From the President

Back to School – A Time of Ingenuity, Inventiveness and Learning or a Period of Risk

By Phyllis J. Sloyer, RN, PhD, PAHM, FAAP

I firmly believe that a good education is the primary bell weather of a successful future. The toddler has become a child and its time to venture into a new world and it seems as though school-aged children and youth are invincible. How remarkable to watch the child process complex information, ponder the events in the world and form peer relationships that may last a lifetime.

Of course, the ability to learn and interact with others is also influenced by the health status of the child and the social factors that present risks to educational achievement. Unfortunately, 2008 data from CDC indicates that three percent of America’s children miss 11 or more days of school due to illness or injury. The media frequently points out the growing number of children who are overweight or obese. We also know that adolescents ages 13-17 are vulnerable to risky behaviors, including substance and alcohol abuse and depression. Finally, children with special health care needs require special accommodations in order to be fully integrated in today’s classroom.

It is of no surprise that school health is a vital service in keeping a child healthy and promoting healthy
From the President cont.
A Time of Ingenuity, Inventiveness and Learning

behaviors. Promoting healthy behaviors, looking for signs and symptoms of depression as well as behavioral issues, improving physical fitness and mental alertness, promoting positive development, and accommodating a child’s special health care needs are important school health functions. This issue will provide you with data, recent trends and school health programs, and real life stories about the world children live in when they go to school. I find nothing quite so important as a successful educational achievement and the world it opens for our children. Enjoy this issue!

From the CEO
Back to School: H1N1 and MCH Preparedness

By Mike R. Fraser, PhD

Almost 11 years ago I started working in the area of “bioterrorism.” My work involved supporting local health departments in their efforts to assess preparedness, use best practices to respond to bioterrorism, and share lessons learned about emergency preparedness with all local health departments. The work was controversial. One respected public health professional told me point blank that a “bioterrorism attack has less of a chance of happening than throwing a snow ball in Santa Clara. We need that money for childhood immunizations.” I told him he was right about the immunizations and I also hoped he was right about the probabilities of an attack but public health preparedness was important nonetheless. During my time in preparedness I visited many local and state health departments, as well as other offices within the Centers for Disease Control and Prevention, and heard similar chatter about bioterrorism being a remote possibility. But then anthrax happened. Then SARS. Then Katrina. And now H1N1.

Years of public health planning have taken place and yet we still have lots of work to do to assure our nation’s women, children, fathers and families are prepared for “bioterrorism” — this time courtesy of Mother Nature. Are we ready? Predictions are that H1N1 will be widespread but only cause “mild” illness. (I am not sure I ever had a “mild” flu, they all stink if you ask me!) Predictions are also that pregnant women and young children are most at risk for serious illness including facing a disproportionate rate of morbidity from H1N1. H1N1 will also be a very serious issue for many children and youth with complex or special health care needs. It seems clear that H1N1 will be a virus that impacts Maternal and Child Health (MCH) populations disproportionately — not only pregnant women and children but also those least likely to have a routine source of medical care or a place to get reliable health
From the CEO CONT.

Back to School: H1N1 and MCH Preparedness

information. We can’t put our heads in the sand: H1N1 will involve MCH leadership and already has. I know many of you have worked in your state’s emergency operations center, have fielded questions about H1N1 from family and community groups, and are working with stakeholders in your state to prepare for a potential outbreak this fall. We want to learn from that experience as we look to the fall and H1N1 as an emerging issue for all of us.

Many of us have started thinking about how to best engage state Departments of Education and other players in a potential outbreak. The U.S. Department of Health and Human Services has begun to work closely with officials in the Department of Education, modeling partnerships that are happening at the state and local levels as well. School nurses, school-based health clinics, and other education-related health facilities need to be engaged in planning for H1N1 along with MCH professionals in public health agencies and in the clinical care setting. Schools do a lot more than just educate these days — they provide medical and social services, act as pharmacies, meeting points, and provide peer counseling and support. Many children receive two meals a day at school, and schools are social and cultural resources for entire communities. When schools close a lot more is lost than opportunities to learn and yet the best intervention we had this spring to address H1N1 was to close schools and practice social distancing techniques to mitigate the spread of this novel flu virus. We have to begin to consider the social impacts of school closings, and work with partners to anticipate major issues that may result.

Whatever the fall brings in terms of H1N1 we can only be better off if MCH programs have been integrated into their agencies’ preparedness planning and response activities. Your colleagues down the hall in public health preparedness may need you now more than ever — have you told them why? And with over $600 million new dollars for H1N1 preparedness going to local and state health departments now might be a good time to think about how to work together on specific MCH related preparedness projects. If you have a good idea for collaboration or a model practice that you think others should know about regarding H1N1 preparedness, please let us know. AMCHP will continue to share information on H1N1 with its members and MCH leaders including passing along information we receive from partners closely monitoring H1N1 in the field.

This year we are facing a different kind of “back to school” which is an event that already triggers lots of anxiety for kids and parents. Getting ahead of a potential outbreak — the essence of preparing — is something MCH programs should do and I know many of you are doing now. AMCHP and its partners will look to learn from you and advocate for those things that would make your work more effective and more efficient. I look forward to hearing from you and working together to tackle the many complicated issues this new virus will pose for you and your states’ MCH populations.

Feature

Impact of Novel H1N1 Influenza on Children and Pregnant Women: Planning for the Fall

Prepared by the Centers for Disease Control and Prevention, Atlanta, GA

Novel H1N1 influenza is a new virus causing illness in people in this country and around the world. The Centers for Disease Control and Prevention (CDC) anticipates that there will be more cases, more hospitalizations and more deaths associated with this pandemic in the United States over the summer and into the fall and winter. Children, particularly those who are less than 5 years old and pregnant women are at higher risk for complications if they become ill with novel H1N1 influenza. This article includes messages that can be given to parents of infants and young children and pregnant women about steps they can take to protect themselves and others.
Impact of H1N1 on Young Children

Children, especially those younger than 5 years of age and those with high-risk medical conditions (such as asthma, diabetes, or a neurologic problem) are at increased risk of influenza-related complications. In a recent study, half of influenza-associated deaths in children were among those with an underlying medical condition.

Young children are less likely to have typical influenza symptoms (e.g., fever and cough) and infants may have fever, increased sleep, decreased activity, but may not have cough or other respiratory symptoms. Children may not be able to tell their caregiver about their symptoms or if they are worsening, thus delaying diagnosis, and leading to additional complications. Parents of young children should be instructed to watch closely for signs of flu-like illness so they can contact their healthcare provider immediately.

Public health authorities may recommend that schools and childcare programs close or dismiss students from classes in the fall if the severity of the novel H1N1 influenza outbreak calls for these protective measures. Children are often sensitive to disruption in routine, such as closure of schools or child care, which may cause them to worry and question why it is happening and how it can be fixed. Parental confidence and calm attitude will help children ease their worries and feel safe and secure.

Impact of novel H1N1 influenza on Pregnant Women

Consistent with past experience during influenza pandemics, pregnant women who have been infected with the novel H1N1 virus have become more seriously ill than non-pregnant women. A recent study shows that the rate of hospitalization for pregnant women is more than four times that of the general population. Adverse outcomes among pregnant women reported during the current outbreak include hospitalization, pneumonia requiring mechanical ventilation, maternal death, spontaneous abortion, and preterm birth. Prompt recognition of influenza-like illness (ILI) and prompt treatment of pregnant women with antiviral medications should be strongly encouraged. Treatment with antiviral medications should be started as soon as possible and the greatest benefits are expected if treatment is started within the first 48 hours after the onset of ILI symptoms. See CDC’s Interim Guidance for Clinicians on Identifying and Caring for Patients with Swine-origin Influenza A (H1N1) Virus Infection for more information.

What Should Parents of Infants Do?

Infants are thought to be at particularly high risk for severe illness from novel H1N1 infection and very little is known about prevention of the infection in infants. Babies who are not breastfed get sick from infections like the flu more often and more severely than babies who are breastfed. Mothers pass on antibodies to their baby during breastfeeding, which help fight infection. Steps that parents of infants can take include:

- Call your infant's health care provider if you think that your infant is ill or has had close contact with a person who has novel H1N1 influenza.
- If your baby is ill with novel H1N1 influenza, do not stop breastfeeding. Your baby needs frequent breastfeeding throughout the illness. Choose breastfeeding over anything else, including water, juice, or Pedialyte. If your baby is too sick to breastfeed, he or she can drink your milk from a cup, bottle, syringe, or eyedropper.
- Do not give aspirin (acetylsalicylic acid) or products that contain aspirin (e.g. bismuth subsalicylate – Pepto Bismol) to infants.
- Children younger than 4 years of age should not be given over-the-counter cold medications without first speaking with a health care provider.
- Make sure your infant gets an immunization for the seasonal flu and that other routine vaccinations are up to date. As soon as a vaccine for novel H1N1 flu is available, get your child (over the age of 6 months) vaccinated for novel H1N1 flu. The seasonal flu shot will only help protect your child from regular flu. The novel H1N1 flu shot will help protect them from the novel virus. There is a chance that it will take two shots, about three
Impact of H1N1 on Children and Pregnant Women

weeks apart, to get the full benefit from the novel H1N1 flu vaccine.

- Take everyday precautions such as washing hands or using alcohol-based hand gel frequently to keep your hands clean and especially after sneezing or coughing.
- Try not to cough or sneeze in your baby’s face when you are close to the infant, and cover your mouth and nose with a tissue when coughing or sneezing.
- If you are sick with novel H1N1 influenza, ask for help from family members and friends who are not ill to feed and care for your baby, if possible. If not, wear a facemask, if available and tolerable, especially while in close contact, such as while feeding the baby.
- Ensure your baby continues to breastfeed and receive breast milk. Continue breastfeeding even if you are taking medication to prevent novel H1N1 influenza. If you are ill with novel H1N1 influenza, call a health professional such as a lactation consultant for help on expressing and storing milk so someone who is not ill can give your baby your expressed milk.
- Ask your infant’s child care provider about their plans for preventing novel H1N1 infection and controlling spread of disease.
- Have an alternative care plan in case your infant’s child care program closes or care provider becomes ill.

What should Parents of School-Age Children Do?

- Keep sick children home from school for at least 24 hours after their fever is gone, except to seek medical care. (Fever should be gone without the use of a fever-reducing medicine.)
- Do not give aspirin (acetylsalicylic acid) or products that contain aspirin (e.g. bismuth subsalicylate – Pepto Bismol) to children or teenagers 18 years old or younger.
- Children younger than 4 years of age should not be given over-the-counter cold medications without first speaking with a health care provider.
- Make sure your child gets an immunization for the seasonal flu and that other routine vaccinations are up to date. As soon as a vaccine for novel H1N1 flu is available, get your child vaccinated for novel H1N1 flu. The seasonal flu shot will only help protect your child from regular flu. The novel H1N1 flu shot will help protect them from the novel virus. There is a chance that it will take two shots, one month apart, to get the full benefit from the novel H1N1 flu vaccine.
- Wash hands frequently with soap and water for 20 seconds (long enough for children to sing the “Happy Birthday” song twice).
- Set a good example for children to cough and sneeze into a tissue and throw the tissue away immediately. Wash hands after coughing or sneezing.
- Help children remember not to share cups, water bottles, utensils, or any other items that go in their mouths.
- Keep children at least six feet away from people who are sick.
- Encourage children to eat well, sleep well, and play outside.

Other Tips for Parents of Children

- Keep activities as consistent and normal as possible.
- Ask the child what they have heard about novel H1N1 flu. Answer questions openly and honestly, at a level they can understand. Be concrete and do not avoid difficult questions.
- Limit unsupervised exposure to media and adult conversations about novel H1N1 flu and make sure you are available to answer questions.
- See here for more information on talking to kids.

What Should Pregnant Women Do?

Pregnant women should be aware that they need to watch for flu symptoms (primarily fever with cough or sore throat) and contact their healthcare provider immediately if they develop these symptoms or if they have had close contact with someone who is sick with the flu. Pregnant women with novel H1N1 flu should start antiviral treatment as soon as possible,
Impact of H1N1 on Children and Pregnant Women

while those who have been exposed to the virus through close contact with someone who is ill should talk to their healthcare provider about the possible need for antiviral medication to prevent getting sick. Fever in pregnant women should be treated promptly with acetaminophen. All pregnant women should be vaccinated once a novel H1N1 vaccine becomes available. Getting vaccinated against both seasonal influenza and novel H1N1 flu, when available, is a critical action that pregnant women can take to prevent influenza illness. Since the novel H1N1 flu vaccine is likely to require two doses, about three weeks apart, health care providers, health departments, and organizations interested in the health of pregnant women should be preparing for the challenges of communicating the need for multiple vaccinations for influenza in the coming season.

In summary, pregnant women, or those who might be pregnant, should:

• Know the signs and symptoms of flu and seek care early. Influenza illness, even seasonal influenza, can be serious in a pregnant woman. Antiviral medications used to treat influenza illness work best if taken within two days of getting sick. It is also very important to treat fever quickly. Fever in a pregnant woman can cause serious problems for her baby.
• Stay home if they are sick. Pregnant women who are ill with flu-like symptoms should stay home and not go to work or in the community for at least 24 hours after fever is gone, except to seek medical care or for other necessities. (Fever should be gone without the use of a fever-reducing medicine.)
• As soon as possible, get a flu shot. Seasonal influenza vaccine is recommended for all women who are or will be pregnant during the 2009-2010 influenza season – roughly October through March of the following year. Flu shots can be given to pregnant women at any time during pregnancy.
• As soon as a vaccine for novel H1N1 flu is available, get vaccinated for novel H1N1 flu. The seasonal flu shot will only help protect you from regular flu. The novel H1N1 flu shot will help protect you from the novel virus. There is a chance that it will take two shots, about three weeks apart, to get the full benefit from the novel H1N1 flu vaccine.
• Use everyday precautions: wash your hands often and cover your coughs and sneezes with a tissue. Encourage all of your family members to use these precautions too.
• Decide now how you will ask for help from your family or neighbors if you or your children get sick with the flu. Pregnant women who get the flu sometimes get very sick. Someone will need to make sure you have the care you need, lots of rest, and fluids, and have nourishing meals. If your children get sick, you may need someone to help care for them so that you aren’t exposed to their germs.
• Stay informed. Information will likely change as we learn more about the novel H1N1 flu virus and as the pandemic progresses. For more information, talk with your health care provider and see the CDC website.

Contributors
Lisa M. Koonin MN, MPH; Georgina Peacock, MD, MPH; CAPT Kitty MacFarlane, CNM, MPH; Juliette Kendrick, MD; Katherine Shealy, MPH, IBCLC, RLC; Jennifer Williams, FNP MPH; Tiffany Colarusso, MD

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What Pregnant Women Should Know About H1N1 (formerly called swine flu) Virus

Considerations Regarding Novel H1N1 Flu Virus in Obstetric Settings
The fields of Education and Health are inextricably intertwined. Children who are healthy learn better, and schools serve as a primary vehicle for spreading public health messages to youth. Thus, in order for the public health and education communities to fully meet their goals, they must partner with one another effectively. For some members of the public health community this can be a daunting task, as they may not know how best to utilize and work with schools. This article will highlight strategies for building positive public health-education relationships.

To successfully advocate for the inclusion of health initiatives in schools, health professionals must first understand that the overwhelming concern of all educators—and the central mission of schools—is to ensure that every student demonstrates good performance to challenging academic standards. Community professionals who understand this core mission are more likely to forge productive working relationships with schools.

In addition to understanding the mission of schools, public health partners must also understand how education is structured. Generally speaking, education is the purview of state and local governments, with minimal (albeit growing) input from federal agencies. At the state level, education policymaking typically takes place through the governor, the state legislature, and the state board of education. State education agency staff, under the direction of chief state school officers, then works to implement state education policies. At the school district level, policies are made by local school boards, which rely on local superintendents and school district staff to implement their directives. The public health community must also be adept at reading the broader political climate under which schools currently operate. With passage of the 2001 No Child Left Behind Act, schools are under increased pressure to raise the performance levels of all students and eliminate academic achievement gaps. Greater educational accountability has largely taken shape in the form of sanctions (and sometimes rewards) for schools and districts depending on how many of their students are achieving to state-adopted academic standards. This means states are clearly articulating what students are expected to learn and testing students to gage how well they meet such goals.

With increased educational accountability has come a shifting of educational priorities, and in some instances this change means that public health professionals must work harder to justify health initiatives, and to construct them in such a way that educators don’t feel overwhelmed. With respect to health curricula, for example, this might mean making sure they are aligned with existing state standards. In this way students can gain health literacy skills while simultaneously strengthening skills in core subject areas on which they will be tested. Health advocates should also use partnerships with outside entities to build schools’ capacity to deliver health services and curriculums. Such arrangements allow educators to view health curricula not as an impediment to state education goals, but as a vehicle through which to meet them.

When presenting proposed health activities to education leaders, whether school administrators, local school boards, or state boards, it is critical to first garner widespread support for the proposed initiative. Allies could be teachers, parents, community members, school nurses, or health researchers. Many schools and local and state education policymaking bodies also have school health advisory councils, which are natural places to solicit support and to generally remain active. Once support is secured, health professionals should approach decision-makers with a detailed plan that provides accurate anticipated costs, legal considerations, and potential implementation problems. The proposal should also include research
evidence as to why the initiative should be adopted, and information on how it will help schools better educate children.

To learn more, visit the National Association of State Boards of Education’s website to purchase a copy of the publication, “How Schools Work and How to Work With Schools.”

Endnotes

2 ibid

Back to School Safety Tips

By Grant Baldwin, PhD, MPH
Director, Division of Unintentional Injury Prevention National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC)

Michele Huitric, MPH
Public Health Advisor, NCIPC, CDC

David Sleet, PhD
Associate Director for Science, NCIPC, CDC

The beginning of a new school year is a time of excitement and adjustment. Our children return to class rejuvenated by summer fun and ready to continue their learning. The ring of the bell on the first day of school marks many transitions. In order to prepare our children for the rigor of the classroom, we work hard to make sure they have what they need to excel. Besides the new clothing and a fresh supply of papers, pens, pencils, folders and other essential equipment, the start of a new school year is also a great time to refocus our attention on safety before, during and after school.

During August and early September, 55 million children return to classrooms across the United States. Whether travelling by car, bus, bike, or walking, once a child leaves his or her home, safety becomes a concern. Injuries are far and away the most prevalent cause of death to all school-age children and youth in our nation. Children need to use seatbelts, cross the street safely, wear helmets when biking, take steps to form respectful relationships, and know how to avoid and reduce personal conflicts without violence. These are highlights among the many lifesaving prevention steps we need to take with our kids.

Injury is also one of the most common health problems treated at schools. Approximately 10 to 25 percent of all child and adolescent injuries occur at school. Fatalities at school are rare — only about one in 400 fatal injuries to children 5 to 19 years old occur on school grounds. School-associated injuries are most likely to occur on playgrounds, particularly on climbing equipment, athletic fields and in gymnasia. Male students are injured 1.5 times more often than female students, and males are three times more likely than females to sustain injuries requiring hospitalization. Middle and high school students sustain more school injuries than elementary school students: 41 percent of students who are injured are 15 to 19 years of age, 31 percent are 11 to 14 years of age, and 28 percent are aged 5 to 10 years.

CDC’s School Health Guidelines to Prevent Unintentional Injuries and Violence were designed to help state and local education agencies and schools promote safety. These guidelines are based on an extensive review of research, theory and current practice in unintentional injury, violence and suicide prevention; health education; and public health.

For more information and resources about school safety, including the guidelines mentioned above, visit here. When parents and educators work together, safety becomes a priority that benefits the entire community and enables our children to reach their full potential. By fulfilling our commitment to safety, schools can be a safe haven for learning and healthy development.
Member to Member
What tips or tools do you have for state health agency employees interested in working with state education agency folks?

Alaska

Terri Campbell
Education Specialist, Teaching and Learning Support, Department of Education and Early Development

Sophie Wenzel
Adolescent Health Program Manager, Division of Public Health, Department of Health and Social Services

In January 2008, Alaska was fortunate to participate in a National Stakeholders’ Meeting in New Orleans, LA. Representatives from the Department of Health and Social Services (Division of Public Health, Sections of Epidemiology and Women’s Children’s and Family Health), The Department of Education and Early Development (Teaching & Learning Support) and the Anchorage School District were in attendance. The event assisted in clarifying and communicating the health-related responsibilities within each agency; building relationships between the two departments; and solidifying solid action plans to improve on-going communication and, ultimately, services to Alaskans.

Since then, the collaboration has grown — the Division of Public Health is now playing a critical role in helping the Department of Education and Early Development design the student health and safety component of the State Education Plan. This collaboration was able to grow and include our Sections of Chronic Diseases and Behavioral Health because members of the two departments wanted to work jointly for the well-being of Alaskan students. In addition, we are co-planning an Institute for School Health and Wellness.

The cross department relationship has been very successful for several reasons. The departments share the common goal of wanting to promote student health and safety. The bulk of our work together is focused around the fact that healthy and safe children learn better. We follow a coordinated school health model, which helps us keep our focus.

We would recommend that state health agencies interested in working with state education agencies identify and contact their counterparts, and begin a dialogue. They can start by finding common goals, and then look for ways to work together towards achieving these goals.

Michigan

Interdepartmental Collaboration around Coordinated School Health Programs

Kyle Guerrant
Supervisor, Coordinated School Health and Safety Programs, Michigan Department of Education

Karen Krabil-Yoder
Coordinated School Health Consultant, Michigan Department of Community Health

Carrie Tarry
Adolescent & School Health Manager, Michigan Department of Community Health

Mary Teachout
Coordinated School Health Education Consultant, Michigan Department of Education

The Michigan Departments of Health and Education have built an effective partnership around efforts to advance Coordinated School Health Programs across Michigan. Coordinated school health is centered on approaching school health without turf or silos within school districts and buildings. Our departments
strive to lead by example. We approach our work as a joint effort. The foundation to making this joint effort successful is communication. Through regular communication we keep each other informed and involved. Interagency School Health Team meetings give us the opportunity to not only share information but also network and partner on various projects. Such partnering greatly increases the scope of our projects and allows us to leverage limited resources to reach more students and families. In addition to regularly scheduled meetings, we communicate daily through email to share updates, gather input, or pass along information. Communication with external partners is also a shared effort with presentations at external meetings or conferences led by staff from both departments. This focus on communication and partnership enables movement away from initiatives being led by one department toward shared leadership. While funding for a project may pass through one department, we don’t believe the other department should be less involved or less responsible for administration of our joint ventures. Those of us working on school health highly value the relationships we have built and are determined to use these positive relationships to further the goal that we all share: healthy, successful students.

Real Life Stories

Back to School: Traveling Different Roads

By Grace Williams
Senior Program Manager, Children and Youth with Special Health Care Needs, AMCHP

Back to school means different things to different parents. As a mother of two older typical children and 17-year-old twin daughters with special health care needs, I have experienced the vast differences between these two experiences. I would like to reflect upon the back to school matters related to my daughters with autism, who function at a very low level, and are nonverbal with limited communication, complex behaviors and ever changing physical and neurological health care issues.

The back to school preparation for the upcoming school year begins at the annual meeting of the Individualized Education Program (IEP), held between January to April. The goals, objectives and related services are written into this legally binding document to be implemented in the next school year and signed by the parents, the school and the county school system. My daughters are also approved for Extended School Year services. They attend school during the month of July and are out for a few weeks only in June and August.

My daughters have always been in different classrooms except for when they were in the first grade in the neighborhood school. They have been attending private, special education schools at out-of-county placement programs because their IEP could not be implemented in our neighborhood or county schools due to their complex behaviors and needs. They have had the same teachers for two or three years at a time and it has been very helpful because of the consistency and they are familiar with my daughters. The speech, occupational and mental health therapists and one-on-one aides often change from year to year.

Both of my girls have been attending schools in two different counties, one to the north and the other to the south of our house, for the last two years. Transportation is a related mandatory service that has been one of our major challenges related to back to school matters. One of my twin daughters rides a total of three hours and her sister rides for two hours on a daily basis. The bus drivers and aides are selected in a bidding process according to their seniority and labor unions and we do not always get back the same bus drivers and aides. We have to depend on the luck of the draw to find out whether these individuals will be
Real Life Stories cont.

Back to School: Traveling Different Roads

able to understand the behaviors and special needs of my daughters and deliver this service in an appropriate manner. I have to use all my advocacy skills and personal connections to educate the transportation department, bus lot and the bus staff to make these bus rides work effectively.

Our typical back to school ritual does consist of buying a new back pack, a new lunch box and a few school supplies and a special daily communication notebook for daily updates, for each daughter. However, we do not shop for back to school clothes and shoes because both my girls have sensory issues and there’s no guarantee that these new items will work. Preparing them to return to school after a few weeks off in August and returning to a routine, which includes getting dressed for school, eating breakfast and taking medicine, is a real challenge even with another trained caregiver to help me in the morning.

In spite of these challenges, back-to-school time brings back structure, consistency and normalcy to our family and I can hardly wait for my twin daughters with autism to go back to school!

Sucess Stories

The Association of State & Territorial Dental Directors’ Best Practices Project: Integrating Oral Health into Coordinated School Health

By ASTDD Best Practices Committee

The steering committee and expert workgroup directing the Best Practices Project administered by the Association of State & Territorial Dental Directors (ASTDD)

The ASTDD Best Practices Project supports state, territorial and community oral health programs to develop best practices that promote optimal oral health for all Americans throughout their lifespan. Programs across the nation participate in this project by sharing their success stories and learning from successes in the field. The ASTDD Best Practices and School & Adolescent Oral Health Committees are currently collecting success stories to help fully integrate oral health into coordinated school health efforts. These stories offer intervention strategies, implementation methods, lessons learned and field contacts that programs can use to promote partnerships between public health and school programs, and the public and private sectors, to assure optimal oral health for all children.

The Tennessee School Based Dental Prevention Program is one of the success stories demonstrating strong partnerships with the state oral health program, Medicaid program, school systems and private sector dentistry:

• Since 2001, the Tennessee Department of Health, Oral Health Services, has administered the Tennessee School Based Dental Prevention Program (SBDPP) for high-risk children. SBDPP has a multi-million dollar annual budget funded by TennCare (the state’s Medicaid program). Schools with at least 50 percent of their students on a free or reduced lunch program qualify for the program; all students (grades K-8) in qualified schools are eligible for SBDPP services. The program includes three service components: screenings and referral for care, oral health education and outreach for TennCare, and dental examinations and dental sealant applications.

• SBDPP is implemented throughout the state (in six metropolitan and seven rural regions) and utilizes 100 dentists/dental hygienists/dental assistants to deliver dental preventive services. A partnership with TENNderCare Outreach provides follow-up care to Medicaid children who need immediate professional dental care. School nurses and health coordinators follow up with families for children with unmet dental care needs. Restorative
treatment for referred children is accomplished through partnerships with local health departments and private practitioners.

- SBDPP services are targeted to more than 960 schools using portable equipment. Since 2001, approximately one million children have been served; the children received oral health education, dental screenings, examinations, preventive care (1.8 million teeth sealed), and care coordination for restorative services. More than one-half of Tennessee’s children ages 5 to 17 are cavity free.

A new ASTDD Best Practice Approach Report, Improving Children’s Oral Health through Coordinated School Health Programs, will feature more success stories (to be released in January 2010 and available online).

For ASTDD tools to assist integration of oral health into the coordinated school health efforts, visit here.

Indiana Takes a Stand for Adolescent Health

By Stephanie G. Woodcox, MPH, CHES
Adolescent Health Coordinator, Indiana State Department of Health

The Indiana Coalition to Improve Adolescent Health (ICIAH) published the state’s first adolescent health plan, Picturing a Healthier Future: A State Strategic Plan for Indiana’s Adolescents. Indiana is a leader in adolescent health as only a few states have developed such a plan. Picturing a Healthier Future details 10 priority health issues (classified into one of two categories: access to care or prevention) that affect the well-being of Hoosier adolescents (ages 10-24). The framework for the plan is the 21 Critical Health Objectives for Adolescents and Young Adults (from Healthy People 2010) and the concept of positive youth development. The ICIAH recognizes that all young people must acquire certain strengths, skills and competencies — academic, emotional, social and physical — in order to achieve a happy, healthy and productive adulthood. Strong communities and relationships provide young people with the positive resources and support they need for healthy development. A 17-year-old female ICIAH focus group participant indicated the need for such relationships stating: “If you are talking about being healthy in the future, you are going to be making your own decisions and now is the time to kind of figure out how to do that with somebody to fall back on in case something goes wrong.”

A unique feature of the plan is the introduction to three adolescents — Michelle, Nathan and Carmen — all of whom face multiple challenges and make decisions which affect their health. Their stories are woven throughout, reinforcing and even reminding us of the complexity and pressures experienced during this time of life.

Adolescents comprise a significant segment of Indiana’s population that needs an informed and healthy roadmap for a successful future. It is essential to focus time and resources on adolescents. A 19-year-old male focus group member’s comment emphasized the need for tailored interventions: “We [adolescents] are different people, we have different thoughts, and we are unique in every aspect of everything.”

The coalition’s mission is to promote optimal health and well-being for all Hoosier adolescents with an emphasis on prevention and access to quality, comprehensive health care. To learn more about the coalition and view a copy of the adolescent health plan, visit here.
Unintentional injury was the leading cause of death for Kansas’ adolescents ages 15 to 19 in 2007 with motor vehicle crashes (MVC) causing the majority of deaths. The adolescent death rate due to motor vehicle crashes without using a seatbelt is 42 percent higher for Kansas (13.9 percent) than for the United States (9.8 percent); however, there have been recent decreasing trends. The Kansas 2007 Youth Risk Behavior Survey data showed that 15 percent of high school students never or rarely wore a seatbelt. Kansas Department of Transportation (KDOT) data for 2007 shows that teen drivers account for six percent of all Kansas registered drivers but 18 percent of all crashes. Kansas’ higher MVC rate might be attributable to teen drivers’ belief they will not be involved in a MVC and therefore do not need to buckle up. In the rural areas in Kansas, there is a higher fatality rate than in urban areas often times because the MVC occurs far from a high functioning trauma facility.

The Kansas Driving Force Campaign was created to decrease death and injury on Kansas roadways. The first step in the campaign was to raise awareness about the number of people being killed and injured on Kansas roadways. KDOT Secretary Deb Miller, Kansas Highway Patrol (KHP) Col. William Seck, KDHE Secretary Roderick Bremby hosted community forums across the state to start a discussion with citizens, city/county officials, and legislators about their perspective on traffic crashes and the overall impact. The consensus was that this multi-faceted problem would require a strategic plan.

The Kansas Department of Transportation established the Kansas Traffic Safety Resource Office (KTSRO) to assist in reducing drinking drivers, promote prevention of underage alcohol consumption and enhance current safe driving activities. MCH collaborates with KTSRO, KHP, local law enforcement, the Kansas Drivers Safety Education Association, American Automobile Association, Kansas Safe Kids, Students Against Destructive Decisions (SADD) and Family Health Partners to provide traffic safety education and to enhance laws protecting Kansas citizens from MVC injuries. This collaboration promoted legislation that resulted in a primary seatbelt law for those under the age of 18 and an upgraded graduated driver’s license law which included restrictions on wireless devices.

The Maternal and Child Health Program and the Bureau of Health Promotion in Kansas work tirelessly to achieve our mission to protect the health and environment of all Kansans by promoting responsible choices.
By Brent Ewig, MHS  
*Director of Public Policy & Government Affairs, AMCHP*

It is August in Washington and that means three things for sure — it’s hot, Congress is on recess, and kids everywhere have begun counting down the last days of summer vacation. As hot as it is here, it’s clear the real heat is in many of the town hall meetings across the country where members of Congress are hearing from constituents about their feelings on health reform. While it is too early to know the final chapter in this health reform saga, it’s obvious these meetings are having a large impact on the public’s appetite for comprehensive health reform — which only makes final passage that much more uncertain.

Meanwhile at AMCHP, we see a fragmented health system that costs too much, leaves too many out, and is unsustainable based on its current trajectory. As we continuously point out, the fact that the nation ranks 29th in the industrialized world in infant mortality rates, 4 of 10 low income American women are uninsured (unless they become pregnant or disabled), and only about half of all children with special health care needs are in a medical home, demonstrates that we have plenty of room for improvement.

Therefore we continue to advocate for health reform that covers everyone, provides a benefit package adequate to meet the needs of children, pregnant women, adolescents, and children with special health care needs, and invests in prevention and public health programs. The good news is that four of the five committees that have already passed health reform legislation in Congress have largely met these principles.

It’s important to acknowledge that these bills are not perfect — but no legislation this large and important probably ever could be. I do want to highlight again...
that both the House and Senate HELP Committee bill include provisions to invest over a billion dollars in medical home demonstrations and to create a mandatory $10 billion Public Health Investment Fund. It’s hard to underestimate how important this would be in shaping the future public health funding landscape and delivering resources to support state and local MCH programs. For summaries of the legislation and many other health reform resources, be sure to visit AMCHP’s Health Reform Hub here.

Another provision in health reform legislation that fits nicely with the back to school theme is the creation of a school-based health center program. The legislation also requires plans participating in the exchange to cover all CDC-recommended immunizations and other preventive services with no cost-sharing, which would go a long way to fulfilling school-entry immunization requirements. The next few weeks will be critical in determining whether health reform legislation will have enough support to finally pass Congress and be signed into law. AMCHP will continue to be your voice in Washington and a resource to you at home, so stay tuned for further updates and analysis on what this means for the MCH populations you serve.

Finally, although directly related to health reform, as kids go back to school there is heightened attention to our national preparedness for H1N1. The recent federal guidance on school closings is essential and available here.

As kids go back to school, we will continue to study health reform legislation and what it means for MCH, so its time to hit the books!

Who’s New

NFPRHA President & CEO Claire Coleman

Coleman most recently served as President & CEO of Planned Parenthood Mid-Hudson Valley in New York.

“My highest priority as NFPRHA's leader will be to work closely with our members to reflect their concerns and experiences with federal policymakers and health care community allies,” said Coleman.

Before joining Planned Parenthood Mid-Hudson Valley in March 2006, Coleman spent more than a dozen years on and around Capitol Hill. Coleman spent six years on the staff of U.S. Representative Nita Lowey (D-NY), serving as Chief of Staff from 2001-05. Coleman served as staff director of the Democratic Pro-Choice Task Force in the U.S. House of Representatives and staffed the Congresswoman on the powerful Appropriations Subcommittee on Labor, Health and Human Services and Education, which sets funding for Title X and sexuality education programs. Before joining the Lowey staff in 1999, Coleman was a federal lobbyist for Planned Parenthood Federation of America. She was also a staffer for then-Rep. Chuck Schumer (D-NY) and former Reps. Jim Jontz (D-IN) and George Hochbrueckner (D-NY).

“It is essential that the real-life experiences of service providers be understood and addressed as policymakers work through changes in health care delivery. I know what it’s like – working to expand convenient access to quality care while carefully adhering to guidelines, undergoing audits, meeting payroll, and handling IT and infrastructure challenges. I also know how members of Congress weigh options and make decisions,” she continued.

“It's exciting to bring those experiences together, and to do so with a President and administration that will give us a fair hearing.”
**Get Involved**

**AMCHP Request for Applications to Participate in a Preconception Health for Adolescents Action Learning Collaborative**

AMCHP, with the support of the Centers for Disease and Control and Prevention’s Division of Adolescent and School Health (DASH) and Division of Reproductive Health (DRH), is interested in working with a small cadre of innovative states who would like to explore the idea of integrating preconception health recommendations into their adolescent health efforts. AMCHP will provide financial and technical support for up to five state teams, composed of five team members, to strategize ways to implement selected preconception health recommendations into their health and education efforts and document successes, barriers and lessons learned. The Request for Applications (RFA) deadline is no later than 5 p.m. (EDT) on Friday, September 4. To download the RFA and the Conceptual Framework for this project, visit [here](#). For additional information, please contact Sharron Corle.

**Webcast on the Adverse Childhood Experience Study**

NACCHO and CityMatCH will host a webcast on “Childhood Trauma and Health and Behavioral Outcomes: The Adverse Childhood Experience Study” on Thursday, August 20 at 3 p.m. (EDT). This webcast will educate participants about a scientific research study which analyzes the link between different categories of childhood trauma and the health and behavioral outcomes that may result later in life. To register, visit [here](#).

**Submit Your Best Practice Today!**

AMCHP is seeking submissions of best practices in maternal and child health from around the country. Whether it’s an effective campaign to promote breastfeeding, an outstanding nurse-family partnership, or a proven early intervention program for young children, get the word out about your best practice. AMCHP defines “best practices” as a continuum of practices, programs and policies ranging from emerging to promising to evidence-based. A best practice could focus on the health of women, adolescents, young children, families, or children with special health care needs. Best practice focus areas include preconception care, mental health, data and assessment, financing, program and system integration, workforce development, injury prevention, emergency preparedness, family involvement, or other public health issues. Best Practice submissions are accepted on a rolling basis.

1) Click [here](#) to download a PDF of the submission form.
2) When you are ready to submit, click [here](#) to start the survey.

For more information on submitting best practices, please contact Darlisha Williams or call (202) 775-0436.
Data and Trends

Reference: Centers for Disease Control and Prevention, Health-Risk Behaviors and Academic Achievement Fact Sheet, 2003 Youth Risk Behavior Surveillance System.

What is the relationship between health-risk behaviors and academic achievement?
Data presented below, from the 2003 National Youth Risk Behavior Survey (YRBS), show a negative association between health-risk behaviors and academic achievement among high school students after controlling for sex, race/ethnicity, and grade level. This means that students with higher grades are less likely to engage in health-risk behaviors than their classmates with lower grades, and students who do not engage in health-risk behaviors receive higher grades than their classmates who do engage in health-risk behaviors. These associations do not prove causation. Further research is needed to determine whether low grades lead to health-risk behaviors, health-risk behaviors lead to low grades, or some other factors lead to both of these problems.

Students with higher grades are significantly less likely to have engaged in behaviors such as:
+ Carried a weapon (For example, a gun, knife, or club on at least 1 day during the 30 days before the survey).
+ Current cigarette use (Smoked cigarettes on at least 1 day during the 30 days before the survey).
+ Current alcohol use (Drank at least one drink of alcohol on at least 1 day during the 30 days before the survey).
+ Ever had sexual intercourse.
+ Did not eat for 24 or more hours to lose weight or to keep from gaining weight (During the 30 days before the survey).
+ Watched television 3 or more hours per day (On an average school day).

Figure 1. Percentage of U.S. high school students who carried a weapon, currently smoked cigarettes, currently drank alcohol, ever had sexual intercourse, did not eat for 24 or more hours to lose weight or keep from gaining weight, and watched television 3 or more hours per day, by types of grades earned (mostly A’s, B’s, C’s, or D/F’s) — National YRBS, 2003.

*This means that 11% of students with mostly A’s carried a weapon and 33% of students with mostly D’s or F’s carried a weapon.

The national YRBS monitors priority health-risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the U.S. It is conducted every two years during the spring and provides data representative of 9th through 12th grade students in public and private schools throughout the U.S. In 2003, students completing the YRBS were asked, “During the past 12 months, how would you describe your grades in school?” and given 7 response options (Mostly A’s, Mostly B’s, Mostly C’s, Mostly D’s, Mostly F’s, None of these grades, Not sure). In 2003, 27% of students received mostly A’s, 38% received mostly B’s, 23% received mostly C’s, 6% received mostly D’s or F’s, and 5% reported receiving none of these grades or not sure.
Resources

American Academy of Pediatrics, Council on School Health: School Health Resources

Center for Health and Health Care in Schools

Centers for Disease Control and Prevention, Division on Adolescent and School Health (DASH)

Adolescent and School Health Tools

- Food-Safe Schools Action Guide (FSSAG)
- Health Education Curriculum Analysis Tool (HECAT)
- Improving the Health of Adolescents and Young Adults: A Guide for States and Communities
- Making It Happen!
- Physical Education Curriculum Analysis Tool (PECAT)
- School Health Index (SHI): A Self-Assessment and Planning Guide

Guidelines and Strategies (CDC)

For the 6 Critical Health Behaviors and more specific health topics at CDC-DASH, also see here.

Data Resources

- Youth Risk Behavior Survey
- School Health Profiles
- School Health Policies and Program Study

Children’s Safety Network

- Bullying Prevention- Bullying in schools: A COPS publication
- General/Multiple Causes- Infant mortality and pregnancy loss: Knowledge Path - An MCH Library guide
- Pedestrian Safety- International scan summary report on pedestrian and bicyclist safety and mobility: A FHWA publication
- Traffic Injuries- Results of the 2007 National Roadside Survey of Alcohol and Drug Use by Drivers: A NHTSA report
- Funding- Safe Schools/Healthy Students Initiative awards

Policy, Regulation & Legislation

  - Laying a solid foundation: Strategies for effective program replication: A P/PV report
  - Strengthening what works: Critical provisions for prevention and public health in health reform legislation. – A Prevention Institute and Policy Link memo

National Assembly on School-based Health Care

Resources to enable school-based health centers to deliver affordable, high-quality services and play an active role in public policy. Tool kits, health education materials, behavioral health and clinical resources, virtual tour of two school health centers.

National School Boards Association (NSBA), School Health Programs

Resources to help policymakers and educators make informed decisions about health issues including “101” information packets such as Asthma in Schools 101 and Tobacco Use Prevention 101, a health newsfeed, NSBA health-related publications, and the School Health Resource Database, which contains abstracts of more than 3,000 articles, training tools, and policy samples.
Resources cont.

Federal Web Sites

- Family Guide to Keeping Youth Mentally Healthy and Drug Free
- Family and Youth Services Bureau, Administration for Children and Families
- 15+ Make Time to Listen...Take Time to Talk
- Find Youth Info
- Maternal and Child Health Bureau, HRSA
- National Institute of Child Health and Human Development
- Office of Juvenile Justice and Delinquency Prevention, Department of Justice
- Office of Safe and Drug-Free Schools, Department of Education
- EPA Healthy School Environments

Non-Federal Web Sites

- American Medical Association's Adolescent Health On-Line
- American Academy of Pediatric Dentistry
- America's Promise: The Alliance for Youth
- Association of Maternal and Child Health Programs
- Association for Supervision and Curriculum Development
- Child Trends
- Collaborative for Academic, Social, and Emotional Learning
- Council of Chief State School Officers
- Data Resource Center for Child and Adolescent Health

- Do Something. Young People Changing their World
- Institute for Youth Development
- National Adolescent Health Information Center
- National 4-H Council / Building Partnerships for Youth
- National Coordinating Committee on School Health and Safety
- National Dropout Prevention Center/Network
- National Longitudinal Study of Adolescent Health (Add Health)
- National Maternal and Child Health Center for Child Death Review
- National Mentoring Partnership
- Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health
- Society for Adolescent Medicine
- State Adolescent Health Resource Center
- School Health Resource Center
- Society of State Directors of Health, Physical Education, and Recreation
- Taking a Closer Look: A Guide to Online Resources on Family Involvement
- World Health Organization's Global School Health Initiative

Other Federal Agency Publications

- Healthy School Environments Assessment Tool (HealthySEAT). EPA has developed a software tool to help school districts evaluate and manage their school facilities for key environmental, safety and health issues. HealthySEAT can be customized and used by district-level
staff to conduct voluntary self-assessments of school facilities and to track and manage information on environmental conditions school by school.


- **Schools Chemical Cleanout Campaign (SC3).** This EPA campaign aims to ensure that all schools are free from hazards associated with mismanaged chemicals. SC3 gives K-12 schools, parents, and local organizations the information and tools to create partnerships for chemical management programs that meets the unique needs of their schools.

- **Understanding Youth Development: Promoting Positive Pathways of Growth.** This document provides a review of adolescent development literature. In addition, a conceptual framework for understanding youth development is outlined.

- **Reconnecting Youth and Community: A Youth Development Approach.** This resource focuses on how communities can shift from a problem-focused approach to serving youth to a community-youth involvement model that captures the talents, abilities, and worth of youth.

**Non-Federal Publications**

- **Safe and Healthy School Environments.** This book explores the school environment using the methods and perspectives of environmental health science. Though environmental health has long been understood to be an important factor in workplaces, homes, and communities, this is the first book to address the same basic concerns in schools.

- **Building Partnerships for Youth Program Assessment Tool.** This assessment tool, developed by

the National 4-H Council and the University of Arizona, was created to help users assess their program's ability to address the 21 elements of youth development, and then make informed decisions regarding future program directions.

- **Community Collaboration Tool.** This tool, developed by the National 4-H Council and the University of Arizona, is details the steps necessary to customize it for use in your state or community.

- **Community Programs to Promote Youth Development.** This report, published by the National Academies, focuses on community-based programs for youth and examines what is known about their design, implementation, and evaluation.

- **Engaging Schools: Fostering High School Students’ Motivation to Learn.** This National Academies document provides recommendations for engaging students and improving academic achievement, as well as promoting positive health behaviors.

- **Enhancing Student Connectedness to Schools.** Developed by the Center for School Mental Health Analysis and Action at the University of Maryland, this document gives an overview of what school connectedness and school climate are, and discusses potential strategies for creating a positive school climate and increasing student connectedness to school.

- **Family Environment and Adolescent Well-Being: Exposure to Positive and Negative Family Influences.** This brief, developed by Child Trends and the National Adolescent Health Information Center at the University of California, San Francisco, provides data on the influences of parents and families on their adolescents.

- **Guide to Federal Resources for Youth Development.** Published by America’s Promise, a coalition of communities, organizations, businesses, and individuals supporting youth development
programs, this guide provides information on federal funds available to support youth development programs.

- **Health Profile of Adolescent and Young Adult Males: 2005 Brief.** This brief, published by the National Adolescent Health Information Center, highlights priority health issues for adolescent and young adult males and identifies key gender and racial/ethnic disparities. Health topics include violence, substance use, mental health, reproductive health, and healthcare access and utilization.

- **Improving Public Health Through Youth Development.** This supplement of the Journal of Public Health Management and Practice (November 2006) presents and discusses youth development approaches in the context of public health programs.

- **Quality of Care for Children and Adolescents: A Chartbook.** Published by the Commonwealth Fund, this chartbook takes a closer look at the health care provided to children and adolescents in the United States. Forty charts and analyses describe the current state of pediatric health care.

- **Parents Matter!** is an evidence-based prevention program for parents of pre-teens. This community-level family prevention program is designed to enhance protective parenting practices and promote parent-child discussions about sexuality and sexual risk reduction.

- **Reducing the Risk: Connections that Make a Difference in the Lives of Youth.** This monograph, based on the first analysis of the National Longitudinal Study on Adolescent Health data, outlines how environment and setting influence how adolescents feel about themselves and the decisions they make about behaviors that can affect their health and future.

- **School Connectedness: Improving Students’ Lives.** This report, published by the Johns Hopkins School of Public Health, discusses the value of school connectedness as a stabilizing force for military children and other children who relocate frequently.

- **System Capacity for Adolescent Health: Public Health Improvement Tool.** Is a set of assessment and discussion tools designed to assist state maternal and child health program in assessing six areas of capacity to support effective state adolescent health programs.

- **Young People’s Health Care: A National Imperative.** This issue paper, published by the National Institute for Health Care Management Foundation, highlights the unique health issues faced by young people, as well as the different socio-economic, cultural, and demographic factors influencing their health status, access to care, and utilization of services.

August is also National Immunization Awareness Month, see below for more resources:

- **CDC Home Page for Vaccines & Immunizations.** This website includes information, schedules, guidelines and recommendations for vaccines for all age groups.

- **National Immunization Awareness Month.** This is the homepage for National Immunization Awareness Month and provides a quick overview of the importance of immunizations.

- **Pre-teen and Adolescent Vaccines.** This site provides specific information about the needs of pre-teens and adolescents related to vaccines (including those against meningococcal disease, pertussis, and HPV).

- **Give It a Shot! A Toolkit for Nurses and Other Immunization Champions Working with Secondary Schools.** This toolkit from the American School Health Association provides several resources to help those advocating for adolescent vaccines.
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SAVE THE DATE!

AMCHP’S 2010 ANNUAL CONFERENCE - “Moving Ahead Together: Celebrating the Legacy, Shaping the Future of MCH”

March 6-10, 2010
Gaylord National Convention Center
National Harbor, MD

The 2010 AMCHP Conference will bring together leaders in maternal and child health, public health practitioners and family advocates. Join us for sessions led by researchers, federal officials, advocates, families, healthcare providers and directors of state programs.

Click here to view the slides, transcripts and videos from the 2009 conference. NOTE: You may need to download RealPlayer and/or PowerPoint 2007 Viewer to view the presentations.

AMCHP Staff CONT.

Adriana Houk, Associate Director, Organizational Performance & Membership

Nora Lam, Executive Assistant

Henry Maingi, MA, Senior Program Manager, Data & Assessment

Lissa Pressfield, MHS, Program Manager, Adolescent Health

Lauren Raskin Ramos, MPH, Director of Programs

Vanessa A. White, MPH, Associate Director, Women’s & Infant Health

Darlisha Williams, MPH, Program Manager, Best Practices

Grace Williams, Senior Program Manager, Children With Special Health Care Needs