AGENDA

• Welcome
• Bright Futures National Center: Key Resources
• NPM 11: Medical Home
  • National Resource Center for Patient/Family-Centered Medical Home
    • Overview & Key Resources
  • New Mexico’s Story
  • Q & A
• NPM 12: Transition
  • Got Transition: Overview & Key Resources
  • Virginia’s Story
  • Q & A
• AMCHP Resources
HOUSE KEEPING

✓ This webinar will be recorded and posted

✓ All participants will be muted

✓ All participants will have opportunities to ask questions throughout the webinar
NOTES ON LOGISTICS

To interact with one another or share reactions as you view the presentation, please use the “chat” box.

To ask one of our speakers a question, please use the “Q&A” box.

For technical difficulties, please email Anna: acorona@amchp.org.
DISCLOSURE STATEMENTS

Anna Corona MPH, CPH

• I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Jamie Jones, MPH

• I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Melissa Mason, MD, FAAP

• I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Susan Chacon, MSW, LCSW

• I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
DISCLOSURE STATEMENTS

Patience White, MD, MA, FAAP, FACP

• I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Peggy McManus, MHS

• I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Marcus Allen, MPH

• I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Kathy Janies

• I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
WHAT IS BRIGHT FUTURES?

The mission of Bright Futures is to promote and improve the health, education, and well-being of infants, children, adolescents, families, and communities.

- Bright Futures is the health promotion/disease prevention part of the medical home
- At the heart of the medical home is the relationship between the clinician and the family or youth
The Bright Futures National Center is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $5,000,000 with 10 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

The National Resource Center for Patient/Family-Centered Medical Home is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $4,100,000 with no funding from nongovernmental sources. The information or content are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.
WHO CAN USE BRIGHT FUTURES?

- States and Communities
- Families
- Health Care Professionals
- Medical Home and Bright Futures
The Periodicity Schedule tells you what to do in well-child visits, while the Bright Futures Guidelines tell you how to do it—and how to do it well.
USING BRIGHT FUTURES AND ITS RESOURCES

Implementation Tip Sheets – Updated in 2020!

brightfutures.aap.org/ → “Clinical Practice”
States & Communities

Learn how the Bright Futures materials and resources are being used across the country by selecting a state with an asterisk (*) beside the state’s name. See UPDATED Hawaii, Kansas, and New Mexico!

For some states, we offer audio recordings along with brief implementation stories gathered through interviews. For other states, implementation examples were gathered through online research. We’re actively gathering implementation stories from states without an *. For all states, you can find state AAP chapter contact information and a link to locate state Maternal and Child Health contacts.

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

brightfutures.aap.org/ → “States & Communities”
NPM 11: Medical Home

• National Resource Center for Patient/Family-Centered Medical Home
  – Who we are
  – What we do

Link: medicalhomeinfo.aap.org
NPM 11: MEDICAL HOME

• Key NRC-PFCMH Offerings
  – Pediatric Care Coordination Curriculum, 2nd Edition
  – Social determinants of health implementation tools
  – Educational webinar series
  – NPM 11 education
  – Advancing Systems of Services for CYSHCN Technical Assistance Network
NPM 11: MEDICAL HOME

• Pediatric Care Coordination Curriculum, 2nd Edition
NPM 11: MEDICAL HOME

- Social Determinants of Health Implementation Tools
NPM 11: MEDICAL HOME

• Educational Webinar Series

Webinars and Podcasts

This page features recordings, PowerPoint presentations, and audience questions from current and previous webinars developed by the National Resource Center for Patient/Family-Centered Medical Home and the former National Center for Medical Home Implementation.

- Making Connections: The Critical Role of Family-Centered Care in Addressing Social Determinants of Health for Children and Youth with Special Health Care Needs (CYSHCN)
- Gaining Ground: The Primary Care Pediatrician’s Role in Public Health Systems of Care for Children and Youth with Special Health Care Needs
- Multidisciplinary Care Coordination Training for CMC: The AZ Experience
- Where the Rubber Meets the Road—Conversations about Innovative and Promising Practices in Pediatric Medical Home Implementation
- Measure What Matters: Advancing Multidisciplinary Care Coordination in Primary and Subspecialty Care Settings
- Rolling Up Our Sleeves: How to Plan and Implement QI Activities Focused on Family Engagement
- Supporting Title V and Medicaid Collaboration in Pediatric Medical Home Implementation
- 2016: Thinking Outside the Box: How to Advance Health Equity and Care Quality in the Pediatric Medical Home
- 2015: Pediatric Care Coordination: Beyond Policy, Practice, and Implementation
- 2014: Fostering Partnership and Teamwork in the Pediatric Medical Home

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
dedicated to the health of all children®
NPM 11: MEDICAL HOME

- NPM 11 Education
NPM 11: MEDICAL HOME

Advancing Systems of Services for CYSHCN Technical Assistance Network

Network Information

The AAP is joined by Catalyst Center (Boston University) and Got Transition (The National Alliance to Advance Adolescent Health) to form a national network of technical assistance resource centers, Advancing Systems of Services for CYSHCN Network (Network). Together—in collaboration with the MCHB—the organizations will develop shared goals and activities to address three main areas to improve outcomes for CYSHCN and their families—health care financing, transitions, and patient/family-centered medical home.

- The goal of the network is to engage 90 percent or more of state Maternal and Child Health Title V / CYSHCN programs in technical assistance, training, education, and partnership building activities designed to demonstrate improvement in one or more of the following areas:
  - Coordinated, ongoing comprehensive care within a medical home for CYSHCN
  - Youth with special health care needs receive the services necessary to make transitions to adult health care
  - Adequate private and/or public insurance to pay for needed services for families of CYSHCN

Contact us: cyshcnetwork@aap.org

Network Year 1 Summary

In response to the COVID-19 pandemic, the Network is bringing together CYSHCN program directors to discuss various topics related to COVID-19 response for CYSHCN and their families. Resources and notes from these discussions are listed below:

- Behavioral Health and Wellbeing
- Emergency Preparedness
- Racial Equity
- Returning to Care
- School Reopening
- Title V/Medicaid Partnership

Resources
NPM 11: MEDICAL HOME

- Contact Us

Contact Us

General Inquiries:
medical_home@aaap.org

National Resource Center for Patient/Family-Centered Medical Home
c/o American Academy of Pediatrics
345 Park Blvd
Itasca, IL 60143
Phone: 630/626-6605
Toll free: 888/433-9016 ext 6605

The National Resource Center for Patient/Family-Centered Medical Home (NRC-PFCMH) offers a variety of technical assistance, including the following:

- Subscription to NRC-PFCMH listserv
- Definition and resources related to pediatric medical home model
- Assistance with beginning the medical home transformation process
- Information about upcoming training and educational opportunities
- Access to practice-based tools and resources for medical home implementation
- Information on benefits of and/or evidence for the medical home model
- Assistance in connecting with national pediatric medical home implementation experts
- Information about state-specific pediatric medical home information
NPM 11: MEDICAL HOME

New Mexico’s Collaboration Story
NM Pediatric Society and Title V
NPM 11: Medical Home

Collaboration Projects

• Early Childhood Comprehensive Systems Committee
• Medical Home Portal
• Action Learning Collaborative – social determinants of health screening
NPM 11: MEDICAL HOME
NPM 11: MEDICAL HOME

Spina Bifida

Overview

Spina bifida refers to a group of conditions involving improper development of the spine during embryonic development, leading to protrusion of the spine and/or its coverings, the meninges, from the vertebral canal. This defect occurs approximately at the end of the first month of gestation. “Neural tube defect” (NTD) is used somewhat interchangeably with “spina bifida” but also includes anencephaly, which is when the brain fails to develop from the neural tube, and encephalocele, which is when the brain and the meninges protrude from the developing skull. Defects above the level of the spinal cord will not be discussed further.

The entire human nervous system develops from a plate of specialized cells that form along the back of the embryo. The edges of this elongated plate curl toward each other and join in as many as 4 places to form a tube. It then proceeds caudally (toward the rear) to where the end of the spinal cord forms and cephalad (toward the head) where further specialization leads to brain development. Spina bifida results from problems during this complex process in which genetic and environmental factors are involved. (Kaufmann, 2004; J. J. Sullan, 2003)

Defects can be classified as open (spina bifida) or closed (spina bifida occulta, diastematomyelia).

Types of spina bifida include:

- Meningocele: This is the most common symptomatic and severe form of spina bifida. The spinal cord and the meninges protrude through the posterior openings in the vertebrae.
- Meningocoele: The meninges protrude through the posterior openings in the vertebrae, but the spinal cord is not involved, although spinal nerves may be.
- Spina bifida occulta: There is an opening or defect in 1 or more vertebrae with no pathology in the spinal cord. This is generally asymptomatic and will not be discussed further.
- Closed neural tube defects: These are a rare, diverse group of defects where the spinal cord is malformed, but the vertebral column is intact. These include lumbar sacral lipomas and diastematomyelia. These defects may range from mildly to very severe. Infants with these defects may be asymptomatic at birth and then develop symptoms over time. Midline sacral skin tags, hairy patches, hemangiomas, and other cutaneous markers may signal the presence of a closed neural tube defect and should be looked for in all newborns. (Brandt, 2007)
Navigating Transitions with Your Child

Under this For Parents & Families Topic
- Transition is a process
- To build a life plan: Start with the end goals in mind
- Resources

Under this For Parents & Families Topic
Children and youth with special health care needs face many changes throughout their lives, such as moves between hospitals, home, schools, work or college, and from child health care to adult health care (see graphic below). Each transition is a chance for your child and family to gain skills that will help you and your child succeed and manage future changes. The sub-topics in this topic include:
- School Transitions
- Transition to Adulthood

Transition is a process
The medical home, as a source of comprehensive care, is an ideal place to talk about these issues, and it should help with transition planning throughout your child’s life. The more you and your child know about his or her special health care needs, the better prepared you will all be for your child to have as much independence as possible as an adult.

...Transition is a process, not an event. The actual process should be gradual, occurring in harmony with adolescent and family development. While there is not one current model, whenever it occurs, communication among pediatric and adult providers, parents and youth is critical. (National Dissemination Center for Children with Disabilities)

This section has two parts:
- School Transitions
- Transition to Adulthood

You can find vital information from many starting points, such as the child’s age or specific needs. No matter their specific challenges, children, youth, and adults with special health care needs will benefit from a team effort toward making transitions as smooth as possible.
NPM 11: MEDICAL HOME

ALC/SDOH Collaborative

• Project with the National Center on Medical Home Implementation and other states

• NM partnerships-LEND, PRO, NMQIP, Title V, Journey Pediatrics
NPM 11: MEDICAL HOME

Lessons Learned and Recommendations
6 DEGREES

Nancy Lewis
- AMCHP
- Conference

Melissa Mason
NMPS

ECCS

MHP

Susan Chacon
- Title V

ALC

PARTNERSHIP
Title V
NMPS
PRO

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
YOUR 6 DEGREES

1. Your Organization
2. www.aap.org
3. About AAP
4. Chapter Websites
5. Find Chapter
6. Chapter Website

PARTNERSHIP

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
FINDING YOUR AAP CHAPTER

AAP Chapters & Districts

Join Your Chapter
Chapter membership offers numerous opportunities for education, leadership and involvement in state and local advocacy.

Chapter Websites
Each chapter is independently incorporated and maintains a website with information about key state initiatives and how you can get involved.

AAP District Map
Find your district.

Executive Directors
Directory of Chapter Executive Directors and contact list (login required).

Chapter Websites

Your complete list of individual chapter websites

- Alabama
- Alaska
- Arizona
- Arkansas
- California Chapter 1
- California Chapter 2
- California Chapter 3
- California Chapter 4
- Colorado

https://aapcolorado.org/

Investing in Colorado’s Future

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics™
DEDICATED TO THE HEALTH OF ALL CHILDREN™
NPM 12: TRANSITION
NPM 12: Transition

New Got Transition Website Updates

- 8-month process eliciting feedback
- No recommendations to change Six Core Elements (6CE) or three HCT packages - overall endorsement
- 6CE updates:
  - New questions and scoring on the transition readiness assessment tool
  - Lower reading levels for 6CE tools (5-6th grade reading level)
  - New implementation guides
  - Updated Current Assessment and HCT Process Measurement tools
  - Updated in Youth/Young Adult and Parent/Caregiver Transition Feedback Surveys
  - New Clinician Transition Feedback tool
Got Transition aims to help youth and young adults move from pediatric to adult health care.

**Six Core Elements™**
(For Clinicians)

**Youth & Young Adults**
(FAQs & Resources)

**Parents & Caregivers**
(FAQs & Resources)

**Resources & Research**
(By Category)

---

**News & Announcements**

**Updated Six Core Elements of Health Care Transition™ 3.0 out now!**
Got Transition has updated its Six Core Elements of Health Care Transition™ with revised tools, samples, and recommendations.

**Step-by-Step Implementation Guides for the Six Core Elements**
Got Transition now offers step-by-step Implementation Guides for each Six Core Element with real world examples for practices.

**Family Toolkit on Health Care Transition**
A toolkit from Got Transition developed for families to use during the transition from pediatric to adult health care.

---

**Bright Futures™**
Prevention and health promotion for infants, children, adolescents, and their families™
Six Core Elements of Health Care Transition Content

- Overview
- 3 Transition Packages:
  - Transitioning Youth to an Adult Health Care Clinician
  - Transitioning to an Adult Approach to Care without Changing Clinicians
  - Integrating Young Adults into Adult Health Care
- Implementation Guides for each core element in each package
- Measurement for each of the 3 Packages
- Payment
- Frequently Asked Questions about the 6 Core Elements
There are three sets of customizable tools available for different practice settings.

Click below for information and samples of each core element and full Six Core Elements packages.

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN
For use by Pediatric, Family Medicine, and Med-Peds Clinicians
Click for details on each element.

TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS
For use by Family Medicine and Med-Peds Clinicians
Click for details on each element.

INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE
For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians
Click for details on each element.

Click here to request a customizable version of any tools.

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
Click on the Six Core Elements below to learn more!

Transition and Care Policy/Guide
Tracking and Monitoring
Transition Readiness
Transition Planning
Transfer of Care
Transfer Completion

Transitioning Youth to an Adult Health Care Clinician

For use by Pediatric, Family Medicine, and Med-Peds Clinicians

Six Core Elements Package
Six Core Elements Package En Español
Six Core Elements Customizable Package
Full Implementation Guide

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™
Six Core Elements of Health Care Transition™

IMPLEMENTING THE SIX CORE ELEMENTS

These Implementation Guides are intended to help clinicians/practices/systems carry out and support health care transition (HCT) improvements using the Six Core Elements of HCT 3.0 for their patients transitioning to adult-centered care with or without changing their clinician. Each guide below contains practical guidance, resources, and examples for conducting HCT quality improvement (QI) in a range of health care settings, using the Model for Improvement as its framework. Each guide contains specific QI considerations, tools, and measures for each core element.

How to Implement the Six Core Element of Health Care Transition includes steps that a health care delivery system or individual practice can consider when utilizing a QI process to implement for the Six Core Elements.

For additional information about the QI framework and methods described in the Implementation Guides, please refer to the Quality Improvement Primer.
A practical step-by-step supplement to the Six Core Elements

Organized into nine steps that a health care delivery system or individual practice can consider when implementing a quality improvement (QI) process for health care transition (HCT)

Step 1: Secure Senior Leadership Support
Step 2: Form the HCT Quality Improvement Team
Step 3: Develop an HCT Improvement Plan

Step 4: Raise Awareness about HCT Activities
Step 5: Implement the Six Core Elements of HCT
Step 6: Plan for Sustainability
Step 7: Plan for Spread
Step 8: Communicate Successes
Step 9: Tips for Success
A companion piece to use with the Six Core Elements of Health Care Transition™

Intended to help practices understand quality improvement (QI) and apply it to their work.

Gives breakdown of QI’s:
- History
- Relationship to research
- Benefit to health care teams and patients

I. What is Quality Improvement?
II. Selecting Improvement Projects
III. Successful Teams
IV. The Model for Improvement
V. Measuring for Improvement
VI. Tools for Improvement
VII. Sustaining Improvement
VIII. Spreading Improvement
IX. Health Literacy
X. Co-Production
XI. Resources and References
I. Purpose, Objectives, and Considerations

II. Quality Improvement Considerations, Tools, and Measurement

III. Sample Transition and Care Policies/Guides

IV. Additional Resources
YOUTH & YOUNG ADULTS

Transitioning to adult health care is a big step in your life. Got Transition has tools and resources for you to help make it a smooth process!

LEARN MORE
PARENTS & CAREGIVERS

Got Transition offers several tools and resources for parents and caregivers to help their youth and young adults transition smoothly to adult health care.

LEARN MORE
Got Transition and its National Family HCT Advisory Group have developed a new Family HCT Toolkit to help families throughout the transition process.

Advisory group members represent:

- ASK Family Services
- Autism Society of America
- Family Voices
- Genetic Alliance
- Institute for Patient and Family-Centered Care
- Jack and Jill of America
- National Down Syndrome Congress
- National Family Association for Deaf-Blind
- Sickle Cell Disease Association of America
- SPAN Parent Advocacy Network
The Family HCT Toolkit includes a set of 10 HCT resources to help youth and parents/caregivers throughout the transition from pediatric to adult health care.

The resources help to answer questions families may have about transition.

- When should my child and I start to think and talk about transition?
- What are the recommended HCT services?
- What questions can my child and I ask our doctor about transitioning to adult care?
- How does my role and my child’s role change throughout the transition process?
- How can I learn if my child needs help with decision-making?
- What are some of the legal changes in health care that happen at age 18?
- What are the differences between pediatric and adult care?
- How ready is my child to transition to adult care and manage their own health and health care?
Health care transition is the process of moving from a child/family-centered model of care to an adult/patient-centered model of care. The sections below include links to national resource centers and transition-related resources selected based on their relevance to a national audience.

*Click on each section for resources related to the topic.*
#1: How can HCT be integrated into preventive care along with Bright Futures?

- Tool: *Incorporating Health Care Transition Services into Preventive care for Adolescents and Young Adults: A Toolkit for Clinicians*
  - Based on age groups used in Bright Futures, with an addition of 22-25 age group
- [https://www.gottransition.org/resource/?clinician-toolkit-preventive-care](https://www.gottransition.org/resource/?clinician-toolkit-preventive-care)
#2: How can Title V identify willing adult primary and specialty providers?

• Webinar Series: Health Care Transition and Title V Care Coordination Initiatives

• [https://www.gottransition.org/resource/?gt-webinar-3-transfer-to-adult-care](https://www.gottransition.org/resource/?gt-webinar-3-transfer-to-adult-care)
#3: How can Title V identify the % of youth with and without special health care needs who have received transition planning services in their state?

- 2018-2019 National Survey for Children’s Health
NPM 12: Transition
Frequently Asked Questions with Associated Got Transition Tools

#4: How can Title V assist clinicians to develop a HCT process for their practice?

• Tool: *How to Implement the Six Core Elements Implementation Guide*

• [https://www.gottransition.org/6ce/?how-to- implement](https://www.gottransition.org/6ce/?how-to-implement)
#5 Where can I find CME for clinicians on HCT?

- CME: 1-hour free CME on 2018 AAP/AAFP/ACP Clinical Report by Dr. Patience White, done in conjunction with DC’s Health Services for Children with Special Needs, Inc.

  - [https://www.hscsnlearning.org/transition/](https://www.hscsnlearning.org/transition/)
THANK YOU!

Patience White, MD, MA
pwhite@thenationalalliance.org

Peggy McManus, MHS
mmcmanus@thenationalalliance.org

Got Transition

The National Alliance to Advance Adolescent Health
NPM 12: Transition - Virginia

- Transition is a focus of all our CYSHCN programs: Care Connection for Children (CCC), Virginia Bleeding Disorders Program (VBDP), Pediatric Comprehensive Sickle Cell (PCSC), Child Development Clinics (CDC)
- Written into work plans with health system partners (contractual relationships)
Examples include:

• CCC unique readiness questionnaire (*Got Transition, CHKD*)
• VCU Camping Sickle Cell Retreat
• Hemophilia Adult Care (VCU, UVA expansion)
• New Adult Comprehensive Sickle Cell Network
Criticism - too much focus on transition in programs, not enough pop health transition work

Applied for TA from UNC Workforce Development Center

Group of stakeholders consulted

Decided to create education modules (transition and medical home)
NPM 12: TRANSITION-VIRGINIA

- Module development = two-year process and we are still working on promotion!
- Partnership with UVA (had existing BF and NBS modules-vision for suite)
- Transition- http://healthycommunityeducation.org (new platform)
  - Got Transition- **HUGE** resource for our VA specific work
  - Provider focused module, complimentary thanks to Title V funding, CMEs offered as carrot for nurses and physicians (made possible by UVA Office of Continuing Medical Education) and open to anyone
  - Separate module for any interested families and lay people wanting to learn about transition (complimentary as well thanks to Title V)
NATIONAL STANDARDS FOR SYSTEMS OF CARE

Created in partnership with NASHP and the Lucille Packard Foundation
Link: cyshcnstandards.amchp.org/

Created by NASHP to compliment the National Standards
View the resource
Data Integration to Improve Systems of Care

Link: http://bit.ly/2MpNSGc
AMCHP RESOURCES: IMPLEMENTATION TOOLKITS

NPM 11—in partnership with the National Resource Center for Patient/Family-Centered Medical Home

Link: https://bit.ly/2VHHsYW

NPM 12—in partnership with Got Transition

Link: https://bit.ly/2CdvM9w
National Performance Measures (NPMs)

States & Territories

Strategic Approaches

Partnerships

Strategic Approach

Resource Key

Resources

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™
# Presenters

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna Corona, MPH, CPH</td>
<td>AMCHP</td>
<td><a href="mailto:acorona@amchp.org">acorona@amchp.org</a></td>
</tr>
<tr>
<td>Kathy Janies</td>
<td>Bright Futures National Center (AAP)</td>
<td><a href="mailto:kjanies@aap.org">kjanies@aap.org</a></td>
</tr>
<tr>
<td>Jamie Jones, MPH</td>
<td>National Resource Center for Patient/Family-Centered Medical Home (AAP)</td>
<td><a href="mailto:jjones@aap.org">jjones@aap.org</a></td>
</tr>
<tr>
<td>Melissa Mason, MD, FAAP</td>
<td>Pediatrician, New Mexico</td>
<td><a href="mailto:melissaemason@gmail.com">melissaemason@gmail.com</a></td>
</tr>
<tr>
<td>Susan Chacon, MSW, LCSW</td>
<td>New Mexico Department of Health</td>
<td><a href="mailto:susan.chacon@state.nm.us">susan.chacon@state.nm.us</a></td>
</tr>
<tr>
<td>Patience White, MD, MA, FAAP, FACP</td>
<td>Got Transition The National Alliance to Advance Adolescent Health</td>
<td><a href="mailto:pwhite@thenationalalliance.org">pwhite@thenationalalliance.org</a></td>
</tr>
<tr>
<td>Peggy McManus, MHS</td>
<td>Got Transition The National Alliance to Advance Adolescent Health</td>
<td><a href="mailto:mmcmanus@thenationalalliance.org">mmcmanus@thenationalalliance.org</a></td>
</tr>
<tr>
<td>Marcus Allen, MPH</td>
<td>Virginia Department of Health</td>
<td><a href="mailto:marcus.allen@vdh.virginia.gov">marcus.allen@vdh.virginia.gov</a></td>
</tr>
</tbody>
</table>
Thank You