Telling the Healthy Start Story

A Report on the Impact of the 22 Demonstration Projects

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Written by
Mary F. Giffin, M.B.A., B. Scott Curry, M.P.H., and Julie Sullivan
Health Care Strategy Associates, Inc.

Edited by
David S. de la Cruz, Ph.D., M.P.H.
Healthy Start National Resource Center
National Center for Education in Maternal and Child Health
Georgetown University

Reviewed by
National Healthy Start Association, Inc.
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Delta Futures (Mississippi)
Detroit Healthy Start
District of Columbia Healthy Start Project
Essex County Healthy Start (New Jersey)
Florida Panhandle Healthy Start
Great Expectations Healthy Start (New Orleans)
Healthy Start/New York City
Allegheny County/Pittsburgh Healthy Start
Milwaukee Healthy Women and Infants Project
Northern Plains Healthy Start (North and South Dakota, Iowa, and Nebraska)
Northwest Indiana Healthy Start
Oakland Healthy Start
Pee Dee Healthy Start (South Carolina)
Philadelphia Healthy Start
Richmond Healthy Start Initiative
Savannah Healthy Start
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Introduction

Overview

The remarkable story of Healthy Start is one worth sharing.

This volume provides examples of the impact of Healthy Start projects on the clients and communities they serve. These examples were reported in Impact Summaries, submitted in December 1997 by each of the 22 Healthy Start projects funded during the demonstration phase (October 1991–September 1997).¹

The stories tell about

- Positive changes in the health behaviors and experiences of indigent pregnant women (e.g., in obtaining prenatal care, reducing rates of smoking, and increasing rates of breastfeeding);
- Better health outcomes, including reductions in the rate of low birth-weight births;
- Significant improvements in how providers organize and deliver services, resulting in more accessible health care;
- Major new collaborative initiatives between public agencies, community-based organizations, and private providers with regard to infant mortality reduction and prenatal service delivery;
- Creation of needed support services—including transportation, child care, education, and life planning services—in areas where none existed; and

¹Diamond bullets (♦) indicate ways in which Healthy Start projects have improved their communities.
Innovations in outreach to hard-to-reach populations, including adolescents, homeless individuals, women in jail, and residents of rural communities.

These accomplishments are measured quantitatively and qualitatively. At the client level (Section II), impact is measured in improvements in birth outcomes, health behaviors, and client perceptions, as well as in the design and introduction of new programs targeted to special groups. At the service delivery and community levels (Sections III and IV), impact is measured in the development of new approaches to delivering care, the restructuring of local delivery systems, and the increase in coordination among community providers and social service agencies.

The Origin of Healthy Start

Phase I of the Healthy Start Initiative was designed as a national 5-year demonstration program to identify and develop community-driven systems development approaches to reducing infant mortality and improving the health and well-being of women, infants, children, and families.

In 1991, the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA) asked project applicants to assess the needs of their target populations and design a unique set of strategies within the common principles underlying the Healthy Start program. These common principles are

- Innovation in service delivery;
- Community commitment and involvement;
- Personal responsibility demonstrated by expectant parents;
- Integration of health and social services;
- Multiagency participation;
- Increased access to care; and
- Public education.

These common principles were established in recognition of the complex interplay of multiple forces on prenatal care delivery and birth outcomes. Healthy Start project applicants were encouraged to address multiple objectives, including

- Providing adequate prenatal care;
- Promoting positive prenatal health behaviors;
- Meeting basic health needs (nutrition, housing, psychosocial support);
- Reducing barriers to access; and
- Enabling client empowerment.
Further, they were encouraged to accomplish their objectives through collaborative relationships between traditional and nontraditional players in the community, including clinical and social service providers, local policymakers, public agencies, consumers, and community-based groups.

In 1991, the U.S. Department of Health and Human Services funded 15 rural and urban sites in communities with infant mortality rates 1.5–2.5 times the national average. An additional seven sites were funded in 1994 as special projects with the goal of significantly reducing infant mortality through more limited interventions. Now in its second (replication) phase, Healthy Start has received funding from HRSA for an additional 55 projects as of September 1998. Twenty of the 22 original phase I projects are mentoring and assisting these new projects while continuing infant mortality reduction efforts in their own communities.

The Challenge of Healthy Start’s Demonstration Phase

From the beginning, in serving high-risk, vulnerable communities Healthy Start projects have sought to accommodate both the challenge of working with multiple organizations and the complexity of dealing with multilevel policy and service delivery environments.

Further, Healthy Start projects have operated during one of the most significant periods of change in state Medicaid programs. Many states have experienced a major shift in the control of Medicaid service delivery and in provider reimbursement from the public sector to private health maintenance organizations (HMOs). The resulting impact on local health departments and public prenatal care services has been significant. This impact has raised challenging issues related to coordinating private- and public-sector funds around prenatal care services. In this environment, Healthy Start projects have actively explored partnerships with the new managed Medicaid partners.

Therefore, an attempt to summarize the impact of Healthy Start’s demonstration phase is complicated by numerous factors:

- The diffusion of success. Healthy Start projects were designed to achieve their objectives through collaborative efforts with existing community-based government, provider, and social service organizations, creating new ones only when necessary to fill an unmet need. Therefore, many accomplishments are integrated into the efforts of other organizations and may be perceived by the local community as successes of “the local health department” or the area’s hospital or community clinic.
The complexity of birth outcomes. Second, the impact of Healthy Start must be understood in the context of the complexity of the problem it was designed to address: improving birth outcomes (by reducing infant mortality, increasing birthweight, etc.). The causes of poor birth outcomes still remain somewhat elusive to researchers. Multiple factors are considered important, yet the complexity of medical care and the psychosocial conditions faced by low-income populations create environments in which it is difficult, if not impossible, to conduct controlled research that isolates the most critical factors.

The Impact of Healthy Start's Demonstration Projects

Whether these complex challenges are adequately addressed, the impact of Healthy Start projects on clients, providers, and others in their communities has been significant and far-reaching.

The stories in this volume describe these experiences, as well as the innovations and initiatives that generated them.
II

Impact on Clients

Between 1991 and 1997, thousands of pregnant women, mothers, and infants enrolled as clients in Healthy Start demonstration projects. In addition, thousands of other family members, partners, and community residents received Healthy Start support, education, and/or other services.

However, one must look beyond the number of individuals served to truly understand the impact of Healthy Start on clients. In particular, Healthy Start demonstration projects brought about significant qualitative changes in

- Client birth outcomes;
- Client health-related behaviors;
- How clients experienced care; and
- The way in which clients accessed care.

The sections in this chapter qualitatively and quantitatively illustrate how clients experienced Healthy Start’s impact.

II.A Impact on Clients: Improved Birth Outcomes

Overview

Researchers and policymakers recognize the difficulty of demonstrating the impact of any project on birth outcomes. Reasons for this include the complexity of factors involved in such outcomes and the difficulty of conducting randomized trials in public service-delivery settings.
This section describes several Healthy Start projects that analyzed their impact on rates of low birthweight or preterm deliveries. In the case of the Florida Panhandle and Baltimore City Healthy Start projects, comparisons were made between an intervention and a control population. For Healthy Start New York City, reductions in the low-birthweight rate in target project areas were more rapid than in other high-rate areas of the city during the phase I demonstration period. In Detroit, Healthy Start project client data were compared to baseline data for the project area population.

**Improvements in the Low-Birthweight Rate Among Poor and Minority Women**

**Florida Panhandle Healthy Start**

The Florida Panhandle Healthy Start Project (FPHS)\(^2\) was a randomized controlled study of at-risk pregnant women in six poverty-stricken, rural north Florida counties. The project improved birth outcomes among the study’s participants, as well as among the entire project-area population.

The project’s randomized design looked at the effect of weekly home visits on an experimental-treatment group (n = 315), as compared with a control group (n = 169). The control group included women who may or may not have received state-provided services available in the community. The study found that

- The more home visits provided during pregnancy to women in the treatment group, the less likely the women were to experience a poor birth outcome (e.g., infant death, low or very low birthweight, an Apgar score less than 7).
- The more home visits received during pregnancy by the treatment group, the more prenatal office visits the women made.
- Women in the treatment group had fewer very-low-birthweight and preterm births than the women randomized to the control group who did not receive state services.
- The more often home visitors talked about smoking cessation with women in the treatment group, the higher the birthweight and gestational age at birth of the babies of the treatment women who smoked.

\(^2\)FPHS is one of seven special projects funded during the later part of phase I (1994). These projects were funded for special purposes, in contrast to the broader scope of the 15 original projects funded in 1991. The purpose of FPHS was to compare nurse and paraprofessional home visiting.
In addition to intensive home visiting and care coordination for study participants, FPHS worked closely with local, regional, and state public and private organizations to improve service availability and accessibility. It helped neighboring maternal and child health community coalitions to coordinate across county boundaries. It improved local medical providers' compliance with prenatal universal risk screening. It improved coordination with key medical providers, including HMOs, hospitals, and private obstetricians and pediatricians. FPHS initiated a multimedia campaign, supported a state hotline, and distributed promotional materials. It also provided intensive support for a redesign of the local perinatal health-care delivery system.

These broad-based project efforts contributed to significant improvements in key birth outcomes in the six-county project area (as compared with the state as a whole) between 1994 and 1996, particularly among minority populations.

- The project area experienced a 43 percent fall in infant mortality between 1994 (before project services began) and 1996 (while project services were operational), compared with a 7 percent fall in the rest of the state during the same time period.
- The project area's overall low-birthweight rate fell by almost 6 percent between 1994 and 1996, compared with a 1.5 percent increase in comparison counties.
- There was a 31 percent drop in the project area's very-low-birthweight rate between 1994 and 1996, compared with a slight increase in comparison counties.
Hispanic women in the project area experienced fewer low-birthweight births (from 10.9 to 7.8 percent) and a dramatic fall in very-low-birthweight births (from 3.3 to 1.9 percent) between 1994 and 1996.

Very-low-birthweight births in black women in the project area also fell dramatically, from 3.2 to 2.2 percent between 1994 and 1996.

The rate of teen births fell by 8 percent in the project area between 1994 and 1996, compared with a decline of 1.6 percent for the state as a whole.

Reduced Rates of Low Birthweight and Preterm Births

**Baltimore City Healthy Start**

Baltimore City Healthy Start (BCHS) offered comprehensive prenatal and postnatal case management, including care coordination delivered primarily through home visiting. Educational and support services were offered at two community-based centers in its target areas (see section II.C)

BCHS compared the birth outcomes of its pregnant client population to a comparison group. Specifically, it compared clients who enrolled during pregnancy to clients who enrolled postpartum. BCHS also looked at a subset of clients who were involved with substance abuse.

BCHS’s model of care coordination had a positive impact on pregnancy outcomes (see Figures 1–3). Even after adjustment for demographic and risk status variations between the prepartum- and postpartum-enrolled groups, differences in birth outcomes remained. Women in the postpartum comparison group were more likely to experience a low-birthweight birth and/or preterm delivery.

Compared to pregnant women who received services, women in the postpartum control group were

- 1-1/2 times more likely to experience a preterm delivery,
- 1-1/3 times more likely to have a low-birthweight baby, and
- 2-1/2 times more likely to have a very-low-birthweight baby.

Women in the treatment group who used substances were significantly less likely to experience a preterm delivery.

---

Figure 1

*The Effect of Healthy Start Participation on Pregnancy Outcomes*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Healthy Start Group</th>
<th>Comparison Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>LBW*</td>
<td>14.2</td>
<td>1.7</td>
</tr>
<tr>
<td>VLBW**</td>
<td>18.1</td>
<td>3.9</td>
</tr>
<tr>
<td>Preterm Delivery**</td>
<td>20.2</td>
<td>13.6</td>
</tr>
</tbody>
</table>

Note: LBW = low birthweight; VLBW = very low birthweight.
*p<0.01.
**p<0.05.

Figure 2

*Adjusted Odds Ratios for Undesirable Pregnancy Outcomes in the Control Group as Compared with the Healthy Start Group*

Note: LBW = low birthweight; VLBW = very low birthweight.
Figure 3

The Effect of Healthy Start Participation on Pregnancy Outcomes Among Substance Users

<table>
<thead>
<tr>
<th></th>
<th>LBW</th>
<th>VLBW</th>
<th>Preterm Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Users in Treatment Group</td>
<td>17.7</td>
<td>2.4</td>
<td>17.2</td>
</tr>
<tr>
<td>Substance Users in Comparison Group</td>
<td>19.9</td>
<td>3.9</td>
<td>22.2</td>
</tr>
</tbody>
</table>

Note: LBW = low birthweight; VLBW = very low birthweight.

Low-Birthweight Reductions in the Healthy Start/New York City Project Areas

Healthy Start/New York City

Healthy Start/New York City (HS/NYC) worked through perinatal agencies in three project areas—Bedford, Central Harlem, and Mott Haven—to significantly increase the focus of health and social services on perinatal care and support. HS/NYC facilitated the initiation or enhancement of programs involving case management and care coordination; family planning and prenatal services; facilitating services; nutrition education; pediatric care and parenting education; substance abuse prevention and treatment; and adolescent outreach and education. Public health statistics for these project areas suggest the impact HS/NYC has had on the population (see Table 1). Low-birthweight rates in HS/NYC project areas declined at significantly greater rates in the 3-year period following active program implementation (1993-96) compared with the prior 3-year period (1990-93). By
comparison, most other high-rate areas of the city did not experience this accelerated rate of decline during the same 3-year period.

**Table 1**  
*Reduction in Low-Birthweight (LBW) Rates for Healthy Start Areas and Non–Healthy Start Areas with High Baseline LBW Rates, New York City, 1990–93 and 1993–96*

<table>
<thead>
<tr>
<th>Percentage of Total Live Births &lt;2,500 g</th>
<th>Percent Change in LBW Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy Start Areas</strong></td>
<td></td>
</tr>
<tr>
<td>Bedford</td>
<td>13.5</td>
</tr>
<tr>
<td>Central Harlem</td>
<td>17.8</td>
</tr>
<tr>
<td>Mott Haven</td>
<td>12.6</td>
</tr>
<tr>
<td>Total Project Area</td>
<td>14.2</td>
</tr>
<tr>
<td><strong>Non–Healthy Start Areas with High Baseline LBW Rates</strong></td>
<td></td>
</tr>
<tr>
<td>East Harlem</td>
<td>11.7</td>
</tr>
<tr>
<td>Morrisania</td>
<td>13.3</td>
</tr>
<tr>
<td>Tremont</td>
<td>11.6</td>
</tr>
<tr>
<td>Brownsville</td>
<td>12.0</td>
</tr>
<tr>
<td>Fort Greene</td>
<td>13.4</td>
</tr>
<tr>
<td>Bushwick</td>
<td>11.0</td>
</tr>
<tr>
<td>Total New York City</td>
<td>9.4</td>
</tr>
</tbody>
</table>


**Comparing Detroit Healthy Start’s Performance with Baseline Data**

**Detroit Healthy Start Project**

Detroit Healthy Start Project (DHSP) emphasized outreach, facilitating services, and enhanced clinical services as key strategies for its project area. DHSP faced some significant obstacles to implementation, including major changes in the service delivery and financing systems for public health and Medicaid services in Detroit.
In spite of these difficulties, DHSP achieved improvements in access to services (see Section I.B) and observed comparatively positive birth outcomes for selected populations for which data was available (see Table 2).

![Table 2](image)

**Observations of Comparative Birth Outcomes in the Detroit Healthy Start Project**

<table>
<thead>
<tr>
<th>Birth Outcome</th>
<th>Baseline or Comparison</th>
<th>Data for Healthy Start Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-birthweight rate</td>
<td>13.7%</td>
<td>6% LBW, and 0% very LBW for 158 live births in 1996 at Grace Ross Health Center (enhanced clinical services model of DHSP).</td>
</tr>
<tr>
<td>Average birthweight</td>
<td>3,029 g for matched comparison group, 1996–97</td>
<td>3,126 g for 535 DHSP outreach team clients.</td>
</tr>
<tr>
<td>Preterm deliveries</td>
<td>17.6%</td>
<td>16% for 158 live births in 1996 at Grace Ross Health Center (enhanced clinical services model of DHSP).</td>
</tr>
<tr>
<td>Gestational age</td>
<td>38.2 weeks for matched comparison group</td>
<td>39 weeks for 535 outreach team clients receiving home visiting services.</td>
</tr>
</tbody>
</table>
II.B Impact On Clients: Education and Changing Health Behaviors

Overview

Many Healthy Start projects directly targeted health choices and behaviors of mothers that may have had a significant impact on birthweight, prematurity, and the long-term health and well-being of their children and themselves. These include

- Early and regular prenatal care;
- Breastfeeding;
- Adequate nutrition;
- Reducing or eliminating smoking or illegal drug use; and
- Well-child care and immunizations for the infant.

In addition, many projects sought to reduce unwanted pregnancies and adolescent pregnancy rates through education and family planning programs.

This section describes the positive changes occurring for the clients in Healthy Start project areas in Pittsburgh, the Florida Panhandle, New York City, Detroit, Philadelphia, Chicago, Washington, DC, and Birmingham. In addition, this section presents information from a qualitative evaluation conducted for Oakland Healthy Start.

The examples in this section are representative of achievements by other projects. All 22 demonstration projects reported an impact on clients' health behaviors.

Project Area Changes in Prenatal Care and Breastfeeding

Allegheny County/Pittsburgh Healthy Start

Allegheny County/Pittsburgh Healthy Start (PHS) used a number of strategies in their project area, including case management, enhanced access to transportation and child care, development of collaborative partnerships between primary and postpartum care providers, and targeted service programs for women in prison and women with substance abuse problems.
A number of health behaviors changed dramatically among pregnant women in PHS target areas between pre–Healthy Start years (1988–90) and 1995–96, when Healthy Start had been in active operation for 3 years (see Table 3).

- The number of women accessing prenatal care during the first trimester increased by 16 percent.
- There was a 29 percent reduction in women giving birth who received late or no prenatal care.
- The rate of breastfeeding more than doubled.
- The number of infants receiving continuing care, including immunizations, increased 43 percent.
- The number of women who smoke during pregnancy declined 16 percent.

<table>
<thead>
<tr>
<th>Table 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in Health Behaviors Among Pregnant Women in Allegheny County/Pittsburgh Healthy Start Target Areas</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Behavior/Practice</th>
<th>Baseline Years 1988–90, %</th>
<th>1995–96, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women with first trimester prenatal care</td>
<td>66.1</td>
<td>73.6</td>
</tr>
<tr>
<td>Women with third trimester or no prenatal care</td>
<td>8.4</td>
<td>6.0</td>
</tr>
<tr>
<td>Breastfeeding initiated for newborns</td>
<td>16.0</td>
<td>35.6</td>
</tr>
<tr>
<td>Well-child care, including immunizations</td>
<td>61.0</td>
<td>87.0</td>
</tr>
<tr>
<td>Women who smoke during pregnancy</td>
<td>35.5</td>
<td>29.9</td>
</tr>
</tbody>
</table>

**Sources:** Allegheny County Department of Health, a 1992 telephone survey of 1,004 women, and a 1996 telephone survey of 500 women in Healthy Start service areas.

**Home Visiting and Improvements in Client Health Choices**

**Florida Panhandle Healthy Start**

The Florida Panhandle Healthy Start (FPHS) program of intensive home visiting was associated with significant improvements in selected key health behaviors.

FPHS was a randomized controlled study of at-risk pregnant women in six predominantly rural north Florida counties. In addition to prenatal care, women in the experimental treatment group (n=315) received weekly home visits from
either a nurse or paraprofessional. These visitors promoted healthy lifestyles, coordinated services, and provided education and support to ensure successful pregnancies and healthy babies.

In contrast, women in the control group (N=169) received whatever services were available in the community. (In some cases, these services included care coordination provided through Florida's Healthy Start state program and local Resource Parents programs.)

Compared with the control group, a greater percentage of FPHS clients took control of their pregnancies by making positive health decisions. The rigorous evaluation component of the FPHS documented the following changes in client health behaviors (see additional information about FPHS under Sections II.A and II.C):

- Only 23 percent of smokers who were home-visited by nurses were still smoking in the last trimester.
- The percentage of smokers who resumed smoking by 3 months after delivery was lower in the experimental group (54 percent) than the control group (75 percent).
- Forty percent fewer women in the treatment group experienced the trauma of their baby having to be rehospitalized after birth.
- Participants in the treatment group received information and support about domestic violence. Three times as many control women as treatment women experienced abuse or violence during pregnancy, and twice as many control as treatment women experienced abuse at any time in the perinatal period.
- Women in the treatment group breastfed twice as long as women who did not receive state services.
- The longer that women in the treatment group breastfed, the higher their scores on tests of maternal-child interaction.
- Compared with women in the other experimental groups, more women in the nurse-visited group had returned to school 3 months after the baby's birth.
- Eighty percent of the nurse-visited group who had not used birth control before their current pregnancy started using birth control by the time their baby was 3 months old. This is significantly more than in the control group (57.7 percent).
- As a result of weekly monitoring by the home visitors, child abuse and neglect was detected earlier in the treatment group than in the control group; the proportion of verified cases of abuse or neglect was similar in the two groups.
Trends in Prenatal Health and Pregnancy Choices in New York City

Healthy Start/New York City

Between 1990 and 1996, Healthy Start/New York City (HS/NYC) served 30,000 women and their families through three lead agencies and 60 programs that served target areas in Brooklyn, the Bronx, and Harlem. As described elsewhere in this report (see Section III.A), HS/NYC collaborated extensively with state, local, and community-based groups as well as leading health care providers to design comprehensive, customized strategies aimed at improving prenatal care, access, and support.

During this period, key perinatal health behaviors for the population in the HS/NYC target areas improved significantly (see Table 4).

<table>
<thead>
<tr>
<th>Reported Behavior</th>
<th>Initial</th>
<th>Final</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>% women receiving late or no prenatal care, among those with live births</td>
<td>23.7</td>
<td>12.4</td>
<td>48</td>
</tr>
<tr>
<td>% infants born to women with reported drug abuse, among live births, based on birth certificate data</td>
<td>6.3</td>
<td>3.6</td>
<td>43</td>
</tr>
<tr>
<td>Birthrate among adolescents (ages 15–19), per 1,000 births</td>
<td>78.7</td>
<td>59.7</td>
<td>24</td>
</tr>
<tr>
<td>% women having babies less than 15 months apart</td>
<td>21</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>% women enrolled in WIC, based on births</td>
<td>38</td>
<td>60</td>
<td>58</td>
</tr>
</tbody>
</table>

Healthy Start Clients Obtain More Resources, Reduce Substance Abuse

**Detroit Healthy Start Project**

The intervention strategies of the Detroit Healthy Start Project (DHSP) included intensive outreach combined with case management, enhanced clinical services, and facilitating services (e.g., transportation).

DHSP’s effectiveness was evaluated with a postpartum survey and linked data set comparing data for clients and nonclients. In particular, DHSP clients were significantly more likely to have

- Received more transportation to prenatal visits;
- Been enrolled in Medicaid or other health insurance programs;
- Reduced alcohol intake during pregnancy; and
- Waited less time for an initial prenatal appointment.

In addition, when compared with baseline or matched data, other sources of DHSP program data suggest that the project enabled clients to change health behaviors and improve their access to services (see Table 5).

**Comparison of Prenatal Care Patterns for Clients and Nonclients**

**Philadelphia Healthy Start Initiative**

The strategy of the Philadelphia Healthy Start Initiative (PHSI) was to work with existing community-based organizations to develop new and enhanced approaches to outreach, lay home visiting, and provider accessibility for the target population. A local evaluation of the experience of PHSI clients for the period 1994–96 illustrates the impact of the project.4

Compared to a group of demographically similar nonclient women, PHSI clients were at higher risk but had similar prenatal care rates and birth outcomes. PHSI was able to maintain clients at levels of prenatal care and birth outcomes that were comparable to other women in their community, despite the clients’ higher risk profile. The evaluation concludes that

---

## Table 5

### A Comparison of Birth Outcomes in the Detroit Healthy Start Project

<table>
<thead>
<tr>
<th>Health Behavior or Experience</th>
<th>Baseline or Comparison</th>
<th>Data for Program Related to Healthy Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug, alcohol, or tobacco use among pregnant women.</td>
<td>16% used drugs, 13% used alcohol, 25% used tobacco.</td>
<td>Only 8% of newborns showed evidence of exposure to drugs and 4% showed exposure to alcohol for 158 live births in 1996 at Grace Ross Health Center (one of two sites for the enhanced clinical services model of DHSP).</td>
</tr>
<tr>
<td>Percentage of pregnant clients who decreased or quit drug, alcohol, or tobacco use.</td>
<td>50% decreased or quit drug use, 37.5% decreased or quit alcohol use, 25% decreased or quit tobacco use.</td>
<td>Among 508 women receiving prenatal care at two enhanced clinics (10/95–9/96), 15% used drugs, 8% used alcohol, and 18% used tobacco.</td>
</tr>
<tr>
<td>First trimester prenatal care enrollment.</td>
<td>64.1% of women enroll in prenatal care in the first trimester.</td>
<td>Among Healthy Start outreach clients who used substances, 61% decreased or quit drug use; 71.4% decreased or quit alcohol use; and 33% decreased or quit tobacco use.</td>
</tr>
<tr>
<td>Postpartum clinic visit within 3 months of delivery.</td>
<td>28% of women received postpartum services within 3 months of delivery.</td>
<td>72% of 654 clients enrolled in 1996–97 at Grace Ross Health Center entered care in the first trimester.</td>
</tr>
<tr>
<td>Provision of institutional support to outreach clients.</td>
<td>75.6% enrolled in WIC (1991), 86.7% covered by insurance (1991), 20.2% received transportation to appointments (1991).</td>
<td>36% of 508 women who obtained prenatal care in 1995–96 at enhanced clinics received postpartum services within 3 months of delivery.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>84.4% outreach clients enrolled in WIC (1996), 97% enrolled in Medicaid or other insurance, 40.7% received transportation to appointments.</td>
</tr>
</tbody>
</table>
the Healthy Start Initiative was able to identify women who were at higher risk compared to their peers in the target area, and to provide them with a level of prenatal care and birth outcomes that were on par with what would be expected in their community... it was able to provide these at-risk women with a minimum threshold or safety net of services below which they would not fall. These results imply that the women who were clients may have fared substantially worse than their peers if they had not been enrolled in the Healthy Start program.5

The Philadelphia Healthy Start Initiative probably improved prenatal care utilization for selected subgroups of clients. Although there were no significant differences between clients and nonclients in prenatal care utilization or birth outcomes, an evaluation of the experience of women with multiple births demonstrated a positive impact. Those women who enrolled as Healthy Start clients before the second birth had a higher average number of prenatal care visits than those who did not enroll before their second birth. This increase in prenatal care between births among clients contrasts with a significant decline in the prenatal care experienced by nonclients for their subsequent birth. (All indicators declined for the nonclient population: number of visits, adequacy, and percentage seeking care during the first trimester.)

Reducing Substance Abuse: A Preventive Antidote

Chicago Healthy Start

Chicago Healthy Start (CHS) sought to reduce many harmful physical conditions for pregnant women and their expected children and recognized the serious issue of substance abuse among their clients. Case-management agency staff were trained to educate families and to identify treat-

5Meyer et al.
ment programs for family members, particularly pregnant women and children affected by substance abuse.

To measure the impact of CHS on perinatal substance abuse, case management agencies issued monthly reports on infants born with a positive toxicology screen, and the Substance Abuse Prevention/Intervention Committee reviewed the cases across agencies.

CHS's 1992 needs assessment identified a baseline (1984–88) rate of 11.1 percent of infants born with positive test results for illegal drugs. After 3 years of service implementation, there was a significant reduction in the percentage of newborns with positive drug screens. From October to December 1995, 22 of 395 infants (5.5 percent) screened were born with a positive toxicology. This is even lower than CHS's stated target of 7 percent. Although the number of newborns born with positive drug screens continues to be of concern, this is an encouraging result.

**Improving Access and Reducing Risk in Washington, DC**

**District of Columbia Healthy Start**

District of Columbia Healthy Start (DCHS) provides intensive case management and care coordination that consists of nurse home visiting; risk assessment; social support through resource parents and male outreach workers; an electronic case-management and information system; and interagency case conferences, referrals, and services coordination.

In the project area (Wards 7 and 8 in the District), several key prenatal-care indicators improved between 1993 and 1995 (the period for which data are available):

- Adequacy of care (initiated in the first trimester with a minimum of nine prenatal visits) increased from 37.2 percent in 1993 to 42.6 percent in 1995.
- Entry into prenatal care during the first trimester increased from 48 percent in 1993 to 51.5 percent in 1995.
- The rate of anemia decreased from 10.5 percent in 1993 to 5.2 percent in 1995.

In addition, the rate of substance abuse among pregnant women in the project area declined:
- Alcohol abuse decreased from 6.5 percent in 1993 to 3.1 percent in 1996.
Tobacco abuse decreased from 13.4 percent in 1993 to 10 percent in 1996. DCHS sought to influence the rate of teen pregnancies and births through a school-based clinic and a drop-in teen center in its project area. The proportion of births to adolescents (15–17 years of age) in the project area declined from 9.3 percent in 1991 to 7.7 percent in 1995.

Areawide Trends in Prenatal Care

Birmingham Healthy Start

Birmingham Healthy Start (BHS) provided services to over 24,000 residents of its 12 low-income target areas over a 6-year period. BHS sought to make it easier for consumers to reach needed health services. Examples of BHS strategies included

- Transportation assistance and gas vouchers;
- An outreach and tracking system that followed up on missed appointments and rescheduled new ones, and that enabled the tracking of client needs and services;
- A significant increase in the number and scope of adolescent-pregnancy prevention efforts;
- The education of city and public health officials about the health problems of low-income and minority populations; and
- Funding of the only residential program for substance-abusing women in the state.

As a result of these efforts, key prenatal care and health behaviors for the target-area population improved between the baseline period (1988–90) and 1996 (see Table 6). For example, the percentage of women obtaining prenatal care during the first trimester increased by 10.6 percent. The percentage of women with a birth-to-conception interval of less than 13 months decreased by 21.6 percent.

The Impact on Client Behaviors of Providing Individualized and Family Support

Oakland Healthy Start

Family perceptions of client experiences provide powerful testimony to the
role that Oakland Healthy Start (OHS) has played in the lives of clients. OHS established three one-stop, family-life resource centers (FLRCs). (Detailed descriptions of these FLRCs are provided in Section III.B.) Each center developed collaborative relationships with local and county health and social service agencies to enable access to a comprehensive array of services. The FLRC purpose and philosophy is to “empower and revitalize individuals, families, and the community within a culturally consistent environment, while also integrating essential clinical and social support services geared to reducing infant mortality.”

Family members were interviewed as part of the Following Families Longitudinal Study. In this study, the evaluation team collected family members’ perceptions of changes in each client’s health, parenting skills, and overall attitude during her use of OHS services. The report noted

The overall perception of family members was that the physical and emotional health of the pregnant and/or parenting woman, as well as

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Table 6

**Improvements in Women’s Prenatal Behaviors**

**Birmingham Healthy Start Target Area**

<table>
<thead>
<tr>
<th>Health Behavior</th>
<th>1988–90 Baseline</th>
<th>1996 Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>% women receiving adequate prenatal care (Kessner index)</td>
<td>54.8</td>
<td>65.6</td>
</tr>
<tr>
<td>% women entering prenatal care during the first trimester</td>
<td>64.4</td>
<td>71.2</td>
</tr>
<tr>
<td>% women abstaining from tobacco use (self-reported)</td>
<td>72.0</td>
<td>84.3</td>
</tr>
<tr>
<td>% pregnant women abstaining from drug use (self-reported)</td>
<td>88.9</td>
<td>91.8</td>
</tr>
<tr>
<td>% women with a birth-to-conception interval of less than 13 months</td>
<td>23.6</td>
<td>18.5</td>
</tr>
<tr>
<td>% completed immunizations among 1-year-olds</td>
<td>49.6</td>
<td>90.0</td>
</tr>
</tbody>
</table>

---

the health of her child, had undergone significant improvement ... [citing such indicators as] reduced stress, improved bodily hygiene, improved eating habits, less reliance on alcohol and drugs, desire to exercise and use of birth control methods.

Community quotes from ... Family members interviewed about the impact on clients of participation in Oakland Healthy Start care coordination

"She's more patient and listens a lot more now to them ... less flying off the handle."

"She changed her ways about parenting her child. I mean she handles stuff differently. Like taking care of the baby .... Now she makes sure that he's not out too late, makes sure that he has a coat on, makes sure his nose don't run, makes sure that he has clothes that are suitable for him."

"She doesn't drink as much, she doesn't smoke weed anymore.... She's learned how to say 'no' when she needs to take care of herself and her baby more. She's learned to deal with her stress a little better than before. She knows to get help if she has a problem."

"She's improved a lot.... She's not as violent as she used to be, she's more mature."

"Sometimes she does real good. I don't know what makes her slip. If she goes and talks to somebody, she'll do all right for a little while again. She's been doing pretty good so far, in the past few months. She's gained a lot of weight. And she eats a lot more than she used to. I don't know what it is, but her eating habits have changed a great deal. Sometimes she's in pretty good spirits, but it's hard to talk to her sometimes."

II.C Impact on Clients: Care Coordination

Overview

Care coordination models developed by Healthy Start projects were designed to simplify the maze of services and paperwork involved in accessing health and social support services, overcome key barriers to accessing care, and provide critical educational and emotional support.

The introduction of care coordination models has influenced standards of practice in many Healthy Start areas. Local providers and social service systems now recognize the benefits of care coordination. Many have found that this approach significantly improves their own service effectiveness and efficiency.

While models vary, Healthy Start care coordination typically includes

- Outreach, client identification, and recruitment;
- Intake/enrollment and risk assessment;
- A customized care plan for support and services;
- Referral assistance (e.g., for housing; the Special Supplemental Nutrition Program for Women, Infants and Children [WIC]; child care; and transportation);
- Health education (in childbirth, parenting, and nutrition);
- Linking clients with primary care providers;
- Follow-up on medical care visits and compliance;
- Ongoing support via home visits, phone calls, appointments;
- On-call availability for emergency needs; and
- Follow-up to ensure infant and well-child care, immunizations, etc.

In creating care coordination models, Healthy Start projects had to address key program design, resource, and training issues.

Healthy Start projects designed effective recruitment and training programs for both clinical staff and paraprofessional neighborhood health visitors. They developed protocols for risk assessment, home visiting, ongoing monitoring, and outcomes documentation. Many implemented management information systems to support case management activities.

This section describes several of the many Healthy Start projects that have developed care coordination strategies. Northern Plains' targeted case manage-
ment process illustrates one approach. Other featured projects include Baltimore, New York, Pittsburgh, Florida Panhandle, and Boston.

The Healthy Start projects reporting a significant impact on care coordination are

- Baltimore City Healthy Start
- Boston Healthy Start Initiative
- Chicago Healthy Start
- Detroit Healthy Start
- District of Columbia Healthy Start Project
- Essex County Healthy Start (New Jersey)
- Florida Panhandle Healthy Start
- Healthy Start/New York City
- Healthy Start Pittsburgh/Allegheny County
- Milwaukee Healthy Women and Infants Project
- Northern Plains Healthy Start (North and South Dakota, Iowa, and Nebraska)
- Oakland Healthy Start
- Richmond Healthy Start Initiative
- Savannah Healthy Start

Targeted Case Management: Respect for Tradition, Respect for Life

Northern Plains Healthy Start

Spanning a four-state service area of 107,377 square miles, Northern Plains Healthy Start (NPHS) faced the challenge of providing culturally relevant services to the members of 19 different Native American tribes. The hallmark of Healthy Start is responding to the needs of diverse communities. In the case of NPHS, 19 tribes with differing beliefs and traditions were united by the common goal of becoming guardians of pregnant women and their unborn children.

Guided by respect for the traditional values of American Indian families, as well as their physical, emotional, psychosocial, and spiritual health, NPHS and tribal communities designed a targeted case management (TCM) system to address concerns about high infant mortality and birth outcomes for Native
American women in the Aberdeen area (see Table 7). TCM provides a continuum of care for each client during her enrollment in the project. TCM encourages and helps the client assess her pregnancy and identify the short- and long-term goals whose outcomes would result in a healthy pregnancy and the nurturing of a healthy baby.

The TCM model was culturally appropriate from its inception. Native American community members were key players in establishing and implementing all aspects of the project. By involving the tribes—including the clients and their families—so deeply, NPHS was able to provide a community perspective in understanding and addressing risk factors associated with infant mortality.

For too long, tribal communities have been kept from the table of discussion regarding the cause and effect of infant deaths. Information related to infant mortality has been controlled by medical providers. The TCM program had legitimacy because it encouraged participants and the community to take ownership of the program and thus make better choices for themselves and their families. By respecting tradition, providing substantial resources, and recognizing the differences inherent in Native American society as compared to other cultures, NPHS crossed over closely guarded territory and brought together more than 700 local and collaborating resource agencies. Duplication of services was not a problem for project staff, since the TCM model included services that had never before been offered.
The results obtained with TCM have been very positive:

- From 1993 to 1996, NPHS surpassed its objective of increasing to at least 90 percent the proportion of clients who were case managed and who received family planning education. Fully 100 percent of case-managed clients received education through the TCM prenatal and postpartum education curriculum.
- From 1993 to the end of phase I, 100 percent of high-risk neonate participants received case-managed services, including follow-up after hospital discharge.
- Between 1993 and 1995, NPHS greatly increased the percentage of clients entering prenatal care in the first trimester: 43 percent in 1993, 46 percent in 1994, and 81 percent in 1995.
- NPHS increased from 22 percent in 1993 to 97 percent in 1996 the proportion of case-managed infants for whom home-based assessments were conducted.
- The percentage of fathers involved in prenatal and postpartum care increased from 10 percent in 1993 to 30 percent in 1995.

| Table 7 |
| The Northern Plains Healthy Start Targeted Case Management System |

**Assessment/Screening**
- Medical and psychosocial risk assessments
- Home environment assessment
- Maternal substance abuse
- Medical history

**Needs Identification**
- Case service plan
- Transportation plan
- Delivery plan
- Discharge plan

**Referral System**
- Referral forms
- Referral logs

**Home Visitation Program** (10 prenatal, 8 infant contacts)
- Schedule of home visits
- Documentation of services

**Education**
- TCM prenatal education curriculum (based on risk factors and trimester of pregnancy)
- TCM well-child education curriculum (based on risk factors and infant's first 16 months)
- Parenting skills
- TCM postpartum education curriculum (emphasis on family planning and women's health issues)

**Evaluation**
- Administrative quality assurance monitoring
- NPHS/MCH team case review meetings
- Routine chart audits
- Participant's summation of services
- Participant/provider/community surveys and questionnaires
High-Penetration Care Coordination and Support Services

Baltimore City Healthy Start

One of the Healthy Start models created by Baltimore City Healthy Start (BCHS) combined several strategies into one concentrated program that focused on two geographic areas.7 The model includes

- "One-stop" family resource centers that offer support programs and serve as the base for care coordination teams;
- Comprehensive facilitating and support services, such as risk prevention services, health and nutrition education, child care, peer group discussions, GED classes, life planning programs, adolescent services, "men's services," and transportation;
- Aggressive outreach by specially trained recruitment teams;
- Intensive care coordination and home visiting, with biweekly contact of pregnant and postpartum women and their families through the infant's first birthday; and
- Special care coordination teams and support resources for substance abuse cases and perinatal monitoring of high-risk cases.

The success of BCHS's model is reflected in high enrollment rates, improved rates of prenatal care attendance, increased rates of identification and referral for special services, and increasing rates of service contact.

Healthy Start had high penetration: 90.6 percent of the women eligible for the project in the target areas were enrolled in the program (3,848 of 4,245). In addition,

- One hundred percent of enrolled women with pregnancies were assessed and referred as needed for care; 97.3 percent of women who were enrolled received care coordination through Healthy Start.
- A total of 67.4 percent of those enrolled were recruited while pregnant; women identified postpartum were enrolled for postpartum and early infant care services.
- The percentage of women in the target area with an "adequate" level of prenatal care (according to the Kessner Index) increased from a cumulative

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7While BCHS also provides a range of services to a broader project area, it developed a special approach in two target areas composed of 14 census tracts. One target area was in East Baltimore (Healthy Start/Middle East), and one was in West Baltimore (Healthy Start/Sandtown-Winchester/Harlem Park).

- From the 1990–92 period to 1997, the percentage of women in the target area receiving first-trimester prenatal care increased from 66.9 percent to 71.2 percent.

- The percentage of Healthy Start clients assessed and referred for substance abuse services increased from 29.8 percent in 1993–94 to 44.5 percent in 1994–96.

- The percentage of clients receiving a 2-week postpartum medical follow-up visit—including contraceptive counseling and breastfeeding support—increased from 9 percent (1993–94) to 26.2 percent (1994–96).

- The percentage of clients receiving a postpartum medical visit within 6 weeks of delivery increased from 22.6 percent (1993–94) to 60.1 percent (1993–97).

- The percentage of infants receiving a 2-week pediatric visit increased from 49.7 percent in FY 1994 to an average of 64.7 percent (1993–97).

- The percentage of infants born to clients who enrolled during pregnancy and received adequate well-child care at 12 months (according to American Academy of Pediatrics guidelines) doubled from 33.3 percent (1993–94) to 66.6 percent (1994–96).

A comparison of the birth outcomes of clients enrolled during pregnancy and those of clients enrolled postpartum further supports the model’s impact. Even after adjustment for demographic differences between the two groups, the group enrolled during pregnancy had lower rates of preterm births and lower rates of low- and very-low-birthweight babies. (See Section II.A.)

**Neighborhood Health Advocates in the BCHS Model**

One of the most important elements of the BCHS model is the neighborhood health advocate (NHA). NHAs are typically community residents who, under the supervision of a social worker or nurse, are trained to conduct client outreach, make ongoing contact (including home visits), and perform ongoing client needs assessment and support.

The role of NHAs in the BCHS model went beyond community residents’ efforts with outreach and client recruitment. NHAs formed the core element of care coordination (see Figure 4). This reflects the idea that the actual delivery of case management services is best performed by trained community residents who are able to gain the trust of clients because they have a clear understanding of the obstacles that these families face. In addition, NHAs were supported by special training and resources designed to address the needs of clients with substance abuse problems and those with signs and symptoms of preterm labor.
Care Coordination in Harlem, Brooklyn, and the Bronx

Healthy Start/New York City

The initial needs assessment for Healthy Start/New York City (HS/NYC) concluded that many prenatal services were available but were scattered and difficult to access. Women entering the health care system faced overburdened, short-staffed, and fragmented services with limited hours. Women were deterred from seeking prenatal care by long waits, long lead times to make appointments, lack of on-site child care, overcrowded waiting rooms, insensitive staff, outdated eligibility rules, and cost concerns.

HS/NYC used social/health case management to increase client access to services vital to improving birth outcomes. HS/NYC implemented its social/health case management model by creating or expanding the capacity of 11 programs. In particular,

- The NYC Department of Health's Infant Mortality Initiative was strengthened by increasing staff and expanding nutrition and social work services.
- The Bronx Perinatal Consortium's Community Health Worker Program was supported and extended to the Mott Haven project area.
• The Northern Manhattan Perinatal Partnership received help in building its community health worker program.

• The Brooklyn Perinatal Network created a one-stop long-term case management and central intake and referral unit.

• Specialized case management services (e.g., the Valley, located in Central Harlem) were supported, providing outreach and leadership development to adolescents.

Healthy Start's case management penetration was significant. For example, in 1996, Healthy Start case management served 32 percent of the project area births (2,744 families received Healthy Start-funded case management). This penetration was associated with significant improvements in rates of low birthweight, as well as changes in health behaviors in the project area:

• Low-birthweight rates in HS/NYC project areas declined at significantly greater rates in the 3-year period following program implementation than during the previous 3-year period. Most other high-rate areas of the city did not experience this accelerated decline (see Section II.A for additional details).

• HS/NYC project areas saw improvements in key perinatal health behaviors between 1990 and 1996, including decreases in the percentage of women receiving late or no prenatal care, in the proportion of infants born to women with reported drug abuse, and in adolescent birth rates. There were also increases in WIC enrollment (see Section II.B for further information about these results).

Table 8 shows the number of case management clients receiving specific types of services between 1993 and 1996.

A New Core Team Model for Pittsburgh

Allegheny County/Pittsburgh Healthy Start

In the target area for Allegheny County/Pittsburgh Healthy Start (PHS), women and their families receive case management services through Healthy Start's core-team case management model. Six multidisciplinary core teams located in the six Healthy Start regions in Allegheny County conduct outreach and case finding to identify clients in need of care coordination. Each team helps pregnant women who are at risk and their families connect with existing perinatal services and community resources. Home visits, phone contacts, and social services continue for 1 year after the birth of the baby.
### Table 8

**Case Management Clients Receiving Specific Services, 1993–96, Healthy Start/New York City**

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Cumulative Clients (4 Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short- and Long-term Case Management</td>
<td>13,429</td>
</tr>
<tr>
<td>Family Planning</td>
<td>3,024</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>2,429</td>
</tr>
<tr>
<td>WIC</td>
<td>1,827</td>
</tr>
<tr>
<td>Other Nutrition Services</td>
<td>3,005</td>
</tr>
<tr>
<td>Immunizations</td>
<td>1,259</td>
</tr>
<tr>
<td>Other Pediatric Services and Support</td>
<td>2,168</td>
</tr>
<tr>
<td>Parenting Education</td>
<td>1,809</td>
</tr>
<tr>
<td>Substance Abuse-related Services</td>
<td>1,952</td>
</tr>
<tr>
<td>Housing Services</td>
<td>2,314</td>
</tr>
<tr>
<td>Education and Job Placement Services</td>
<td>1,696</td>
</tr>
<tr>
<td>Smoking Cessation Programs</td>
<td>1,468</td>
</tr>
<tr>
<td>Child Care/Transportation</td>
<td>1,131</td>
</tr>
</tbody>
</table>

From 1994 to 1996, the infant mortality rate among 3,000 women whose cases were managed was 10.6 deaths per 1,000 live births, compared to 18.9 deaths per 1,000 among women in the same communities who were not Healthy Start participants. While these numbers have not been adjusted for severity or risk, in general Healthy Start core teams serve a high-risk population.

Pregnant women in the Healthy Start project areas made significant changes in key health behaviors as well, including an increase in the percentage of women accessing prenatal care, a reduction in births in which the mother had received late or no prenatal care, an increase in breastfeeding rates, and an increase in the percentage of infants receiving continuing care and immunizations (see Section II.B for specific data on these indicators).

### Intensive Home Visiting Model

**Florida Panhandle Healthy Start**

Florida Panhandle Healthy Start (FPHS) chose case management through intensive home visiting as its primary strategy. FPHS's target area included six rural counties in the Florida Panhandle. As described in Sections II.A and II.B, FPHS's model resulted in improvements in health behaviors and outcomes for
clients and for the project area in general.

FPHS provided significant training and education to home visitors to help them help their clients. Extensive curriculum materials, protocols, a manual, and a handbook were developed with input from experts in key fields. Five weeks of preservice training covered a broad range of topics and included presentations by experts in a variety of fields. Trainees participated in role playing and hands-on demonstrations, watched videos, and took pretraining and posttraining tests. After individuals graduated from preservice training, they continued with in-service training via biweekly full- and half-day workshops.

Between May 1995 and September 1997, 315 at-risk pregnant women were served by a total of 20 trained home visitors. More than 10,000 visits were made during this period. Each visitor served no more than 15 women at a time and saw each of her clients once a week for an hour. Although half the participants were not recruited until their second trimester, the average number of prenatal visits for the client group was 9.6. This high rate of compliance with prenatal care visits is attributable to the intense efforts of home visitors in these areas:

- **Education** on the importance of prenatal care; fetal growth; proper weight gain, diet, and nutrition; exercise and fitness; emotional health; avoiding sexually transmitted diseases (STDs); avoiding the use of alcohol, drugs, and tobacco; childbirth preparation; and premature labor warning signs.

- **Assistance** in enrolling in childbirth education classes, paying enrollment fees, and obtaining transportation and child care when they were unavailable.

- **Referral** to special programs and services, such as smoking cessation programs, mental health counseling, and violence protection services.

- **Emotional support** and other assistance on a case-by-case basis, including accompaniment to prenatal visits, crisis intervention, and childbirth coaching.

The FPHS program developed a system for maintaining an effective home-visiting program. Careful documentation of the frequency and content of home visits provided valuable, reliable information for supervision, quality improvement, and reporting on client outcomes. Data collected for evaluation purposes were also used by supervisors to monitor the performance of home visitors, identify training needs, and guide project decisions.

Key findings from the FPHS project include the following:

- The more education that was provided about the importance of breastfeeding to the treatment group, the longer the women breastfed; the longer women breastfed, the higher their scores on tests of maternal-child interaction;
The more education that was provided to young women who had dropped out of high school on the importance of returning to school, the more likely new mothers were to return to school; and

The more frequently that discussions of emotional and family support issues were held with mothers in the treatment group, the more likely they were to have higher self-esteem and the longer the intervals between their pregnancies at the time of the evaluation.

See the sidebar for profiles of five FPHS clients.

### Five Case-Study Profiles of FPHS Clients

**SW** was a 21-year-old single mother who had had two miscarriages and multiple emotional problems. There was a confirmed family history of mental illness. Her home visitor helped her come to terms with these problems and reestablish a relationship with the baby’s father. SW now has an apartment and a job and has returned to school.

**ZC** was a 13-year-old single mother struggling to stay in school. Her grades and attendance level had dropped considerably. She was living with her maternal grandmother because her mother was still recovering from using crack cocaine. Because of ZC’s lack of resources and family structure, her home visitor provided her with transportation to and from prenatal, WIC, and other appointments. The home visitor also served as a role model and a mother figure to ZC. ZC would call her home visitor two to three times each day for support and encouragement. In spite of all these problems ZC is now back in school, she is using oral contraception, and she managed to breastfeed for more than 2 months.

**PK** was a 23-year-old in her seventh pregnancy. She was single and developmentally delayed. She smoked and drank before and during pregnancy. Her home visitor convinced her to decrease her smoking and alcohol use during her pregnancy, and she is also now using contraception.

**TH** was an 18-year-old single mother who had dropped out of school and had been struggling financially. Her home visitor encouraged her and her boyfriend (who later became her husband) to return to school. Both have now earned GEDs. The home visitor assisted the couple with obtaining housing and enrolling in Medicaid and food stamp and WIC programs.

**TT** was a 15-year-old single mother who had dropped out of school and who reported experimenting with marijuana before and during her preg-
nancy. Her baby's father is a known drug dealer. TT's mother was recently released from the penal system after serving some years for drug abuse. Home visiting supported TT during her pregnancy, got her back in school, and helped her enroll in counseling to improve her self-esteem. The home visiting staff successfully convinced TT to reduce her drug use and helped her enroll in WIC.

Care Coordination Partnerships with Community Providers

Boston Healthy Start Initiative

It is ironic that Boston has a reputation of excellence in academic medicine and hospital care, even though the city has communities in which infant mortality rates are two to three times the city average.

Boston Healthy Start Initiative (BHSI) provided outreach and care coordination to these communities by enhancing the responsiveness and services of organizations already located in the target area (see Table 9). Working with existing organizations to intensify outreach and care coordination was a critical strategy of the project.

Clients in the BHSI target area cited a lack of child care and transportation as reasons why they failed to keep clinic appointments. From 1993 to 1994, only 10 percent of over 3,000 clients surveyed had access to such services. Through the interaction of the Healthy Start partners, BHSI was able to increase this percentage to 25 percent by 1996 to 1997. From 1993 to 1994, only 45 percent of BHSI enrollees had adequate prenatal care. By 1997, the collaborative partners had improved this rate to 60 percent of over 500 pregnant clients.

Consumers Rate Healthy Start Services

Savannah Healthy Start Initiative

Savannah Healthy Start Initiative (SHSI) caseworkers played a critical role in the SHSI program, linking clients to a wide range of services and providing support, encouragement, and education on parenting and prenatal care. To ensure the effectiveness of its caseworkers, SHSI conducted a consumer survey of 40 of their
### Table 9

The Boston Healthy Start Initiative's Outreach and Care Coordination Achievements

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Activities</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women, Inc.'s S.T.O.P.P. program</td>
<td>Outreach, referral, and detox services for pregnant women with substance abuse problems, including home follow-up.</td>
<td>Outreach extended to 4,013 women, including 128 pregnant women.</td>
</tr>
<tr>
<td>Martha Eliot Health Center</td>
<td>Home visits to pregnant and postpartum women by family health advocates, registered nurse (RN) case managers, and social workers/psychologists.</td>
<td>Home visits made by family health advocates (7,286), RN case managers (1,788), and social workers/psychologists (956); 272 of the women who gave birth during the period October 1994–December 1997 received a home visit within 72 hours of birth.</td>
</tr>
<tr>
<td>Geiger Gibson Community Health Center</td>
<td>Home visits—including postpartum visits—for all pregnant women.</td>
<td>During the period October 1994–December 1997, 147 women received a home visit within 72 hours of giving birth.</td>
</tr>
<tr>
<td>Uphams Corner Health Center</td>
<td>Case management and postpartum visits.</td>
<td>During the period October 1994–December 1997, 142 women received postpartum visits within 72 hours.</td>
</tr>
<tr>
<td>Whittier St. Community Health Center</td>
<td>Home visiting postpartum women.</td>
<td>During the period October 1994–December 1997, 211 postpartum women were visited.</td>
</tr>
<tr>
<td>Project Life</td>
<td>Biweekly home visits to postpartum women.</td>
<td>During the period October 1994–December 1997, 183 postpartum women were visited.</td>
</tr>
</tbody>
</table>

(continued on next page)
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Activities</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dorchester Cares</td>
<td>Home visiting to postpartum women.</td>
<td>During the period October 1994–December 1997, 310 postpartum women were visited.</td>
</tr>
<tr>
<td>Healthy Baby/ Healthy Child, BHCH, Dimock Community Health Center, Women's Inc., and MOM's Project</td>
<td>Increased access to pediatric care.</td>
<td>Reached 1,983 infants.</td>
</tr>
<tr>
<td>Boston Public Health Commission</td>
<td>Door-to-door outreach at housing projects to (1) identify families with young children, and (2) ensure that infants received on-time immunizations, pediatric care, and WIC.</td>
<td>During the period October 1994–December 1997, 139 families were served.</td>
</tr>
</tbody>
</table>

200 clients. The survey allowed clients to evaluate their caseworkers as well as SHSI. The survey found that

- 97 percent of those surveyed said their caseworker was readily available when needed;
- 93.5 percent said their caseworker had linked them to other needed services;
- 87 percent said their caseworker took the time to explain things they didn’t understand (10 percent stated they didn’t need anything explained to them);
- 23 percent reported that caseworkers returned their calls in the same day, and 61 percent said calls were returned within 24 hours; and
- 90 percent described the program as very helpful, while 6.5 percent described it as somewhat helpful.
II.D Impact on Clients: Reducing Barriers

Overview

Even when health care and social service providers are in “adequate” supply, a client may not be able to access them because finding multiple services in many locations with varying schedules and eligibility requirements is an overwhelming obstacle. Projects’ needs assessments identified a lack of information, public transportation, and child care as among the many obstacles to accessing care.

This section describes projects’ efforts to eliminate barriers to care. These efforts resulted in

- The addition of new services to low-access communities (Pee Dee);
- Innovations in scheduling and staffing transportation services, and high rates of client satisfaction with those services (Dallas, Detroit);
- Increased rates of WIC enrollment earlier in pregnancy (Pittsburgh);
- Successful enrollment of women at highest risk (Philadelphia); and
- Improved rates of prenatal care appointment compliance (Boston).

All of the 22 demonstration projects reported a significant impact in reducing barriers through facilitating services and increasing capacity.

Increasing Access in Rural Areas

Pee Dee Healthy Start Initiative

Pee Dee Healthy Start worked to increase the number of and access to services in a rural, six-county target area in northeastern South Carolina. To meet its goals, Pee Dee Healthy Start had to design interventions and strategies that could serve even the most isolated communities.

The Rural Outreach Advocacy and Direct Services (ROADS) intervention served the most isolated clients by transporting health care services to them. The target population—women of childbearing age, infants up to 1 year old, and their families—was offered comprehensive and continuous care within their own communities. Community outreach workers provided invaluable assistance in locating participants and keeping them in the health care system. ROADS staff included a
clinical social worker, certified nurse practitioner, health educator, resource moth-
er, early intervention specialist, and community outreach/eligibility worker.

The ROADS program featured a holistic case management approach to care
that utilized the community health model of primary prevention, health promo-
tion, and maintenance. ROADS team members traveled in vans and personal vehi-
cles. Each member covered a particular service area, recruiting participants via
referrals, home visits, door-to-door and community canvassing, and group pre-
sentations. Services such as case management, routine prenatal care, family plan-
ning, infant screening, immunizations, parenting skills classes, health and nutrition
education, and referrals to other agencies were available to participants in
their neighborhoods.

Many rural areas suffer from a shortage of medical and other services. The
Pee Dee target area was similarly afflicted, especially in the area of prenatal care.
Because of the Pee Dee Healthy Start Initiative, by September 1994 the number of
perinatal service sites increased from 116 to 136. By September 1997, the number
of sites had increased to 194. In addition, by September 1997 at least six additional
maternal-and-child-health specialist providers were recruited to the Pee Dee
Healthy Start target area.

MomMobile Transportation Program

Dallas Healthy Start

Clinic-based focus groups in the Dallas Healthy Start (DHS) target area iden-
tified lack of transportation as a major barrier to women accessing prenatal and
infant care. DHS initiated its MomMobile program with two 15-passenger vans in
1995. At first, this program served women at highest risk who had medically com-
plicated pregnancies, as well as parents of infants in neonatal care. Initially, service
was limited to a small geographic area where the need was determined to be
greatest.

As word spread about the service, both the size of the transportation service
area and the population eligible for ridership expanded. The program expanded
to five vans in 1997 and provided transportation to all medical appointments, as
well as parenting classes and other related maternal and child health services.

From May 1995 through September 1997, approximately 9,500 adolescent or
adult clients8 rode the MomMobile, with two vans in operation for much of the
period. Public media campaigns were successful in introducing the service to the

8Infants or children accompanying the mother were not counted as separate riders.
community. Radio and television stations, including local Spanish stations, were very responsive to providing public service announcements about the service.

A client survey conducted in March 1996 among randomly selected MomMobile riders showed that 95 percent expressed strong satisfaction with the service. Funds have been raised locally to acquire and operate two additional vans.

Expanding Transportation Services—
The Healthy Baby Service

Detroit Healthy Start Project

Transportation was a critical problem in the Detroit Healthy Start Project (DHSP) target area. A baseline needs assessment showed that

- 22 percent of women missed medical appointments; the average number of appointments missed was 2.2;
- Only 9.3 percent of target-area women citing a need for transportation received free transportation from existing services;
- Only 20.2 percent of women served by target clinics received free transportation from existing systems;
- The public transportation system was inadequate due to underfunding and often late; and
Low-income parents visited hospitalized newborns less frequently than they wanted to because of a lack of transportation.

Through a progressive partnership with an existing transportation program, DHSP significantly expanded service to the target area. The Healthy Baby Service provides transportation to perinatal services, neonatal intensive care units (NICU)s, parenting classes, and WIC appointments.

In particular, the program:
- Exceeded its ridership goals of 2,500 trips by 77 percent (4,442 trips) in its most recent full year;
- Effectively marketed the program, resulting in an increase in demand for transportation services for women living in the Healthy Start service area from 9.3 percent to 18 percent;
- Expanded service hours by going to a "flex time" schedule to accommodate evening appointments;
- Maintained a high level of client satisfaction, considering the increased demand for the service;
- Expanded a taxi-sponsored "return trip" policy in cases where the van was not available for DHSP clients; and
- Hired bilingual drivers to address language barriers.

Expanding Access to Nutrition Services

Allegheny County/Pittsburgh Healthy Start

A critical goal of Pittsburgh Healthy Start (PHS) was to increase participation in WIC. Healthy Start nutrition staff developed new strategies for locating WIC services and designing programs. These strategies significantly enhanced access and enrollment, partly through partnerships with local hospitals and health centers.

Strategies included:
- Setting up new on-site clinics at local hospitals;
- Coordinating WIC enrollment with pregnant women's first prenatal visits to hospital clinics;
- Expanding WIC orientation programs and clinic hours at local community-based sites;
- Creating an open, friendly, and inviting atmosphere through "Welcome to WIC" programs; and
Coordinating maternal and child health and WIC client services in a one-stop health care model.

As a result of these efforts,

- 2,977 women enrolled at hospital sites within the first 2 years.
- First trimester enrollments increased; 44 percent of pregnant women who enrolled through hospital-based clinics did so in the first trimester of pregnancy. (This contrasts with 22.2 percent at the original, single-location WIC clinic in downtown Pittsburgh.)
- Hospitals expanded their nutrition staff to extend health education to high-risk participants.
- A successful “Welcome to WIC” pilot orientation and intake program was expanded to six other community health centers.

Reaching Those at Highest Risk

**Philadelphia Healthy Start Initiative**

A community needs assessment conducted by the Philadelphia Healthy Start Initiative (PHSI) identified a paradox: While there seemed to be sufficient perinatal service capacity, a high percentage of women in the target areas were not obtaining any or adequate prenatal care.

A local evaluation of PHSI’s target area population confirmed the success of PHSI outreach efforts. First, the evaluation demonstrated progressive annual growth in Healthy Start enrollment. Second, it confirmed that Healthy Start was successful in reaching women at high risk.

Between 1994 and 1996, the percentage of women in the target area who were enrolled as clients increased from 18.2 percent to 40.6 percent. Healthy Start was able to reach and serve a substantial and growing proportion of all of the births in the target area.

A comparison of clients (4,242 births) vs. nonclients (9,280 births) in the target areas during 1994–96 showed that Healthy Start clients were more likely to be adolescent and single than nonclients. They were also more likely to have smoked, drank, and had multiple medical risk factors. An analysis of a subset of demographically similar client and nonclient populations showed that Healthy Start consistently identified women who were at higher risk than their demographically similar peers.

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9Meyer et al.
Ensuring Kept Appointments

Boston Healthy Start Initiative

Lack of reliable transportation and lack of adequate child care are two major barriers preventing many pregnant and prospective mothers from seeking or receiving adequate medical care. In seeking to overcome these barriers, Boston Healthy Start Initiative (BHSI) funded 11 community health centers and 2 community agencies starting in January 1994.

The purpose of this funding was to reduce the high percentage of prenatal/pediatric patients who did not keep appointments. During fiscal year 1997, 12,002 clients used transportation for postpartum and pediatric visits, and 20,828 infants (some duplicated counts) received child care.

Before BHSI's involvement, the percentage of unkept prenatal and/or pediatric appointments in the project area was 30 percent. Through BHSI's efforts to remove the barriers of inadequate transportation and child care, the percentage of patients who did not keep appointments in 11 community health centers and 2 community-based agencies declined to 10 percent (exceeding the stated objective of 15 percent) by September 30, 1996. Table 10 provides some notable examples of BHSI accomplishments.

Enhancing Access to Care for High-Risk Women

Boston Healthy Start Initiative

Case management services funded by Boston Healthy Start Initiative (BHSI)
<table>
<thead>
<tr>
<th>Program Name and Duration</th>
<th>Initial % DNKs</th>
<th>Final % DNKs</th>
<th>Number of DNKs</th>
<th>Number of Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowdoin Street Community Health Center</td>
<td>30*</td>
<td>9</td>
<td>123</td>
<td>1,350 perinatal and pediatric (0–3 years)</td>
</tr>
<tr>
<td>South Cove Community Health Center</td>
<td>30*</td>
<td>7</td>
<td>176</td>
<td>5,286 perinatal</td>
</tr>
<tr>
<td>Whittier Street Community Health Center</td>
<td>30*</td>
<td>9</td>
<td>180</td>
<td>1,810 perinatal and pediatric (0–3 years)</td>
</tr>
<tr>
<td>Project Life</td>
<td>30*</td>
<td>10</td>
<td>139</td>
<td>1,350 psychosocial and advocacy</td>
</tr>
<tr>
<td>Martha Eliot Community Health Center</td>
<td>30*</td>
<td>10</td>
<td>355</td>
<td>3,400 perinatal and pediatric (0–3 years)</td>
</tr>
<tr>
<td>Codman Square Health Center</td>
<td>30*</td>
<td>10</td>
<td>257</td>
<td>2,344 perinatal and pediatric (0–3 years)</td>
</tr>
<tr>
<td>Uphams Corner Health Center</td>
<td>40</td>
<td>10</td>
<td>95</td>
<td>956 perinatal and pediatric (0–3 years)</td>
</tr>
<tr>
<td>Haitian Multiservice Center</td>
<td>30*</td>
<td>10</td>
<td>48</td>
<td>480 psychosocial and advocacy</td>
</tr>
</tbody>
</table>
have had the greatest impact on high-risk mothers. These women run the risk of not receiving care because of issues related to homelessness, substance abuse, adolescence, and domestic violence.

BHSI developed a relationship with the Boston Health Care for the Homeless (BHCH) program and the Department of Transitional Assistance (DTA) in the Welfare Department to address the needs of high-risk women. The BHCH program stations a case manager at the DTA office where shelter referrals are made for homeless families. Pregnant women are identified at the point of intake and are followed by the BHCH case manager through the transition to shelter living, where they receive prenatal care and support services from the BHCH clinical team.

Collaborations between WIC, community health centers, community-based agencies, and BHSI case managers have made a major impact on care coordination. Each woman receiving WIC services now receives an individual care plan. These plans were developed after it became apparent that many women allowed their vouchers to expire because they did not know where to go to get WIC items, had no knowledge of what items they are allowed to purchase, and did not know how to substitute WIC vouchers for food stamp purchases.

Reducing Barriers to Care

Philadelphia Healthy Start Initiative

Philadelphia Healthy Start Initiative (PHSI) linked its outreach and lay home visiting programs with a range of community support services to help clients overcome barriers to care.

- Two neighborhood-based and PHSI-established “Lending Closets” provided maternity and infant supplies to pregnant women who agreed to participate in health care services.
- The threats of inadequate housing and homelessness were addressed through PHSI’s emergency housing assistance grants. These grants helped forestall eviction and utility cut-offs and provided coverage of security deposits for prepartum and parenting families. The housing assistance program benefited 8 percent of PHSI enrollees.
- To help clients reach their clinical appointments, PHSI provided van services as well as public transportation tokens and cab vouchers to over 20 percent of clients receiving PHSI services.
- In partnership with Philadelphia’s emergency food system, PHSI provided infant formula to families in need and facilitated enrollment in the WIC infant program.
PHSI provided translation services at several provider sites.

Families who have lost an infant are at increased risk for poor physical and mental health and future pregnancy outcomes. With this in mind, PHSI offered bereavement counseling through workshops, support groups, and one-on-one counseling, as well as assistance in burial and funeral arrangements.

II.E Impact on Clients: Substance Abuse Programs

Overview

Substance abuse is one of the most difficult risk factors to address in perinatal care. Communities targeted by Healthy Start often had few or no programs that could adequately meet the special needs of pregnant women who abuse substances. This section describes how the Richmond, New York, and Pittsburgh Healthy Start projects innovatively addressed this critical shortage.

Treatment Assistance Services Center

Richmond Healthy Start Initiative

Before the Richmond Healthy Start Initiative (RHSI), no service provider in the City of Richmond provided specialized substance-abuse treatment services to pregnant or postpartum women. RHSI worked with the Treatment Assistance Services Center (TASC) to establish such a program.

The program includes extensive case management as well as transportation and child care support for women in treatment. More than 140 women participated in the program through 1996.

Significantly, the Virginia Medicaid program used RHSI's model to design Medicaid intervention services in Virginia. TASC treatment services are in transition for Medicaid reimbursement beginning in 1998 under the new Medicaid State Plan Option (SPO) Program. This plan is designed to provide Medicaid funding for substance abuse treatment to eligible pregnant and postpartum women with children, as well as residential treatment programs being implemented by community service boards.
Additionally, RHSI’s creation of the Pregnant and Post-Partum Women Program has fostered new collaborations between TASC, other programs within the RHSI network, and other social service agencies, including

- Children’s Health Insurance Program (CHIP) of Richmond
- Healthy Families Richmond
- Minority Health Consortium
- Adult Career Development Center
- The Emergency Shelter
- Richmond Redevelopment and Housing Authority
- Richmond Department of Social Services
- Community corrections agencies
- The Medical College of Virginia
- The Center for Perinatal Addiction
- Richmond Head Start

**Attacking Substance Abuse**

**Healthy Start/New York City**

Healthy Start/New York City (HS/NYC) used a variety of substance-abuse prevention and treatment strategies. All case management services, some adolescent services, and some nutritional programs included special assessments, counseling, and referrals for substance abuse.

In addition, Healthy Start helped to start or support the following specialized substance abuse programs.

- **Youth Survival Strategies Program at Inwood House/TASA (Mott Haven Healthy Start).** This program provides extensive outreach through collaboration with the school system, social service agencies, and other community-based programs. It also provides substance-abuse prevention education and counseling to at-risk adolescents as well as workshops, individual counseling, and peer counseling training.

- **Reality House, Inc. (Central Harlem Healthy Start).** Drug abuse treatment and comprehensive case management and support are offered to women enrolled in substance-abuse treatment services who are pregnant and/or parenting a child under 1 year of age. This program also offers support groups, parenting education, and child care.
1115 Demonstration (Bedford Healthy Start). The Bedford Healthy Start lead agency collaborated with the New York State Health Care Financing Administration 1115 Waiver demonstration project in providing enhanced Medicaid reimbursement for drug treatment services to pregnant women with substance abuse problems.

Between 1990 and 1996 the percentage of live births representing illicit drug use during pregnancy declined significantly in HS/NYC project areas (Table 11).

### Table 11

*Reported Illicit Drug Use during Pregnancy, Healthy Start/New York City: Percentage of Live Births and Percent Decline, 1990–1996*

<table>
<thead>
<tr>
<th>Healthy Start Project Area</th>
<th>% Live Births, 1990</th>
<th>% Live Births, 1996</th>
<th>% Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedford</td>
<td>3.9</td>
<td>2.1</td>
<td>46</td>
</tr>
<tr>
<td>Central Harlem</td>
<td>11.8</td>
<td>6.9</td>
<td>41</td>
</tr>
<tr>
<td>Mott Haven</td>
<td>5.8</td>
<td>2.2</td>
<td>62</td>
</tr>
<tr>
<td>Total Project Area</td>
<td>6.3</td>
<td>3.2</td>
<td>49</td>
</tr>
</tbody>
</table>

*Source: New York City Department of Health, Office of Vital Statistics and Epidemiology.*

*A community quote from ... Doug Watterston, substance abuse counselor for the Youth Survival Strategies Program at Inwood House/TASA, Mott Haven*

"Judging by our success rate—95 percent of our young mothers delay further pregnancies and avoid drugs, and most complete school—our program is doing something right.... Our teens are faithful to their Friday night meetings, and to one another."
Mentoring Sisters

Allegheny County/Pittsburgh Healthy Start (PHS)

In 1996, Pittsburgh Healthy Start (PHS) seeded Mentoring Sisters, an approach new to the Pittsburgh area that provided ongoing support to pregnant women with substance abuse problems.

In a project that pooled the efforts of the Department of Human Services, Certified Addictions Counselors (CAC), and trained paraprofessional peer counselors, PHS significantly increased the range of options available to these high-risk cases while minimizing the potential for separation of child and mother.

Key features of the program include

- Integration with Healthy Start's care coordination teams for identification and follow-up.
- The use of paraprofessional peer counselors: individuals who themselves are in recovery from addiction and who have been drug- and alcohol-free for at least 2 years. These individuals engage, motivate, and bring clients to treatment and provide support following reentry into the community.
- A safe living environment in the residential treatment phase and in the community-based halfway house setting.
The development and maintenance of a formal multidisciplinary treatment process, including life skills training, parenting, and child development education; therapeutic exploration of interpersonal relationships; and individual and group work to promote sobriety.

- The establishment of concurrent child welfare goals upon referral, during residential treatment, and during aftercare treatment.
- The provision of a safe, nurturing, stimulating, and family-like setting.

II.F Impact on Clients: Special Populations—Adolescents, Fathers, and Women in Jail

Overview

Healthy Start projects faced challenging questions in determining how to reach key segments of their target communities:

- How do you reach someone who is of high-school age, pregnant for the first time, and too proud or too afraid to talk to even her own family?
- What role can male partners play in supporting healthier pregnancies and providing child care?
- How can community-based programs link with incarcerated women, many of whom are both pregnant and at high risk for serious infections?

This section describes Healthy Start strategies targeted at adolescents (Cleveland, New Orleans, Philadelphia, and New York City), male partners (Baltimore), and women in prison (Pittsburgh, Cleveland).

Getting to Adolescents Where They Live: Partnering with Public Schools

Cleveland Healthy Family/Healthy Start

Cleveland Healthy Family/Healthy Start (CHF/HS) significantly increased the outreach and impact of its school outreach teams with a major reorganization of this key service component in 1995. Before this time, the school outreach program
was operated by community health organizations whose prevention specialists worked with 23 public schools to identify pregnant or parenting students and refer them to outreach workers. However, the ability of the underfunded public school staff to capitalize on this coordinated relationship with outside providers was limited, as were program results.

In 1995, the school outreach teams were transitioned to the Cleveland public school system. The teams were restructured and based at secondary school sites. They were more regularly available on-site to refer students directly to health care providers and any needed support services; answer students' questions regarding pregnancy, delivery, and infant care; work with teachers to provide preventive health education to students; and work with the school system's Health Education Office to develop curriculum-enhancing materials.

By March 1997, 29,355 middle- and high-school students had received prevention education. During the 6-month period from November 1996 to March 1997, there were 337 identified pregnancies within Cleveland's public secondary schools. This declined by 217 to 120 during the 6-month period from April through September 1997.

**Focusing on Adolescents' Needs**

**Great Expectations Healthy Start**

Developing specialized services for adolescents was a natural evolution for the Great Expectations Healthy Start (GE) in New Orleans. GE served areas with high rates of adolescent pregnancy and was very successful in attracting and maintaining adolescent clients. Although GE was not originally designed as an adolescent program, about 40 percent of GE's clients were under 19 years of age.

GE's Teen Awareness and Peer Counselor programs achieved significant success among adolescent clients and with collaborating agencies.

**Teen Awareness Program**

This program started when GE outreach workers began working at a nearby junior high school, providing educational activities related to pregnancy prevention. Because of their success, in 1993 the school approached the workers and asked them to provide these programs once a week during physical education classes. This evolved into the Teen Awareness Program, through which GE outreach workers provide regular educational sessions in middle and junior high schools. The number of requests for GE to provide this program in local schools continued to increase during phase I.
Peer Counselor Program

An effective way to reach adolescents is through other adolescents. For three summers, up to 30 students participated in a 6-week training program that prepared them to be peer counselors when they returned to school in the fall. They received training in topics ranging from STDs to conflict negotiation to self-esteem. Each student was also assigned to a GE service site to gain work experience and earn a small stipend. Upon returning to school, peer counselors represented GE at their school, educating peers on the impact of adolescent pregnancy and referring pregnant or at-risk adolescents to the program. They continued their work experience at the GE sites.

As a result of the peer counseling program,

- More than 60 percent of the peer counselors increased their knowledge about the risks of unprotected sex and the consequences of early sexual behaviors.
- 46 percent of the peer counselors felt they had gained knowledge as result of the program, and 50 percent reported an increase in their interpersonal skills.

Reducing Adolescent Pregnancy

Philadelphia Healthy Start Initiative

Addressing pregnancy among adolescents ages 19 and younger was a high priority for Philadelphia Healthy Start Initiative (PHSI). Ten PHSI programs focused their services exclusively on adolescents. These included six adolescent peer-power programs, a community health-education demonstration project, an adolescent mothers’ clinic for postpartum mothers under age 15, and two Healthy Start “Health Corners.” In addition, PHSI clinical enhancement efforts and educational programs increased access and awareness among adolescents as well as other clients.

Health Corners

Health Corners were special outreach sites located in community settings that provided entry-level care, referrals, and health education. Each site represented a partnership between a medical provider and a community organization.

One site was located in a recreation center in the Mantua neighborhood of Philadelphia. Pregnant women obtained both direct prenatal and early childhood services, as well as referrals (as needed) to institutional services. Because the site
was located at a recreation center, it was also very effective in reaching the male partner population and connecting with staff and students at the local high school.

Another Health Corners site was established at a housing development in Eastwick at the request of a local housing organization. Healthy Start worked closely with Eastwick PAC to develop plans and staffing for the service and establish a partnership with the local Miseracordia (now Mercy) Hospital. This site has evolved into a full prenatal care provider that is staffed by a certified nurse-midwife and is eligible for Medicaid reimbursement.

**Positive Project Outcomes**

A local evaluation by the Family Planning Council in 1996 compared trends from 1991 to 1994 in adolescent pregnancy rates and prenatal care utilization rates between Healthy Start target areas and a comparison area in north Philadelphia.\(^{10}\)

By 1993 and 1994, the number of prenatal care visits made by adolescents in the Healthy Start areas had increased from an average of 7.3 to 8.8, a statistically greater increase than that of the comparison area.

The difference in the average number of prenatal care visits between the two areas—8.8 in Healthy Start areas vs. 7.8 in the north Philadelphia comparison area—was statistically significant. The number of prenatal care visits made by adolescents increased in both areas, but the increase was twice as great in the Healthy Start area as in the north Philadelphia area (20 percent vs. 10 percent). By 1994, adolescents in the Healthy

\(^{10}\)PHSI programming coincided with several other well-funded and publicized initiatives expanding prenatal care access for women in most geographic regions of Pennsylvania. The greater increase in the number of prenatal care visits made among Healthy Start area adolescents may reflect a more intensive effort made by Healthy Start providers than other programs to enroll adolescents early in pregnancy and promote consistent attendance.
Start area averaged one full prenatal-care visit more per pregnancy than adolescents in north Philadelphia.

For adolescents ages 15–19, between 1991 and 1994 birth rates dropped significantly in both the Healthy Start and north Philadelphia comparison areas, as well as across the city as a whole. However, by 1994, the birth rate of 72 per 1,000 adolescents among the oldest adolescents (ages 18–19) in the Healthy Start area was 62.5 percent lower than the citywide rate of 117 per 1,000, and 54.2 percent lower than the rate for the north Philadelphia comparison area (111 per 1,000). While the number of adolescents participating in Healthy Start programs was only a fraction of the total number of area adolescents (about 20,000), these observations should lead to further exploration of these adolescent strategies.

In addition, the evaluation helped to identify the most successful—in fact, critical—program design characteristics from the points of view of both the adolescent clients and the providers:

- The opportunity to share experiences with peers or a community adult had the greatest value to adolescent clients, when compared with video and radio outreach.
- Adolescents expressed strong feelings about the quality of provider care, including provider appearance, facility cleanliness, and ways in which they were made to feel comfortable and empowered.
- Providers confirmed that keeping them informed about referral services and agencies would significantly enhance their ability to make effective referrals.

**Reaching Inner-City Adolescents**

**Healthy Start/New York City**

Healthy Start/New York City (HS/NYC) implemented more than a dozen programs aimed at adolescents across its three target areas. These programs sought to give adolescents alternatives to pregnancy, improve their health, and help them make constructive life choices. HS/NYC has funded student internships, peer mentoring, male involvement and leadership development efforts, after-school programs, and prenatal care and family planning services for pregnant and parenting adolescents.

From 1993 to 1996, the project exceeded annual targets for utilization of its adolescent services. The program cumulatively served almost 14,000 adolescents in school-based adolescent pregnancy programs who would not have been otherwise served.
In response to the underserved male population, in 1994 the project implemented several male involvement programs, serving a total of 5,194 young men over 2-1/2 years.

The project was particularly successful in reaching at-risk youth. For example, the Bedford Healthy Start/Ellison Youth Initiative (EYI), used entertainment and talent development to attract some of the most at-risk youth. To participate in this program, adolescents had to enroll in HS/NYC-supported health education and homework help programs. This grassroots effort has served more than 300 youth annually, and has received national attention for its innovation and ability to provide youth with an alternative to gang-related activities, violence, and adolescent pregnancy. The program has had only four pregnancies in 3 years.

A community quote from ... Seiko Dolson, youth participant in the Ellison Youth Initiative, Bedford Healthy Start (as reported in the New York Amsterdam News, September, 18–24, 1997)

“If it wasn’t for [my mentor] I’d be dead. I’m one of the kids he saved from the streets.... He motivates us, he keeps us going.”

Men’s Services Program

Baltimore City Healthy Start (BCHS)

The Baltimore City Healthy Start (BCHS) Men's Services program has received a tremendous amount of local and national recognition for its work with young inner-city African-American fathers. This population group is often feared and disdained by the general public and ignored by maternal and child health policymakers and practitioners. BCHS has demonstrated that this group of individuals instead should be perceived as an extremely influential and potentially very positive force in the lives of their children.

The primary goal of the Men's Services program is to assist fathers and other male support persons associated with BCHS clients in assuming their paternal responsibilities and maintaining involvement with their children and families. BCHS promotes parenting and communication skills and provides peer and program support related to child support and visitation, substance abuse treatment, and employment.
Through September 1997, Men's Services enrolled 305 fathers of infants or significant others of infants' mothers enrolled in Healthy Start. Of these men, 68 percent became actively engaged participants in support and education groups. The men ranged in age from 16 to 41 years; the average age was 24.

Preliminary analyses of 1-year postpartum reassessment interviews of female BCHS clients indicate that their male partners are more involved with their children and provide more financial support than the male partners of a control group of area women.

Women in Prison

Allegheny County/Pittsburgh Healthy Start

The number of female inmates in the Allegheny County Jail Annex ranges from 125 to 175. About 15 percent of these women are pregnant at any given time. This population is at high risk for STDs and HIV infection. Many of these women are residents of Healthy Start communities.

Historically, although they were routinely screened for STDs and HIV, pregnant inmates received limited support services. Follow-up care after pregnant women's release into the community was not coordinated with other services provided to inmates.

Pittsburgh Healthy Start (PHS) initiated the Women's Health Initiative as a partnership with community health organizations and agencies. PHS's partners were

- Allegheny County Jail
- Healthy Start/Allegheny County Health Department
- Primary Care Health Services, Inc.
- BirthPlace—the Midwifery Services of West Penn Hospital
- The Family Health Council
- The American Cancer Society
- The Centers for Disease Control and Prevention's STD public health advisors for Pennsylvania and Allegheny County

This partnership significantly increased the scope and availability of services available to female inmates. These services included

- Routine screening of all new residents for STDs
- Health education classes on STDs, HIV, drugs, alcohol, smoking, hygiene, self-esteem, and parenting
Family planning services
- Prenatal, delivery, and postpartum services by a certified nurse-midwife

More than 200 women received services during an average 6-month period. Upon release, women were followed by a Healthy Start core case-management team in their service area, and follow-up care with nurse-midwives was coordinated.

The program model became self-sustaining through funding within the prison system. Another unexpected but important benefit that resulted from the program was a significant decrease in the number of general grievances filed by female inmates.

**Correctional Facility Care: A High-Risk Team Approach**

**Cleveland Healthy Family/Healthy Start**

In early 1996, Cleveland Healthy Family/Healthy Start (CHF/HS) was contacted by the director of the Cuyahoga County Corrections Center for help with a critical problem. At any given time, about 10 percent of the female inmate population incarcerated for 15 days or more was pregnant and had high rates of HIV infection (8 percent) and chemical dependency (71 percent).

In response, CHF/HS developed a risk-reduction model to address the critical psychosocial needs of this population. Twice a week, a high-risk team of three licensed independent social workers provide one-on-one counseling, planning, and group educational sessions. They function as advocates for the women upon their release and help to arrange appropriate placement in a treatment facility or shelter. The team also helps these women access public assistance, Medicaid, and transportation services for follow-up care.

One hundred percent of the 74 women approached in the project’s first quarter year agreed to participate in the program. They welcomed the chance to work with the high-risk team members to make arrangements for their infants to be placed with a family member. Workers conduct home visits to assess the appropriateness of placement and help prepare the home and family members for the infant’s arrival.

Because of its success and innovation, CHF/HS’s high-risk team program has attracted additional funds (from the criminal justice system and the Ohio Department of Health) for services to these women. The program will expand to include pregnancy testing for all female inmates incarcerated for 15 days or more,
as well as services for women in the early stages of pregnancy. Liaison outreach worker positions were created at 11 settlement houses to address the needs of women reentering the community from the penal system.

Furthermore, other city agencies have sought out CHF/HS's assistance in servicing this population and have used CHF/HS's existing infrastructure and the trust CHF/HS staff have gained in the jail. For example, the Commissioner of Health requested CHF/HS assistance in developing programs providing substance abuse treatment and STD testing for all incarcerated women.

Comprehensive Care for Female Detainees at Cook County Jail

*Chicago Healthy Start*

In 1993, Chicago Healthy Start began a program with Cermak Health Services, the largest single-site, correctional health-care service in the United States, to provide health care at Chicago's Cook County Jail. The program offers case management services, health education classes, and comprehensive medical care to women detained at the jail.

Case management includes coordination with follow-up services and primary care providers in the community, referral to substance-abuse treatment services, and follow-up home visits. More than 5,000 female detainees have participated in health education classes on topics such as family planning, STDs, prenatal/infant growth and development, pregnancy and childbirth, and nutrition.

In 1997, the Healthy Start Program at Cook County Jail received the 1997 Program of the Year Award from the National Commission on Correctional Health Care, on the recommendation of the commission's accreditation committee. As described in the award announcement,

This prestigious award is presented to only one program per year selected from among the numerous programs offered at over 400 prisons, jails, and juvenile confinement facilities participating in the National Commission's accreditation program. The Committee was particularly impressed with the link this program has with community health care providers, and the assistance it offers to those just starting out on life's journey.
Impact on Providers and the Service Delivery System

As discussed in the previous section, directly reaching and assisting high-risk indigent clients is challenging but essential to improving community prenatal care and birth outcomes. However, it is only one part of the equation. Another critical element is improving the system of care—both clinical and social support services—for pregnant women and children with limited means.

One of Healthy Start's greatest achievements has been to improve systems of care. This impact can be measured by the number and scope of new working relationships established among community providers and agencies, and by other state agencies' use of Healthy Start service-coordination models. Healthy Start efforts reduced the duplication of services and increased the sharing of data and information between providers and agencies.

A list of all Healthy Start projects reporting an impact on their community's provider and social-service delivery system is provided below.

- Baltimore City Healthy Start
- Birmingham Healthy Start
- Boston Healthy Start Initiative
- Chicago Healthy Start
- Cleveland Healthy Family/Healthy Start
- Dallas Healthy Start
- Detroit Healthy Start
- District of Columbia Healthy Start Project
• Essex County Healthy Start (New Jersey)
• Florida Panhandle Healthy Start
• Great Expectations Healthy Start (New Orleans)
• Healthy Start/New York City
• Allegheny County/Pittsburgh Healthy Start
• Milwaukee Healthy Women and Infants Project
• Northern Plains Healthy Start (North and South Dakota, Iowa, and Nebraska)
• Northwest Indiana Healthy Start
• Oakland Healthy Start
• Pee Dee Healthy Start (South Carolina)
• Philadelphia Healthy Start
• Richmond Healthy Start Initiative
• Savannah Healthy Start

III.A Impact on Providers and Service Delivery Systems: Collaboration and Integration

Overview

Healthy Start projects have enhanced the coordination and integration of clinical and social services by

◆ Encouraging community-based collaboration through subcontracting requirements and the grant-making process (Dallas);
◆ Serving as a model to be replicated in other areas of the state and/or at other levels of government (Oakland);
◆ Bringing together multiple providers and community-based agencies for collaboration and large-scale special purpose initiatives (Cleveland, Pittsburgh, New Orleans, Richmond);
◆ Facilitating the development of memorandums of understanding (MOUs) and other collaborative efforts to serve special groups (e.g., New York, Northwest Indiana); and
Aggressively working with Medicaid and/or public health departments to coordinate efforts to fund and evaluate local services (Boston).

Giving Priority to Local Agencies That Collaborate

Dallas Healthy Start

The Dallas Healthy Start's (DHS's) process for subcontracting to community agencies encouraged applicants to maximize resources through joint projects and the sharing of curricula and training. To facilitate collaboration, DHS held workshops that emphasized collaborative program strategies to prepare community agencies for networking.

As a result, new and important alliances have been created among service providers. For example, traditional, well-established organizations such as Girls Incorporated of Metropolitan Dallas are working with nontraditional grassroots agencies like African American Men of Peace (AAMOP). Girls Incorporated’s programming on pregnancy and substance abuse prevention is provided to AAMOP’s male and female youth.

Other partnerships formed under DHS's collaborative funding criteria include those linking

- Wesley-Rankin Community Center and the Greater Dallas Community of Churches;
A Model for Community Health Services Organization and Integration

Oakland Healthy Start

Oakland Healthy Start's method of integrating health and social support services has served as the model for a broader communitywide reorganization of health services in Alameda County. In November 1995, the Alameda County Board of Supervisors approved a restructuring of the public health department. This restructuring reduced the number of departments from 11 to 5 and included a new division: Community Health Services.

The Division of Community Health Services (CHS) is being developed along the lines of Oakland Healthy Start (OHS). Services are being placed more directly within the community, and the administrative focus is shifting from a traditional, local health-department model to a more centralized, integrated-services model. Programs being included in CHS are WIC, public health nursing, maternal and
child health outreach, health care for the homeless, dental services, alcohol and drug prevention, and case management for drug-exposed infants (the Healthy Infant Program).

OHS also provided information to California's Maternal and Child Health Division. This division is preparing to restructure funding to six other counties selected as pilots for developing alternative methods of serving high-risk populations. These counties will have some latitude for creativity in program development, but will be required to include community involvement and an outcomes orientation. OHS's one-stop-shopping service sites were viewed as a positive model that could be duplicated in these pilot areas.

From Competition to Cooperation through Infant Mortality Review

Cleveland Healthy Family/Healthy Start

Before the implementation of Healthy Family/Healthy Start (HFHS), there was no infant mortality review (IMR) project in the Greater Cleveland area. There was also very little collaboration between hospitals on comprehensive planning for services for inner-city residents.

HFHS's development of an IMR structure and process resulted in unprecedented collaboration between health facilities, providers, and public agencies in the Cleveland area. The IMR team was instrumental in gaining the initial support of medical institutions to share medical records. The team's presentations to organizations such as the Center for Health Affairs (formerly the Greater Cleveland Hospital Association) encouraged the relationships between providers. Support from the Center for Health Affairs helped launch a 24-hour hotline that allowed hospitals to provide rapid notification of all infant deaths in the community.

The IMR project also enlisted the support of local medical associations, including the Cleveland Academy of Medicine, the Northern Ohio Pediatric Society, and the Cleveland Society of Obstetricians and Gynecologists, all of which strongly endorsed the project. Relations were improved between the Department of Public Health and the university, between the city and county health departments, between HFHS and the Department of Children's and Families' Services, and between the IMR program and county offices (the coroner's and commissioner's offices and the health department).

One of the additional strengths of HFHS's IMR project was its effect on the broader community. The IMR team sponsored outreach-worker training sessions,
community-based informational presentations, and staff participation in other Healthy Start committees, as well as local, regional, and national presentations of its process, findings, and recommendations. Through phase I, the IMR presentations reached a combined audience of almost 3000.

Integrating Public Health Services into Community Clinics

Allegheny County/Pittsburgh Healthy Start

The collaborative efforts between private community clinics and public health services initiated by Allegheny County/Pittsburgh Healthy Start (PHS) significantly reduced fragmentation of family health care and duplication of services.

McKeesport

In McKeesport, a community once known for steel production but now suffering from high unemployment, the services of Primary Care Health Services (PCHS) (a community health center) and the well-child clinic of the county’s health department were combined into one location. PCHS helped negotiate a letter of understanding, forming a partnership to provide comprehensive family services to the area.

As a result, all clients receive primary care, public health home visiting, community outreach, and nutrition and health education through the same partnership. In addition, new services such as obstetrics and gynecology (OB/GYN), nurse-midwifery, and child reading activities during waiting time were added with support from a local hospital and community service agency. This effort not only maximized health service resources, it also included the sharing of experience, education, and training among staff.

Wilkinsburg

No community health center existed in Wilkinsburg until a collaboration between Healthy Start/County Health Department, PCHS, Hosanna House, Inc., and the Forbes Health System led to the development of the Wilkinsburg Community Health Advisory Council. As a result, a new Wilkinsburg health center was established and is continuing as a satellite of PCHS. It includes county health department programs as well as additional health services.
Network Formation in New Orleans

Great Expectations Healthy Start

Great Expectations Healthy Start (GE) in New Orleans sparked many collaborative initiatives among state and local public officials, provider organizations, and community groups. Efforts included creating new task forces, establishing the first infant mortality review board in Louisiana, and developing service coordination partnerships.

These initiatives resulted in increased health services capacity and more effective and consumer-centered coordination of care across service levels.

The New Orleans Perinatal Task Force

The New Orleans Perinatal Task Force was developed as a forum for key state and local officials and clinic and institutional providers to address perinatal issues in New Orleans. GE facilitated a significant key relationship among the Medical College of Louisiana at New Orleans, Louisiana State University, Tulane School of Medicine, and the community health centers.

Before Healthy Start, obstetrical capacity was limited because of difficulty in recruiting physicians. With GE support, physicians from medical centers now provide services in clinics, thereby improving accessibility, quality, and continuity of care in local communities. The sensitivity of providers to community issues also has increased. Among other things, the task force has been instrumental in

- Staffing federally qualified health centers and community-based clinics with medical residents from local teaching hospitals;
- Developing a discharge planning and guaranteed appointment system for infants born at University Hospital and referred to the City of New Orleans well-baby clinics;
- Designing and adopting standardized perinatal forms; and
- Expanding family planning services provided at clinics.

New Orleans Coalition for Family Empowerment

GE played a critical role in establishing the New Orleans Coalition for Family Empowerment (NOCFE), one of the first large social-services collaborations in New Orleans. This coalition of 20 agencies seeks to coordinate and develop services aimed at reducing the number of children who end up in foster care. Coalition goals include providing case management to parents, reducing the num-
ber of adolescents in the criminal justice system, and improving the long-range prospects for problem youth through tutoring and after-school programs. The coalition has developed a centralized intake and assessment process to ensure that consumers are able to draw on the full resources of the coalition.

**Family Planning Coalition**

Another coalition formed through the leadership of GE is the Family Planning Coalition. Among its accomplishments, the coalition developed a consumer-oriented brochure and protocols for Depo-Provera to improve consistency of use. Through monthly meetings, the group has worked to improve coordination of services throughout the city, improve accessibility, standardize treatment of consumers, and minimize duplication of services across agencies.

The members of the Family Planning Coalition are
- Great Expectations, Inc.
- State of Louisiana Office of Public Health, Family Planning Office
- The Family Planning Clinic
- The Maternal and Child Health Department
- St. Thomas Health Services
- Medical College of Louisiana at New Orleans
- The New Orleans Health Corporation
- The New Orleans Department of Health
- Planned Parenthood

**A Catalyst for Collaboration**

**Richmond Healthy Start Initiative**

Fragmentation can debilitate what may otherwise appear to be a well-supplied health delivery system. Before the Richmond Healthy Start Initiative (RHSI), Richmond lacked an entity that could pull together service providers and coordinate service delivery to improve maternal and child health.

As a result of RHSI, service agencies that were once competitors began to see each other as team players striving to meet common goals. RHSI has led to significant collaboration between private and community-based providers, as well as within the public health system itself. Examples of collaborative programs are listed below.

- The Foster Care Sexual Education Program, designed to reduce the rate of adolescent pregnancy, was initiated by RHSI through a collaboration with
Coordinators 2/Inc. (a private agency), the Richmond Behavioral Health Authority, and the city's Department of Social Services.

- The Sibling Project, targeted at the siblings of pregnant adolescents, is a collaboration between multiple RHSI contracting agencies and the Boys and Girls Clubs.

- Greater Expectations is a program that uses adolescent education to reinforce postponing sexual involvement. RHSI's contractor, the Virginia League for Planned Parenthood, implements this program, which is targeted at sixth- and seventh-grade students under an agreement with the Richmond city schools.

- RHSI is part of the Richmond City Department of Public Health. Because of RHSI's success in developing collaboration among local agencies, significantly greater coordination is also occurring within the health department. Various efforts related to infant mortality beyond Healthy Start are better coordinated. For example, key initiatives have been reorganized to require collaboration with Healthy Start, including the Virginia Department of Health (VDH) Teen Pregnancy Prevention Program, the VDH Unintended Pregnancies Initiative, and the Family Planning and Male Responsibility Initiative. These programs have been integrated into a division of the Richmond Public Health Department, maximizing resources and reducing service duplication.

**Structural Changes Supporting Service Integration**

**Healthy Start/New York City**

Before the implementation of Healthy Start/New York City (HS/NYC), many agencies and institutions provided services to project area residents. While some of these groups were involved in efforts to reduce infant mortality, such efforts were fragmented.

HS/NYC helped forge well-defined working relationships between agencies at the project-area level and within project areas. The community-driven process implemented by HS/NYC created clear mechanisms for collaboration on project objectives while fostering community control and consumer involvement.

The structural accomplishments of this effort include

- Launching a new perinatal agency: the Northern Manhattan Perinatal Partnership.
• Developing an enduring association among HS/NYC lead agencies; the perinatal networks in Queens, Nassau, and Suffolk Counties; and the project's founding members.

• Creating a specially designed management information system to coordinate case work for HS/NYC case management clients. This enabled the standardization of case management policies, procedures, delivery, and quality assurance.

• Developing memorandums of understanding (MOUs) across provider networks, thereby enhancing collaboration.

• Initiating and supporting a project-area consortium of New York City–based providers, the first of its kind.

• Creating consumer involvement groups at the local level, thereby enabling residents to become involved in program development in a meaningful way.

Improving the infrastructure for perinatal services in the project area contributed to HS/NYC's impact on birth outcomes and changes in health behaviors that are detailed in earlier sections (II.A and II.B). Project-area low-birthweight rates declined at significantly greater rates following program implementation. Improvements in health behaviors included decreases in the percentage of women receiving late or no prenatal care.

Community quotes from ... Representatives of agencies participating in HS/NYC, interviewed in focus groups in October 1997

"We collaborate more—much more—than before Healthy Start. Especially recently, there has been a push on the part of the subcontractors that there must be some type of linkage and networking, in that people really feed into 15 different programs."

"Healthy Start served as a galvanizing tool for various groups coming together. People were able to get together for specific joint planning around the issue of infant mortality and health services."
Linking Services in East Chicago

Northwest Indiana Healthy Start Project

One of four urban communities in the Northwest Indiana Healthy Start Project (NIHSP), East Chicago is an area with severely limited resources and poor coordination across services. NIHSP created partnerships with a broad range of organizations to improve client access to services and to create much-needed new programs.

NIHSP case managers identify and refer first-time adolescent mothers to Healthy Families, the state-funded child-abuse prevention program. They also collaborate with the care plan and follow-up developed by Healthy Families. Healthy Families staff come to the Healthy Start site to interview mothers who are referred or who agree to participate. WIC, Healthy Families, and the health department also collocate their services at the Healthy Start site.

A mutual referral and follow-up system was developed between NIHSP and Central Life Awareness Support Services (CLASS) at Central High School. Healthy Start provides a parenting class and sponsors "Lunch and Learn" sessions with students.

With St. Catherine's Hospital and other health agencies, NIHSP actively assisted in planning and designing a new East Chicago health center. NIHSP staff work closely with the labor, delivery, and emergency room staffs at St. Catherine's Hospital on referrals, prenatal care, and postpartum follow-up of Healthy Start clients. Forty-four percent of St. Catherine's deliveries receive Healthy Start services. As a result of this working relationship, the hospital's walk-in rate has declined 40 percent since 1994. Also, together with St. Catherine's, NIHSP provides a children's fair, free immunizations, and health fairs in local community centers.

Working with the area welfare office, NIHSP developed a procedure that allowed its case managers to assist clients in completing Medicaid applications. The welfare office notifies Healthy Start case managers of the date of the scheduled interview, allowing case managers to facilitate with follow-through.

NIHSP also participated in the Healthier East Chicago Initiative, a task force formed by East Chicago residents and providers to conduct community health planning.
Maximizing the Accessibility and Accountability of Public Services

Boston Healthy Start Initiative

The Boston Healthy Start Initiative (BHSI) implemented numerous structural changes—including changes to procedures and policies—to achieve a more integrated system. While structural changes tend to be difficult to achieve because of the resistance to change that is inherent in many established systems, BHSI has made some important accomplishments and inroads (see Table 12).

Table 12

Boston Healthy Start Initiative Achievements Affecting the Delivery System

<table>
<thead>
<tr>
<th>Activity</th>
<th>Accomplishment/Description</th>
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<tbody>
<tr>
<td>Creation of the BHSI hotline.</td>
<td>This hotline allowed women to access both state-funded insurance and BHSI programs. The hotline was the result of negotiations with Boston's Department of Public Health and the Department of Medical Security.</td>
</tr>
<tr>
<td>Revision of the Massachusetts Department of Public Health funding procedure for maternal and child health.</td>
<td>In consulting with BHSI, MDPH (the State Title V agency) adopted a new process for allocating state maternal/child health funds. The process was reconstructed to disburse funds on a 5-year health (MDPH) cycle, using the concept of community health networks in an effort to increase coordination and collaboration among same-area service providers.</td>
</tr>
<tr>
<td>Coordination of the BHSI and MDPH proposal review process.</td>
<td>A reciprocal proposal review process was established in which BHSI and MDPH jointly planned and reviewed proposals affecting the project area.</td>
</tr>
<tr>
<td>Negotiations with Medicaid.</td>
<td>Two significant agreements with Medicaid were made to share information and better coordinate program and funding decisions: (1) Implementation of a managed care system would not preclude the choice of provider by clients seeking care under the presumptive eligibility clause; and (2) exemptions for school-age clients to use school-based clinics would be allowed.</td>
</tr>
</tbody>
</table>
Impact on Providers and Service Delivery Systems: Enhanced Clinical Capacity and Accessibility

Overview

Health care services for low-income families, low-income workers, and/or persons on Medicaid are often under-funded or simply unavailable. Even where basic services exist, they are often limited in scope and hours of availability, culturally and linguistically limited, and uncoordinated with needed support services.

Healthy Start projects made targeted efforts to partner with clinical providers and achieved significant improvements in the standards for service delivery in their communities. This section contains descriptions of programs in Baltimore, Philadelphia, New York, Oakland, the District of Columbia, Detroit, and New Orleans.

Medical Reform

Baltimore City Healthy Start (BCHS)

Although the supply of clinical providers was adequate in Baltimore’s target areas, their accessibility was not. Through agreements with 16 prenatal and pediatric clinics located throughout the project area, Baltimore City Healthy Start (BCHS) helped reform medical services delivery to make it more user-friendly and accessible.

BCHS established standards that became objectives for providers participating in medical reform. These objectives included maximum wait times at clinics of no more than 20-30 minutes; scheduling the first prenatal visit within 2 weeks of initial call (or sooner if the woman is at high risk); expanded clinic hours; continuity of individual providers; encouraging male partner involvement; and selecting a pediatrician before the baby is born.

BCHS then provided a variety of assessment tools and training programs to help providers achieve these objectives. For example, together with providers,
BCHS developed a patient/client/customer relations training program; 484 provider staff participated in the program in 1995. BCHS also made the patient flow analysis (PFA) evaluation tool available to clients.

The medical providers participating in the medical reform initiative of BCHS were

- University of Maryland Hospital Obstetrical Clinic
- Western Center for Women's Health Care
- University of Maryland Pediatric Ambulatory Care Clinic
- Total Health Care Obstetrics and Pediatric Clinics
- Druid Family Health Centers
- East Baltimore Medical Center
- Baltimore Medical System, Inc.
- Johns Hopkins Hospital Obstetrical Clinic
- Maternity Center East
- Johns Hopkins Harriet Lane Pediatric Clinic
- Sinai Hospital Obstetrical and Pediatric Clinics

The impact of the medical reform initiative was measured in several ways. BCHS policy and evaluation staff monitored providers through ongoing evaluation activities over 4 years. Evaluation interviews were conducted in 1995, and quarterly client satisfaction surveys were administered to patients from each participating clinic. Annual PFAs were conducted in all clinics for 3 years.

Many of these efforts resulted in permanent changes to the delivery of care, and can now be viewed as institutionalized activities that are continuing beyond the life of the Healthy Start program. These changes include new appointment policies in which individually scheduled appointments are made with specific providers, the computerization of appointments, the implementation of staff patient-relations training, improved patient flow, and the use of team nursing and case management models.

In addition,

- For all medical reform providers, the percentage of patients enrolling in prenatal care during the first trimester improved from 29 percent in 1995 to 59 percent in 1996.
- The benefits of PFA were recognized by the University of Maryland OB/GYN clinic and Druid Family Health Center. These two groups now conduct periodic PFAs on their own as a process monitoring and evaluation tool.
Total Health Care, Inc., and the Johns Hopkins Medical Systems Corporation (East Baltimore Medical Center) adopted BCHS’s patient/client/customer relations training program for systemwide training.

Other effects are listed in Table 13.

| Table 13 |
| Baltimore City Healthy Start Medical Reform Service Accomplishments |
| Criteria | Baseline | Improvement |
| % women who had a family planning consultation prenatally. | 58 (1993–94) | 64.2 (1995 and 1996) |
| Number of prenatal providers who scheduled first prenatal visits within 2 weeks of initial call. | 6 of 9 (1992) | 9 of 9 (end of 1996) |
| Number of prenatal care providers who provided a health and nutrition education component to every patient, including information about nutrition, preterm labor, the prevention of alcohol and drug use, the dangers of smoking and second-hand tobacco smoke, family planning, and well-child care. | 2 of 9 (1992) | 9 of 9 (end of 1996) |
| % of women who selected a pediatrician prenatally. | 51% (1993–94) | 61.4% of 3,496 women (1995 and 1996) |
| Number of providers who provided a 2-week postpartum clinic or home visit for psychosocial assessment and family planning purposes. | 3 of 9 (1992) | 7 of 9 (end of 1996) |
| Number of providers who had on-site, staffed playrooms for children, accessible during regular hours of operation. | 4 of 18 (1992) | 14 of 18 (end of 1996) |

(continued on next page)
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Baseline</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of providers who maximized continuity of care by scheduling all patients with a particular practitioner.</td>
<td>13 of 18 (1992)</td>
<td>18 of 18 (end of 1996)</td>
</tr>
<tr>
<td>Number of providers who met an average waiting time standard of no more than 30 minutes from appointment or arrival time (whichever was later) to contact with the provider.</td>
<td>5 of 18 (1992)</td>
<td>9 of 18 (end of 1995)</td>
</tr>
<tr>
<td>Number of providers who met an average total visit time standard of no more than 2 hours.</td>
<td>13 of 18 (1992)</td>
<td>16 of 18 (end of 1995)</td>
</tr>
</tbody>
</table>

Notes: Target objectives were customized to each provider, so that for each of the standards above, the number of potentially involved providers varies. Clients include all women receiving care from the participating medical reform provider, not only Healthy Start–enrolled clients. The year prior to implementation was 1992. 1993–94 was the first implementation year. Some accomplishments relate to prenatal obstetrical care; others relate to pediatric care clinics (as noted).

**Enough Providers, Not Enough Care**

**Philadelphia Healthy Start Initiative**

Although perinatal service capacity in Philadelphia Healthy Start Initiative (PHSI) target areas appeared to be sufficient, a high percentage of women in the target areas were not obtaining adequate prenatal care. Consumers attributed this insufficient care to long waits for scheduling appointments; block scheduling that caused long periods spent in waiting rooms; abbreviated visits with clinicians; difficulty getting to and from appointments; lack of on-site child care; unsupervised or dirty play areas for children; policies prohibiting food in waiting rooms; inconvenient clinic hours for working women; overcrowded and unpleasant facilities; confusing paperwork; lack of interpreters; and discourteous staff.

PHSI's efforts to enhance clinical service led to dramatic improvements in the accessibility of prenatal care in the target area. PHSI worked with multiple clinics and provider sites to address key obstacles and improve the availability of services.
Five sites were assisted in expanding service hours and/or adding evening hours for prenatal, family planning, and pediatric services. Before PHSI initiatives, only 1 out of 10 prenatal providers in the target area offered evening clinic hours.

PHSI established hospital liaisons at five area hospitals. Liaisons were social workers trained to identify pregnant women who received little or no prenatal, postpartum, or pediatric care. They worked in emergency rooms, labor and delivery units, and outpatient clinics to identify women in need of high-risk care and/or care coordination. This initiative resulted in increased care as well as more appropriate levels of care. It shifted people out of emergency settings and into prenatal care units and other outpatient settings. For hospitals, this resulted in shorter emergency room waits and more appropriate emergency room use.

Other improvements included the following:
- Six sites received one-time grants for physical improvements, including remodeling and redecorating patient waiting rooms and patient care areas, updating public address systems, equipping play areas for children, and purchasing new medical equipment.
- Eight sites received staffing enhancements in areas such as social work, nutrition, lactation consultation, family planning, parenting education, adolescent peer counseling, and drug and alcohol counseling.
- PHSI helped establish supervised play spaces at six sites for children while parents attended appointments.
- While many of Healthy Start’s initiatives were targeted at Healthy Start clients specifically, this initiative likely had significant spillover effects in improving accessibility for all users of care.

Increasing the Role and Responsibility of Providers

Healthy Start/New York City (HS/NYC)

Efforts by Healthy Start/New York City (HS/NYC) to improve coordination and service delivery in the provider community resulted in new programs that ultimately became self-sustaining. HS/NYC’s contributions included providing technical and management assistance, training staff about cultural diversity, and funding increased staffing, expanded hours, and outreach.

- The Martha Neilsen School Clinic for Pregnant and Parenting Teenagers. With initial funding from HS/NYC through the Bronx Perinatal
Consortium, this clinic is the first on-site facility at a New York City high school dedicated to providing prenatal, postpartum, and primary care services to pregnant and parenting adolescents. The clinic serves more than 1,300 students of the Martha Neilsen High School for Pregnant and Parenting Teenagers and the other schools located in the same building: the James Baldwin Literacy Center, the Bronx Regional High School, and the Satellite Academy Alternative High School.

- **The Harlem Birth Action Program.** With start-up support from the Northern Manhattan Prenatal Partnership’s Central Harlem Healthy Start Project, the Harlem Birth Action Program provides peer support and outreach, counseling, and childbirth education to pregnant clients.

- **The Integrated Midwifery Program.** Funds supporting nurse-midwives led to growth of the hospital’s OB/GYN unit, improved perinatal services, and increased coordination with local health providers.

### An Effective “One-Stop-Shopping” Model for Coordinated Care

**Oakland Healthy Start**

The Oakland Healthy Start (OHS) Family Life Resource Centers (FLRCs) bring together—physically as well as organizationally—multiple health and social service programs. This collaboration significantly enhanced the ability of providers to reach their clients and provide more effective and comprehensive services. The initiative was so successful that it was used as the model for a major countywide restructuring of health services (see Section III.A).

Three FLRCs were established throughout Oakland, each anchored by an existing community-based organization. In addition to providing outreach and care coordination, each FLRC developed its own set of programs and collaborations with neighboring agencies, community groups, food banks, churches, social services, youth and advocacy agencies, schools, and physician groups.

An OHS assessment revealed very positive observations about the impact of FLRCs. The assessment was partly based on interviews with clients and family members at each of the three sites.

The majority of women interviewed found services at ASHA House to be beneficial. The “one-stop-shopping” model of service delivery is

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an effective remedy to the obstacles that some clients experience when attempting to access necessary services. ... ASHA House has been able to retain the interest of client families and achieve some measure of success in stabilizing families.

Family support providers at Ujima House are able to offer client families comprehensive family support by providing health care services, mental health counseling, peer support groups, parenting education, substance abuse treatment, services to fathers and transportation services. ... One-third of the responding clients indicated that the substance abuse treatment they received was a critical component in their family's growth and development.

Because of its family-focused model, West Oakland Healthy Start has seen a significant proportion of family members recruiting other family members into its program. ... Additionally, WOHS has been highly successful in providing parents with material support related to child care issues.12

Agencies and organizations that collaborate in providing staff and/or services to one or more of OHS's one-stop-shopping FLRCs are

- Alameda County's public health nurses
- Alameda County's Healthy Infant Program

12Center for Reproductive Health Policy Research.
A key philosophy of the Oakland model is the delivery of "culturally consistent" services. This goal was developed during the initial planning of the OHS model, and its accomplishment involved several critical steps. First, OHS contracted with a nationally recognized and respected organization, the Institute for the Advanced Study of Black Family Life and Culture, to facilitate sessions with OHS providers on the importance of culture in the delivery of services. OHS then hosted cultural events reflective of the race and ethnicity of the client and community population (e.g., Black History Month, Cinco de Mayo). These cultural events were enhanced by foods, decorations, rituals, and entertainment that reflected the target population. In addition, written materials and the physical environment of OHS facilities included culturally appropriate images and symbols.

These strategies have resulted in a project staff that reflects the race and ethnicity of the service population and that is sensitive to clients' diverse needs.
Establishing Sonogram Services in Indigent Communities

District of Columbia Healthy Start

District of Columbia Healthy Start (DCHS) established a perinatal team in response to the fact that perinatal consultations and level II sonograms were not available in the most impoverished and underserved areas of the district (Wards 7 and 8). The team consisted of a perinatatologist, a neonatologist, an obstetrical nurse, a sonogram technician, a social worker, and clerical support staff at D.C. General Hospital (DCGH), the facility used by most women in the target area.

The perinatal team provided consultation, level II sonograms and other diagnostic procedures, fetal monitoring, personalized education about risk factors, social service interventions, and referrals for high-risk and at-risk obstetrical patients. The team worked closely with DCGH staff and other providers such as neighborhood health clinics, private hospitals, private physicians, and community agencies providing care for pregnant women. Members of the team also provided family planning and health education workshops for prenatal clients at DCGH.

Sonogram services at DCGH were utilized by 4,178 women during the demonstration phase. Each sonogram included consultant information about proposed future treatment plans. In-depth consultations were provided to 466 patients; multiple biophysical profiles (BPPs) and nonstress tests were performed; and 2,335 social service interventions were made. When possible, sonogram and clinical data were verified on all infants who were delivered prematurely, diagnosed prenatally as having a congenital abnormality, or exposed to an adverse uterine environment.

When viewed with the rest of DCHS's strategies and programs, the services provided by the perinatal team proved vital to the target area. Feedback from two 1996 focus groups indicated that those in the target population believed that without DCHS, their community would experience a consistent increase in infant mortality rates. The report further indicates that Healthy Start was one of the few positive institutions in the lives of participants. The program gave people peace of mind, knowing they had access to quality prenatal and postpartum care.

A hallmark of the Perinatal Center at DCGH is the fact that services are reimbursable through Medicaid. For the 12-month period ended in September 1997, the center was reimbursed more than $700,000 for services rendered, demonstrating the potential for this model to become self-supporting. In addition, the Perinatal Center staff formed a relationship with an obstetrical group to educate practitioners about the importance of expanding hours of operation and utilizing
ultrasound, BPPs, amniocentesis, cervical vaginal surveillance, and PUBS to enhance fetal surveillance.

**Improving Service Availability and Access**

*Detroit Healthy Start Project*

Detroit Healthy Start Project (DHSP) worked closely with existing clinical services in its target area to improve capacity and service delivery. DHSP also shared data gathered from its local evaluation studies with other local providers and HMOs, resulting in some significant improvements.

DHSP increased the number of sessions available in the target area clinics by adding nurse-midwives and support staff. The wait time for new prenatal appointments at the Grace Ross Health Center was reduced by 83 percent, from a 6-week wait in 1993 to a 1-week wait in 1997.

Services to women at high risk were enhanced by bringing perinatologists into community clinics and adding Saturday sessions. After a perinatalogist began providing on-site care at Grace Ross Health Center, high-cost referrals to the area tertiary hospital decreased by 85 percent.

Grace Ross Health Center also increased the range of services available, becoming a “one-stop-shopping” model for pregnant women. In addition to routine and high-risk prenatal care, the center offers a full complement of support services, including WIC, Mich Care (a state program), family planning, well-child care, a pharmacy, and parenting classes.

At consortium and local advisory council meetings, DHSP provided feedback from its local evaluations. In one case, after hearing from these reports that his clin-
had the longest wait period for first prenatal appointments, a clinic director made major changes in the way appointments were made and increased prenatal staff. This resulted in significant decreases in wait time.

DHSP surveys identified special issues associated with enrollees in Medicaid HMOs. For example, in the project area between 1991 and 1996, waiting times for initial prenatal appointments were reduced for all payer sources except HMOs. Further, women in Medicaid HMOs were more likely to use tobacco or illicit drugs, have negative attitudes toward pregnancy, and have higher parity. This information was shared with area HMOs. One of the results of this exchange was the formalization of arrangements between DHSP and HMOs to provide home visits to pregnant and postpartum patients.

**Bringing Providers Together Through Infant Mortality Review**

**Great Expectations Healthy Start in New Orleans**

Great Expectations (GE) initiated the first case-by-case infant mortality review (IMR) panel in the state of Louisiana. The IMR panel brought together, for the first time, physicians and other professionals to review cases. A very positive rapport was developed among participants. The process significantly changed provider thinking about how to handle certain types of cases and how to help disadvantaged women.

Between 1993 and 1996, the IMR technical review panel brought together perinatologists, neonatologists, midwives, social workers, hospital and clinic administrators, community health interests, and state and city health departments. They analyzed information about infant deaths that had never been abstracted before and developed recommendations that would affect the entire system of care in the city.

The IMR's purposes were to

- Investigate on a regular basis the circumstances of infant deaths in the GE target area;
- Identify personal risk factors and medical and social system factors whose correction might have prevented infant death; and
- Recommend corrective measures, and communicate the recommendations to the perinatal provider community and state and local maternal and child health agencies.
The GE IMR process resulted in significant system enhancements, in addition to changing provider views about appropriate standards and approaches to care:

- Minimum standards for the licensure of nurseries were established.
- Following recognition of the need for grief therapy for women who lost infants, a counseling and therapy program was extended to include low-income women.
- The Agana Burial Fund was established. This fund raised money and provided funds and support for women who could not afford the burial cost of deceased infants.

III.C Impact on Providers and Service Delivery Systems: Shared Information

Overview

The "information highway" within the public health delivery system plays an important role in coordination across multiple services and organizations. Creating common definitions and standards of care and developing shared or centralized information services are increasingly critical to improving quality and efficiency of services.

Examples of different Healthy Start achievements in this area include the following:

- Richmond Healthy Start Initiative's development of a single database and comprehensive records system has created the foundation for coordinated care among participating agencies.
- Chicago Healthy Start's Cornerstone management information system has simplified and centralized client data, resulting in more effective and efficient service to clients.
- Philadelphia Healthy Start Initiative's work in defining standards for home visiting has had statewide impact.
- Boston Healthy Start established information sharing and coordination among participating agencies in multiple ways.
- Northwest Indiana Healthy Start implemented communications protocols to facilitate agency collaboration and reduce duplication.
The Milwaukee Healthy Women and Infants Project initiated multiple efforts to share strategies and outreach techniques among providers and agencies.

Improving Care with a Centralized Database

Richmond Healthy Start Initiative

One of the most significant challenges faced by care coordinators is having accurate and current information about client needs and services being used—or not used.

Richmond Healthy Start Initiative (RHSI) developed a comprehensive records system and single database for all participating agencies. Developed by the Survey and Evaluation Research Lab, the system can track individual clients and identify the type and frequency of services provided. RHSI also successfully developed the capability to evaluate and report on outcomes of community projects by standardizing methods of outcome evaluation, providing consultation services, and developing a plan for data linkages.

The database system has provided a strong basis for further improving information sharing and agency collaboration. Future plans include increasing the ease of collecting data at the time of contact and intervention, expanding the number of organizations submitting data, and achieving better linkage of data with infant mortality review data. With the database system's client identification code, multiple organizations have the ability to track clients. The tracking helps agencies maximize resources, prevent the duplication of services, and promote coordination and consultation among service providers.

Establishing Standards for Care

Philadelphia Healthy Start Initiative

Philadelphia Healthy Start Initiative (PHSI) had a major impact on improving standards and the comprehensiveness of services for pregnant and parenting families through its influence on the definition of health care services overseen by local and state health agencies.

PHSI compelled the Philadelphia Office of Maternal and Child Health to finalize and implement service delivery standards for MCH-funded outreach and home visiting programs. These standards clarified roles and responsibilities for home visitors and outreach workers and required specific protocols to ensure continuity of care, adequate follow-up, improved care coordination, and sharing of
data. These standards are now the established model for all MCH-funded outreach and home visiting programs.

When the Pennsylvania Department of Health (DOH) began to develop its guidelines for managed Medicaid, the PSHI package of prenatal services was adopted by DOH for Medicaid managed care recipients. This package included definition of services and standards for outreach, home visiting, and supervised play of children.

Working in collaboration with local outreach and home visiting organizations, PHSI developed standards for training programs and home visiting. Subsequently, PHSI funded four organizations to conduct intensive lay home visiting in the target community: two organizations for high-risk clients and two for the Southeast Asian population.

Home visitors worked under the direction of a nurse or social work case manager. Home visitors completed a comprehensive needs assessment to identify the needs of at-risk families. They then provided family-focused counseling, health education, and health promotion activities. Pregnant women were visited a minimum of every 2 weeks by a home visitor and/or nurse and received follow-up through the first year after birth.

An Information Cornerstone for Care Coordination

Chicago Healthy Start

Chicago Healthy Start’s (CHS) Family Centers serve as a single point of entry for a wide range of health and social services. This was made possible largely by their use of the Cornerstone management information system (MIS). CHS was the “stick of dynamite” used to clear the way for this new approach to data management and integration in Illinois. CHS’s early funding of Cornerstone’s development established a base for subsequent improvements and expansion.

With the Cornerstone system, CHS better serves client families by integrating all potential services available to them. The first step in using the Family Centers is registration into the Cornerstone MIS, which ensures that key information is collected only once and distributed among service providers and programs only when appropriate.

The Cornerstone MIS reduces duplication of data collection and allows CHS’s Family Centers to focus on client service rather than paperwork. Information is accessible from all connected programs in Illinois, thus reducing the possibility of
a client falling through the cracks. Case managers have a potent tool for ensuring that clients previously at risk for being lost in the public-service sector will receive a continuum of needed care. Furthermore, confidentiality is strictly observed, and access is restricted to only those providers who need it.

Cornerstone has had a significant impact throughout the state. The Illinois Departments of Human Services and Public Health have used the Cornerstone MIS to facilitate maternal-and-child-health service integration throughout the state, and over 300 separate community-service locations now use the MIS.

Responses to a post-implementation survey revealed that Cornerstone has had a positive effect on community health delivery in most of service sites that have used the system:

- "Cornerstone has added structure and accountability. There is better documentation in the agency." (Chicago Department of Health)
- "Cornerstone was the impetus for integration." (DeKalb County Health Department)
- "Cornerstone forces a thorough service and doesn't allow short cuts." (Stephenson County Health Department)
- "Communications between programs regarding appointments, case notes, and immunizations has improved." (Adams County Health Department)
- "Cornerstone will help us manage clients more efficiently and help all programs to present a united and common message to the clients." (Kanakee County Health Department)
Facilitating Provider Exchange

Boston Healthy Start Initiative

Boston Healthy Start Initiative (BHSI) took on a leadership role in establishing coordination and linkages among the health and human service providers funded by the project.

The implementation of an MIS data system significantly improved the efficiency of agency records systems and data sharing across providers. BHSI agencies received their own computers and software, allowing them to generate agency-specific reports. Providers were able to customize their own versions of reports, which in turn allowed them to maximize the use of collected data.

To ensure the privacy of clients, all confidential information remained on-site. Further, the MIS prevented duplication of records. If a client received services at multiple sites, records from the multiple sites could be combined to produce a complete client record.

BHSI strongly encouraged collaboration and participation among all their funded agencies via mandatory monthly provider meetings for certain geographic subdistricts within the project area. The project also invited others to participate in the process. BHSI established memorandums of agreement between all Healthy Start providers during the first year of the project.

BHSI further encouraged a strong sense of collaboration by organizing forums for information sharing, training, and technical assistance. BHSI linked all Healthy Start providers with MIS, allowing for uniform data collection and enabling the project to plan service delivery with objective data that supported collaborative arrangements.

A Shared Communications Strategy Among Agencies in “Moms, Kids and Company”

Northwest Indiana Healthy Start Project

“Moms, Kids and Company” is an extension site of the Northwest Indiana Healthy Start Project (NIHSP) started in 1995 in Hammond, IN. Located in the largest housing project in the city, it serves as an excellent example of innovative ideas for engaging hard-to-reach participants.
Women who are reluctant to visit the Healthy Start site at the local hospital for service coordination appear to be willing to visit the housing development site. This neighborhood “point of entry” into prenatal care provides pregnancy testing and is collocated with six agencies. Healthy Start is the lead agency and coordinates the day-to-day operation of the site. Other participating agencies include WIC, the Immunization Action Plan (IAP), the Lake County Child Health Program, Step Ahead, Project Link, and the Hammond Housing Authority.

What makes this initiative so effective is the way in which the agencies work together. Each agency has developed a “script” to help the staff of other agencies understand its mission, services provided, hours of service, client eligibility criteria, and contact information. Healthy Start staff are trained to schedule appointments for the other agencies, complete WIC certifications if needed, and promote all services at the site. Over 90 percent of clients use multiple agencies; these clients are identified, and their charts are flagged to coordinate communication between agencies and contact the client if needed.

Collocation of social service agencies has been well-received by the communities and has enhanced service delivery by the individual agencies. A good example of this is the increase in immunizations given by IAP. Before the collocation, IAP was threatened with closure because the number of encounters was negligible. IAP encounters grew from an average of 3 per month in 1995 to 25 in 1996 and 30 in 1997. WIC visits have steadily increased from a monthly average of 191 in 1995 to 272 in 1996 and 281 in 1997.

Exchange Among Area Agencies on Consumer Involvement, African-American Infant Mortality, and Outreach

Milwaukee Healthy Women and Infants Project

Milwaukee Healthy Women and Infants Projects (MHWIP) initiated and actively participated in several initiatives to enable area agencies to share models, approaches, and information. These efforts had a significant impact on the capacity of organizations to respond to consumer needs.

MHWIP has shared its model for community and consumer involvement—including organizational structure and education and training models—with other area organizations. Agencies that have adopted MHWIP’s consumer involvement strategies include the Children's Health Alliance of Wisconsin, Common
Ground, Milwaukee Children's Hospital advisory committees, and the Wisconsin maternal and child health committees.

MHWIP was the lead agency and coordinator of the Outreach Consortium, which provided support and training to entities that offer outreach and/or public health education (e.g., the Milwaukee AIDS project and other agencies with perinatal outreach workers).
Beyond their impact on clients and the delivery system, Healthy Start projects aggressively sought to empower the broader communities in which they are centered. Consumer involvement was structured into all phases and levels of project implementation and governance, including project area and local consortia. Public information and education campaigns employed multiple innovative strategies to focus community attention on the issues surrounding infant mortality, the role of the community in addressing these issues, and feasible community strategies.
Many projects found it essential to go beyond the health and social support needs of clients and aid in economic and community development efforts. Client self-sufficiency and empowerment ultimately depend on these efforts.

All of the 22 demonstration projects reported a significant impact on consumer involvement, public education and awareness, and/or community development.

IV.A Impact on Community: Consumer Voice and Community Support

Overview

Healthy Start projects employed many strategies to involve consumers in community needs assessments, planning, implementation, oversight, and evaluation. Project area local consortia, special issue task forces, and other approaches were developed.

Establishing communitywide consortia turned out to be both one of the greatest challenges and one of the greatest resources for many Healthy Start projects. In seeking to achieve inclusiveness in diverse communities, most projects had to address issues of structure, process, training, and consensus-building. It was usually a challenge to retain clients in these advisory groups. Compared with individuals employed by providers and agencies, clients were disproportionately challenged with child care, transportation, systems knowledge, and other obstacles, making participation in voluntary efforts very difficult.

At the same time, community representation in project consortia provided a solid base on which to build programs and initiatives. Consortia ensured that program design reflected the composition of the community, which in turn accelerated program implementation and acceptance by community clients.

Innovation in Involving Consumers

District of Columbia Healthy Start

From its inception, the District of Columbia Healthy Start (DCHS) Consortium was organized around the principle of openness. All meetings were
open to any interested members of the community. Early organizing efforts led to recruitment of leaders who were committed to openness, consensus-building, and community empowerment. DCHS sought the ideas and contributions of all participants to develop an understanding and appreciation of the strengths and resources of the target communities.

DCHS staff supported the consortium's development and team building with several activities: A 1-hour orientation for new work group members (conducted quarterly), orientation of new members before each consortium meeting, and special training for consumer members, conducted by outreach staff who were in touch with the needs and culture of the community.

Throughout phase I, the consortium convened strategic planning sessions, retreats, and four sets of focus groups composed of consortium members and other community residents. The purpose of these focus groups was to maintain DCHS's link to the communities it served by providing feedback on how the project and services offered were viewed. As DCHS continued its efforts to gain the support, trust, and participation of the community, consortium members grew in their willingness to share information, cosponsor events, share meeting space and other facilities, and offer cooperative training and technical assistance.

Other strategies for increasing participation included using indigenous resource parents and male outreach workers to recruit consumers, providing transportation to all project events, and involving consumers in recruiting their peers.

In addition, 100 community residents were selected to enroll in subsidized educational and training sessions. The sessions were developed in response to needs identified by the consortium, and they included a series of education and skills development workshops for staff, community-based agencies, and consortium members over a 12-month period. Training was provided by the American Management Association and included workshops on coaching and counseling, interpersonal effectiveness, time management, total quality management, promoting and marketing a nonprofit organization, managing multiple priorities, and dealing with employee attitude problems.

DCHS saw increases in consumer representation and involvement in consortium meetings, which strengthened its core and at the same time increased its influence and recognition throughout the target area. Perpetuating this growth, coordinating committee and other consortium members represented DCHS by making presentations in the community and throughout the city. Some members took active roles on panels and in workshops at city and national conferences. Annual recognition and awards dinners rewarded the volunteer leadership and increased their visibility in the community.
Helping Public Services Become More Responsive to Communities

Birmingham Healthy Start

Historically, communication and collaboration between the Jefferson County Health Department (JCHD) and community social service agencies and consumers have been limited in nature. Birmingham Healthy Start (BHS) changed this situation through contracts with community services and aggressive outreach and interaction with clients. Outreach activities included satisfaction surveys among clients and focus groups, which have resulted in the development of an advisory group of consumers and agency representatives.

One of BHS's greatest accomplishments has been increasing the sensitivity of JCHD to the needs of the low-income and minority populations in the county. There has been a reevaluation of the importance of outreach and a reconsideration of how services are best provided to low-income populations and special needs populations such as the homeless, pregnant women with substance abuse problems, women with small children, males, and adolescents.

Community quotes from ... Administrators of Jefferson County Department of Health health centers

"The biggest single change due to BHS is the more widespread involvement of the community in Health Department services. Consumers of services are now better represented and involved as advocates for health care."

"Community involvement and visibility increased due to outreach and health awareness programs. JCHD is more keenly aware of the need to market services to its communities."

"The partnership between BHS contractors and the Health Centers caused an increased awareness of referral resources such as Intercession Ministries, Girls, Inc., Birmingham Health Care for the Homeless, Aletheia House, and others, that will continue to be resource options for JCHD staff to use for its clients."
Community quotes from... Community-based service agencies contracting with BHS

"BHS allowed for stronger development of working relationships between our organization and the health department in obtaining care for our patients...especially quicker appointments for prenatal care."

"BHS worked with JCHD to improve prenatal services for pregnant addicts."

The Latino Health Initiative

Boston Healthy Start Initiative

The diverse cultures in any urban area display differences in tradition, attitudes, and needs that must be recognized and properly addressed. In March 1995, in response to a rise in infant mortality in the Latino community and the lack of Latino agencies in the Boston Healthy Start Initiative (BHSI) provider network, BHSI brought together seven community-based Latino agencies to develop a coordinated and comprehensive approach to infant mortality in the Latino communities.

Called the Latino Health Initiative, this comprehensive program established a system to provide a range of linguistically and culturally appropriate services to Latino infants and pregnant and parenting adolescents and adults, including case-management home visiting, domestic violence intervention, infant health care, and women's health education and support.

All efforts are coordinated through the Latino Health Institute. The institute convenes a monthly meeting of all service providers to offer support to providers, update progress on the initiative, and present opportunities for networking, resource sharing, training, and peer support. The institute also holds case management meetings to coordinate needed services for Latino families with extremely complex problems.

This initiative is the first of its kind in Boston. BHSI provided the seed money to develop it and fund the initial round of service provision. The Latino Health Initiative had a significant impact, not only in terms of cultural competency in service delivery but in raising overall community awareness of Latino infant mortality and the importance of cultural factors in developing solutions to the prob-
As such, the initiative provides the foundation for a Latino public health group to attract other funding to provide health care and social services in the area of maternal and infant care for Latino families.

A key indicator of success is that other Latino agencies throughout the state have replicated the model and become organizational partners in the initiative. Furthermore, the program successfully developed alternative and sustainable funding sources outside of Healthy Start.

Expanding Countywide Community Participation

*Delta Futures (Mississippi)*

Delta Futures Healthy Start formed consortia each of six rural counties as a means of involving communities in project implementation and program planning. In addition, the consortia helped make the residents aware of services and resources available in their community.

Several consortia developed community resource directories that included information gathered from local health, social service, and community-based organizations. The directories provided descriptions of services offered, contacts, addresses, telephone numbers, business hours, and eligibility requirements.

Some consortia developed subcommittees to educate consortium members as well as the community on pending state and federal legislation. They also sponsored forums on such issues as welfare reform. Legislative forums were conducted periodically—in some communities for the first time—to give the local residents the opportunity to talk to their elected officials about issues important to them.

Other consortia sponsored health fairs and developed adolescent parent organizations to bring resources into schools and provide ongoing services for pregnant and parenting adolescents. These adolescent parents received information about prenatal and postnatal health care, parenting skills, job training, self-esteem, HIV/AIDS, and sexually transmitted diseases.

One example of a consortium-sponsored project is the Boyz-to-Men Mentoring project, which engaged 33 African-American teen males and a group of adult mentors. The teens and their mentors participated in workshops and other training events over 3 months. To measure the impact of the program, a test was given to the teens at the beginning and end of the project. The improvement in their knowledge of key health and other issues was statistically significant, with participants making an average 16-point gain on a scale of 90 points.
IV.B Impact on Community: Public Awareness and Community Education

Overview

A critical question for any social service that is attempting to increase community awareness is "How can we stand out in a media-saturated environment dominated by aggressive private advertising?"

Healthy Start projects attacked this issue with multiple strategies:

- Involving community members and consumers in designing and implementing communications, public awareness, and education strategies;
- Integrating public education initiatives into well-accepted community events and cultural celebrations; and
- Employing a variety of approaches (print, radio, special events, billboards, hotlines, health fairs, etc.).

In addition, projects designed public awareness and education efforts to target specific audiences—adolescents, male partners, racial/ethnic groups—with messages geared to their particular needs.

Diverse Strategies for Public Education and Client Outreach

A Healthy Start for Essex County

Public information and outreach efforts were needed to educate the community about the new services offered by AD House, a small community-based social service agency that became a leading adolescent family resource center (FRC) for pregnant and parenting teens in the Essex County (Newark) target area. A Healthy Start for Essex County distributed several incentive products bearing the Healthy Start name and telephone numbers through the community, particularly in local schools. Outreach workers used these incentive items to open discussions with prospective clients and discuss what services the target area's FRCs could offer.
In addition to this incentive strategy, A Healthy Start for Essex County’s local project director enacted a diverse range of programs to raise the awareness of, educate, and train members in the community. On an annual basis,

- More than 40 speaking engagements dealing with infant mortality reduction and the endorsement of AD House FRC were held in the community.
- More than 25 providers participated in two community health fairs in the target area. More than 500 community residents attended each fair.
- An advertising campaign with New Jersey Transit displayed prominent posters detailing the Healthy Start program on more than 250 buses.
- Two Healthy Start newsletters amassed a total circulation of 5,000.
- The project director appeared on several local cable television shows, representing and advocating the project and FRCs.
- For a year, SONY movie theaters in the project area ran Healthy Start public service announcements (PSAs) before each screening. The PSAs displayed the local Healthy Start symbols, FRC names and locations, and information about the program’s efforts to provide prenatal care and reduce infant mortality.

**Education of Communities, Education by Communities**

**Boston Healthy Start Initiative**

Boston Healthy Start Initiative (BHSI), like many other Healthy Start programs throughout the United States, came to the conclusion that the most substantive way to affect its community and ensure the sustainability of the program was to involve the community directly in all aspects of program planning and implementation. BHSI’s public information committee launched an impressive campaign to inform the public of problems posed by high infant mortality and to lower barriers to care. With greater public involvement, BHSI was better able to spur community action to assist it in promoting family and perinatal health.

Between October 1, 1995, and September 30, 1996, BHSI placed 70 infant mortality education advertisements in nine local newspapers with a combined weekly distribution of more than 18,000. At the same time, 2,300 television advertisements and 225 radio PSAs and paid advertisements were aired, reaching an audience that included the vast majority of project area residents. The results of this far-reaching campaign were significant: 90 percent of calls to the BHSI hotline referred to the television ads, and the other 10 percent referred to the radio ads.
BHSI recognized the cultural diversity of its communities and used their subtle strengths to reach and raise the awareness of individuals of all races and cultures throughout the project area. Summer activities were held with important festival days celebrated by different communities, among them the Caribbean festival, the Chinese (Moon) festival, the Puerto Rican festival, the Kite festival, Boston Housing Authority Health Fairs, the Rainbow festival, and Music in the Park. These fairs each had an attendance of 5,000–10,000 people.

BHSI produced and distributed 32,000 educational handouts (printed in English, Spanish, Vietnamese, and Haitian Creole) to project area parents in fiscal year 1997 alone. Eight editions of the BHSI newsletter were distributed to 900 people, and the BHSI hotline received more than 22,000 calls in the same time period. Posters in the public transit system further enhanced awareness; 65 percent of area residents were estimated to have seen these. Outreach workers contacted nearly 43,000 area parents via community and church health fairs.

Targeted client education initiatives played a crucial role in the success of BHSI. The initiative made education a priority in its communities and derived substantial results. For example,

- BHSI's Food for Life Program provides mothers with nutritious lunches at three different sites and uses these lunches as a forum to discuss health care issues and available services. The program has educated 789 groups and sponsored 36 special workshops.
- The BHSI hotline, established in part to increase women's access to state-funded insurance and BHSI programs, has received more than 31,800 calls.
- In 1997, more than 4,500 project-area parents received parenting education, STD counseling (including HIV/AIDS), family counseling and treatment, and education about reproductive health through BHSI.

Public Education: From Holidays to Hotlines

District of Columbia Healthy Start

District of Columbia Healthy Start's multipronged informational approach and its willingness to share lessons and training opportunities with its partners have earned it a strong positive image as a program that helps women and their families. DCHS's strategy enhanced its image not only within the target area, but within the District of Columbia and on a national level.

One "prong" of DCHS's approach capitalized on special events and holidays. Each year on Mother's Day, supermarkets donated food shopping sprees as prizes
for DCHS-sponsored contests. One year, 1,500 Mother’s Day cards and flyers were distributed to remind clients to seek early and continuous prenatal care and post-partum care available through DCHS.

In 1997, First Lady Hillary Rodham Clinton joined the Mother’s Day event. Other events included the following:

- Over 500 people attended a community Father’s Day picnic held to promote male involvement. This promotional event encouraged fathers to fight for the health of their children by awarding 50 tickets to a heavyweight championship bout.
- A trio of locally elected council members were recruited by DCHS to publicize a “baby shower” to collect items needed for the Patient Incentive Program.
- Staff worked with the U.S. Department of Health and Human Services to promote national health concerns, such as National Immunization week.

DCHS worked throughout phase I to gain and retain media support. A media partnership aired some 680 public service spots on local radio stations and provided on-site exposure for an annual community event that was attended by an estimated 95,000 residents. DCHS, in cooperation with the Washington Metropolitan Area Transit Authority, displayed advertisements on Metro bus and rail systems using artwork created by public school students. This campaign promoted healthy lifestyle choices leading to healthy babies, advertised the DCHS Baby Hotline, and emphasized the role men play in the health of their partner’s pregnancies and their children. Officials estimated that 3,600,000 subway riders were exposed to the first wave of the campaign.

Over the past several years, DCHS has used PSAs and “media buy” discounts to communicate its message. PSAs routinely aired on at least four local radio stations and three local commercial and cable TV stations. Print PSAs ran in six local minority print media outlets. The project developed numerous tip/fact sheets and brochures on various topics and services. In addition to providing general information about healthy behavior and services, the various ad campaigns focused on the effects of alcohol and tobacco on birth outcomes and the prevention of unintended pregnancies.

During the demonstration period, DCHS also

- Distributed 57,000 quarterly newsletters, 500 posters, and 20,000 flyers, brochures, and diaries;
- Distributed 10,200 Baby Hotline cards and tip sheets;
- Aired more than 700 PSAs annually;
- Received 1994 Bronze and Silver Awards for Excellence in Public Health
Communications from the National Public Health Information Coalition for newsletter and brochure production;

- Presented sessions at annual American Public Health Association meetings and published an article in the *American Journal of Public Health*; and
- Saw the participation of 35,000 project area residents in outreach and educational initiatives, including health fairs.

**Helping Others Help Themselves**

**Pee Dee Healthy Start Initiative**

Pee Dee's public information/public education (PI/PE) program focused primarily on developing regional strategies to reduce infant mortality, while the six-county coalition's public awareness subcommittees focused more on local strategies. Public awareness campaigns targeted certain segments of the population to generate awareness of infant mortality and the leading indicators affecting pregnancy outcomes.

The PI/PE campaigns used diverse and creative strategies to generate awareness about the emotional, social, and economic impact of infant mortality in communities and encouraged families and communities to find ways to reduce the high infant death rates in the region.

Of the many strategies that Pee Dee implemented during phase I, five major activities stand out:

- *Training and technical assistance*. Through this component, the Pee Dee staff provided substantive training and technical support to volunteers and service providers. These efforts gave individuals the skills they needed to create public awareness about the importance of communities taking ownership of reducing infant mortality.

- *Adolescent pregnancy prevention*. Pee Dee Healthy Start sponsored quarterly "Gaining by Thinking" workshops for consumers, volunteers, providers, and staff. Adolescent pregnancy prevention workshops entitled "Baby Think It Over" were held to train youth consumers, service providers, and staff on how to use life-like dolls that simulated infant behavior. These dolls proved to be an effective pregnancy prevention tool and were in high demand by Healthy Start Initiatives, agencies, organizations, schools, and other community groups.

- *Postponing sexual involvement campaign*. Pee Dee cosponsored a major
social marketing campaign encouraging abstinence. As a result of this campaign, Healthy Start cultivated service partnerships with several prominent entities. The momentum produced by these affiliations encouraged other segments of the community—health agencies, hospitals, media organizations, and schools—to join forces to prevent adolescent pregnancy.

- **Male involvement campaign.** The “Whatta Man, Whatta Man” male-involvement public awareness campaign was developed to educate the community on the important role that a father plays in his child’s life. The program emphasized the father’s role in producing a child, ensuring that the mother has a healthy pregnancy, and raising the child. The campaign encouraged male involvement and discouraged negative stereotypes and other “male bashing.” To ensure that the campaign reached its target audience (fathers and significant male others), a male involvement committee was organized. Using focus groups, the committee helped ensure that the program was culturally and linguistically sensitive. This campaign also used PSAs and a radio talk show featuring volunteers and Pee Dee staff to get out its message.

- **Health education.** This component utilized “Kicks Kount,” a well-researched and well-documented health education campaign launched with the March of Dimes and the Pee Dee health district. The campaign teaches expectant mothers how to accurately count their unborn child’s movements as a way to monitor their pregnancies and thereby prevent miscarriages. Billboards and a massive industry mailing advertised the campaign in the six counties. In addition, more than 15,000 “Kicks Kount” cards were distributed through payroll inserts to county employees.

Prominent partners of the Pee Dee Healthy Start Initiative are
- The Pee Dee Wateree Division of the March of Dimes Perinatal Board
- Pee Dee Health District
- McLeod Regional Medical Center
- Carolinas Hospital System
- Francis Marion University
- Holder-Briggs Marketing
IV.C Impact on Community: Economic and Community Development

Overview

Healthy Start projects working with indigent communities face a critical challenge. To help women take charge of their pregnancies, it is often necessary to help them deal with other fundamental needs: nutrition, shelter, basic supplies, emotional stability, ongoing financial support, safety from violence, etc. However, community resources are very often insufficient to meet these needs.

This challenge led projects to address some of these needs on a programmatic basis, going beyond helping individual women obtain services on a case-by-case basis to creating and/or participating in community development activities such as:

- GED and life planning programs
- Job training and placement programs
- Employing Healthy Start clients directly
- Promoting the development of low-income housing
- Other economic development initiatives

Community Job Creation

Baltimore City Healthy Start

Throughout phase I, Baltimore City Healthy Start (BCHS) was committed to keeping as many federal dollars in its communities as possible, primarily through large-scale employment and training of community residents.

Through an agreement with Project Independence (PI), Maryland’s welfare-to-work program, BCHS employed about 30 community residents who received on-the-job training at the Neighborhood Healthy Start Centers. PI trainees were hired and trained for jobs such as Neighborhood Health Advocates (NHAs), life planning advocates, early childhood assistants, and office assistants. Beyond basic job-related training, a number of permanent staff and PI trainees received extensive training in a variety of areas, including early childhood development, first aid,
and basic and infant cardiopulmonary resuscitation (CPR). All NHAs received basic training in perinatal health issues. PI NHAs received additional advanced training in perinatal health, for which they received three college credits from Baltimore City Community College. This training allowed many PI trainees to move into permanent positions at the Neighborhood Healthy Start Centers or gain permanent employment at other local organizations and businesses.

Particularly during the last 2 years of phase I, significant staff work focused on the employment and educational needs of clients. This was in response to strong client feedback asking for additional services in these areas. Job-development specialist positions were created to establish relationships with local employment agencies that had proven histories of successful job placement. For the 6-month period from April to September 1997, BCHS life-planning specialists referred 179 clients to job openings; 108 were actually placed.

Between 1993 and 1997, BCHS employed more than 400 persons in salaried positions with benefits. At the end of phase I, BCHS had a staff of approximately 200. Over the course of the demonstration, more than half of all the staff employed at the Neighborhood Healthy Start Centers were residents of the target areas at the time of their employment. BCHS was the major employer of community residents in the west Baltimore target area.

**The Alternative Education Enhancement Project**

**Northwest Indiana Healthy Start Project**

Keeping up in school is almost an insurmountable task for pregnant or parenting adolescents with limited support systems. The Alternative Education Enhancement Project (AEEP) was developed by the Northwest Indiana Healthy Start Project, in partnership with the public schools of Hammond, IN, to provide a one-stop educational environment for pregnant and parenting adolescents ages 13–18.

The project developed a comprehensive yet flexible program with the following components:

- Attendance requirements are flexible so that an adolescent mother who has been up at night with a sick infant can arrive at school later than normal with no penalty and has the opportunity to make up missed work.
- The ratio of one teacher to 20 students allows for more individualized attention and the development of supportive relationships with adult staff and peers.
• A school nurse is assigned to follow each student’s health throughout the pregnancy and during the remainder of her enrollment in AEEP (which may be until the baby turns 1 year old).

• All students are encouraged to enroll in Healthy Start. Healthy Start also provides regular education programs for AEEP students.

Other community resources that contribute to the program include Planned Parenthood, Purdue University, and the county extension program.

The project enrolled 113 students with a total of 80 births between February 1994 and the end of 1995. The average birthweight (per year) ranged from 6 lb. 12 oz to 7 lb. 1 oz. Over 86 percent of the infants were born at 37 weeks’ gestation or later.

Education for Life

Boston Healthy Start Initiative

One of the most successful Boston Healthy Start Initiative (BHSI) programs is adult education for pregnant and parenting women in the project area (see Table 14).

The benefits offered by adult education are immense. In non-English-speaking communities, this education/training has allowed women to obtain the skills they need to access care and advocate for themselves, as well as comprehend the prenatal care, pediatric care, and parenting health education services available to them. GED classes improve the employment potential of women without a high school degree and build their confidence so that they can advocate for appropriate health services.

Dramatic results were reported during the period from October 1, 1993, to September 1, 1997:

• 27,824 individuals received parenting education;
• 2,769 individuals were enrolled in literacy and/or ESL classes;
• 4,798 individuals received GED preparation; and
• 5,103 individuals received employment counseling and/or training.

BHSI worked with the Massachusetts Union Tenants Association to train public housing tenants as health advocates. Many of these individuals subsequently became employed, often at community health centers. Of 55 trained, 49 became employed.
Table 14
Examples of Boston Healthy Start Initiative Programs Offering GED/ESL Classes, 1996 to 1997

<table>
<thead>
<tr>
<th>Name</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackstone Community Center</td>
<td>Served 109 students. Four students enrolled in college classes after certification.</td>
</tr>
<tr>
<td>Crittenton Hastings House</td>
<td>Enrolled 35 students. After certification, 4 students enrolled in college program.</td>
</tr>
<tr>
<td>Haitian Multi-Service Center*</td>
<td>Placed 32 pregnant, postpartum, and/or parenting women in ESL classes.</td>
</tr>
<tr>
<td>Hyde Park Municipal Building*</td>
<td>Served 163 students.</td>
</tr>
</tbody>
</table>

* These locations also offered numerous ongoing workshops and work groups on topics such as health education, self-esteem, HIV education, lead poisoning awareness, sexuality, birth control, STDs, prenatal care, birth preparation, parenting, child development, alcohol/drug abuse, domestic violence, housing issues, nutrition, money management, personal independence, and the impact of smoking.

A Step Up

Chicago Healthy Start

Chicago Healthy Start's goal of developing an employment infrastructure within target area communities resulted in programs designed to provide marketable skills to clients and guide them along productive future paths.

Chicago Healthy Start (CHS) targeted its programs at wage earners in families of childbearing-age in the project area. CHS coordinated job referral programs and job readiness classes that offered job skills training, literacy improvement, and activities aimed at increasing self-esteem. In a 3-month period in 1995, 99 students attended CHS's job readiness classes, 149 individuals were referred for employment, and 25 individuals were placed in jobs.

CHS's economic development committee called for each funded case-management agency to offer ongoing workshops on client employability, job skills, and job development techniques (e.g., resume writing, appropriate dress). Upon com-
pletion of these workshops, clients are linked to prospective employers via a job fair. Additionally, each case management agency has developed a “job club” to provide information on employment opportunities to its members.

CHS took a direct hand in increasing the employment rate in its target area by hiring and training 20 people who were referred by Healthy Start agencies. The Healthy Start Training and Employment Program employed these individuals to provide photo-identification badge services in WIC clinics, other human service agencies, and businesses. After completing their training in this project, participants are provided with referrals and directed to the private sector for employment.

Sustaining Success

A Healthy Start for Essex County

One of the goals of Healthy Start is uplifting the communities that they serve and in which they work. The life of each program and the time it has to create positive change are limited by the resources at its disposal. Because of this, each Healthy Start program must constantly look ahead, so that the services it has provided in the past can be sustained in the future.
A Healthy Start for Essex County has worked for this future through resource development and the creation of marketing approaches to other funding sources. Through the program’s efforts, AD House, Essex County Healthy Start’s primary family resource center (FRC), achieved some level of self-sustainability.

Initially, AD House was a small, community-based social service agency. With the aid of the Healthy Start program, it is now an licensed ambulatory care facility. With their Medicaid certification as a comprehensive maternity provider, AD House is able to bill Medicaid a modest amount for prenatal services (including case coordination, nutrition, psychosocial, and health education services). This is a new beginning for an agency that had never before billed for services.

Wide-scale cooperation and effort laid the groundwork for AD House’s sustainability. Staff from the Department of Health and Senior Services (DHSS) worked with the executive director of AD House to apply for an ambulatory care license. AD House was approved, allowing it to seek Medicaid provider status. The agency received further technical assistance from DHSS’s staff on the paperwork and regulatory requirements for completing Medicaid’s provider application. These efforts were successful, and AD House is now able to bill for services provided to Medicaid recipients.

A significant sustainability effort was the perseverance of Healthy Start and DHSS staff in assisting AD House in obtaining a “HealthStart Provider Certificate,” New Jersey’s comprehensive maternity package of case coordination, medical care, and psychosocial and health education services. This status gave AD House the opportunity to become a Medicaid “Presumptive Eligibility Certified Site.”

AD House continues to pursue additional funding and sustainability strategies. Currently, it has one contract with a local HMO and is negotiating with another. It has received grants to provide immunizations in various areas of the former target area (primarily in Newark) and perform home visiting for high-risk adolescents. It has also received a Newark New Start grant for case managing (in conjunction with the Division of Youth Family Services) pregnant women at high risk for abandoning their babies. Some of AD House’s service staff are past clients.
Healthy Start's Impact on the Future

During the demonstration phase, Healthy Start projects had a significant impact on the clients, delivery systems, and communities they served. Now these projects are contributing their knowledge and experience to programs funded under the replication phase of Healthy Start (phase II). During the current replication phase, 20 or the 22 Healthy Start demonstration projects are serving as mentors, extending their impact to over 55 Healthy Start projects and other interested agencies and communities throughout the United States.

In the replication phase, the Healthy Start Initiative has begun to have a broader impact on existing and new public programs. Perhaps the most significant of these are state-managed Medicaid and child health insurance programs. These programs will benefit from the interventions and strategies developed during the Healthy Start demonstration phase, which sought to achieve the same goals that these public programs seek to achieve: better health outcomes, significantly improved outreach, better preventive and prenatal care, and enhanced quality and cost-effectiveness of provider delivery systems.

As federal and state policymakers define and refine the regulatory and contractual requirements for Medicaid and child health insurance programs, they can learn from the innovations and strategies of the Healthy Start demonstration phase. These include

- Innovations in outreach to low-income, culturally diverse communities and high-risk target populations such as adolescents, youth offenders, women in jail, individuals with substance abuse problems, and pregnant women with medical and social risk factors.
• Effective strategies to encourage better health behaviors such as reduced use of alcohol, breastfeeding, compliance with prenatal and well-child visits, compliance with immunizations, and better nutrition and self-care.

• Partnership strategies that bring together clinical and social service providers, public agencies/programs, and community-based groups to improve systems of care, collaboration, and communication.

• Effective approaches to improving access and enhancing clinical service settings, from providing transportation and child care to improving scheduling and enhancing cultural competency.

Managed care organizations (MCOs) and state and county health delivery programs can benefit from these intervention models as well. Medicaid MCOs seek to improve outreach and client satisfaction and retention within the cost constraints of state-set premium rates. Healthy Start initiatives have significantly improved outreach and achieved high rates of satisfaction among their clients. Further, they have done so in cost-effective ways, emphasizing preventive care, careful risk evaluation, and behavior changes to minimize adverse outcomes and the need for high-cost emergency care.

Healthy Start projects have also helped increase immunization rates and well-child visits, typical quality indicators shared by the managed care industry.

In order to help public agencies, private MCOs, and other organizations learn from Healthy Start, it will be important for project experiences to be publicized and documented. For this reason, HRSA's Maternal and Child Health Bureau established the Healthy Start National Resource Center (HSNRC) in 1997. Currently HSNRC is administered by Georgetown University's National Center for Education in Maternal and Child Health.

The resource center has four major functions:

• Maintenance of databases: HSNRC maintains data and materials related to research and development of infant mortality reduction strategies.
• Development of publications to keep the Healthy Start projects and the general public informed on issues relevant to perinatal health (communications function).
• Communication through a Web site (www.healthystart.net), information identification, referrals, and dissemination.
• Continuing education via technical assistance and consultation on a variety of issues through conferences, meetings, and other forms of presentations.

The changes in welfare and health care delivery systems in the United States during the 1990s have been major and significant. The shift from Medicaid to private-sector insurers and the implementation of “welfare-to-work” policies have dramatically changed the rules for low-income and at-risk populations. Within the context of these changes, Healthy Start has created new approaches to enabling clients, providers, and communities to improve their health, well-being, and future potential. Despite the ongoing presence and impact of poverty, the program truly has created new ways in which at-risk pregnant women and their families can begin to establish a new and healthy start.
Appendix A: Brief Profiles of Phase I Healthy Start Projects

The following profiles are alphabetized by state and are based on information provided by projects in impact reports, needs assessments, and grant applications. Profiles are included for the 15 projects funded in 1991, as well as 7 sites funded in 1994 (Special Projects).

Alabama: Birmingham Healthy Start

Grantee
Jefferson County Health Department

Target Area
- Twelve low-income communities in Birmingham/Jefferson County.
- Total 1990 population: 188,869 (80 percent African American). Over 53,000 women of childbearing age (ages 14–44), of which 84 percent were African American.
- 1984–88 baseline infant mortality rate of 18.4 per 1,000 live births (21 among African Americans).

Baseline Community Needs Assessment and Characteristics
- Significant service gaps.
- Barriers to access, including lack of transportation.
• Significant rates of substance abuse.
• High rates of unplanned pregnancies, late or no prenatal care, and inadequate weight gain.
• High rates of smoking, drinking, drug abuse, and domestic violence.

Service Models and Special Populations
• Outreach, recruitment, and tracking.
• Case management and care coordination.
• Facilitating services, including transportation and child care.
• Enhanced clinical services and extended hours, including pediatric care, family planning, and residential substance abuse treatment.
• Risk prevention and health education (smoking, breastfeeding).
• Infant mortality review.
• Public education and information.
• Adolescents and male partners.

Organization and Profile
Birmingham Healthy Start (BHS) provided services through staffing in neighborhood-based centers and contracts with community-based agencies. In addition, BHS increased collaborative efforts with the health department, contractors, major area health providers (hospitals), and other agencies.

Key Trends/Impacts
◆ Increased collaboration and communication between public health services and community providers and agencies.
◆ Improved access to target population; improved methods for reaching clients, including a culturally appropriate health education model.
◆ Enhanced public awareness.
◆ Increased service capacity (substance abuse, family planning).
◆ Increased community and consumer involvement in public health service delivery.

California: Oakland Healthy Start

Grantee
Alameda County Healthcare Services Agency—Public Health Department
Target Area
- Three areas in Oakland: Fruitvale/San Antonio, East Oakland, West Oakland.
- Total 1990 population: 176,270 (92,000 African Americans, 33,000 Hispanics).
- 1984–88 baseline infant mortality rate of 17.9 per 1,000 live births (22 among African Americans).

Baseline Community Needs Assessment and Characteristics
- Barriers to access, including transportation and child care.
- Significant cultural barriers to accessing care.
- Lack of comprehensive family services.
- Inadequate case management; fragmentation and insufficient service coordination across health and social services.

Service Models and Special Populations
- Family Life Resource Centers (FLRCs) providing one-stop shopping.
- Community-based consortium and community advisory boards.
- Outreach and client recruitment.
- Enhanced clinical services.
- Mobile clinic providing services and outreach in communities.
- Public education and information.
- Women at risk for premature delivery; male partners.

Organization and Profile
The Oakland Healthy Start (OHS) consortium currently consists of three tiers: the advisory board, the contractors' meeting (service providers), and the community advisory boards (CABs), composed of residents and program participants. CABs, staffed by community development associates, are in place at each of the FLRCs and provide a consistent venue for client, consumer, and community input into OHS planning and direction.

OHS's FLRCs serve as the conduit for many of OHS's program developments and system collaborations. They provide a collocation for participating agencies and services. Each FLRC has developed its own set of collaborations with neighboring agencies, groups, and programs to meet the needs of each unique community. Collaborations typically include community groups; food banks; churches; community-based health, social service, youth, and advocacy agencies; schools; physician groups; and child care agencies.
Key Trends/Impacts

- Served as the model for reorganizing the Alameda County Public Health Department's new Community Health Services Division.
- More responsible service delivery system.
- Collaboration and linkages across health and social service agencies, and linkages with community-based organizations.
- Simplification and standardization of client information forms and data.
- Increased sensitivity to ethnic and cultural diversity.
- A significant increase in community residents' knowledge of resource availability.
- Improved access to services; enhanced coordination of care.

District of Columbia: District of Columbia Healthy Start Project

Grantee
District of Columbia Department of Health

Target Area

- Wards 7 and 8 in the District of Columbia.
- Total 1990 population: 145,145 (94 percent African American).
- 1984–88 baseline average infant mortality rate of 23.2 per 1,000 live births.

Baseline Community Needs Assessment and Characteristics

- High rates of low or no prenatal care; high rates of insufficient weight gain among pregnant women.
- Fragmented systems of care; few mechanisms for coordinating referrals and service delivery among agencies; limited or nonexistent data and referral systems.
- Insufficient service capacity for prenatal care, family planning, substance abuse counseling, and treatment.

Service Models and Special Populations

- Outreach, such as mobile units, resource-parent home visiting, male outreach workers, and hotlines.
• Case management and care coordination.
• Facilitating services, such as transportation.
• Education and training.
• Enhanced clinical services.
• Risk prevention and reduction.
• Adolescent services.
• Infant mortality review.

Organization and Profile

The project was operated by the Office of Maternal and Child Health within the D.C. Department of Health. The core of the project was managed under the public health agency through agreements with other D.C. government entities such as D.C. General Hospital. Many District of Columbia Healthy Start (DCHS) services were provided under contract with private organizations and public agencies.

As of April 1997, the DCHS consortium had 195 members, including consumers, providers, agency representatives, regional service organizations, and others. The consortium also established itself as a nonprofit 501(c)(3) agency to secure other grants for sustaining services. A 15-member coordinating committee met every 6 weeks to conduct business between the quarterly meetings of the consortium. One-third of consortium members participated in one of four work groups: the infant mortality review work group, the public education work group, the interagency work group, and the community affairs work group. There were also two technical advisory groups: the data and evaluation work group and the public information work group.

Key Trends/Impacts

- Increased clinical service capacity, service enhancements, and broader range of services.
- Improved access to and use of clinical care and support services; reduction in barriers to access.
- Increased coordination and establishment of formal referral mechanisms among providers and services.
- Integration and automation of client data and information; standardization of forms across participating providers and agencies.
Florida: Florida Panhandle Healthy Start
(Special Project)

Grantee
Partners for a Healthy Baby

Target Area
• Six north Florida rural counties: South Leon, Gadsden, Madison, Jefferson, Taylor, and Calhoun.
• 1990 total population: 295,975, with 78,657 women of childbearing age.
• 1988–90 infant mortality rate of 14.5 per 1,000 live births (18.7 among African Americans).

Baseline Community Needs Assessment and Characteristics
• High infant mortality rates and rates of low birthweight.
• Limited health education programs.
• Limited participation of providers in risk assessment programs.

Service Models and Special Populations
• Case management, health education, and referral through home visiting.
• Fetal and infant mortality review.
• Outreach and public education with target population as well as providers.

Organization and Profile
The Panhandle Healthy Start program was funded as a special project in 1994. It was designed as a randomized controlled study of at-risk pregnant women to evaluate the impact of home visiting on health behaviors and outcomes. The project was intended to test the viability of a high-quality, coordinated paraprofessional home visiting model to maximize utilization of resources and reduce duplication of services in the project area. The project included development of curriculum and training programs for home visitors, development of supporting data and management information systems, and significant outreach to providers and health clinics. Over 10,000 home visits were provided to over 300 pregnant high-risk women during a 2-year period of the study.

To support this project, three preexisting local Healthy Start coalitions formed the Panhandle Healthy Start coalition as a formal structure for regional planning.
Key Trends/Impacts
- Significant drop in the very-low-birthweight rates in the project area, while state rates remained stagnant.
- Reduction in the low-birthweight rate for Hispanic women, in contrast to statewide increase; dramatic reduction in very-low-birthweight rates for this population.
- Declines in smoking during pregnancy; increases in the duration of breast-feeding; increases in the use of birth control.
- Increased compliance of providers with state prenatal risk screening.

Georgia: Chatham-Savannah Healthy Start Initiative (Special Project)

Grantee
Youth Futures Authority

Target Area
- High-risk target areas (five key zip codes) within Chatham County, including Savannah.
- Total 1990 population: 137,537 (over 50 percent African American).
- 1988–90 infant mortality rate of 15.5 per 1,000 live births (17.9 among African Americans).

Baseline Community Needs Assessment and Characteristics
- Significant population of at-risk adolescents; high adolescent pregnancy rates.
- Limited resources for outreach, education, and risk prevention.
- High rates of crime, unemployment, adolescent pregnancy, child abuse, and HIV infection.
- Lack of access to health and social services.

Service Models and Special Populations
- Outreach.
- Case management and care coordination (perinatal/family advocacy case management).
- Perinatal education.
- Public education and information.
Organization and Profile

The Youth Futures Authority (YFA) is a unique hybrid of public agency and nonprofit organization mandated by the state legislature to develop a comprehensive plan to deal effectively with the problems of youth in the Chatham-Savannah area. The Chatham-Savannah Healthy Start Initiative is governed by YFA and a Healthy Start advisory council. It is also supported by the YFA consortium.

Key Trends/Impacts

- Reductions in adolescent pregnancy.
- Decline in the infant mortality rate and low-birthweight rates.
- Significant changes in clients' knowledge, attitudes, and behaviors.
- Reduction in percentage of women receiving no prenatal care.

Illinois: Chicago Healthy Start

Grantee
Illinois Department of Human Services

Target Area

- Six areas in Chicago: the Near North Side, West Town, and Near West Side areas (the north/west service area); and the Near South Side, Douglas, and Grand Boulevard areas (together the south service area).
- Total 1990 population: 227,838.
- 1984–88 infant mortality rate of 19.6 per 1,000 live births (24.6 among African Americans).

Baseline Community Needs Assessment and Characteristics

- Fragmentation of the clinical and social-service delivery system.
- Insufficient resources to ensure care coordination across clinical and social support services.
- High rates of substance abuse, smoking, and other risk factors.

Service Models and Special Populations

- One-stop health and social service centers: Chicago Healthy Start Family Centers (CHSFCs).
Outreach and case management, enabling services (transportation and child care), health education, job training, and enhanced clinical services were all incorporated into the one-stop centers.

- High-risk pregnancies, women in jail.

**Organization and Profile**

The management and governance of the Chicago Healthy Start Initiative (CHSI) is the combined responsibility of the Illinois Department of Human Services and the Healthy Start consortium. The consortium's standing committees include data and evaluation, operational development (which includes several subcommittees), and financial resources and marketing.

CHSFCs were developed in the context of a statewide case management program. Each CHSFC is a collaboration between a community-based social service agency and a medical clinic or hospital. CHSFC case management funds are used to assist high-risk families in the agency's target area. Other resources are used to serve women in other risk categories.

**Key Trends/Impacts**

- Increase in the overall project-area rate for receiving adequate prenatal care; fewer infants born with positive drug toxicology.
- Increased capacity of the primary health care system; increased coordination and referral among multiple support services.
- Expanded range of services and educational programs provided by primary health centers.
- Improvements in community employment infrastructure.
- Development of a user-friendly management information system to track client services.

**Indiana: Northwest Indiana Healthy Start**

**Grantee**
Northwest Indiana Health Department Cooperative

**Target Area**

- Four urban areas located in upper Lake County: East Chicago, Gary, Hammond, and Lake Station.
- Total 1990 population: 248,673.
- 1984–88 infant mortality rate of 16.2 per 1,000 live births.
Baseline Community Needs Assessment and Characteristics

- Fragmented services, medical model only.
- Insufficient clinical provider capacity.
- No provisions to promote early entry into prenatal care.
- Barriers to access, including lack of child care, transportation, and health education classes.

Service Models and Special Populations

- Outreach.
- Clinical services enhancement.
- Transportation and child care.
- Public information and education.
- Infant mortality review.
- Pregnant adolescents.

Organization and Profile

The Northwest Indiana Healthy Start Project's grantee agency, the Northwest Indiana Health Department Cooperative (NIHDC), is governed by an interlocal cooperative composed of the mayors and health directors of East Chicago, Gary, Hammond, and Lake Station, and the president of the county commissioners. Each of the four cities appoints 20 members to a Healthy Start consortium; an additional 20 members are appointed by county and state representatives.

Key Trends/Impacts

- Innovations in outreach to and education of pregnant adolescents.
- Successful collocation of and collaboration among health and social support services, including WIC, prenatal substance-abuse programs, and child-abuse prevention services.
- Expansion of clinical capacity; addition of care coordination services.
- Reduced barriers to access through enhanced transportation and child care.
Louisiana: Great Expectations/Healthy Start (New Orleans)

Grantee
Great Expectations Healthy Start

Target Area
- Ten contiguous neighborhoods in New Orleans.
- 1984–88 baseline infant mortality rate of 23.3 per 1,000 live births (23.2 among African Americans and 26.2 among whites).

Baseline Community Needs Assessment and Characteristics
- Fragmentation of services; limited continuity of care.
- Limited or no access to perinatal or pediatric services in some areas.
- Few programs to serve pregnant women with substance abuse problems.
- Case management is not generally provided.

Service Models and Special Populations
- Outreach.
- Care coordination and referral.
- Facilitating services: child care and transportation.
- Enhanced clinical services.
- Home visiting.
- Fetal and infant mortality review.
- Adolescents.

Organization and Profile
Great Expectations (GE) was founded as a project of the City of New Orleans Health Department, and for its first 5 years was managed through the city. In February 1996, the project’s consortium incorporated the Great Expectations Foundation, which subsequently entered into a contractual relationship to operate the program. The board of directors includes appointees by the mayor and the Medical Center of Louisiana, as well as members of the consortium’s leadership council.
The foundation of GE's consortium is neighborhood-based organizations known as service area advisory councils (SAACs). In addition, there is an advisory board and a representative body of community organizations.

**Key Trends/Impacts**

- Increased collaboration and coordination among key provider organizations and support agencies.
- Established first infant mortality review program in the area.
- Increased public recognition of issues related to infant mortality and family health.
- Increased consumer participation at local level.
- Expanded service capacity and services delivered to target communities.
- Established grief therapy program and minimum standards for licensure of nurseries.

**Maryland: Baltimore City Healthy Start**

**Grantee**
Baltimore City Health Department

**Target Area**

- Special target area within inner-city project area: 14 census tracts in two locations in east and west Baltimore.
- 1990 project area population: 427,136; target area population: 69,493.
- 1984–88 project-area baseline infant mortality rate of 20.1 per 1,000 live births.

**Baseline Community Needs Assessment and Characteristics**

- Barriers to access to prenatal care, including limited information, lack of transportation and child care, and limited scheduling systems.
- Limited care coordination and support services; lack of outreach and awareness of available services.
- Psychological and cultural barriers to access; depressed communities with limited opportunities for education, training, and employment.

**Service Models and Special Populations**

- Intensive care coordination and referral, including home visiting, based in two community-based centers.
• Medical reform (clinical service enhancement) through agreements with 16 prenatal and pediatric clinics.
• Health education, life planning, GED, and other support services.
• Public education and information.
• Community empowerment and development initiatives.
• Special target groups include high-risk prenatal cases and male partners.

Organization and Profile

The Baltimore City Health Department established Baltimore City Healthy Start, Inc. (BHSI), as a nonprofit, quasi-public 501(c)(3) organization. This ensured public accountability and facilitated effective management and timely implementation of Healthy Start goals. BHSI has a five-member board of directors appointed by the mayor. Currently, the Commissioner for Maternal and Infant Care of the health department serves as the director of the corporation. There are three consortia. A project area consortium includes a 19-member executive committee and serves an advisory role to Healthy Start. Two target area consortia focus on the quality and accessibility of services in their areas and provide an understanding of local problems and needs.

Neighborhood Healthy Start centers are the base for teams that provide intensive outreach, case management, and home visiting. These centers also serve as the location for a wide range of educational and support activities.

Key Trends/Impacts

• Improved birth outcomes for case-managed clients, including clients with substance abuse problems.
• A high care-coordination penetration rate in the target population; improved accessibility of health and social support services.
• Enhanced practices among providers.
• New systems for earlier identification of high-risk cases; increased rates of early and regular use of prenatal care.
• Improved health behaviors related to nutrition.
• Community employment.
Massachusetts: Boston Healthy Start Initiative

Grantee
Boston Medical Center

Target Area
- Urban, inner-city area that includes part or all of nine neighborhoods.
- 1990 total project-area population of 283,167; over 30 percent are women of childbearing age.
- 1984–88 baseline infant mortality rate of 17.1 per 1,000 live births (24.6 among African Americans).

Baseline Community Needs Assessment and Characteristics
- Inadequate availability of perinatal and pediatric sessions and perinatal substance-abuse treatment and outreach.
- Insufficient WIC and nutrition counseling services, family planning resources, women's health services, school-based health services, and adult basic education.
- Lack of case management and home visiting; lack of adequate child care and transportation.
- Complex eligibility requirements; lack of follow-up for high-risk infants; insufficient referral systems.
- Insufficient linkages between family planning services, primary care facilities, maternity hospitals, and neonatal intensive care units.

Service Models and Special Populations
- Outreach services required from all direct service programs funded by BHSI.
- Case management and care coordination, including home visiting, referrals, education, and counseling.
- Facilitating services, including transportation and child care.
- Education and training, including adult basic education, employment training, public information and education, and diversity and domestic violence training for providers.
- Enhanced clinical services.
- Risk prevention and reduction; fetal infant mortality review.
- Adolescents, male partners, high-risk cases, and Latinos.
Organization and Profile

Boston Healthy Start Initiative (BHSI) is a partnership between the Boston Public Health Commission and a consortium of community residents and providers. Consortium members have the opportunity to participate in decision-making through the executive committee or one of seven subcommittees: membership, public information, finance, personnel, education, evaluation, and transition. Both the 27-member executive committee and the consortium core group meet monthly to develop implementation plans and put into action consortium recommendations. BHSI achieves its goals through contracts with community providers and agencies. BHSI has developed extensive capabilities and resources to monitor and provide technical assistance to funded organizations. Ongoing coordination meetings of the entire BHSI program network are scheduled quarterly. Requirements for contract renewal include reporting on progress in meeting original goals and objectives.

Key Trends/Impacts

- Significant collaborative relationships among maternal and child health and related programs within neighborhoods and at the city, state, and federal levels.
- Strengthened case management and referral infrastructure in community health centers in the target area.
- Improved access to and adequacy of prenatal care; expanded health center ancillary services.
- Improvements in provider responsiveness to consumer needs.
- Community empowerment through job creation and community-controlled health initiatives.

Michigan: Detroit Healthy Start Project

Grantee
City of Detroit Department of Health

Target Area

- Seventeen contiguous subcommunities constituting the central core of the City of Detroit and all of Highland Park.
- 1988–90 baseline infant mortality rate of 26.3 per 1,000 live births.
Baseline Community Needs Assessment and Characteristics

- Forty percent of women of childbearing age do not have a high school education.
- High poverty/unemployment rates (20 percent).
- High infant mortality rates (predominantly neonatal).
- Low utilization of prenatal care; notorious inaccuracy regarding utilization.
- High rates of substance abuse (smoking, drinking, drugs) during pregnancy.
- Lengthy average wait times for appointments for prenatal care, with lack of transportation adding to the barriers to access.

Service Models and Special Populations

- Outreach (e.g., door-to-door canvassing, information sharing, and recruitment).
- Case management and care coordination.
- Facilitating services by enhancing transportation resources.
- Enhanced clinical services.
- Risk prevention.
- Fetal and infant mortality review.

Organization and Profile

Detroit Healthy Start Project's (DHSP's) organizational structure included a 55-member consortium as the governing body, local advisory boards in each of the three service divisions, a single project director appointed by the mayor, and a director of operations. The Detroit Health Department (DHD) was designated as the grantee agency and Wayne State University (WSU) was responsible for program and contract management and evaluation. Responsibility for DHSP management has gradually shifted from WSU to DHD over the years. A new mayor and subsequent appointment of a new public health director in 1995 resulted in improved coordination between WSU and DHD and the increased involvement of the public health director in DHSP's operation. DHSP established outreach teams in three divisions in its target area.

Key Trends/Impacts

- A steady decrease in infant mortality.
- Improved health status of women and infants served, including improved pregnancy outcomes.
- Increased access to services, with a focus on eliminating lack of transportation.
Mississippi: Delta Futures (Special Project)

Grantee
Mississippi Primary Health Care Association

Target Area
- Eight counties in rural northwest Mississippi: Bolivar, Holmes, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, and Washington.
- Total 1990 population: 239,456 (150,204 African Americans).
- 1988–90 baseline infant mortality rate of 18.7 per 1,000 (20.7 among African Americans).

Baseline Community Needs Assessment and Characteristics
- Need for better coordination among federal, state, and local services.
- Poor access to services, especially among adolescents.
- Limited community education.
- Need for additional service capacity.

Service Models and Special Populations
- Education and training.
- Facilitating services: transportation and child care.
- Clinical service enhancement, provider recruitment.
- Adolescent programs.
- Risk prevention and reduction.
- Outreach and client recruitment.

Organization and Profile
Delta Futures was a Healthy Start Initiative’s management and governance structure consisting of the project grantee (Mississippi Primary Health Care Association), a project area council (PAC), the PAC executive committee and sub-committees, and local county consortia. The PAC provided local participation, oversight, and advice to the grantee and the project. Mississippi Primary Health Care Association was responsible for managing the project and awarding all contracts. Three field offices were established to serve the project area.

Six county-based consortia were formed to involve their communities in project implementation and planning. They conducted monthly meetings and implemented a variety of activities at the local level.
Key Trends/Impacts
- Enhancement of access.
- Increased community involvement in planning and implementation.
- Public education and awareness about adolescent pregnancy, prenatal care, and infant mortality.

Other Note
Delta Futures is no longer a federally funded Healthy Start project as of October 1997.

New Jersey: A Healthy Start for Essex County (Special Project)

Grantee
New Jersey Department of Health and Senior Services

Target Area
- Four neighboring cities in northeastern metropolitan areas of New Jersey: Newark, Orange, East Orange, and Irvington.
- 1988–90 baseline infant mortality rate of 17.7 per 1,000 live births (20.2 among African Americans).

Baseline Community Needs Assessment and Characteristics
- Inadequate prenatal care: 20.1 percent of project area women received from no to six prenatal care visits (compared to 11.1 percent for the rest of the state).
- No prenatal care was received by 5.5 percent (compared to 1.0 percent for the rest of the state).
- Rate of births to adolescents under 18 was over three times that of nonurban New Jersey.
- Rate of births to adolescents ages 18–19 was nearly three times that of non-urban New Jersey.

Service Models and Special Populations
- Family resource center for teens, providing case management services, prenatal care, pediatric health care, family planning, and social services, including
substance abuse counseling, education programs, outreach services, and enhanced transportation and child care services.

- Local project coordination/public information.
- Fetal infant mortality review (funded in the last year of the grant).
- Concerted effort to find hard-to-reach populations via outreach workers canvassing neighborhoods door-to-door.

**Organization and Profile**

As the grantee, the New Jersey Department of Health and Senior Services (NJDHSS) oversaw many core functions of the Essex Healthy Start program, including funding staff positions and working closely with the Healthy Start advisory board. In August 1995, an executive committee of the advisory board was created to oversee implementation and maintenance of the Healthy Start project. This seven-member committee representing NJDHSS and the Healthy Start project meets at least bimonthly and informs the full advisory board, which meets quarterly, of its actions. The current advisory board has been expanded to include a greater number of culturally representative consumers and community members, and focuses on evaluation and sustainability.

**Key Trends/Impacts**

- Enhanced collaboration among health, social service, and community-based agencies.
- Increased public awareness and education of the Healthy Start program and the issues that it represents.
- Development of a family resource center (AD House) into a sustainable entity capable of providing adolescent-oriented ambulatory services and Medicaid maternity/prenatal services.

**New York: Healthy Start/New York City**

**Grantee**

Medical and Health Research Association (MHRA)

**Target Area**

- Three communities: Bedford in Brooklyn, Central Harlem in Manhattan, and Mott Haven in the Bronx.
- 1990 population of about 500,000, almost one-third of whom were women of childbearing age.
Seventy-one percent non-Hispanic black, 25 percent Latino, 3 percent non-Hispanic white, and 1 percent Asian or other.

1984–88 baseline infant mortality rate of 19.4 per 1,000 live births (21.6 among African Americans, 14.5 among Hispanics, and 10.9 among whites).

Twenty-four percent of women received late or no prenatal care; 21 percent of postpartum women gave birth within 15 months of previous delivery.

Baseline Community Needs Assessment and Characteristics

- Population at high risk for poor birth outcomes.
- Insufficient service capacity for high-risk groups.
- Limited care coordination and support services.
- Barriers to access, including lack of cultural sensitivity and distant service locations.
- Limited outreach, public education, and nutrition and health education services.
- Highly stressed communities with basic education, employment, and housing needs, and high rates of substance abuse and crime.

Service Models and Special Populations

- Case management and care coordination.
- Community development (education and training).
- Family planning and prenatal services (enhanced clinical services).
- Facilitating services (outreach vans, child care).
- Nutrition programs (education).
- Pediatric care and parenting education (risk reduction and prevention).
- Public information (education and training).
- Substance abuse prevention and treatment.
- Adolescent programs.

Organization and Profile

Healthy Start/New York City built on the capacity and expertise of its founding partners as well as on the community-based strengths of its three lead agencies. The founding partners included the Medical and Health Research Association of NYC, Inc. (MHRA), the New York City and New York State Departments of Health, the New York State Department of Social Services, the Bronx Perinatal Consortium, Inc., and the Brooklyn Perinatal Network, Inc. Three state-sponsored perinatal networks served as lead agencies: the Bronx Perinatal

**Key Trends/Impacts**
- Increased number and percentage of women accessing prenatal care.
- Lower percentage of infants born to women with reported drug abuse problems.
- Declines in rates of adolescent birth, low infant birthweight, and infant mortality.
- Increased WIC enrollment.
- Expanded service capacity and improvements in provider collaboration.

**Ohio: Greater Cleveland Healthy Family/Healthy Start**

**Grantee**
Healthy Family/Healthy Start Project

**Target Area**
- 15 at-risk neighborhoods in Cleveland.
- 1990 total population: 240,234; 28 percent were women of childbearing age; 87 percent were African American.
- 1984–88 baseline infant mortality rate of 21.4 per 1,000 live births (21.8 among African Americans).

**Baseline Community Needs Assessment and Characteristics**
- Lack of service integration and coordination at community level.
- Low rates of adequate prenatal care.
- Inaccessible health care services.
- Limited or no collaboration among health provider organizations.

**Service Models and Special Populations**
- Outreach.
- Infant mortality review.
- Risk reduction.
- Public information/public education.
• Education and training.
• Adolescents, women in jail.

Organization and Profile

The overall Healthy Family/Healthy Start Project (HF/HSP) consortium is community centered and community driven. The project area includes 15 neighborhoods, each with its own consortium group that meets at a local settlement house for easy access. During neighborhood consortium meetings, participants identify and rank community concerns and propose strategies for corrective action. Each neighborhood consortium identifies two individuals to represent them at the Consortia Leadership Committee (CLC). Volunteer representatives from the CLC participate in each of the other active committees: the executive council, the administrative management group, the infant mortality review committee, the clinical and social services committee, the consortium development committee, the leadership committee, and the health education, promotion, and training committee.

During the demonstration phase, the HF/HSP consortium maintained an active membership of more than 500 individuals from more than 50 community organizations and businesses, including substantial representation from the religious sector.

Key Trends/Impacts

◆ The first significant collaboration among area provider organizations related to infant mortality (via infant mortality review activities); unprecedented communitywide collaboration between public, private, and academic sectors.
◆ Significant penetration and enhancement of school-based outreach and services.
◆ Enhancement of standards and practice for outreach and services to women in jail.

Pennsylvania: Philadelphia Healthy Start

Grantee
Office of Maternal and Child Health, Philadelphia Department of Health

Target Area

• Inner-city neighborhoods in West and Southwest Philadelphia.
• 1990 total population: 301,000 (68 percent African American).
• 1984–88 infant mortality rate of 22.3 per 1,000 (24.7 among African Americans).

Baseline Community Needs Assessment and Characteristics
• Significant barriers to access: limited evening hours and service locations, block scheduling, deteriorating facilities, long wait times and appointment lead times, lack of child care, etc.
• High rates of no or inadequate prenatal care.
• Limited outreach and case finding; no uniform or comprehensive case management.
• Limited or ineffective health education.
• Limited coordination and referral among providers (e.g., for substance abuse treatment).
• Special needs of underserved Southeast Asian population.

Service Models and Special Populations
• Clinical service enhancement, working with existing provider system.
• Lay home visiting.
• Outreach.
• Community support and community education.
• Adolescent peer power.

Organization and Profile
Philadelphia Healthy Start Initiative's (PHSI's) 100-plus member consortium provides ongoing counseling and support regarding program design and implementation to the grantee. Consortium members participate in one of five work groups that make recommendations to the 24-member steering committee. The five work groups address collaboration, linkages, public awareness, public policy, and support services. Consumers, concerned residents, and representatives from community-based organizations hold 60 of the 103 consortium seats and 17 of 24 steering committee positions.

PHSI's strategy was to enable and encourage existing community-based organizations and providers to respond to maternal and child health needs. This strategy built on existing health and non–health care organizations that had a presence in the community. PHSI subcontracted with over 65 organizations through a request for proposal process. Through this process, as well as through ongoing monitoring and administrative technical assistance, PHSI increased the capacity and involvement of key community-based organizations.
Key Trends/Impacts

- Decline in service area rate of no prenatal care; increase in average number of prenatal care visits.
- Adoption of PHSI outreach and lay home-visiting standards by city and state public health/Medicaid agencies.
- Increased percentage of target population enrolled in PHSI over time; success in outreach to high-risk populations.
- Capacity building among local health and community-based organizations.
- A significant consumer role in defining service needs and developing effective strategies.
- Contribution to knowledge about the use of lay home visiting and successful outreach strategies to adolescents.

Pennsylvania: Allegheny County/Pittsburgh Healthy Start

Grantee
Allegheny County Health Department

Target Area

- Six regions, including 45 Pittsburgh neighborhoods and 4 municipalities in Allegheny County.
- 1990 total population of 230,000 (43 percent African American).
- Approximately 3,200 births annually.
- 1984–88 baseline infant mortality rate of 20.2 per 1,000 births (25.8 among African Americans).

Baseline Community Needs Assessment and Characteristics

- Fragmentation and specialization of services.
- Significant geographic and transportation barriers to accessing care.
- Significant percentage of women with late or no prenatal care, no prenatal care education, and no well-infant care.

Service Models and Special Populations

- Case management, care coordination, and outreach.
- Enabling services: transportation and child care.
• Public education and information.
• Communitywide information and referral.
• Collaborative and partnership models in primary and postpartum care and community nutrition.
• Special target populations: women in prison, women with substance abuse problems, male partners.

Organization and Profile

The project’s design is the product of extensive collaboration among Healthy Start; the Allegheny County Health Department; federal, state, and local officials; hospital and health care providers; health and human service agencies; foundations; the public schools; and the community. Healthy Start funds are used to expand, enhance, and coordinate the continuum of care as well as add initiatives to fill gaps in services as they are identified. A central consortium initially served as strategic advisor to the grantee and was composed of representatives from each of the six target regions, an at-large community representative, and key community leaders from the public and private sectors.

A 501(c)(3) organization, Healthy Start, Inc., was created by the consortium in 1992 and manages the Healthy Start project under contract to the health department. Healthy Start, Inc., board members are broadly representative of both the provider and consumer communities.

Six regional consortia, each with 20–25 members elected by community representatives, serve as advisors to Healthy Start and assist in identifying needs and monitoring program implementation.

Key Trends/Impacts

• Increased numbers of women receiving care; increased utilization of services.
• Reduced behavioral risk factors (e.g., smoking).
• Increased breastfeeding.
• Enhanced clinical services that build on existing delivery system.
• Successful collocation of services and improved access to and coordination of care.
• Improved family and community support for pregnant women and women with infants.
• Increased public awareness of the seriousness of infant mortality and its contributing factors.
• Broad-based public- and private-sector partnerships.
Positive economic impact through employment and job training.
Integrated state and local maternal and child health services.

South Carolina: Pee Dee Healthy Start

Grantee
Pee Dee Healthy Start, Inc. (United Way of South Carolina)

Target Area
- Six rural counties in northeastern South Carolina classified as medically underserved, based on health status and provider availability.
- 1990 total population: 229,617 (27.7 percent were women of childbearing age).
- 1984–88 baseline infant mortality rate of 15.9 per 1,000 live births (20.1 among African Americans).

Baseline Community Needs Assessment and Characteristics
- Fragmented and duplicative health care system with no means of tracking high-risk women or infants.
- Nearly one in three mothers has less than a high school education.
- Profound isolation of rural women and their families; 25 percent of minority households lack access to a vehicle, 20 percent of all households lack a telephone.
- Highest alcohol and illicit drug use in the state.

Service Models and Special Populations
- Rural outreach teams provide case management, medical care, counseling, and education.
- Public information/public education.
- Facilitating services: transportation.
- Teen Life Centers, providing services ranging from counseling and education to referrals to other services.
- Rural, hard-to-reach women and adolescents.

Organization and Profile
The Pee Dee Healthy Start Consortium (PDHSC) is a community-based and community-driven initiative designed to combat infant mortality. It is a triad,
formed of local (county) and state consortia and a regional council. Notable county Healthy Start coalition responsibilities are oversight and guidance on plan implementation, public awareness, intercounty collaboration, and volunteer recruitment. The regional Healthy Start consortium provides primary leadership and guidance to county coalitions, ensures collaboration/communication, coordinates financial support plans, and sets the agenda for regionally significant social and health issues. The state governing consortium is responsible for comprehensive plan approval, sets overall project direction, monitors project effectiveness, and provides technical assistance and information to regional and local consortia.

Key Trends/Impacts
- Increased immunization rates in the project area.
- Increased access to prenatal care.
- Increasing awareness and education of health professionals and the community at large, particularly adolescents.
- Recruitment and retention of maternal and child care providers.

South Dakota: Northern Plains Healthy Start

Grantee
Aberdeen Area Tribal Chairmen's Health Board

Target Area
- Nineteen tribal communities in four states: North Dakota, South Dakota, Iowa, and Nebraska.
- 107,377 total square miles of service area.
- 1990 total population of 84,450 Native Americans.
- 1984–88 baseline infant mortality rate of 18.7 per 1,000 live births.

Baseline Community Needs Assessment and Characteristics
- Insufficient access and transportation to care.
- No community-based maternal and child health programs providing services to tribal families.
- Inconsistencies in the health care system, including lack of permanent physicians and underfunded operating budgets.

Service Models and Special Populations
- Perinatal care.
• Psychosocial services.
• Facilitating services.
• Community development.
• Local/public education information.
• Local evaluation, administration, and data.
• Previous services and new ideas were merged, and a definition of targeted case management (TCM) was established that was better received and better served the 19 culturally distinct Native American tribes.

Organization and Profile

The administrative structure of the Northern Plains Healthy Start (NPHS) project was composed of two levels: The grantee level included the board of directors, the administrative staff, and project management staff, and the local tribal level included the tribal governing body, tribal health administrator, and community coordinator. The NPHS project's consortium development was unique in that there were 4 statewide and 19 local tribal site-specific consortia. Program participants were part of the local tribal consortia, as were tribal elders and community leaders. Their participation helped guide the project staff and ensured a consumer and community perspective. The consortia identified issues and helped organize community activities and cultural events.

Key Trends/Impacts

◆ Established new links to care and support services.
◆ Developed a foundation of public information and education.
◆ Increased service utilization, early identification of pregnant women, and support for quality maternal and child services for tribal families.
◆ Attracted local resource agencies to the care management model, and replicated the model's procedures and protocols by local services.

Texas: Dallas Healthy Start (Special Project)

Grantee
Parkland Health and Hospital System

Target Area

• 13 contiguous communities covering 105 square miles in the south, west, and central areas of deepest poverty in Dallas.
1990 total population: 223,375 (61,374 were women of childbearing age; 68 percent were African American, and 14 percent were Hispanic).

1988–90 baseline infant mortality rate of 14.5 per 1,000 live births (16.4 among African Americans).

Baseline Community Needs Assessment and Characteristics

- Limited transportation options to access services.
- High rates of adolescent pregnancy and smoking among pregnant women.
- Low rates of prenatal care, continuing care for infants (including immunizations), and WIC enrollment.

Service Models and Special Populations

- Consortium.
- Outreach.
- Risk reduction and prevention.
- Facilitating services: transportation.

Organization and Profile

The project consortium includes about 200 individuals, representing consumers as well as more than 40 agencies and organizations. A 23-member executive committee was responsible for approving program subcontracts and strategic planning for the project. Community involvement teams (CITs), which include residents of the target area, convene monthly to determine gaps or barriers to service and strategies for publicizing the Healthy Start effort. Another important vehicle for consumer representation and input is the Teen Advisory Committee, which also meets monthly and is involved in creative approaches to promoting important health behaviors.

In addition to staffing outreach and van (Mom Mobile) programs, the project achieves its objectives through community agency subcontracts. Criteria for evaluating agency proposals include the degree to which they involve collaboration with other area agencies and/or providers.

Key Trends/Impacts

- Expanded access to health care and social services through transportation and outreach.
- Increased capacity among social support agencies.
- Enhanced collaboration among providers and social service agencies on issues relating to methods of outreach, prenatal care delivery, adolescent pregnancies, and substance abuse.
Virginia: Richmond Healthy Start Initiative (Special Project)

Grantee
Richmond City Department of Public Health

Target Area
- City of Richmond, with emphasis on the east district of the city.
- Total 1990 population of 203,056.
- 1988–90 baseline infant mortality rate of 18 per 1,000 live births (22.4 among African Americans).

Baseline Community Needs Assessment and Characteristics
- High-risk adolescent population.
- Gaps in access to maternal and child health services.
- Inadequate transportation; scarcity of child care.
- Deficits in education and inability to exercise personal responsibility.
- Complicated paperwork to access adequate care.

Service Models and Special Populations
- Case management/care coordination.
- Outreach/client recruitment.
- Education and training.
- Risk prevention and reduction.
- Facilitating services.
- Infant mortality review.
- Adolescent education.

Organization and Profile
Richmond Healthy Start Initiative (RHSI) is a citywide consortium with over 100 members representing consumers, the business community, hospitals, Richmond city schools, local universities, volunteer agencies serving women, social service agencies, and others. Consortium members contribute to decision-making through several committees that meet monthly: the steering committee, the consumer involvement committee, the data and evaluation committee, the public education committee, the sustainability committee, the conference planning committee, and the year-end review committee.
RHSI achieves its objectives by distributing requests for proposals to community organizations and public/private agencies; the proposals must address one or more Healthy Start intervention models identified as priority by RHSI.

**Key Trends/Impacts**
- Programs have served as models for the Virginia Medicaid program (e.g., substance abuse treatment for pregnant women).
- Program innovation and capacity-building by community agencies.
- Creation of a model for collaboration between the public health department and community-based organizations.
- Creation of outreach capacity and staffing in the community.
- Job creation in the community.
- Establishment of family and child health divisions in the local health department; greater interagency collaboration.
- Implementation of an abstinence-based teen-pregnancy prevention program in all city middle schools.

**Wisconsin: Milwaukee Healthy Women and Infants Project (Special Project)**

**Grantee**
Milwaukee Healthy Women and Infants Project

**Target Area**
- High-risk inner-city target areas within Milwaukee (eight central city zip codes).
- Total 1990 population of 277,657.
- 1988–90 infant mortality rate of 14.7 per 1,000 live births (18.7 among African Americans).

**Baseline Community Needs Assessment and Characteristics**
- High rates of adolescent pregnancy, prenatal smoking, poor nutrition, and noncompliance with prenatal care appointments.
- Lack of child care, transportation, insurance, and physicians.
- Lack of cultural competency among providers.
- Fragmentation and competition among providers leading to lack of available adequate care.
Service Models and Special Populations

- Case management and care coordination.
- Outreach.
- Facilitating services: transportation, translation, food pantry, and clothing bank services.
- Education and training; public information and education.
- Enhanced clinical services.

Organization and Profile

Milwaukee Healthy Women and Infants Project is a 501(c)(3) agency. The project was governed through three components: a large consortium that included community task-force members as well as service providers, community-based organizations, businesses, educational institutions, and local and state health officials; a community task force of health consumers and area residents; and a 19-member board of directors that included 11 community task-force members and 8 providers/community-based organization members.

Key Trends/Impacts

- Enhanced service capacity; increased coordination and collaboration among providers, agencies, and social services.
- Improved access to care and support services (prenatal care, immunizations, child health checks).
- Significant improvement in the percentage of women in the target area initiating medical care during the first trimester.
- Improved health-related outcomes and expanded access to prenatal care among high-risk categories of clients, including African Americans, adolescent mothers, and low-income mothers.

Other Note

The Milwaukee Healthy Women and Infants Project is no longer a federally funded Healthy Start project as of October 1997.
Appendix B: Healthy Start Projects in the Local Press

Infants and mothers at risk may be among the few topics that successfully compete for press attention with such "hot" issues as the latest political or Hollywood scandal.

This appendix highlights examples of local press coverage of Healthy Start projects between 1991 and 1997.

Setting Community and Personal Goals

*Healthy Start has received praise for developing specific and wide-ranging goals to reduce infant mortality in the United States. Healthy Start has established techniques to approach these goals, as well as methods to evaluate progress.*

*Medical Herald—New York, NY*  
(January 1997)

"Healthy Start/NYC seeks to assure that every infant lives beyond his or her first birthday, that every pregnant woman has access to quality, affordable health care, and that all communities be empowered to obtain know-how and resources enabling them to be independent and self-sufficient. We are proud of the results." [Michelle Drayton-Martin, Healthy Start director]
**The Sun (commentary)—Baltimore, MD**  
(July 28, 1996)

At a recent meeting of the Maryland Commission on Infant Mortality Prevention, Healthy Start officials presented preliminary findings showing that pregnant women enrolled in Healthy Start programs had significantly better outcomes than women who enrolled after their babies were born.

Despite all the money we have spent on issues like infant mortality, too few of these programs have done what Baltimore's Healthy Start is doing: relentlessly monitoring its activities, tracking its clients, and evaluating the results.

Thanks to a clear goal and the investments in research and evaluation to document its results, Healthy Start stands a good chance of proving that there really are ways to make a difference in a social problem as difficult and elusive as infant mortality.

**The Plain Dealer—Cleveland, OH**  
(December 25, 1995)

Another major goal of the program is to educate and involve entire neighborhoods, from clients to utility companies that offer special help to the poor. Meetings are regularly held in project area neighborhoods to discuss solutions.

“It can't just be the city Department of Public Health. It can't just be millions of dollars from the federal government. It's a collaborative effort,” [Juan Molina Crespo, Director of Cleveland Healthy Families/Healthy Start].

**Pittsburgh City Paper—Pittsburgh, PA**  
(August 20, 1997)

Healthy Start “is a critical component of the Social Service system with its mission of healthy babies.” [Marc Cherna, Director of Allegheny County Department of Human Services]

**The Oakland Tribune—Oakland, CA**  
(August 1995)

Infant death rates in three problem-plagued Oakland neighborhoods have dropped by a phenomenal 50 percent in the past four years.

Jubilant health officials credited the impressive achievement to Oakland Healthy Start. Started in 1991, the federally funded program links pregnant women and new mothers to health and social services in their communities.
"We've seen an important change in women entering prenatal care early," said Ross [Risë Ross, Healthy Start Director]. "This was a massive undertaking. It was four cities with one common purpose—to save their babies—and that's a wonderful goal."

The Healthy Start program kicked off Saturday with the high-pitched jabber of children and festoons of bright balloons. The carnival atmosphere belied the serious problem Healthy Start will fight: the shamefully high infant mortality rate in parts of Dallas.

Several children's advocacy groups placed funding for Healthy Start-style programs on their state legislative agendas. That's because the early intervention programs work. Strong prenatal and parenting programs, combined with home visitation, can lower rates of child abuse and neglect among high-risk parents.

Rather than impose its services on women, Healthy Start organizers hope that services will seep into targeted communities. They want moms who participate to help carry the word back to other women of childbearing age. Healthy Start already includes teen-age advisers who help develop programs—a smart idea.

Healthy Start projects aggressively recruited women with infants and pregnant women in their own communities. These women were continually encouraged to seek prenatal care and utilize the other support services offered to them.

Outreach workers fanned out across Boston, knocking on doors and sending vans to take pregnant women to prenatal care appointments, getting women out of abusive relationships, and delivering food to hungry families.... The
outreach efforts that have helped bring down the infant mortality rate are visible daily in the city's neighborhoods.

*The Connection*—Cleveland, OH
(December 1993)

The program also assists neighborhood families with parenting classes at East End Neighborhood House. It promotes its services at such events as a health fair at Harvey Rice School, where preschoolers received immunizations, the library branch staff gave out library cards, and safety forces finger-printed the youngsters.

*Birmingham News*—Birmingham, AL
(January 23, 1994)

The program offers pregnancy testing, infant immunizations, nutrition counseling, maternity referrals, substance abuse services and referrals, family planning, and parenting, human sexuality, smoking cessation, and prepared childbirth classes. "We treat the whole person," said Ida Biffle, an outreach worker at the Central Park site.

*The New York Times*—New York, NY
(August 17, 1997)

From a pastoral point of view, Greenmarket's aroma of basil, mint, and peaches, as well as its kaleidoscope of flowers and produce, transforms city corners, emanating what one shopper at La Marqueta, an open-air market in East Harlem, recently described as "ripples of hope." In some neighborhoods, the sensory onslaught kindles an interest in flavor and novelty, freshness and variety. In others, the ripples of hope extend far beyond dinner. . . . So rare is fresh, unpackaged food in some parts of the borough that the Bronx Perinatal Consortium, a program dedicated to improving maternal and infant health, began two farmers markets in the Mott Haven section, as part of the federally funded Healthy Start Program.

*The Dallas Morning News*—Dallas, TX
(July 23, 1997)

Rita McCoo returned from work last week, and quickly prepared to head out for her other job: making sure babies are born healthy. She helps locate pregnant women and girls who are unlikely to seek prenatal care, and cajoles them into seeing doctors. . . . Ms. McCoo has volunteered for Dallas Healthy Start
almost since its birth in late 1994. The program’s new goal is to reach the most
difficult populations such as substance abusers.

Volunteers staff health fairs, speak at churches and hold “baby safety showers.”
Once they have an audience, volunteers can refer pregnant women to medical
care, substance abuse programs, family planning services, parenting classes
and other care. And Healthy Start’s donated vans ensure women without cars
or easy access to buses keep their appointments.

“The great thing about Healthy Start is the transportation, the Mom-Mobiles,”
Ms. McCoo says. “I work for an organization that goes all the way.”

The Washington Times—Washington, DC
(November 24, 1993)

If pregnant women in certain areas of the city can’t go to get health care, bring
the health care to them. That’s the reasoning behind a joint District-federal
program in which two huge mobile vans—each with doctors, two examining
rooms, a small kitchen, a television screen, and a small office—will soon visit
Wards 7 and 8 in Southeast to educate expectant mothers.

Those wards for years have had the District’s highest infant mortality rates . . .
and have lacked needed health services, officials said. “I think the most impor-
tant thing is to let people know they’re out here,” said Vincent Gray, director of
the D.C. Department of Human Services. Women who visit the vans will get
medical screenings, counseling, risk assessments and continuous prenatal
education. Staffers will help the women apply for food assistance and health
programs such as Medicaid.

Gaining Trust

For its outreach programs, Healthy Start frequently recruited case man-
agers who were from or were very familiar with the target communities.
This strategy was designed to gain trust and credibility among the resi-
dents.

City Paper—Baltimore, MD
(August 20, 1993)

“I have a personal stake in this neighborhood,” [Judy Washington, recruitment
supervisor for the Healthy Start–Baltimore Project] says. “I’m from this area,
my daughters are from this area, and my grandchildren are from this area.” While growing up, Washington says, she remembers her neighbors being there for her when her mother wasn’t around. And she says she is here to help those who need it. “If I have anything to say about it, they will be helped whether they want it or not,” she says.

In the West Baltimore neighborhoods of Sandtown-Winchester and Harlem Park, “someone’s always delivering a baby or getting pregnant.” As the recruitment supervisor for the Healthy Start–Baltimore Project, Washington knows all about pregnant women, new mothers, and their babies. She has been with the Project since it started in 1990. . . . Healthy Start hires members of the community as neighborhood health advocates (NHAs) to recruit high-risk pregnant women.

When Washington started recruiting on the streets, she says, the women at first thought she was a Jehovah’s Witness or a health-insurance peddler. But Washington says she simply explained Healthy Start to them and they listened. “I’m nice to people, and they’re nice in return,” she says. And in the three years she’s been at Healthy Start, she says she remembers only three women who refused to talk with her about the program.

_Argus Leader—Sioux Falls, SD_ (June 23, 1996)

Caseworker Kathy Lays Hard covers a big chunk of . . . territory . . . with a current caseload of 94 prenatal women and 64 infants. “It keeps you moving, but it’s really important to keep regular, frequent contacts with each of the people,” she said. “We work hard to keep that personal contact.”

Like most workers in the Healthy Start programs, [Kathy] Lays Hard and [Jo Ann] Sierra grew up in the area they serve. That’s one way the program breaks through mistrust toward medical people that sometimes exists on reservations, said Donna Haukaas, who works in the Aberdeen office.

“What works for Healthy Start is that each community is involved.”
Changing Attitudes

Attending prenatal care appointments will not alone ensure the birth of a healthy infant. Healthy Start has tried to change the fundamental attitudes of women toward themselves and their health to encourage more healthful behaviors.

Pittsburgh Post-Gazette—Pittsburgh, PA
(November 30, 1997)

Social service staff who work with at-risk black mothers said they saw this distrust [of hospitals] repeatedly. And they said it often made black women reluctant to use medical facilities and likely to disregard medical advice when they did use the medical facilities. “I hear a lot of mothers saying I’m not going back to that hospital—they see I’m on medical assistance and they treat me poorly. I don’t want them to judge me,” said Corley [a family advocate in Pittsburgh].

The Washington Post—Washington, DC
(August 26, 1993)

But Healthy Start workers have to surmount a host of barriers, including convincing pregnant women to eat enough.... “We hear such things as: ‘If you have a small baby, it won’t hurt as much,’” [Barbara J. Hatcher, the D.C. Healthy Start project director] said. To promote healthy eating, Healthy Start has begun giving $20 coupon books to pregnant women who are receiving prenatal care at area health centers. The coupons can be used to buy fruits, vegetables, and dairy products at area Giant food stores.

Dallas Morning News—Dallas, TX

“Regular visits to the doctor are very important and pregnant women sometimes don’t recognize their significance,” says Ms. Dominguez. “I’ve heard women say, ‘When I had my third child, I didn’t even see a doctor until I delivered.’ That’s dangerous. It doesn’t matter if it’s your first or your fifth pregnancy, you should receive prenatal care.”

Because of the increasing demand for the Mom-Mobile services—the number of participants doubled between July and November 1995—Dallas Healthy Start plans to add four vans to its fleet. “There’s no excuse not to get prenatal care, especially now that women who need it can get a free ride to the doctor,”
says Ms. Dominguez. "In the long term, prenatal care is cost-effective. . . . A prenatal program costs about $4,500 per patient. Caring for a low birth-weight baby can cost between $20,000 and $100,000."

Empowering Communities

*Healthy Start utilized education and the development of support networks to empower communities. The communities could then aid parents, infants, and children in their development even after they are no longer part of the Healthy Start program.*

**El Hispano—Sacramento, CA**
(October 8, 1997)

A larger shift in the world of anti-poverty programs, away from service provision and toward fostering relationships through which poor people can help each other and themselves. The new "community building" thrust recognizes that many poor neighborhoods once were richer in social relationships—extended families, church networks, neighborhood associations—that provided ladders of opportunity into the mainstream.

**Argus Leader—Sioux Falls, SD**
(June 23, 1996)

"What works for Healthy Start is that each community is involved," [Donna Haukaas, Aberdeen Office of the Northern Plains Healthy Start program] said. "It started with community meetings to determine what the people believed they needed specifically for their area. Although the goals of the programs are the same, each site has its own unique features. And the staff comes right from the community."

**Daily Review—Hayward, CA**
(August 4, 1995)

Infant death rates in three problem-plagued Oakland neighborhoods have dropped by a phenomenal 50 percent in the past four years. Jubilant health officials credited the impressive achievement . . . to Oakland Healthy Start. Started in 1991, the federally funded program links pregnant women and new mothers to health and social services in their communities.

"We've heard the saying 'It takes a village to raise a child,'" Arnold Perkins, a public health director for Alameda County, said at a news conference in front
of Oakland's new federal building. "Healthy Start has brought people together in a village concept."

Tribune Review, Pittsburgh Edition—Greensburg, PA
(February 12, 1995)

"That's what Healthy Start is all about—saving lives and giving babies the best possible start in life. We don't know exactly why the death rate is declining, but believe it's related to Healthy Start's case management approach, which encourages agencies to be more responsive to individual needs and individuals in turn to take greater responsibility for their health. As a result, women in the project area now have access to more comprehensive supportive services which are having a positive impact on individual and community health," said County Health Director Dr. Bruce W. Dixon.

Medical Herald—New York, NY
(January 1997)

Over the past five years, Healthy Start/NYC has worked diligently to involve community providers, residents, and leaders in shaping our initiative. The essence of our success is that our HS/NYC communities have assumed ownership of the project. . . . Healthy Start has initiated or supported some 60 innovative community-based health and social services initiatives, while providing crucial integrated services to a yearly average of 30,000 women and their families in conjunction with our partners in Brooklyn, the Bronx, and Central Harlem.

The Connection—Cleveland, OH
(December 1993)

The strength of the HF/HS program says Grier (outreach coordinator), lies in this neighborhood approach. Outreach workers must be able to do the kind of door-to-door, person-to-person, mother-to-mother work which is at the heart of an effort dedicated to making lives better for children and their families. Outreach workers receive 12 weeks of instruction, 8 weeks in the classroom and 4 weeks on site. Their first days in the field are as part of a team, with an experienced worker. To help refine their skills, they receive continuing education. Many have studied for and passed GED levels and have gone on to take college courses.

The program also assists neighborhood families with parenting classes at East End Neighborhood House. It promotes its services at such events as a health
fair at Harvey Rice School, where preschoolers received immunizations, the library branch staff gave out library cards, and safety forces finger-printed the youngsters.

**The Sun—Baltimore, MD**
(August 13, 1995)

It’s also easier when the program operates as part of the community, rather than imposing itself on neighborhoods. Nothing demonstrates this better than the program’s hiring patterns: In Sandtown-Winchester, about 80 of the 100 staff members live in the neighborhood. The east-side operation anticipates having about the same ratio. . . . “De-professionalizing” these programs can make them more effective. Rather than giving jobs to social workers who rarely live in the neighborhood, Healthy Start throws out educational and degree requirements and instead hires women from the community to knock on doors and bring young women into the program. Many of these women are thriving in their first real jobs. The staff also tries to find jobs for fathers, helping maintain facilities or working in a rehab program that Healthy Start administers.

**Men’s Services**

*The impact of a father on his child is tremendous. Men’s services programs of Healthy Start educated men on masculinity and fatherhood and provided counseling and support services, so that fathers could support their children, themselves, and their families both emotionally and financially.*

**The Sun—Baltimore, MD**
(February 28, 1997)

Recently, Housing and Urban Development Secretary Andrew Cuomo praised Baltimore’s efforts [in the Men’s Services Division of the Baltimore Healthy Start Program]. “The Baltimore program, along with a similar program HUD funds in Hartford, is a national model. We will work with housing authorities around the country to help them start similar programs. These programs are rebuilding lives as they rebuild affordable housing,” Cuomo said.
Involving Males in Preventing Teen Pregnancy—A Guide for Program Planners
(Washington, DC: Urban Institute, 1997)

Jones [director of the Men's Services Division of the Baltimore City Healthy Start] seeks to bring out the male potential to be a strong source of support and encouragement for better health in both their female partners and their children... helping men to further themselves emotionally, educationally, and financially... fostering a sense of empowerment in these men.

The case managers seek out the male partners in the community and invite them to come to “Father’s Journal” meetings or group therapy sessions... Many see it as an alternative to the “madness of the community.” Ultimately, Jones says, 50 to 60 percent of recruited men become involved with the Men’s Services Program.

The Los Angeles Times—Los Angeles, CA
(May 12, 1996)

Birth is what experts call “a teachable moment,” the point when young fathers, still puffed up with pride, are most attentive... Healthy Start requires its male clients to study a “fatherhood curriculum,” which touches on such issues as family health and domestic violence. They must attend prenatal visits with their pregnant girlfriends and accompany their children to the pediatrician.

Personal Accounts

Healthy Start has changed lives one individual at a time. The program has had a unique impact on each life it has touched: the young lives it has saved, the clients it has influenced dramatically and permanently, and the project staff and administrators who have learned the many sides of collaboration.

The Boston Globe—Boston, MA
(June 10, 1997)

Elizabeth Fernandes and Adelina Alves, foot soldiers in the war on infant mortality, knocked on Maria Barros’s door in Dorchester to check up on the 32-year-old and her three young daughters... “Everything I need you help me with,” she gratefully told the outreach workers in Portuguese.
Efforts to promote responsible fatherhood emerge both inside and outside government. Most, like the Baltimore program, target fathers who are young, poor, uneducated, unemployed, and unmarried. Helping these young men is far more complicated than teaching them how to change diapers or discipline their children.

“Man, I need a job. I need a job bad. I just come from the streets. I could go back out there, but I don’t wanna do that. I wanna live, and out there, the only thing that can happen to you is you die, or you kill someone,” said [Russel, an unwed father, at his first visit to a Healthy Start office].

Healthy Start discovered a very real reason many women delay prenatal care is that they can’t keep a doctor’s appointment if they don’t have child care for their other children, the siblings of the unborn child they are carrying. Tot Drop has resolved that barrier.

Darlene Wilson, child care specialist for the Gary Tot Drop, sees as many as 30 children each week while their mothers are keeping a medical appointment, visiting a case manager who monitors the progress of the pregnancy or attending one of the many classes offered by Healthy Start.

Says Sheryl Williams, “Tot Drop is tremendous. It allows me to take classes and participate in other Healthy Start activities that help me and my family. I feel comfortable leaving my baby there.” Another Healthy Start participant, Tinesha Sheffield, points out that “everything is so clean and the toys are wonderful! My daughter loves Tot Drop and she loves Darlene too. The service makes it so easy for me to go to the doctor, and I don’t have to lug other children around.”

Patricia Moore of Titusville has eight children—her youngest is six months old—and she also cares for three of her seven grandchildren. So she goes to the Healthy Start site a few blocks from her home to get advice from outreach worker Glenda Daniels about coping with family life and learn about community programs that can help her.
"I can come and talk about what’s troubling me," Ms. Moore, 42, said. "Whenever I leave here, I have peace of mind."

Nadine Jones of Central Park is expecting her first baby in February. Her mother-in-law told her about Healthy Start, an inner-city federal program to cut infant mortality . . . so she takes time from her job to attend prepared childbirth and parenting classes at the Central Park Healthy Start site. . . .

"I don’t have nieces and nephews, so I haven't had much experience with babies," she said. "These classes help me learn a lot about what to expect."

The Washington Post—Washington, DC
(November 20, 1997)

Within hours of learning about the distraught pregnant woman who was hearing voices, Rose Washington was at the woman's home, knocking on the door. Once inside, Washington found the woman sobbing, repeating over and over that "he keeps telling me to jump out the window." Washington put her arms around the woman and kept talking and talking. The woman, who has nine children, looked to be about five months pregnant, was in denial and had not had any prenatal care. First Washington calmed her down, then step by step began putting into play the various services available through the D.C. Healthy Start Project.

Washington, 32, grinds away at the problem one woman at a time. In the case of the woman hearing voices, Washington brought in medical staff who determined that the woman was expecting twins and that her blood pressure was dangerously high. Washington arranged for the woman to get prenatal treatment and to meet with a nutritionist, a social worker, and a psychiatrist. She made sure the woman kept her doctor appointments, even if it meant someone from Healthy Start had to drive her.

The efforts paid off with the birth of two healthy babies—babies who did not require long stays in an intensive care ward and who will not be burdened with severe disabilities. Washington continues to visit the woman, making sure the babies have checkups and are immunized, offering services and advice, encouraging the woman to choose a birth control method.
Costs and Prevention

Healthy Start has tried to intervene during high-risk pregnancies to prevent the devastation of low-birthweight infants, prematurity, and infant death. Healthy Start’s efforts to reduce infant mortality have also reduced medical costs for premature and low-birthweight infants. The reduced emotional cost to young mothers and struggling communities is immeasurable.

Pittsburgh Tribune-Review—Pittsburgh, PA
(March 11, 1997)

“In the first year, direct medical costs (for low-birthweight babies) are in excess of $50,000,” said Bruce Dixon, M.D., director of the Allegheny County Health Department. “Case management to reduce the risk of low birthweight costs about $2,500 per client.”

San Francisco Chronicle—Oakland, CA
(November 1997)

Oakland’s Healthy Start program has received funding to continue its crusade to reduce the number of infant deaths in the city’s poorest neighborhoods for at least another year, just 1 month before it was supposed to shut its doors for good.

The program started in 1991 as part of a nationwide pilot project. It was scheduled to end this year, but its record of reducing Oakland’s infant mortality rate by 55.1 percent was so good that federal and Alameda County officials announced yesterday that it should continue.

Pittsburgh City Paper—Pittsburgh, PA
(August 20, 1997)

The costs associated with drug use in pregnancy and early childhood are enormous. According to CYS [Allegheny County Child and Youth Services] and Allegheny Health Department reports, 30 percent of drug-exposed infants need foster care because their mothers are unable to care for them. Annual costs for foster care are $3,600 to $5,000 per infant, and can go higher when special services are required. The human cost associated with the disruptions of so many young lives is incalculable. The Healthy Start/CYS Substance Abuse Initiative hopes to fix families cheaper, and better.
The Sun—Baltimore, MD
(July 28, 1996)

Many of the gains in reducing infant mortality have come through improvements in technology that keeps premature infants alive. It has been much more difficult to tease out the factors that can help ensure that babies are born healthy in the first place. . . . Although technological advancements are important, good public policy should address ways to avoid the need for high-tech intervention by increasing the chances of a healthy birth.

Florida Flambeau—FL
(March 17, 1994)

Florida State University researchers have found that if prevention and early intervention programs reach children early, then crime and violence will be decreased in the long run and the state could save billions of dollars. . . . [According to Mimi Graham, Associate Director of the FSU Center for Prevention and Early Intervention], “For every dollar spent on family planning, a savings of $4.40 would be made in medical, welfare, and nutritional services. The savings is incredible, but we just have to invest.”

The study also concluded that there is a direct correlation between child abuse and later violent crime. . . . “A lot of good research has been done for this prevention and early intervention policy,” Graham said. “The data received has been very positive in response to the Healthy Start and Early Head Start Programs.”

Argus Leader—Sioux Falls, SD
(June 23, 1996)

“Prevention is better than cure any day,” Dr. Marvin Cameron [a medical doctor at the Pine Ridge reservation] said.