passed with the intent of improving outcomes for children and adolescents in foster care. Among other provisions, the law requires that each state develop, in consultation with health care and child welfare experts, a plan for coordination and oversight of health care services for children in foster care.¹⁷ The plan must include a coordinated strategy to identify and respond to children’s health care needs and must account for mental health and dental health.¹⁸ The law enumerates six specific issues that must be addressed by the plan, including:

- Schedules for health screenings;
- How identified needs will be monitored and treated;
- How health records will be shared and kept updated;
- How continuity of care will be achieved;
- How prescription medicines will be monitored; and
- How the state will work with health professionals to assess health status and provide treatment for children in foster care.¹⁹

Maternal and child health programs will likely be impacted by the improved coordination this new law requires. They can ensure that the changes will be positive and realistic by partnering with their state health and child welfare agencies to develop and implement

their coordination and oversight plan.

Opportunities for Impact

Urban maternal and child health programs across the country are working to improve health outcomes for children and adolescents in foster care. If your program wants to help, here are several strategies you can use:

Establish a Medical Home and Implement Electronic Health Records

Continuity of care and accurate, up-to-date medical records are essential for children in foster care, whose residence and primary caregivers may change frequently, and who are at greater risk for numerous health problems. The Fostering Connections to Success Act specifically refers to electronic medical records and medical homes for children in foster care as ways to potentially meet its requirements regarding medical records and continuity of care.²⁰

The Duval County Health Department in Florida, along with several other agencies, provides the Kids ‘N Care Health Center. Children and adolescents entering foster care in Duval County are referred to Kids ‘N Care and receive a health screening within 72 hours, a comprehensive exam within 30 days and a timely follow-up assessment. They also receive developmental and mental health screenings and appropriate follow-up services. Through this medical home, children in foster care receive enhanced primary medical and dental care (including immunizations and physicals) targeted towards their unique needs, health education and necessary referrals.

Many communities are also using health passports (also known as medical passports), which are brief electronic medical histories. When professionals keep these records up-to-date, use them regularly as a resource, and ensure that privacy protections are in place, health passports can help children by ensuring immunizations, follow-up assessments and other necessary services aren’t missed and avoiding duplication of services. Since children may change foster care placements, it’s helpful for health passports to be easily accessed and shared. In California, information from children’s health passports is entered into a statewide Child Welfare Services/Case Management System.

Appoint a Liaison between Agencies or Co-Locate Professionals

The San Francisco and Los Angeles Departments of Public Health place public health nurses in their local child welfare agency to help social workers and foster parents make sure that children’s health needs are being met, and to connect children to medical and dental providers. These nurses provide case

management services, rather than direct medical care, and the costs for this position are shared by the child protection agency, public health, and the state.

MCH programs that do not have the funding to co-locate staff can still improve coordination with their child welfare agency by designating a specific staff member as a point person for keeping that agency updated on services and programs that may benefit children in foster care and answering questions that come up. Similarly, asking the child welfare agency to appoint someone to let the health department know about any gaps they are seeing in health care access for children may lead to solutions. Setting a regular meeting or conference call time (e.g., the third Thursday of each month), can ensure that each department stays updated and has the opportunity to get (or give) help, information or advice when needed.

Provide Direct Services

Scarcity of services and a lack of providers who accept Medicaid are frequent barriers to health care access for children in foster care, particularly mental and dental health services. MCH programs that provide direct physical and mental health services may find children in foster care a particularly important group to reach, due to their higher rates of health concerns and the barriers to access they face. Jefferson County Department of Health and Environment in Colorado provides public health nursing visits to children from birth through age six through a program called Expedited Permanency Planning. Through a contract with their county department of human services, the nurses conduct assessments, teach and counsel parents whose children have been removed from their custody, and make referrals for services related to growth and development, parenting, nutrition, and health.

Start an Inter-Agency Workgroup or Taskforce

The Durham County Health Department (DCHD) in North Carolina is part of a Child Abuse Multi-Agency Review Team that meets weekly to review complicated child protection cases. "The Health Department staff role is usually to raise health questions, help identify resources, and provide information about families that we're familiar with," explains Sue Guptill, Director of Nursing for DCHD. Confidentiality issues often pose a challenge to multi-disciplinary collaboration, but this group has a judge's order specific to their team, allowing them to share information appropriately.

DCHD participates in several other groups working to reduce out-of-home placement among children and adolescents as part of Durham's "system of care" approach. "This involves community-wide policy and procedure development, as well as commitments from all public agencies and many private ones to work collaboratively with individual families," says Guptill. "Since we started this, we have developed strong relationships

"If I had a million dollars..."

We asked CityMatCH members: "If your department was offered funding specifically to improve the health of children and youth in foster care, how would you spend it?" You told us that you would use the money to:

- Improve access to dental care
- Train medical providers, foster parents and social workers on childhood obesity
- Provide mental health and substance abuse treatment services for parents of children in foster care
- Conduct a needs assessment
- Provide youth who become pregnant while in foster care with services through a Nurse Family Partnership program
- Hire additional staff so caseloads could be reduced
- Provide health and dental screenings, immunizations, and treatment for acute conditions
- Undertake a communication and outreach campaign among community providers and stakeholders
- Educate families involved with the child welfare system about chronic diseases and provide preventative services
- Provide services to address trauma for children in out-of-home care, and family therapy to facilitate reunification of children with their parents
- Create a dedicated foster care services unit at every level in multiple systems
- Work with school districts to set up school health sites with comprehensive services
- Establish a specific liaison with your child protection agency (to be a consultant for health issues particular to individual children and to provide a general health orientation to child protection staff)

and commitments to working together, and have pushed ourselves to let go of a lot of territorialism."

Many localities, including Durham, also have child fatality review teams. These groups investigate deaths of children (sometimes focusing on those who were in out-of-home care) to identify possible systemic or preventable causes. A listing of team contacts for each state is available at <http://www.ican-cnfr.org/stateteams.asp>.

As Durham's experience shows, workgroups and taskforces can focus on individual cases, large policy and systemic issues, or anything in between. They can meet weekly, monthly or even less often, by phone or in person, and can be specific to children involved with child protective services or include multiple target populations. In any of these permutations, however, inter-agency workgroups hold enormous potential to help children achieve better health outcomes.

Help Health Care Providers and Child Welfare Workers Navigate Administrative Burdens

In North Carolina, Wake County Human Services' Children's Health and Development Program (CHDP) recommends, based on AAP guidelines, that children in foster care see a provider for interperiodic screening every six months. To help ensure this happens, they send providers information on how to code those visits so that they can get reimbursed by Medicaid. CHDP also provides the child welfare caseworker with all of the medical information and forms she needs to become knowledgeable about the child's past and current health status, and obtain the child's social security card and

birth certificate. (For a detailed description of the Children's Health and Development Program, see page nine) A Promising Practices Issue Brief authored by the National Conference of State Legislatures Forum for State Health Policy Leadership also describes the experiences of three states who improved access to dental care by Medicaid patients through increased reimbursement rates, outreach to providers, and administrative simplification.²¹

Provide Training or Information Sessions

Even if a health department doesn't have funding to send a full-time staff member to the child welfare agency, or establish a medical home, it can still help child welfare professionals improve the health of children. Strategies could include offering a lunchtime training session on a substantive health area (e.g., mental health effects of witnessing violence, or STI and pregnancy prevention for adolescents), or meeting with caseworkers and supervisors to educate them about health services and resources the health department and others provide that might be helpful for children and adolescents in foster care.

Children and adolescents in foster care have experienced abuse or neglect, and often inadequate health care before entering state care. Once they are placed with a foster family or in a group home, they still face tremendous barriers to receiving adequate assessments and follow up services, along with the coordinated care that at-risk children particularly need. Urban MCH programs, in collaboration with their child welfare agency counterparts, are in a unique position to help this vulnerable population improve their health and well-being.



Program Profile: The Children's Health and Development Program in Wake County, NC

By Lisa Pilnik, Esq., American Bar Association Center on Children and the Law

Recognizing the increased risk of poor health outcomes for children and adolescents involved with the child protective system,

the Children's Health and Development Program (CHDP) in Wake County, North Carolina ensures that these youth receive necessary health screening and treatment.

The program, supported by the John Rex Endowment, is mandated for all of the 200 to 300 children entering foster care in Wake County each year.

CHDP also works with some children who are receiving in-home child protective services, but are not in foster care. In Wake County, public health, mental health, and child welfare are fortunate to all be part of the same agency (Wake County Human Services), thus enabling them to work together and share information more easily. As a result of CHDP, children in Wake County foster care receive more timely, comprehensive and coordinated health services. Children are connected to medical homes, and caregivers are better able to provide for children's health needs.

Initial Coordination and Information Gathering

The process begins when the child enters out-of-home care and the Children's Health and Development Program (CHDP) is sent a copy of the legal document alleging that the child has been abused or neglected. A member of the CHDP attends a planning meeting with relevant individuals including parents, child, attorneys, representatives from the school district, and child protective agency.

The group discusses why the child came into foster care and their background, including their health history. In addition, information is obtained by a diligent search for and thorough review of medical, school and mental health records, including results of assessments performed prior to child protective agency involvement, and any individualized education plan or program. CHDP uses a program coordinator to communicate with the different agencies and individuals involved with the child, schedule service appointments, and ensure that relevant information is shared among program staff and other professionals.

Innovative CHDP Product: "A Child's Journey" Organizer

To assist caregivers in meeting the health needs of children in foster care, CHDP developed an organizer where foster parents can keep important documents. The organizer is updated while the child is placed in a foster home, and updated when a child is reunified with birth parents or moves to a new placement. Foster parents are encouraged to fill them with updated copies of the child's records in five areas:

- Immunization records, the birth certificate and Medicaid card
- Medical Information (including the Plan of Care described in this article, which contains results of the screenings)
- Placement letter, permission to enroll, and WIC vouchers
- Visitation Plan
- Court orders or other legal documents

The organizer also includes resources for the foster parents, including lists of local dentists and optometrists who accept Medicaid, developmental and mental health providers, and contact information for CHDP staff, Medicaid offices, and the Social Security Administration.

Screenings and Evaluations

Each child receives age-appropriate screenings and evaluations. All children receive a comprehensive medical exam, immunizations, and treatment for immediately presenting conditions. Children under age two also receive a skeletal radiological survey to identify any extant/untreated fractures or breaks. All children are also assessed to determine if HIV screening is necessary.

Children under age five receive developmental screenings using validated screening tools and school age children receive neurodevelopmental screenings. Mental health assessments are performed on children ages four to 18. The developmental assessment and medical exam are performed on the same day, preferably within seven days of the child entering foster care. The mental health assessment is usually delayed four to six weeks, as some children will adjust with time, while for others it can take time for issues to come to surface.

The health professionals are starting with a good health and developmental history, for improved health services coordination and provision. When potential problems are identified, the child is referred for further evaluation or treatment, as warranted.

After the child has received a comprehensive physical exam, the social worker is sent a state-mandated form that documents the exam occurred and describing the child's basic health status. The CHDP program

coordinator provides the social worker with any other paperwork needed to enroll the child in daycare, and gathers pertinent legal documents for the child. If a child lacks immigration status for Medicaid, CHDP enrolls them in a local program called Project Access that provides health care for uninsured patients.

Follow-up and Plan of Care

Once a child has received all necessary exams and assessments, the CHDP program coordinator develops a Plan of Care (POC) that includes a summary of the child's assessment results, a list of referrals made, and recommendations.

The program coordinator meets with the caseworker to review the plan, and determine the child's medical home. The medical home and foster parents receive copies of the POC. CHDP also asks each medical home provider to see each child for inter-periodic screening every six months, and provides information on how to code these visits for Medicaid reimbursement.

Questions? Contact **Sandra Nuss**, Assessment Coordinator,



Children's Health and Development Program by E-mail: Sandra.Nuss@co.wake.nc.us or by phone: (919) 212-8361.



Annual CityMatCH Board Elections Underway

On Friday, April 10, 2009, CityMatCH closed nominations for the annual election to the Board of Directors and Nominating Committee. Elections to the Board and Nominating Committee open in May. Members will receive voting information and instructions shortly; stay tuned for Member E-mails and alerts. Elected Board members assume their offices at the annual Conference in New Orleans. Nominees this year are:

- South Central Region (Arizona, New Mexico, Texas, Oklahoma, Kansas, Missouri, Arkansas, and Louisiana): **Sherry Williams**, BSN, Program Administrator for the Waco-McLennan County Public Health District in Waco, TX.
- West Region (Washington, Oregon, California, Alaska, Montana, Idaho, Nevada, Utah, and Hawaii). **Audrey Stevenson**, PhD, MSN, FNP-BC, MPH, Division Director for the Salt Lake Valley Health Department in Salt Lake City, UT and **Pamela Stuver**, BS, MA, MCH Nursing Supervisor for Lane County Public Health Services in Eugene, OR.
- At-Large: **Kimberlee Wyche Etheridge**, Director Family Youth and Infant Health for the Metro Nashville/Davidson County Public Health Department in Nashville, TN.
- Nominating Committee: The Nominating Committee assists the CityMatCH Central Office with the annual Board election process. **Cheri Pies**, MSW, DrPH, Director, Family, Maternal & Child Health Programs for the Contra Costa County Health Services Department in Martinez, CA.

If you did not take the opportunity to run this year, please consider grabbing the brass ring by running in 2010, the 20th Anniversary of CityMatCH! Service to the Board is a remarkable opportunity for those with vision for the future of urban MCH, passion for protecting the health of women, children, and families, business acumen to help implement our strategic plan, and creativity to shape cutting-edge products and services.

Regional Representatives retiring from Board service this year are **Ann Saylor Caldwell** – South Central and **Kathy Carson**— West. CityMatCH thanks them for their commitment and dedication.

Questions? Contact Mark Law, Organizational Effectiveness Manager, at (402) 561-7500 or mlaw@unmc.edu or visit the website at www.citymatch.org.

FIMR/HIV Prevention Methodology Request for Applications to be Announced

Recent years have seen a remarkable decline in perinatal HIV transmission (also known as mother-to-child transmission of HIV). Yet, as the CDC reports, “between 120,000 to 160,000 women of childbearing age in the United States are infected with HIV, the virus that causes AIDS. Nearly one out of four of these women don’t know they have HIV. This puts them at high risk of passing the virus to their babies.”

CityMatCH and the American College of Obstetricians and Gynecologists, including the National Fetal and Infant Mortality Review (NFIMR) Program, were funded by the CDC to adapt the FIMR methodology for the investigation of perinatal HIV transmission. The methodology includes the collection of comprehensive quantitative and qualitative data, via medical record abstraction and maternal interview, which provides an in-depth look at the systems that result in a perinatal HIV exposure or transmission.

Three cities (Baton Rouge, LA; Detroit, MI; and Jacksonville, FL) were selected to pilot the new methodology. Lessons learned from these communities are documented in the final report FIMR/HIV Pilot Project: Overview and Lessons Learned (available online soon at www.citymatch.org). Based upon the success of this pilot project, CityMatCH has received funds to support the implementation of the FIMR/HIV Prevention Methodology in additional communities. A Request for Applications (RFA) will be issued in the near future for communities interested in implementing the FIMR/HIV Prevention Pilot (FHPP) Methodology as part of an 18-month-long national practice community experience.

If your community is interested in participating in this new round of FIMR/HIV work, or if you would like additional information about the methodology, contact Brenda Thompson, MPH, CityMatCH, via E-mail at brendathompson@unmc.edu or by phone at (402) 561-7500.

1. Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Pregnancy and Childbirth. Available at: <http://www.cdc.gov/hiv/topics/perinatal/index.htm>. Accessed April 24, 2009.



CityMatCH Founder and MCH Advocate Delivers MacQueen Public Health Lecture at AMCHP 2009 Conference

Magda Peck, Sc.D., founder of CityMatCH, and Professor of Pediatrics and Public Health for the University of Nebraska Medical Center, was selected for the 2009 John C. MacQueen Lecture Award for her innovative work in the field of maternal and child health.

The award is one of the most prestigious honors given by the Association of Maternal and Child Health Programs (AMCHP), one of the nation's leading public health groups advocating for quality health care for women, children and families. Dr. Peck was honored on Feb. 24 at the 2009 AMCHP Conference in Washington, DC.

Each year, the awardee of the John C. MacQueen Lecture Award is invited to present at the Annual MacQueen Lecture Luncheon during the AMCHP conference. Selection for the award is based on the individual's contributions and advocacy to the field of maternal and child health and for their efforts in endeavoring to establish and maintain healthy communities.

This Award is named in honor of Dr. John C. MacQueen, the former director of the Iowa Child Health Specialty Clinics, the state's program for children with special health care needs. Two prominent United States senators – Sen. Ted Kennedy (D-Mass.) and Sen. Chris Dodd (D-Conn.) – also received major awards at this year's AMCHP Conference.

"It was so sweet to deliver this year's lecture to my maternal and child health colleagues from across the country," Dr. Peck said. "To join former Surgeon General C. Everett Koop and Children's Defense Fund founder Marian Wright Edelman on the list of MacQueen awardees was a tremendous honor."

In 1990, Dr. Peck founded CityMatCH, whose members include leaders and public health organizations from the largest urban centers in the country and is dedicated to improving the health of women, children and families in urban areas. Dr. Peck's innovative work through CityMatCH has advanced the field in translating research into practice and created new strategies for building local capacity to use data to inform practice and policy.



A life-long champion for public health education, leadership and practice, in 2002, Dr. Peck was named the founding director of the Master of Public Health (MPH) Program through UNMC and the University of Nebraska at Omaha. She later helped initiate the new College of Public Health. In 2005, Dr. Peck was instrumental in forming the Great Plains Public Health Leadership Institute, which she continues to direct. The institute is one of 14 CDC-funded public health leadership institutes nationwide.

For more than 70 years, AMCHP has worked as a nonprofit organization to protect the health and well-being of all families, especially those who are low-income and underserved. AMCHP members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, adolescent health coordinators and public health leaders, as well as academic, advocacy and community-based family health professionals and families themselves.

Used with permission, University of Nebraska Medical Center, Department of Public Affairs, Tom O'Connor.

Improving the Health of Children and Adolescents in Foster Care: Opportunities for Urban MCH

(Footnotes from story on pages seven and eight)

1. The views expressed herein have not been approved by the American Bar Association House of Delegates or Board of Governors and, accordingly, should not be construed as representing policy of the Association.
2. Adoption and Foster Care Analysis and Reporting System (AFCARS) data, U.S. Children's Bureau, Administration for Children, Youth and Families, available at: http://www.acf.hhs.gov/programs/cb/stats_research/afcarts/trends.htm. 2007 refers to Fiscal Year 2007. State by state data can be found at http://www.acf.hhs.gov/programs/cb/stats_research/afcarts/statistics/entryexit2006.htm.
3. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. The AFCARS Report: Preliminary FY 2006 Estimates as of January 2008 (14). Available at http://www.acf.hhs.gov/programs/cb/stats_research/afcarts/tar/report14.htm.
4. Ibid. 34% were age 5 or under, 24% were ages

5. Wulczyn, F., Chen, L., & Hislop, K.B. (2007) *Foster care dynamics. 2000–2005: A report from the Multistate Foster Care Data Archive*. Chicago: Chapin Hall Center for Children at the University of Chicago.
6. Ibid.
7. American Academy of Pediatrics, Task Force on Health Care for Children (2005) *Fostering Health: Health Care for Children and Adolescents in Foster Care* (American Academy of Pediatrics), pg. 1
8. CFRS stat on provider shortages.
9. American Academy of Pediatrics, pg. ix
10. Child Welfare League of America, *Standards for Health Care Services for Children in Out-of-Home Care*, citing Simms and dosReis. (<http://www.cwla.org/programs/standards/cwsstandardshealthcare.htm>)
11. Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272; The Adoption and Safe Families Act, Public Law 105-89.
12. Ibid; Code of Federal Regulations Section 1355.25 (Principles of Child and Family Services).
13. The Adoption and Safe Families Act, Public Law

- 105-89.
14. U.S. Department of Health and Human Services. *General Findings from the Federal Child and Family Service Review*, available at <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/ch2.htm>.
15. Ibid.
16. Ibid.
17. Fostering Connections to Success and Increasing Adoptions Act of 2008, Public Law 110-351.
18. Ibid.
19. Ibid.
20. Fostering Connections to Success and Increasing Adoptions Act of 2008, Public Law 110-351.
21. National Conference of State Legislatures Forum for State Health Policy Leadership, Promising Practices Issue Brief: Does Raising Rates Increase Dentists' Participation in Medicaid? The Experience of Three States (National Conference of State Legislatures 2004), available at http://www.ncsl.org/print/health/forum/dentalreimbursementrates_04.pdf



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August 22 ~ 25, 2009, New Orleans, LA
19th Annual CityMatCH Urban MCH Leadership Conference
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Visit the [website for more information: www.citymatch.org](http://www.citymatch.org)

Registration Opens May 1, 2009

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