The Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction: Volume VI, Replicating the Healthy Start Models of Intervention
Volume VI

Replicating the Healthy Start Models of Intervention

A Community-Driven Approach to Infant Mortality Reduction
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Volume VI

Replicating the Healthy Start Models of Intervention

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The authors wish to thank all those who have contributed to *The Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction—Volume VI: Replicating the Healthy Start Models of Intervention*. Most important, we are grateful to the 22 communities across the nation that were funded during the Healthy Start Initiative's demonstration phase. Healthy Start communities have worked hard to reduce infant mortality and to ensure that health care and related services for women, children, and their families continue to improve. This volume, the sixth in the Healthy Start Initiative series, is a result of their hard work.

The authors also wish to thank Mary Giffin of Health Care Strategy Associates, Inc., for her reviews and comments on this document.
America's future will be determined by what we do to improve the health of mothers, children, and families. One of the best markers of a healthy society can be seen in the quality of life of its most vulnerable members, especially the infants and young children. Despite the recent gains in reducing infant deaths in the United States, infant mortality remains a tragic problem that can be solved only if all stakeholders—community leaders, businesses, health care professionals, and policymakers—work together to find solutions.

In 1991, the Healthy Start Initiative was funded by the U.S. Department of Health and Human Services' Maternal and Child Health Bureau to support model (demonstration) programs to reduce infant mortality, based on the premise that community-driven strategies were needed to attack the causes of infant death and low birthweight, especially among high-risk populations. Healthy Start focuses on the need to strengthen and enhance community systems of maternal and infant care, and works with communities to address the medical, behavioral, social service, and cultural needs of women and infants. Healthy Start empowers communities with extremely high rates of infant mortality to provide community-based, culturally sensitive, family-centered, comprehensive perinatal services to women, infants, and their families and to integrate these services into existing perinatal systems of care.

During the demonstration phase, the Healthy Start Initiative was charged with reducing infant mortality in 22 of the nation's most distressed communities. This mission required reaching beyond the well-being of newborns to address the well-being and empowerment of mothers, fathers, families, and entire communities.

When the Healthy Start Initiative began, a great deal was already known about the chief causes of infant mortality such as congenital disabilities, complications from low birthweight and prematurity, and sudden infant death syndrome. In addition, early and regular prenatal care were known to play an important role in ensuring healthy pregnancies and
birth outcomes. Less well known were the reasons why many women were not accessing needed prenatal care, and the approaches that help break down barriers to care such as the limited availability of health care providers in some communities.

The 22 Healthy Start communities that participated in the demonstration phase have contributed enormously to our knowledge of what works to reduce infant mortality. Taking responsibility as innovators, these Healthy Start sites have worked within their individual localities, forming partnerships and drawing on the unique strengths of their own community life to transform their neighborhoods—urban or rural—into successful Healthy Start communities.

Core Principles

Five core principles guide the planning and operation of the Healthy Start Initiative: innovation, community commitment and involvement, increased access to services, service integration, and personal responsibility. Developing and mobilizing strong consortia (collaborative efforts at the project level) and community coalitions to help reduce infant mortality is a unique hallmark of Healthy Start. These broad-based partnerships involve consumers, local and state governments, the private sector, schools, health care providers, and neighborhood organizations—all working together to help communities solve the problem of infant mortality.

Soon after receiving funding, members in each of the Healthy Start communities began learning how to identify needs, involve the community, work with consortia, establish and maintain an array of program initiatives, and evaluate their efforts. At the end of the demonstration phase, these teams—including consumers, consortia members, and Healthy Start project staff—had learned valuable lessons and were able to use their experiences and position themselves as peer mentors in the Healthy Start Initiative's replication phase.

Replication

Healthy Start grew to encompass 75 projects in 1998 and will add more projects in fiscal year 2000. During the replication phase, many of the initial demonstration projects are serving as mentors, helping the new Healthy Start communities replicate or adapt strategies for increasing positive birth outcomes.

Although a review of the demonstration projects' documented experiences revealed some program aspects that were unique to individual sites, many common themes were found throughout the Healthy Start communities. The replication phase of Healthy Start, and therefore each funding application submitted for this phase, is organized into eight service models of intervention, with community-based consortia being an additional (ninth) organizational model.

During the demonstration phase, these nine model intervention strategies emerged as most successful in building each community's capacity to increase positive birth outcomes. The Healthy Start demonstration sites' experiences
with the models form the basis for this publication. Although a more detailed discussion of the development of community consortia can be found in the first volume of this series, Chapter 2 of this volume presents a discussion of lessons learned and experience to date since the Healthy Start sites formed their consortia several years ago.

**The Healthy Start Initiative Series**

This publication is part of the multivolume series *The Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction*. The series provides a mechanism by which current and critical information about the projects' activities can be shared and widely disseminated. Although each volume in the series stands alone in content and subject matter, reading the entire series provides a more complete overview of the Healthy Start Initiative. Following is a listing of the other volumes in the series:

- **Volume I: Consortia Development**
  (Spring 1994)
- **Volume II: Early Implementation—Lessons Learned**
  (Fall 1994)
- **Volume III: Sustainability**
  (Fall 1995)
- **Volume IV: Community Outreach**
  (Fall 1996)
- **Volume V: Collaboration with Managed Care Organizations**
  (Summer 1997)

In keeping with the spirit of sharing the Healthy Start lessons and the format of the five previous volumes, this book is intended for three audiences:

- Healthy Start communities and those involved with the Healthy Start Initiative
- Community-based initiatives faced with the challenges of providing health care to women, children, and families
- Community-based initiatives that want to learn the lessons of Healthy Start and perhaps replicate its philosophy and methods

This volume, like the others in the series, contributes to a philosophy of collaboration and partnership and helps sustain crucial maternal and child health programs around the nation. Much was learned during the demonstration phase of the Healthy Start Initiative, and this volume summarizes and highlights many of these lessons and experiences. Armed with this information, Healthy Start continues its fight against infant mortality.

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Replicating the Healthy Start Models of Intervention, the sixth book in the Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction series, is based on information supplied to the Healthy Start National Resource Center by each of the 22 sites funded during the Healthy Start Initiative's demonstration phase. This volume presents the lessons learned and shared through a series of case presentations, including peer mentoring-related Regional Conferences and Open Houses; special meetings; personal communications; and grant applications and progress reports.

Chapters 1 and 2 contain essential information for replicating any aspect of the Healthy Start Initiative. Although many readers will find the information on all of the Healthy Start models useful, chapters 3 through 10 are designed to be self-contained: readers interested in replicating a specific model can obtain the necessary information from the chapter dealing with the model.
Introduction
From Demonstration to Replication

Nine Model Intervention Strategies: The Healthy Start Legacy

Healthy Start is responsible for developing, demonstrating, disseminating, and replicating strategies for reducing infant mortality. In designing community-based approaches to reducing infant mortality, each of the Healthy Start demonstration sites has examined the factors that have contributed to infant mortality within its own neighborhoods and has identified the community's needs and resources. Although the 22 demonstration sites vary widely, the following 9 models have evolved over the course of the 6-year demonstration phase (1991–97) and have been implemented in ways that address each community's special needs:

- Community-based consortia
- Outreach and client recruitment
- Care coordination/case management
- Family resource centers
- Enhanced clinical services
- Risk prevention and reduction
- Facilitating services
- Training and education
- Adolescent programs

These nine models are a means of empowering communities to reduce low birthweight, the incidence of preterm births, and infant mortality and to increase access to prenatal care. These interventions will also guide other new Healthy Start communities as they seek to adapt programs and strategies to address their own unique circumstances. These models are the Healthy Start legacy.

Replication Phase: Reaching Other Communities

During its demonstration phase, Healthy Start supported model programs in diverse settings and populations to learn what works best to reduce
infant mortality. Healthy Start is now in its replication phase, disseminating to other communities the lessons learned and experience gained by the 22 Healthy Start sites during the demonstration phase. The purpose of the replication phase is to institute the successful infant mortality reduction strategies developed during the demonstration phase and to launch Healthy Start projects in other rural and urban communities. During the replication phase, the Healthy Start Initiative is supporting cooperative agreements in additional communities to help replicate and/or adapt successful Healthy Start strategies to reduce infant mortality, in conjunction with individual programs already underway in these communities. Successful strategies are those that have achieved the agreed-on program performance for a specific activity. In addition, specific measures of outcomes from the demonstration phase will be forthcoming via special comprehensive reports from the national cross-site evaluation of 15 of the 22 projects and individual local studies.

**Regional Mentoring Conferences and Open Houses**

The replication of a demonstration project provides the unique opportunity to use and refine the lessons learned by the demonstration sites that are now mentoring new Healthy Start communities. Regional Conferences provided by multiple mentoring sites and Open Houses sponsored by a single peer mentoring project have enabled new Healthy Start projects to experience and address implementation issues associated with each of the nine intervention strategies.

To help the new Healthy Start sites better understand the nature of the models being replicated, two sets of Regional Conferences were held during the first year of the replication phase. The intent of these conferences was to provide new sites with an overview of several intervention models, specifically noting design and implementation issues. Each of the regional conferences featured presentation and discussion of two to four models by several mentoring sites. Through this format, new sites learned about the featured models through the experiences of more than one mentoring site.

Open Houses provided a more intensive look at each of the models featured and addressed an individual replication site's issues and concerns, including fiscal, administrative, and management information system issues. Each Open House was attended by approximately three to five replication sites. In total, 50 Open Houses in 19 cities took place during the initial year of the Healthy Start replication phase.

Through the Regional Conferences and Open Houses, the new communities receiving Healthy Start Initiative funds have had the opportunity to travel to the mentoring sites to see first-hand how to overcome barriers and obstacles. In addition, mentoring matches, mentoring contacts, and other forms of technical assistance have enabled greater sharing of the lessons learned. The mentoring
plan components scheduled for the replication phase are designed to ensure that the new sites are able to implement activities readily and to successfully replicate the Healthy Start models of intervention.

**Beyond the Healthy Start Communities**

The lessons learned during the demonstration phase have been valuable to the Healthy Start communities, but these lessons are applicable to many other communities as well. Currently, more than 300 communities across the United States have an infant mortality rate greater than one-and-a-half times the national rate; the information in this volume can be used by all of these communities regardless of whether they are funded as Healthy Start sites. The Healthy Start legacy serves as a model not only for Healthy Start communities but for all communities striving to improve the health of women, infants, and their families.
Regional Mentoring Conferences and Open Houses

The Healthy Start Initiative recognizes the unique opportunity to bring together the community to celebrate the initiatives that support the Healthy Start Program. Regional Conferences and Open Houses provide an opportunity for stakeholders to learn more about the Healthy Start Program and its impact on community health. The conference includes keynote speakers, panel discussions, and interactive workshops to discuss best practices and innovative solutions for improving health outcomes for infants and families. The event also features exhibits from partner organizations, including housing, education, and health services. This collaborative approach fosters a sense of community and encourages partnerships to address the needs of the community.
The nine community-based Healthy Start models of intervention to reduce infant mortality were built on similar foundations. All of the models rest on considerable community input. The Healthy Start demonstration sites have found that, while many elements vary by model, two underpinnings are essential to partnering with the community and are therefore essential to all models: cultural competence and partnerships (often through contracts or memoranda of understanding) with both large and small community organizations.

Cultural Competence in Model Design and Implementation

No matter what service is being offered, cultural competence and cultural sensitivity must be intrinsic parts of its design, implementation, and marketing. Cultural sensitivity is a self-reinforcing cycle: culturally sensitive programs will attract and involve the community, which will strengthen the program's cultural competence, which in turn will attract more community input, and so on. This process is ongoing and continuously strengthens programs.

Improvements in cultural sensitivity

Improvements in community involvement

Three strategies make cultural competence happen throughout the design, implementation, and marketing of each model and of the program as a whole: staff selection and training, culturally appropriate activities and materials, and community leadership.

Staff Selection and Training

- Hire staff members (both direct service and management) who are from the community and/or reflect its racial and cultural diversity
- Hire staff members who are proficient in the languages and dialects spoken in the community
• Provide ongoing cultural competence and communication skill training for direct service staff, management staff, contractual staff, and providers
• Hire staff members who are experienced with the population being served (e.g., adolescents, pregnant women, young fathers)
• Recruit, train, and employ former clients as staff

Culturally Appropriate Activities and Materials
• Select or develop culturally appropriate health education, training, and marketing materials in multiple languages and with appropriate literacy levels
• Use focus groups or representatives of the target population to develop, review, and evaluate materials
• Learn cultural influences on health promotion and health-seeking behaviors (e.g., level of comfort with medical providers, infant feeding, male-female relationships, family support networks)
• Provide translation services to facilitate access and follow-up to care
• Make service delivery sites comfortable for the clientele with culturally appropriate artwork, reading materials, and space for all family members
• Hold community events that promote cultural understanding (e.g., workshops, health fairs)

Community Leadership
• Establish a strong consortium with membership reflective of the project population
• Establish partnerships and/or contracts with community-based organizations (CBOs) as service providers
• Serve as a role model for diverse people and programs working together

New York, NY
Cultural sensitivity has been a major priority for Healthy Start/New York City. At all levels, staff are hired from the communities they serve and represent the dominant racial or ethnic groups. Priority has been placed on hiring workers with community-appropriate cultural competency and linguistic sensitivity. Case management staff attend cultural diversity training programs. Key issues are discussed at case manager meetings, such as the impact of immigration restrictions on the Healthy Start population, and culturally specific ways to approach the issues of nutrition, family violence, and child rearing. In the Healthy Start Mott Haven target area, training in cultural sensitivity is part of the basic preparation for community health workers, and is available to Healthy Start subcontractors. A major focus in Mott Haven has been on the service barriers faced by undocumented immigrants.
by developing working relationships with minority physicians, churches, school staff, and others

- Monitor contractors for cultural sensitivity and cultural competence
- Have consortium members distribute Request-for-Proposals (RFP) announcements throughout the community; place them in local community newspapers with African-American, Latino, and other culturally specific readership
- Partner with grassroots organizations representing cultural groups (e.g., Asian-Pacific American Advisory Committee) and assist them in addressing infant mortality

**Partnering with Community-Based Organizations: Role Models and Resource Development**

Healthy Start projects are developed with community needs, resources, and strengths in mind. In every demonstration site, and for each model, this foundation has led to partnerships with CBOs, as well as with traditional health care institutions. Contracting with these organizations formalizes partnerships and helps the organizations to grow and become more involved in the community's livelihood. Therefore, contracting is an essential tool for developing community infrastructure to reduce infant mortality. True collaboration requires preparation, guidance, and ongoing
monitoring and feedback. The following are activities and protocols commonly found among the Healthy Start grantees. While the list is extensive, it is not exclusive nor prescriptive.

**Preliminary Activities**

- Develop clear RFPs that include appropriate criteria for awarding contracts
- Develop a contract procedures manual to standardize the contracting process that will serve as a learning tool for current and future staff
- Follow the established procedures from the application phase through the implementation phase
- Convene and train proposal review panels of consumers (from the consortium and elsewhere), community residents, nonaffiliated providers specializing in the area of case management, and project staff
- Keep the consortium involved in the selection of contractors and implementation of contracts
- Have at least two appropriately trained staff members conduct site visits to RFP applicants
- Assign a staff member or consultant to develop and implement a contract management plan
- Convene workshops for local organizations to learn about the RFP process
- Establish guidelines to avoid conflicts of interest that may arise during a proposal’s review or implementation

**Contract Development**

- Develop a clearly defined scope of work
- Specify deliverables and time frames
- Specify performance measures
- Clearly communicate all relevant program policies, to avoid inadvertent conflict
- Develop a letter of agreement with partners (especially those with whom services will be collocated) to ensure expectations are clear, understood, and agreed to by all parties
- Specify the nature of the collaboration (e.g., sharing referrals, sharing data) in letters of agreement with partners
- Require systematic data collection and reporting methods
- Specify consequences for failure to deliver according to work plan and schedule, including forfeiture of fees, cancellation of the contract, and other penalties
- Obtain an agreement from the contractor to cooperate with all evaluations of performance efforts, including penalty provisions in the contract to ensure data integrity/accuracy in a timely manner
- Involve representatives from all parties in the negotiation process to ensure full consideration of the various legal, financial, and service aspects
- Rely, if applicable, on standard policies from the lead agency (e.g., health department, nonprofit organization, business community)
Northern Plains, Aberdeen, SD

The Northern Plains Healthy Start (NPHS) site focuses on American Indian populations in a multistate area. Tribal philosophy is woven into every component of the project. For example, through the help of elders, spiritual leaders, and community members, the NPHS project has rekindled traditional teachings and has promoted the message that "it is the responsibility of everyone to help and support women during pregnancy." Consistent with traditional values, the community as a whole is guardian of pregnant women and their unborn children. Therefore, the project's case managers work with clients' families, extended families, and the tribal community to support mothers and infants. The overall approach to the program is nurturing and nonjudgmental.

- Provide technical assistance from program and fiscal staff to contractors in the development of their scopes of work

**Specialized Contract Provisions**

- Include specific performance requirements (e.g., time in clinic, referral protocols, telephone and off-duty availability) in clinical contracts
- Contract for biohazardous waste disposal and environmental cleaning that meet the Occupational Safety and Health Administration guidelines, when necessary
- Require contractor to hire staff from the community
- Include cultural competency issues such as matching clients with program staff based on similarity in cultural backgrounds and experience
- Include provisions for the security and confidentiality of battered women

**Contract Administration**

- Train project staff to observe legalities of contract (e.g., confidentiality, minor consent, parental rights)
- Use key partners' contracting staff and legal departments to provide technical assistance and control costs
- Require monthly progress and statistical reports to monitor performance
- Approve invoices upon approval of work products
- Ensure that vehicle contracts include regular maintenance and insurance
- Require analyses that include input on the project's strengths, weaknesses, opportunities, and threats as perceived by the contractors

Formalizing partnerships through carefully designed and administered contracts helps ensure community contribution, involvement, monitoring, buy-in, and understanding among all entities involved.
In designing community-based approaches to reducing infant mortality, each Healthy Start community examined the contributing factors within its own neighborhoods. During the demonstration phase, nine categories of infant-mortality reduction strategies emerged as being most successful. Chapters 2–10 of this volume highlight the key components, steps for design and implementation, and strategies for sustainability of and collaboration within each of the identified models of intervention.
At the heart of the Healthy Start Initiative is the belief that, guided by consortia of families, community leaders, and organizations from the private, public, and nonprofit sectors, communities can design and implement services needed by their families. Programs designed by local communities will best address their unique needs and mobilize their resources. Advised by the consortia, the Healthy Start communities focus the power of collaboration on the problem of infant mortality.

**Model Definition:**
Establishment of a local community-based consortium/advisory board of consumers (i.e., recipients of project services residing in the catchment area), providers, and others in an advisory capacity for program planning, operations, monitoring, and evaluation.

**Purpose:**
To partner with the community to reduce infant mortality.

**Anticipated Results**
- Development of community capacity and infrastructure
- Development of programs that reflect community needs and values
- Increased community knowledge of, and investment in, the project
- Increased community and institutional coordination and collaboration

**Key Components**
- Time to build consortia (because development is a complex, labor-intensive process that requires long-term, team-building activities)
- Committee structures that allow for direct input and participation from all members
- Clear definitions of roles, authorities, and structure
- Decision-making authority and participation in all phases of the project
**Boston, MA**

Boston Healthy Start Initiative (BHSI) is a partnership between the Boston Department of Health and Hospitals and a consortium of community residents and service providers. This structure places the power for change directly in the hands of families and communities. Consumers and residents make up over 60 percent of the consortia membership and are well represented on all of its committees. These committees play a major role in planning as well as monitoring project activities and progress. The Evaluation Committee receives regular reports from administrative staff as well as the Management Information System and Infant Mortality Review, and recommends modifications of current programs. The Transition Committee develops proposals for new programs. The Executive Committee and Core Group Committees receive recommendations and information from other committees and establish overall policy. The Finance Committee establishes the budget and monitors financial performance. In addition to guiding the internal work of BHSI, the Consortium develops relationships with other collaboratives and organizations, such as the March of Dimes, the Boston Housing Authority, the Massachusetts Department of Public Health, the Latino Health Institute, the Alliance for Young Families, and Community Health Education Centers.

- Sustainable infrastructures built on community ownership and empowerment

**Steps for Establishing and Implementing a Community-Based Consortium**

The Healthy Start consortia were at the forefront of the design, implementation, and evaluation of the projects. Their accomplishments have been wide-ranging and impressive. Although each project is unique, each consortium's achievements have formed the vital link between the project and the community it serves.

**Community Empowerment and Awareness**

- Use neighborhood-based activities to strengthen the community's buy-in and its relationships with outreach workers
- Train consortium members for their roles and responsibilities
- Provide in-service training on Healthy Start programs for consortium members so they can better educate others
- Increase the level of community participation and leadership
• Facilitate consumer participation by providing transportation, child care, and training for skill development

• Develop culturally competent educational materials (e.g., a video to help consumers navigate the processes of managed care)

• Produce marketing materials to increase the community's awareness of the project and the community's participation in community fairs, male responsibility programs, and community development initiatives

• Host a meeting of former consumers to assist with program implementation

• Have consortium members serve as role models and mentors

**Program Monitoring and Feedback**

• Participate in meaningful decision-making at all project levels to ensure that the services meet client needs

• Monitor project activities and progress toward goals; recommend changes (e.g., express the need for more mobile and collocated services)

• Monitor referrals and feedback regarding provider sensitivity and waiting time for clinic appointments

• Review media materials as well as culturally competent educational materials for cultural appropriateness

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**Dallas, TX**

To minimize duplication of services and to promote collaboration, the Dallas Healthy Start model focuses on organizing and coordinating existing services of agencies such as the Greater Dallas Community of Churches, Visiting Nurses Association, Girls, Inc., the YMCA and YWCA, Dallas Housing Authority, and Boys and Girls Clubs. These agencies provide services and education for nutrition, parenting, smoking cessation, male mentoring, early childhood development, and other topics relevant to reducing infant mortality. This community-based approach also mobilizes local community residents, helping them design and implement successful programs.
Collaboration and Coordination

- Collaborate with a broad array of health, social welfare, educational, and housing agencies/institutions to improve the integration of systems of care for impoverished community residents
- Coordinate and link with all health and human service providers funded by the project
- Resolve organizational-boundary and resource-competition issues to forge links with other agencies
- Collaborate with the state health office, district health office, and county public health units
- Reduce duplication of services through strong collaborations forged by the consortium, thus allowing limited funds to be used more judiciously
- Have the consortium serve as a clearinghouse for information and a point of contact for community groups and individuals in the project area
- Establish effective linkages among community-based and clinic-based services

Limitations and Corrective Actions

Because of the complex, diverse nature of each community, projects found it challenging to share information, communicate productively and clearly, and engage all consortium members in the decision-making process. The Healthy Start projects addressed this issue by

- Holding retreats with staff and consortium members
- Discussing issues with focus groups
New Orleans, LA

To address the city's fragmentation of maternal and child health services, Great Expectations Healthy Start of New Orleans is building relationships among communities, churches, health care advocates, providers, and government agencies. The Great Expectations strategy is to organize Service Area Advisory Councils (SAACs) in each community and provide them with staff support and technical assistance. SAAC members identify their own community agendas for reducing the city's infant mortality rate. The consortium committee provides local oversight and ideas necessary to make the program responsive to client needs and helps agencies, contractors, and staff to monitor progress, coordinate work, and plan and evaluate services. Great Expectations relies upon the knowledge, commitment, and experience of its consortium members to help design future programs and services.

- Conducting surveys
- Team building
- Developing a comprehensive manual of policies and procedures

It has been a challenge for all projects to recruit and retain involved consumers. Some strategies to address this issue are

- Intense outreach efforts to recruit consumers
- Bylaws that allow many to participate
- Provision of transportation and child care to facilitate consumer participation
- Training of consumers in consortium skills

Resource competition issues are exacerbated by urban or rural systems issues, state and local politics, Medicaid managed care, and welfare reform. These issues are addressed through

- Intense efforts to collaborate with other agencies
- Coalitions with the business community, professional and service institutions, and philanthropic individuals and organizations
- Building on existing systems and increasing systems integration
- Collocation, resource sharing, and information sharing to reduce duplication of services

All projects addressed conflict-of-interest issues by having clearly written policies and procedures, usually included in the bylaws.

Steps for Sustaining a Community-Based Consortium

Any program that continues without a consortium will lose the essence of the Healthy Start philosophy: partnership with the community. Consortia members
are powerful advocates with diverse sources of support. Keeping members involved helps secure the future of Healthy Start services. Three consortium sustainability strategies were used by the Healthy Start projects: collaboration and integration with existing groups, seeking other sources of funding, and advocacy.

**Collaboration and Integration with Existing Groups**
- Integration into already existing coalitions
- Collaboration with health and social agencies and state and local government entities to provide services
- Collaboration with managed care organizations to provide technical assistance
- Provision of technical assistance to other groups
- Collaboration with other CBOs to apply for funding

**Outside Funding Sources**
- Foundations
- Other federal agencies
- In-kind contributions
- Contracting with managed care organizations
- Medicaid reimbursement
- Formation of an incorporated nonprofit entity to seek additional funding opportunities

**Advocacy**
- Continued community awareness activities
- Education of state and local policymakers
- Public dissemination of local evaluation
- Relationships with the philanthropic community
Chapter Three

OUTREACH AND CLIENT RECRUITMENT

To fulfill their mission, Healthy Start projects provide services to those who are most difficult to reach. Client recruitment through proactive outreach provides an open door to families that have been underserved by the health and social service systems. Specially trained community residents go door-to-door to various locations to find underserved women, their male partners, and other family members to promote the importance and availability of Healthy Start services. Such resourceful efforts remind and encourage these community residents to obtain the care and services they need. Community members help Healthy Start projects recruit more clients earlier in their pregnancies.

**Model Definition:**
Provision of case-finding services that actively reach out into the community to recruit perinatal clients.

**Purpose:**
To identify and enroll those community members that are most in need of Healthy Start services.

**Anticipated Results**
- Increased community knowledge of infant mortality reduction efforts
- Increased access to services
- Increased enrollment in perinatal care, including Healthy Start services, care coordination, and health and social services
- Increased job training and employment opportunities for community members

**Key Components**
- Creative and diverse outreach strategies, including providing services at a variety of locations
- Outreach workers who live in the community, are familiar with the area, and "speak the language." As an added benefit, this component also provides...
Outreach and tracking play a key role in Birmingham Healthy Start (BHS). To recruit clients and facilitate service delivery, BHS employs both novel and conventional strategies: door-to-door canvassing, computer databases, referrals, telephone inquiries, home visits, and the distribution of flyers and calendars. To help Birmingham women access prenatal care, family planning, and child health services, BHS employs several residents as community outreach workers (CORWs) in each of the site's 12 service areas. Selected by the consortium in each area, the CORWs help provide a core of approximately 35 services, including health education, nutrition counseling, and referrals to social services and nursing. The CORWs visit clients at home and follow up to ensure that health care appointments are kept. CORWs also recruit clients, manage cases, offer transportation assistance, and help clients apply for entitlement programs. During one project year, resource mothers and CORWs completed 810 home assessments during visits to expectant mothers. Through the resource mothers' program, at-risk pregnant adolescents receive social support and prenatal education during prenatal appointments and support in the home once the baby is delivered. The resource mother works one-on-one with the client to bridge the gap of isolation often experienced by these young women. Intercession Ministries provide outreach services for BHS through the Rough Riders Pregnant Males Initiative (PMI). The purpose of the church-based PMI is to enhance the involvement of high-risk young males (and some females) in the prenatal and infant stages of the birth process. Clients identified through door-to-door canvassing and flyer distribution are offered general equivalency diploma (GED) tutoring, job placement assistance, counseling, training in parenting and social skills, and referrals to BHS for additional assistance.

- Recognition of outreach workers as full members of the health care team and the conduit for messages to members of the community
- Ongoing outreach-worker training to serve the needs of clients and provide professional and economic development opportunities for the community and its members
- Close coordination with case managers so that those identified as needing services actually receive those services
Steps for Designing an Outreach and Client Recruitment Program

Key Partners

Key partners for building outreach programs are those who know the community well, provide services to families who would benefit from Healthy Start, support the systems that serve the community, and make up the community itself. Indigenous organizations and leaders design outreach programs that truly reach the community.

The following is a list of possible partners. The specific agencies/organizations that a site should approach should be determined by the community being served.

Health and Social Services Providers

- Health care providers, including hospitals, clinics, and private physicians
- Social service providers, including mental health and substance abuse services
- Transportation and child care programs
- Public school system
- Police department
- Recreation department
- Other community-based programs

Systems Builders

- State maternal and child health (MCH) programs
- City, county, and state health departments
- Public housing authority
- Managed care organizations
- Private providers
- Hospitals and community health centers
- Social service agencies

Grassroots Support

- Healthy Start Consortium and other coalitions
- Community residents and consumers
- CBOs
- Tenant and housing organizations
- Natural community key leaders (e.g., school principals, neighborhood organizers, religious leaders)
New Orleans, LA

Bearing the French nicknames for godfather and godmother, parrains and nanans are outreach workers who have become an integral part of New Orleans' Great Expectations culture and progress. The use of these traditional names exemplifies cultural competence and the continued emphasis on incorporating local customs into community efforts to reduce infant mortality. Following a 26-week training program, parrains and nanans work with pregnant women and infants to ensure their access to health care and social support.

- Civic organizations
- Churches and other faith communities
- Outreach worker organizations
- Local businesses

Role of the Healthy Start Consortium

Designing outreach programs means listening to the community. A well-designed consortium represents segments of the community that will benefit from and/or that can implement outreach strategies. Because outreach is, by definition, done within the community, the consortium may be more integrated into outreach efforts than most other project efforts. In fact, outreach workers serve as a vital link between the community and the Healthy Start program, and often are instrumental in recruiting community participation in the consortium.

Building Partnerships

- Identify community needs and barriers to enrollment and services
- Identify key community leaders and interested civic groups
- Target agencies for collaboration and referral
- Develop informal networks of care
- Pinpoint target areas for reaching high-risk women

Identifying and Developing Resources

- Develop outreach plans and methods
- Recruit and select staff
- Market outreach events and activities
- Staff special outreach events (e.g., health fairs)
- Coordinate outreach in specific neighborhoods

Building Sustainability

- Act as spokespersons and representatives to local civic and political bodies
- Monitor, evaluate, and provide feedback on outreach efforts
Cleveland, OH

Creative outreach methods have been developed by Outreach Workers at the Cleveland Healthy Family/Healthy Start Project to reach pregnant women in the community, including door-to-door canvassing and recruitment in neighborhood gathering places such as laundromats, bingo halls, meal programs, and check-cashing establishments. Enrolled women are offered supportive services and incentives such as bus tickets, diaper bags, baby bottles, and health education materials, as well as advocacy services with medical providers, utility companies and landlords. Outreach Workers also provide a variety of one-on-one education sessions such as parenting education, sexually transmitted disease (STD) prevention, family planning, nutrition, and the dangers of substance abuse. All sessions are designed to empower participants to solve problems on their own and eventually move beyond the need for support from their Outreach Workers. When a participant’s situation requires specialized intervention, Program Coordinators provide case consultation services to the Outreach Workers.

An additional outreach strategy has involved working with schools by using a School Outreach Team. The purpose of this team is to provide immediate intervention services that focus on the unique needs of adolescents to help them understand the complexities of childbearing and the need for pregnancy prevention. Action plans are designed by the School Outreach Team to better educate students in order to reduce the incidence of first teen pregnancies and repeat pregnancies and the resulting number of dropouts, and to increase the number of young people who have the basic life skills to improve their chances to graduate, go to college or get a job, and form healthy families. Students are made a part of the Team’s planning processes to ensure cultural appropriateness and to strengthen and reinforce the message of prevention.

Resources Needed

Most crucial to successful outreach efforts are the outreach workers themselves. Recruiting, training, and retaining high-quality outreach workers is the most basic element of this model. Needs differ depending on which activities are contracted to other organizations.

Personnel

- Position descriptions that allow for training and focus on recruiting indigenous outreach workers
- Outreach workers who are from the community they serve
- Appropriate managerial staff members who develop protocols, work with partners, and supervise and coordinate services and staffing
- Contract monitors
- Financial, administrative, and data entry support
- Volunteers
- Hotline operators, if needed

**Office Space and Equipment**

- Centrally located site that is accessible to the community (in some programs, outreach workers use their own homes as bases of operation)
- Private counseling space
- Conference space
- Computer equipment for data collection
- Mobile telephones or pagers
- Hotline equipment, if needed

**Service Tools**

- Culturally competent recruitment fliers, brochures, door hangers, and other literature in appropriate languages and styles
- Transportation for outreach workers (e.g., program vehicles, public transportation tokens, travel reimbursement)
- Lending closet and incentive items and space for their storage
- Detailed, current maps of the community for planning the outreach strategy
- Uniforms and picture identification cards for outreach workers
- Mechanisms and protocols to protect the safety of outreach workers

**Milwaukee, WI**

Milwaukee Healthy Women and Infants Program (MHWIP) employs seven full-time outreach workers and three case managers who market MHWIP services to the targeted neighborhoods and community organizations within those neighborhoods, attempting to identify pregnant women and children in need. Marketing includes door-to-door canvassing and targeted outreach to agencies, malls, parks, laundromats, and other local gathering places. MHWIP staff also coordinate health information parties. Modeled after Tupperware parties, these events are designed to create a festive forum for the dissemination of prenatal and general health care information to families residing within the MHWIP service area. Those attending can receive confidential testing for sexually transmitted diseases and HIV, obtain health education information, and have their children immunized on the spot. Folders filled with health information on local resources are distributed at each health information party. Attendees receive refreshments, party favors, sample toiletries, baby items, safety items, and nutritional snacks as incentive items. Participants are encouraged to bring family members and friends. MHWIP collaborates with schools, child care centers, local health departments, clients, and other CBOs to collect donations and party items.
Public Information and Outreach

Outreach and client recruitment programs focus on bringing consumers into the Healthy Start programs (i.e., individual outreach). However, outreach is most effective when Healthy Start efforts are known and respected by the community as a whole.

- Meet with community organizations and community leaders to garner support for outreach methods and activities
- Market to health care providers
- Increase public awareness of the Healthy Start program
- Distribute culturally competent public awareness campaign materials to promote the importance of prenatal care and male involvement in parenting, including radio and television public service announcements, community publications, posters in businesses and community centers, billboards, and bus cards
- Disseminate a resource guide of Healthy Start providers and other sources of care to increase interagency referrals and communication

Steps for Implementing an Outreach Program

Tools for Fiscal and Program Monitoring

For contractors or program staff, the following tools are useful. They may be part of an integrated management information system (MIS).

- Client tracking and data collection MIS
An essential component of the Philadelphia Healthy Start program involves aggressive outreach to pregnant and parenting women. With the help of a van, the program has enjoyed great success by capitalizing on an existing infrastructure of health providers, community organizations, and advocates to furnish a range of psychosocial, education, outreach, community development, and referral services. Services include educational block parties and incentive baskets for clients who comply with prenatal and postnatal care appointments, and the Lending Closet, well-stocked with donated essentials such as highchairs, cribs, bassinets, and playpens available free to clients who schedule and maintain prenatal and postnatal care visits. Mobile services use a van driven by a trained worker to provide outreach, education, and referral. The Asian Pacific advisory committee continues to refine culturally sensitive programs for Philadelphia's Asian population. The program has produced three videotapes to encourage Southeast Asian women to seek early prenatal care and to sensitize providers to cultural issues.

- Client contact reports/staff activity reports
- Fiscal monitoring database
- Data procedures and protocols
- Computerized inventory of incentive items
- Outreach service standards, protocols, procedures, and data forms to collect and track consistent information on recruited clients
- Time sheets and travel reimbursement forms

**Technical Assistance Needs**

For project and contractor staff members who are implementing the program, technical assistance needs may include

- Initial and ongoing training for new staff as turnover occurs, including on-the-job training or direct observation of experienced outreach workers
- Ongoing training in the outreach protocols and the procedures for data collection and submission
- Outreach-worker networking meetings
- Supervisory training
- Cultural competency training
- Training to be safe on the job
- Training or assistance in identifying community resources to meet clients' needs
- Foreign language training

Contractors can vary from large, complex organizations (such as hospitals or universities) to small CBOs. Most outreach and client recruitment contractors are small CBOs. Contractor staff may need the technical assistance listed above, plus support for organizational capacity building. Organizational technical assistance may include
Steps for Sustaining an Outreach and Client Recruitment Program

If Healthy Start services are to be effective in reaching those community members most in need, outreach efforts in client recruitment and retention must continue. All of the Healthy Start sites have a sustainability plan, which includes specific strategies for outreach and client recruitment services.

Marketing and Resource Development

- Publicize results of a valid and reliable evaluation of outreach services
- Conduct studies on the cost-effectiveness of outreach and client recruitment services
- Garner media attention, including television, radio, and print media
- Work with sustainability consultants, or consultants with specialized expertise such as Medicaid pricing and marketing
- Inform local and state elected officials, policymakers, and other key community leaders about outreach services and the number of constituents the project has served

Funding for Current Services

- Work with the state Medicaid program to make outreach and client recruitment services reimbursable

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Known as Maternal Obstetrical Mobiles (MOMs), DC Healthy Start's curbside mobile units bring the OB/GYN office to the streets. MOMs have an outstanding record of outreach to at-risk and high-risk pregnant women. Through the recent addition of laboratory services, substance abuse screening and counseling, family planning, and midwifery services, these mobile units can provide the equivalent of a comprehensive first prenatal visit on a walk-in basis. Along with medical screenings, clients can also receive help in applying for food assistance. Two minivans are available to transport eligible women and children to and from medical appointments. The Male Outreach Worker program targets expectant and parenting fathers, offering support groups, information on general and reproductive health issues, job training, and job referrals. In partnership with the DC Correctional Complex at Lorton, VA, DC Healthy Start offers similar services to incarcerated males who are fathers-to-be or fathers of children in the District of Columbia.

- Market outreach and client recruitment directly to managed care organizations, and develop contracts for providing these services to their members
- Pursue donations of in-kind services or products, such as items for lending closets or incentive items
- Seek funding from non-Healthy Start federal sources and private-sector businesses and foundations

Collaboration and Coalition Building
- Establish partnerships with other federal demonstration programs in the local area, such as Empowerment Zones/Enterprise Communities, Community Integrated Service System grantees, and Early Head Start organizations

- Work with the Healthy Start Consortium to build relationships with potential supporters
- Integrate outreach services into existing community or state programs, including state Title V
- Help contractors sustain outreach services, and coordinate and oversee resource development efforts of multiple contractors to ensure cooperation rather than competition
- Build partnerships with private foundations and other funders with missions similar to those of Healthy Start
- Partner with local businesses, corporations, and foundations, and invite them to participate as consortium members
The coordination of comprehensive care of pregnant and parenting women and their families is a cornerstone of Healthy Start operations. Care coordination, relying on direct relationships between case managers and families, helps ensure that families have access to the health and social services they need and helps projects know which system barriers families face. Care coordination is family-level services integration: care management's goal is to make services and systems work together to meet each family's needs. Case managers realize that individualized needs assessments and service plans developed with the woman and her family are more likely to be followed than plans that are made for the woman without her input. This process empowers, rather than directs, the woman and her family.

**Model Definition:**
The coordination of services across providers to meet a client's identified needs through client assessment, monitoring, facilitation, and follow-up on use of needed services.

**Purpose:**
To coordinate services from multiple providers to meet each family's individual needs to the extent resources are available, and to have the client agree with the scope of planned services.

**Anticipated Results**
- Increased access to needed services
- Increased consumer empowerment and satisfaction
- Increased follow-through with service plans
- Development and improvement of community and institutional coordination and collaboration

**Key Components**
- Coordination and continuity of services (including education, prevention,
The Boston Healthy Start program uses case management (CM) as a contracted model, based on a team approach. (All providers are contractors of the project.) The CM contractors are required to have a registered nurse, case manager, and nutritionist, with a midwife involved at times. The nurse, nutritionist, and midwife must have state licensure or certification; case managers must have a minimum of two years' experience in maternal and child health. Some contractors use nurses and social workers as case managers, others use outreach workers who have received additional training as case managers. A home visit within 72 hours of delivery and a second visit during the first 30 days are both mandatory; a nurse usually accompanies the case manager on these and other selected visits. Monthly case conferences are held concerning all clients. During these conferences, the service plans developed by case managers with their clients are reviewed and revised. Boston's Department of Public Health and Community Health Education Center each had a preexisting training curriculum for case managers. Project staff worked with both agencies to revise and expand the curricula to place greater emphasis on maternal and child health so that case managers can better meet the needs of the project population.

and intervention) to ensure that families have all of the services they need, and that gaps in service do not occur

- Proactive partnerships among case managers, families, service providers, and the community so that case managers know the resources that are available just as well as they know their clients' needs
- Individualized needs assessments and service plans, developed with families, to put each individual at the center of care coordination
- Case managers who advocate for system changes on behalf of their clients
- Service intensity that matches level of risk more effectively (e.g., first-time parents and families with histories of violence or substance abuse receive more intense services than families without such histories)
- Mobile service delivery in community sites, including homes, so that case managers learn firsthand about each family's actual environment and needs
- Ongoing training to ensure that case managers have the most up-to-date information, continued skill development, and support necessary to coordinate care (because case managers most often come from the communities in which they work, training is also a source of economic development for the community)

The Healthy Start Initiative
Steps for Designing a Case Management Program

Key Partners

Partners can be providers of services or training, recruiters of case managers, sources of referral and outreach, or system builders that facilitate integrated service systems. Community grassroots support is also essential to the case management effort and to ensuring that case management services are meeting the needs of the community.

Health and Social Services Providers

- Health care providers, including hospitals, clinics, and private physicians
- Social service providers, including mental health and substance abuse services
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and other food and nutrition programs
- Existing infant health projects (local and/or state)
- State Cooperative Extension programs
- Welfare-to-work projects/income maintenance programs
- City office of employment development

Northwest Indiana

Case management offers referrals, home visits, counseling, pregnancy testing, and educational enrichment classes. Four leased vans that work much like a taxi service—with a dispatcher and master areawide computer network—provide clients with free transportation to and from Northwest Indiana Healthy Start centers. Van drivers must complete an advocacy training program. Furthermore, because they are an integral part of the client's care, drivers participate in case planning and review conferences. Free child care is offered at each center. To alleviate the shortage of affordable and safe child care services, children may spend up to four hours a day at the Tot Drop, an on-site child care program. Clients who do not have other child care arrangements may bring their young children to appointments.
Chicago, IL

Interagency case-management coordination facilitates seamless links between social and medical services, including primary health care for all family members, Welfare-to-Work programs, postpartum and early discharge home visitation, and health education for asthma, diabetes, and hypertension. Chicago Healthy Start’s collaboration with other organizations helps not only to ensure participant access to available services but to strengthen key relationships among community-based agencies. Care coordination in Chicago Healthy Start builds on the Family Resource Center model by integrating scheduled appointments. This collocation means that families can receive prenatal and pediatric health care on the same day as their WIC and housing appointments, making coordination of their care a reality.

**Systems Builders**
- State MCH programs (Title V, Title X, Children with Special Health Care Needs, Pediatric AIDS, and others)
- City, county, and state health departments
- Medicaid and managed care organizations

**Grassroots Support**
- Healthy Start Consortium and other coalitions
- Consumers and community residents
- Civic organizations
- Places of worship
- Schools and universities, including fraternities and sororities

**Role of the Healthy Start Consortium**

The project consortium is the vehicle for grassroots support. This kind of coordinating body is indispensable to the design of a case management program that uses so many community resources. During development of the case management model, the consortium can provide guidance, direction, and other advice.

**Building Partnerships**
- Assess community needs
- Build consensus in the community
- Provide community education and outreach
- Become a source of consumer feedback and quality assurance

**Identifying and Developing Resources**
- Determine organizational structure and priorities
- Determine program goals
- Decide on contractors and funding allocation
- Develop protocols, standards, and tools
- Recruit and select staff
Building Sustainability

- Advocate with key stakeholders in the community
- Monitor progress of the program toward its goals

Resources Needed

Personnel

Personnel needs differ depending on how the services are delivered (through the program, a contractor, or multiple contractors).

- Appropriate managerial staff members who provide supervision, develop protocols, and work with partners
- Contract monitors, based on the number of contracts
- Case managers (e.g., nurses, social workers, paraprofessionals)
- Case manager supervisor(s)
- Financial, administrative, and data entry support
- Consultant experts (e.g., physicians, nutritionists)
- Trainer(s)

Office Space and Equipment

- Centrally located site that is accessible to the community
- Private counseling space
- Conference space

Chatham-Savannah, GA

Chatham-Savannah Healthy Start Initiative's care coordinators are called family advocates. Two main groups make up this program: resource advocates (RAs) and family advocates (FAs). The RAs work with first-time mothers ages 13–19 to (1) ensure a healthy birth outcome, (2) prevent a second pregnancy, and (3) ensure that the mothers complete their education. The FAs work with women 20–44 years of age, providing such services as child care, transportation, WIC, home visits, individual assessments and service plans, and community outreach.

All FAs have completed nursing assistant training, with at least 6 months' additional on-the-job training in case management. The training includes social work concepts, cultural diversity with a special emphasis on African-American issues, perinatal case management, and adolescent health. Ongoing in-service opportunities and training updates are provided quarterly at a minimum. The FAs are supervised by a licensed social worker.

Both the FA supervisor and Healthy Start project director are licensed social workers, and having these licensed professionals on staff has enabled the project to be reimbursed for case management services.
Pittsburgh/Allegheny County Healthy Start defines case management as the coordination of services from multiple providers to meet a participant's identified needs. Assessment, monitoring, facilitation, and follow-up on services utilization are integral elements. “Core Teams” are a central part of Pittsburgh/Allegheny County Healthy Start's case management. Based in six regional communities, the teams serve 54 Pittsburgh neighborhoods and 4 other Allegheny County municipalities.

Each team is made up of a registered nurse and specially trained outreach staff members who work to ensure that women and children have access to the medical care and human services necessary to help build healthy families. Core Team nursing staff duties consist of providing management and education services for prenatal participants, conducting assessment and follow-up with participants to help them keep their appointments, and supporting medical providers' interventions regarding proper care instructions. Referrals are made to other health and human service providers for participants with special risks. Outreach staff members' duties include recruiting potential participants, acting as the intake point for bringing participants into the system, and serving as support for participants to help facilitate their use of existing services such as transportation and child care. Nearly all outreach staff members are community residents, hired and trained to serve as the nucleus of the six Core Teams; they are truly representative of the project population, which is predominantly African American.

- Lockable filing cabinets to ensure confidentiality of records
- Computer access to data, information, and the Internet
- Computer design capability to develop culturally competent educational materials
- Mobile telephones or pagers
- Laptop computers, as needed by case managers

Service Tools
- Case manager training curricula
- Protocols for dealing with routine situations (data collection, supervision, case planning)
- Protocols for dealing with difficult situations (e.g., child abuse, unintentional injury, miscarriage, infant death)
- Resources for clients' emergency needs (e.g., food, diapers, clothing, shelter)
- Transportation for consumers, such as taxi vouchers or bus fare
- Transportation for case managers (e.g., personal vehicles, public transportation tokens, travel reimbursement)
- Culturally competent health education materials (e.g., written materials, videos, toys)
Medical equipment (e.g., thermometer, Doppler equipment)

Public Information and Outreach Strategies

Case management services must be marketed not only to consumers, but also to providers and the community as a whole. All of these audiences are represented in Healthy Start Consortia, and therefore consortium members are a source of ideas and actual outreach.

- Meet and present to community organizations and leaders
- Use direct recruitment of private and public prenatal care providers
- Conduct a collaborative needs assessment of services to increase providers’ awareness of the need for case management
- Obtain endorsement from community leaders (e.g., elected officials, elders, spiritual leaders, businesses, schools, tenant associations)
- Market services to area hospitals, clinics, and social service agencies/centers
- Inform the community of employment opportunities for case managers
- Develop culturally competent materials in languages that are appropriate for the target population
- Conduct culturally competent media campaigns and social marketing, including toll-free hotlines, public service announcements (television, radio, print media, billboards, stickers on pregnancy kits), posters, brochures, and fliers
- Conduct special events, such as health fairs

District of Columbia

Establishing a case management team was a key step in linking fragmented health and social support services and in streamlining care. A diverse team of citizens, community health educators, and public health nurses provides case management and care coordination. These services include case identification, home visitation, referral, and intensive follow-up. The case management model provides intensive in-home assessment and support to pregnant and postpartum women and their infants and children through 2 years of age. Case managers, who are residents of the neighborhood, nurture clients who are reluctant to go to health care providers until trust in the medical establishment has been achieved. The DC Healthy Start program is particularly proud of its resource parent model. These “parents” visit homes in their neighborhoods to identify at-risk pregnant women and families, provide information and guidance about healthy behaviors and parenting skills, help families access services, and offer ongoing support and encouragement.
• Actively seek involvement of male partners of pregnant and parenting women and their extended families
• Target outreach at WIC sites, prenatal clinics, pregnancy testing sites, postpartum bedsides, and community events
• Target specific locations for a media campaign and door-to-door canvassing (e.g., housing projects, specific streets, laundromats, PTA meetings)
• Have materials reviewed by consumers and implement suggested improvements
• Encourage client-to-client recruitment

Florida Panhandle

Florida Panhandle Healthy Start’s care coordination is based on a home visiting model. This project originated as an extensive research effort comparing the relative effectiveness of lay and professional home visiting services. Among other subjects, the research addresses comparative caseloads (a ratio of 1 home visitor to 15 consumers, compared with a more common ratio of 1 visiting nurse to 60–100 consumers) as well as client outcomes. In an area with a critical shortage of professional nurses, the lay visitors act as providers and extenders of health care. They are supported by a multidisciplinary team that includes a nurse, obstetrician, child development specialist, social worker, and nutritionist. The home visitors’ backgrounds reflect the cultural diversity of the project area. Both nursing and paraprofessional staff complete an initial six-week training course. Subsequent training occurs through supervisory guidance and biweekly in-service sessions.

After the baby is born, the emphasis of the home visits shifts to well-baby care, immunizations, safety, maternal well-being, continuing career/education, family planning, and parenting. By the time the baby is 4 months of age, home visitors begin to address the family’s changing needs by assisting with the mother’s transition back to school and/or work. Biweekly parent support groups augment the home visits. These groups assist new mothers in returning to work or school and provide peer support, positive parenting models, and a forum for continuing health information. Fathers are urged to participate. The groups have been effective in reducing unintended pregnancy rates, enhancing self-esteem, improving parenting skills, and motivating parents to complete high school. Preparing home visitors as health care educators and preparing pregnant women for childbirth and parenting are paramount in this program. To ensure maximum effectiveness, project staff members have developed extensive training programs and curricula.
Steps for Implementing a Case Management Program

Tools for Fiscal and Program Monitoring

For project and contractor staff, the following tools are useful. They may be part of an integrated MIS.

- Client tracking and data collection MIS
- Client contact reports/staff activity reports
- Case record auditing procedures
- Fiscal monitoring database
- Position descriptions
- Expenditure approval process and reporting
- Standards for case manager performance
- Data collection and reporting procedures and protocols
- Confidentiality training/certification that includes monitoring
- Ongoing training in the case management protocols and the procedures for data collection and submission
- Supervisory training
- Cultural competence training
- Training on data collection procedures and practice
- Team-building training
- Training on emerging issues (e.g., Medicaid managed care, welfare reform) and public health concepts

Technical Assistance Needs

For project and contractor staff members who are implementing the program, these needs may include

- Initial and ongoing training for new staff as turnover occurs, including on-the-job training or mentoring by experienced case managers
- Identifying funding sources
- Data management

Contractors can vary from large, complex organizations (such as hospitals and universities) to small CBOs. Contractor staff may need the technical assistance listed above, plus support for expanding the organization's capacity. Organizational technical assistance may include

- Identifying funding sources
- Data management
• Organizational structure and strategic planning
• Managing budgets
• Developing links and collaborations with other agencies
• Applying to organizations for resource development

Role of the Healthy Start Consortium
• Provide community feedback and monitoring
• Establish and review policies, procedures, and protocols for case management
• Provide expert consultation on methodology
• Analyze progress reports and make suggestions for improvements

• Continue to build consensus about community needs and program methods
• Continue to build credibility with community stakeholders
• Participate in the evaluation of the program

Steps for Sustaining a Case Management Program

Since Healthy Start's inception, the sustainability of case management services has been a priority in the demonstration sites. All of the sites have a sustainability plan, which includes specific strategies for case management services.
Marketing and Resource Development

- Publicize results of a valid and reliable local evaluation of case management services
- Seek grant funds from government agencies (federal and state) for case management services for special populations
- Plan and initiate income-generating efforts in the areas of home health care and training
- Publish and market case management curricula and materials
- Work with sustainability consultants or consultants with specialized expertise in areas such as Medicaid pricing and marketing

Funding for Current Services

- Work with the state Medicaid program to make case management services reimbursable
- Market case management directly to managed care organizations, and develop contracts for providing these services to their members
- Market services to public hospitals, community centers, and child welfare organizations

Collaboration and Coalition Building

- Establish partnerships with existing programs and combine resources, which may include centralizing the activities of public health nurses and others to reduce duplication of effort
- Establish partnerships with other federal demonstration programs in the local area, such as Empowerment Zones/Enterprise Communities, Community Integrated Service System grants, and Early Head Start
- Integrate case management services into existing state initiatives, especially MCH programs (including those funded under Title V)

Richmond, VA

Richmond Healthy Start's case management techniques are quite similar to those used by social workers. Case managers ensure that clients are linked to the services they require. A key component of this model is the Home Visitors program, which is responsible for increasing the accessibility and use of health, social, and other services by pregnant and postpartum women and their families. Home visitors help women obtain early and ongoing prenatal care and improve their parenting skills. The visitors also encourage preventive child care (such as immunizations and child safety), discourage unhealthy behaviors, and work to decrease child abuse and neglect. Home visitors operate in their own neighborhoods and undergo rigorous training.
• Establish links with local hospitals, clinics, and social service agencies that serve current and potential Healthy Start clients
• Support contractors in their efforts to sustain case management services, and coordinate and oversee fundraising efforts of multiple contractors to ensure cooperation rather than competition

• Build partnerships with private foundations and other funders with missions similar to Healthy Start's
• Establish partnerships with local businesses and corporations
• Educate local and state policymakers about the importance of case management
Healthy Start communities have demonstrated the positive impact of providing multiple services under one roof in a single accessible location. Family resource centers minimize the number of places clients must go to receive services while reducing the number of forms clients must complete. This increases the chance that clients will have access to, and make use of, the care and services they need. Commonly called one-stop shopping, the concept encompasses collocating existing maternal and pediatric primary health care with WIC and/or Medicaid eligibility processing, health education programs, counseling and support services, and employment and other programs.

**Model Definition:**
Provision of a community-driven, comprehensive array of client services at a single, accessible community location.

**Purpose:**
To provide access to related services in one central location.

**Anticipated Results**
- Increased community capacity and infrastructure
- Increased access to services
- Increased community and institutional coordination and collaboration
- Increased use of services

**Key Components**
- Family-centered services to create a hub of community health activities that promote health while serving the needs of the community
- Community involvement in planning and guidance of the family resource centers to ensure that services provided are linked directly to the community’s needs, priorities, and resources
- Collaboration with existing community resources to create opportunities to bring services together (by collocation or by increased coordination)
Steps for Designing a Family Resource Center

Key Partners

In order to physically bring services together partners must share resources as well as information and support. This may require moving services from existing locations, changing the way services are publicized, and ultimately understanding and working together to serve more people in each program through cross-referrals and coordination of cases.

Health and Social Services Providers

- Medical providers, including hospitals, community health centers, clinics, and physicians
- Health, education, and social service providers, including WIC, family planning, mental health and substance abuse services, housing assistance, income assistance
- Public school systems

Systems Builders

- State MCH programs
- City, county, and state health departments

Grassroots Support

- Healthy Start Consortium and other coalitions
- Community-based organizations
- Community residents
- Consumers
- Civic organizations
- Churches and other faith communities

Baltimore, MD

Baltimore City Healthy Start’s family resource centers (FRCs) are called Neighborhood Healthy Start Centers (NHSCs). The project has designed and established two of these full-service centers and two smaller satellite centers, with one of each located on Baltimore City’s west side and one of each on the east side. Two of the major components of the project’s case management and outreach/recruitment operate through these FRCs. Additionally, many center-based interventions are provided through the NHSCs. Baltimore City Healthy Start’s approach is to employ neighborhood residents as neighborhood health advocates. The advocates aggressively identify pregnant and postpartum women and promote enrollment in Healthy Start. Case managers then work with each woman to develop an individual plan of care addressing her specific needs (e.g., basic prenatal care and other medical services, substance abuse counseling, employment assistance). With services located in one area, centralized one-stop resources facilitate continued care while nurturing healthy lifestyles. The services offered include on-site links to Medicaid, WIC services, income maintenance and food stamp programs, health education, GED classes, and life planning.
• Local businesses
• Local media

Role of the Healthy Start Consortium

The consortium includes agencies that can locate in the centers and those that can make these moves possible, either through political or financial support. Because of the intense collaborative nature of a family resource center, conflicts of interest may arise among consortia members. Healthy Start demonstration sites have addressed these issues through formal memoranda of understanding and consensus building to avoid or solve conflicts.

Building Partnerships
• Bring services together under one roof
• Build consensus and resolve conflict

Identifying and Developing Resources
• Identify community needs and available resources
• Provide guidance, direction, and advice to family resource centers
• Identify service providers for the family resource center
• Recruit, select, train, and retain staff
• Market family resource centers to a variety of stakeholders
**Building Sustainability**

- Build partnerships that lead to sustainability
- Formulate a strategic plan of implementation and sustainability
- Provide continuous community and consumer input and feedback

**Resources Needed**

Unlike other models, family resource centers rely on the accessibility and design of a facility. Particular emphasis is placed on making the facility acceptable for its occupants and consumers.

**Personnel**

- Services of an architect and/or building engineer
- Service teams appropriate to services provided, including outreach workers, male involvement specialists, information specialists/health educators, case managers, child care providers, substance abuse counselors, intake workers, medical staff (physicians, nurses, nurse practitioners), and/or economic development specialists
- Administrative and management staff appropriate to the center, which could include a director, perinatal systems liaison, data abstractors, fiscal/contract manager, and administrative assistants
- Van drivers and other transportation coordinators/providers

**Office Space and Equipment**

- Centrally located site accessible to the community and designed to facilitate multiple services that are consumer friendly, including medical services with properly equipped offices, resource libraries, child care services, and recreation space
- Private counseling space
- Conference space
- Computer equipment for data collection

**Service Tools**

- Program van or other vehicles
- Child care supplies and equipment
- Culturally competent educational materials, including videos, tapes, and books, and the equipment to use them
The five Chicago Healthy Start Family Centers provide a comprehensive array of social and health services to men, women of childbearing age, and their young children. The services are offered at a single, accessible community location and in a culturally and socially appropriate manner. The Chicago Healthy Start Family Centers are a collaborative effort between five community-based case management agencies and their primary health care partners. The Chicago Healthy Start communities support the concept of an alternative form of primary care delivery—one that is more family centered and committed to providing services in a setting that invites participation. The success of the Family Center programs is found in the unique aspects of each center. The involvement of members of the community in the design of the Family Centers helped foster tangible community ownership. The community members’ values and opinions of their community’s needs, the types of programs the Family Centers would provide, and the ability to draw upon available local resources were key factors in establishing community ownership.

**Public Information and Outreach**

A family resource center should, by its very existence, reach out to the community. Placed in a prominent and accessible community location, the center can become a hub of community activity. Clients of one service will automatically be informed about other services, with referral follow-up being as simple as a walk down the hall. However, active public information and outreach are necessary to reach this goal.

- Meet with community organizations and community leaders to garner support for the family resource center
- Establish linkage agreements with local agencies
- Present plans at community meetings and to interested groups
- Base outreach workers at the family resource center
- Establish health information centers in existing health and human service agencies
- Provide a resource guide of center-located providers and other sources of care to increase interagency referrals and communication
- Have consortia members and other stakeholders market centers to colleagues
- Conduct public awareness campaigns, including fliers, billboards, and door-to-door canvassing
- Distribute incentive items (e.g., tote bags, key chains, magnets) to the community and at community events
- Advertise general employment announcements in the center and in community locations
Steps for Implementing a Family Resource Center

Tools for Fiscal and Program Monitoring

For contractors or program staff, the following tools (which may be part of an integrated MIS) are useful:

- Data collection procedures and protocols
- Monthly reporting format for all contractors
- Client tracking and data collection MIS
- Client contact reports/staff activity reports
- Fiscal monitoring database

Technical Assistance Needs

For project and contractor staff members who are implementing the program, technical assistance needs may include:

- Ongoing training in the service protocols and the procedures for data collection and submission
- Team-building training
- Training in writing and computer skills
- Supervisory training
- Cultural competence training
- Sustainability and marketing training, including grant writing

Contractors can vary from large, complex organizations (such as hospitals or universities) to small CBOs. Some family resource-center contractors are small CBOs while others may be state programs or other large, long-standing organizations. Organizational technical assistance may include the following:

Essex County, NJ

Family resource centers are the entry point for Healthy Start services in Essex County. Two centers provide health care and social services for needy families. Although the Newark AD House was officially launched as a Healthy Start site in 1995, it actually opened its doors years earlier with the mission of helping adolescents improve their self-esteem, self-direction, and self-control. The second center is an established community health center in Orange County that recently linked with Healthy Start. At both family resource centers, Healthy Start has coordinated placement of workers from traditional agencies to provide prenatal care, family planning, pediatric care, lead screening, Medicaid enrollment, drug treatment referral, family counseling, and other services. Case managers reflect the cultural composition of the community. Transportation is now available as needed, as are child care services (featuring educational toys, games, and books) and educational and job assistance.
Observing the one-stop shopping concept, Oakland Healthy Start established three neighborhood-based family life resource centers (FLRCs) that provide access to a range of services that were previously unavailable or isolated. Asha, Ujima, and Imani House each seek to meet the needs of their respective communities by providing a range of needed services in one location. These include case management, child care, counseling for domestic violence, mental health services, parenting classes, youth development activities, and enrollment for WIC and MediCal. Staff members from the centers also work extensively with existing health and community service providers, including food banks, churches, advocacy agencies, schools, and clinical providers. Over time, each of the FLRCs has developed its own set of collaborations with neighboring agencies to meet the unique needs of its community. These centers have become a hub of activity for the surrounding community, and local businesses, schools, residents, and providers regard the sites as community assets.

Role of the Healthy Start Consortium

- Monitor, evaluate, and provide feedback on implementation, including review of utilization and quality assurance reports
- Build partnerships that bring services together or that lead to sustainability
- Provide training by member agencies
- Assist with consensus building and conflict resolution

Steps for Sustaining a Family Resource Program

The operation of the family resource center may be costly, and funding for infrastructure can be difficult to secure. However, with many agencies working together to keep one roof over their heads, powerful collaboration and
partnerships may also develop. All of the Healthy Start sites have a sustainability plan, and some include specific strategies for family resource centers.

**Marketing and Resource Development**

- Publicize the results of a valid and reliable evaluation of family resource centers
- Build name recognition and client satisfaction, with targeted marketing strategies for different audiences

**Funding for Current Services**

- Market family resource centers directly to managed care organizations and local industry and businesses, and develop contracts for providing these services to their members
- Reorganize services to be self-supporting through Medicaid and other third-party payer reimbursement
- Become licensed Medicaid providers and pursue Medicaid reimbursement
- Have outreach workers receive certification as nursing assistants
- Partner with state initiatives, including the state Title V MCH Block Grant and Title X family planning services

**Collaboration and Coalition Building**

- Establish partnerships with other federal demonstration programs in the local project area, such as Empowerment Zones/Enterprise Communities, Community Integrated Service System grants, and Early Head Start
- Integrate family resource centers into existing community or state programs
- Seek and receive foundation and/or philanthropic assistance
- Work with the consortium to build relationships with potential supporters
- Seek partnerships with existing providers (e.g., home health company) to be compensated for services (e.g., community health nursing services)
- Build partnerships with private foundations and other funders with missions similar to Healthy Start's
- Support contractors in their efforts to sustain family resource centers, and coordinate and oversee fundraising efforts of multiple contractors to ensure cooperation rather than competition
In many Healthy Start communities, existing clinical services did not meet the needs of many families. The Healthy Start communities developed strategies to enhance the quality, availability, accessibility, and utilization of clinical services provided by traditional providers such as health department clinics, hospitals, and community clinics. Depending on community needs, these strategies might include increasing the number of available providers; expanding the hours or locations of services; creating clinic atmospheres and protocols more welcoming to fathers, male partners, and extended family members; and conducting cultural sensitivity training for service providers. Enhancing cultural understanding improves the climate of care, and, in turn, pregnant and parenting women are more likely to follow through on provider recommendations.

**Model Definition:**
Improvement of quality, availability, access, and use of clinical services that are usually offered by providers such as health department clinics, hospitals, and community clinics.

**Purpose:**
To improve accessibility, quality, and client satisfaction levels of existing perinatal health services.

**Anticipated Results**
- Increased access to services
- Increased consumer satisfaction with services
- Development and strengthening of institutional capacity and quality
- Increased use of services

**Key Components**
- Holistic approach to client families to increase providers' satisfaction and make the providers' jobs more manageable, which helps to retain current providers and attract new ones
Steps for Designing Enhanced Clinical Services

Key Partners

Once a community has identified the need for enhanced clinical services, implementing solutions requires partnerships with medical care providers. While this model is more narrow than the others, and fewer partners may be required, these partnerships must be strong and active for this model to succeed. Clinical service providers must be involved in the design of the model and must, from the beginning, be prepared for implementation and sustainability efforts.

- A Healthy Start Consortium that includes providers, administrators, and consumers and other community coalitions
- Clinical providers, including nurse-midwives, perinatologists, registered nurses, social workers, and nutritionists
- Health care providers, including hospitals, community health centers, clinics, medical schools, and physicians
- City, county, and state health departments

Baltimore, MD

Through contractual agreements with 16 prenatal and pediatric clinics located throughout the project area, Baltimore City Healthy Start initiated and supported the reform of medical services delivery to make clinics more "user-friendly" and accessible to all women utilizing the services. Key service standards were promoted, including no block appointments, waiting times no longer than 20–30 minutes, scheduling the first prenatal visit within 2 weeks of the client's initial call (sooner if the woman is high risk); expanded clinic hours, on-site child care, continuity of care (allowing the patient to see the same nurse or physician), appealing physical settings, expanded health and nutrition education, and staff encouragement of male partner involvement. This effort has created permanent change in the delivery of care at many of these clinics, including improved patient flow, new appointment policies, facility renovations, staff-patient relations training, and team nursing and case management models.
Role of the Healthy Start Consortium

For enhanced clinical services, the consortium is key to assessing the project's needs. The consortium will be able to help determine if there is a shortage of medical personnel, a lack of services available after business hours, and/or a feeling of mistrust between providers and consumers. The consortium—providers and consumers working together toward solutions—then serves as a model of the partnerships needed to resolve these problems.

Identifying Resources

- Develop requests for proposals
- Develop solutions to gaps in services
- Select contractors
- Provide training and technical assistance to those implementing enhanced clinical services, including cultural sensitivity training

Building Sustainability

- Work toward shared responsibility for quality of clinical services

Resources Needed

Enhanced clinical service needs vary depending on the community's needs. Making perinatal health services more accessible may require little more than expanded hours, or it may require recruiting medical specialists to work in the community.
Personnel

- Appropriate management and administrative personnel, including a program coordinator and administrative assistant
- Appropriate culturally competent service personnel, possibly including a clinic coordinator, nurse practitioner, lab worker, social worker, case manager, and health educator
- A sufficient number of consumer-friendly clerical staff

Office Space and Equipment

- Accessible program space in existing clinics, which should include private examination rooms and appropriate waiting areas
- Medical equipment and supplies as required to meet client service needs

Service Tools

- Child care equipment
- Culturally appropriate educational materials, including posters, brochures, and other reading material that make waiting areas comfortable for all consumers, including males, and for diverse clientele

Public Information and Outreach

Once services are made more accessible and friendly, both consumers and providers must be informed of these improvements. Informing consumers will encourage them to use services they may not have previously accessed. Informing providers will work toward
Detroit Healthy Start staff members have devoted considerable effort to enhancing clinical service integration through clinics that now offer increased access to primary health care for those in greatest need. Core services such as family planning, sexually transmitted disease prevention and identification, laboratory and pharmacy services, parenting classes, social work, OB/GYN care, and well-baby care are crucial for the residents of this project area. The Grace Ross Health Center and the Herman Keifer Health Center are one-stop shopping facilities where clients can receive medical care, enroll in workshops, and apply for WIC vouchers, Medicaid, and other assistance. Staffed with nurses, physicians, and nutritionists, the clinics improve access to prenatal care and make available high-risk obstetric care within the community. Grace Ross is also staffed with nurse-midwives and perinatologists. These clinics serve as community health care hubs offering a full spectrum of support services to vulnerable families by providing comprehensive, community-based care for women of childbearing age, adolescents, and infants. A complete health risk appraisal is given to each client. Clients visiting the enhanced health centers can participate in smoking cessation programs, learn about congenital anomalies, have their children immunized or tested for tuberculosis or lead poisoning, and be referred for substance abuse counseling and/or domestic violence intervention.

the sustainability and replication of service enhancements.

- Conduct provider orientation sessions to introduce enhanced services
- Distribute culturally competent brochures and fliers, and present at community events to inform community of service improvements
- Publicize requests for proposals in community newspapers and through all consortium members
- Work with community providers to encourage referrals
- Encourage word-of-mouth publicity among consumers
- Use outreach workers to inform the community about enhanced services
- Conduct culturally competent public information campaigns that include billboards and toll-free phone numbers

Steps for Implementing Enhanced Clinical Services

Tools for Fiscal and Program Monitoring

For contractors or program staff, the following tools are useful. They may be part of an integrated MIS.
• Data collection procedures and protocols
• Client tracking and data collection MIS
• Client contact reports/staff activity reports
• Fiscal monitoring database
• Reports of clinical performance
• Client satisfaction surveys/questionnaires
• Site visits to monitor performance at enhanced clinical providers

Technical Assistance Needs
Training and technical assistance needs for this model are fewer than with many other models. Contractors implementing the enhanced clinical services tend to be larger, long-standing institutions with much organizational capacity. However, training and assistance are still necessary in several crucial areas, which may include
• Training for cultural competency
• Training on practice protocols, especially emerging clinical protocols endorsed by the Maternal and Child Health Bureau (e.g., *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)
• Inclusion of physicians as part of the planning and training teams
• Assistance with meeting accounting, fiscal management, and reporting requirements

Role of the Healthy Start Consortium
• Resolve consumer complaints and conflicts of interest
• Help select culturally sensitive health education materials

Great Expectations Healthy Start of New Orleans' Community Care Centers are neighborhood-based multiservice centers. Some centers offer one-stop shopping, permitting pregnant clients to apply for Medicaid and WIC programs and partake in a range of vital services, including community health nursing, family planning activities, and breastfeeding clinics. Along with client tracking and monitoring, these centers also offer group health education, adolescent awareness, peer counselor training, classes in parenting and male involvement, and comprehensive family planning services. Great Expectations has developed important relationships between local medical schools and the Community Care Centers. Because of these partnerships, medical school faculty and residents are working in the community clinics so that the obstetric and pediatric departments are able to serve more clients.
• Identify possible staff or contractors
• Continue partnership between providers and consumers
• Continue partnerships with health care institutions in planning, implementation, and design
• Evaluate improvements in clinical services

Steps for Sustaining Enhanced Clinical Services

Since enhanced clinical services often supplement existing services, joint sustainability planning can occur between the project and providers. Often, if services are provided within an institution (e.g., lengthening hours in a community health center), the project can work toward institutionalizing the service. This is possible only if the project can demonstrate that the program benefits both the institution and the community.

Marketing and Resource Development

• Publicize the results of a valid and reliable evaluation of enhanced clinical services, including client satisfaction
• Market to the community through promotional materials and community events

Funding for Current Services

• Market enhanced clinical services directly to managed care organizations, and develop contracts for
providing these services to their members
- Reorganize services to be self-supporting through Medicaid and other third-party payer reimbursement
- Become certified Medicaid providers and pursue Medicaid reimbursement
- Encourage providers to institutionalize enhanced services

**Collaboration and Coalition Building**

- Support contractors in their efforts to sustain enhanced clinical services, and coordinate and oversee resource development efforts of multiple contractors to ensure cooperation rather than competition
- Integrate enhanced clinical services into existing community or state programs
- Work with the Healthy Start Consortium to build relationships with potential supporters
- Build partnerships with private foundations and other funders with missions similar to Healthy Start's
Chapter Seven

Risk Reduction and Prevention

Healthy Start communities have targeted specialized services to and implemented interventions and activities for families experiencing stressors that threaten their health and well-being. This model of intervention provides services that prevent, reduce, or eliminate stressors that may lead to family violence, child abuse, depression, substance abuse, neighborhood crime, economic decline, homelessness, and fewer father figures who are actively involved in parenting activities. Involving male partners of pregnant and parenting women in all areas of services has been shown to result in positive long-term effects on birth outcomes, mothers, and the partners themselves. Educational programs such as parenting and smoking cessation classes provide support to those pregnant women and families attempting to change behaviors and reduce risk. Infant mortality reviews identify system-level issues and provide opportunities for community education and input.

Model Definition:
Provision of specialized services or activities that address population-based or system-oriented issues to reduce, modify, or eliminate specific stressors or unhealthy behaviors that threaten child-bearing women and their families.

Purpose:
To reduce high-risk behaviors associated with infant mortality within specific communities or factors contributing to these behaviors.

Anticipated Results
- Reduced incidence of stressors or unhealthy behaviors that are known to affect healthy birth outcomes
- Increased access to services
- Increased intensity of intervention for those most at risk for infant mortality
- Increased community and institutional coordination and collaboration
• Increased job training and employment opportunities for community members

**Key Components**

• Expansion and/or enhancement of existing services that reduce high-risk behaviors for pregnant women and their families (e.g., substance abuse treatment and counseling, child or domestic abuse prevention)

• Risk assessment and identification protocols that identify areas of greatest concern for each client and her family

• Recruiting and retention of staff specializing in risk areas

• Interaction between the community and the service providers

**Steps for Designing Risk-Reduction Programs**

**Key Partners**

Potential partners for reducing and preventing particular risks are those in the community who are already dealing with the risks, even if they are not specifically serving pregnant women. This could include substance abuse treatment and prevention and smoking cessation programs, prisons and law enforcement initiatives, or male mentoring programs. Partners for fetal and infant mortality reviews (FIMRs) usually include hospitals or county/city government service agencies.

**Chatham-Savannah, GA**

In 1993, America's oldest African-American social fraternity started Project Alpha, a mentoring program to help young males ages 10–16 gain access to health care and to foster their participation as fathers and providers for their children. In partnership with Chatham-Savannah Healthy Start, the program has been broadened to include a males-only clinic, a male responsibility curriculum, a resource fathers program, and a fathers' support group.
Boston, MA

One of Boston Healthy Start’s goals is to assist its funded agencies in identifying actual cases of domestic violence and supporting the women involved through counseling and referral. Interventions target pregnant and parenting women. Clients attend culturally sensitive workshops that explain the dynamics of abuse and the characteristics of an abusive partner, and offer risk appraisal for both client and infant. Boston Healthy Start also trains medical providers in risk assessment and cultural sensitivity. Another risk prevention program, the Latino Health Initiative, was launched in response to a rise in postnatal infant mortality among Latinas and to the scarcity of Latino agencies within the Boston Healthy Start network. This model proved a breakthrough for area Latinas, whose health and social services were previously isolated from the services available to the larger population. Through home visits, case managers offer domestic violence intervention and women’s health education and support for pregnant and parenting adolescents and adults, as well as health care for their infants.

Key Partners for Service Risk-Reduction Models

**Health and Social Services Providers**
- Existing network of neighborhood agencies working on risk reduction
- Homeless or abused women’s shelters
- Correctional facilities, courts, and probation officers
- Substance abuse service centers, including central intake programs
- Providers of high-risk pregnancy services
- Mental health programs
- Children’s assessment services (including those serving children with special health care needs)
- Family intervention services, including child welfare services
- Legal aid services
- Self-help support groups

**Systems Builders**
- Public housing agencies
- State MCH programs
- City, county, and state health departments
- Managed care organizations
- Schools and youth service networks
- Correctional systems

**Grassroots Support**
- Healthy Start Consortium and other coalitions
- Consumers
- Community residents
- Advocacy groups such as the American Lung Association
Chicago, IL

Chicago Healthy Start's prison initiative was established in response to the needs of Chicago's incarcerated women. A review of the women incarcerated at Cermak, a Cook County correctional facility, revealed an increased incidence of mental illness, substance abuse, asthma, STDs, and infectious diseases; no specific provision for any continuity in health care after release; and little or no prenatal care for the pregnant women within the prison system. Although these women are at extremely high risk for infant mortality, there was no mechanism for a case management approach for care during incarceration. Case managers also provide services to the children of incarcerated mothers and to these children's caregivers. When a woman is ready for release from the correctional facility, Chicago Healthy Start works with a Cermak case manager for a smooth transition to follow-up medical and social services in the community. Case managers provide these services to high-risk, first-time Hispanic parents. Because of its success, Chicago Healthy Start's prison initiative was awarded the National Commission on Correctional Health Care's 1997 Program of the Year Award. The commission was particularly impressed with the link that Chicago Healthy Start has with community health care providers and the assistance it offers to those just starting out on life's journey.

Key Partners for FIMR Models

Health and Social Services Providers

- Area hospitals and hospital associations, since access to hospital records is essential and may require institutional review board approval
- Professional provider associations
- Medical examiner's/coroner's office and other institutions instrumental to the timely notification of infant deaths
- Support services for bereaved women and families

- An infant mortality review team that includes hospital-based social workers, obstetricians, pediatricians, nurse-midwives, family planning counselors, public health officials, representatives from managed care companies, and substance abuse counselors

Systems Builders

- State MCH programs
- Managed care organizations
- City, county, and state health departments (family access to vital records is critical for systems building)
Grassroots and Political Support

- Local government and elected officials
- Healthy Start Consortium and other coalitions
- Community residents
- Consumers

Role of the Healthy Start Consortium

Consortium members can support Healthy Start's design of risk-reduction and prevention efforts.

Building Partnerships

- Convene community health forums and focus groups
- Establish an infant mortality review team that includes multidisciplinary members
- Include program staff in consortium meetings for exchange of service improvement ideas

Identifying and Developing Resources

- Identify community needs, capacity, and available resources
- Set priorities for risk-reduction/prevention services
- Advocate to bring risk-reduction/prevention services to people in geographically isolated and economically deprived neighborhoods
- Identify and provide resources and funds
- Identify organizations and services with which to partner
- Identify and develop service tools and materials

Building Sustainability

- Identify resources for supporting the program

Baltimore, MD

At Baltimore City's Neighborhood Healthy Start Centers, services are provided to help parents and children who were having difficulty bonding or who exhibited the need for therapeutic intervention. An on-site clinician provided individual and group psychotherapy and regularly attended case management team meetings to provide advice and technical assistance to teams about problematic bonding or emotional problems of clients and infants. In addition, an intensive therapeutic group for families of children at risk for severe emotional/mental disorders was established. This "Motherly Love" support group was conducted by a pediatric psychiatrist and a therapist. Its goal was to reduce stress among participants by providing therapeutic interventions that would result in better parenting.
New Orleans, LA

Great Expectations Healthy Start of New Orleans is licensed to provide case management for people in high-risk environments: women who are unlikely to seek regular health checkups, women who abuse alcohol or other substances during pregnancy, high-risk Hispanic residents, and high-risk males. Once identified, a client benefits from a range of services and programs, including health services provided by an assigned community health nurse as well as nutrition education for herself and her baby. Great Expectations provides specialized services to pregnant women involved in substance abuse. Spanish-speaking case managers continue to be effective in identifying Hispanic clients and facilitating their involvement through language translation during classes in all programs. Great Expectations brings supportive males into the maternal and prenatal care loop through such activities as the Annual Male Involvement Week and a citywide male involvement conference focusing on how to build and sustain positive relationships.

- Build partnerships that lead to sustainability

**Resources Needed for Service Risk-Reduction Models**

Resource needs vary widely depending on the specific risk-reduction/prevention programs being implemented.

**Resources Needed for FIMR Models**

**Personnel**

- Management and administrative/data entry staff
- FIMR interviewers and transcribers
- Research assistants to code and analyze FIMR data

**Office Space and Equipment**

- Confidential space for group meetings and individual counseling and secured recordkeeping
- Portable audio recording equipment for FIMR interviews

**Service Tools**

- Culturally competent health education materials and the necessary audiovisual equipment (e.g., overhead and slide projectors, television/VCR, audiocassette player, camcorder, projection screen)
- Resources for staff training
- Referral network to provide access to risk-reduction services needed by women with multiple risk factors
- Resources to ensure forms and recordkeeping comply with federal, state, and local requirements and standards of confidentiality
Public Information and Outreach

Public awareness may mean many things with risk-reduction models. It may mean community awareness of the availability of specialized services for families in need. It may mean publicizing FIMR findings to encourage systemic change, or it may mean community education about high-risk behaviors. In turn, FIMR findings influence future public awareness campaigns by identifying critical risks or providing powerful examples of infant deaths.

- Employ an extensive, multifaceted marketing approach, including culturally competent fliers, brochures, radio and television public service announcements, and hotline numbers
- Distribute a resource guide of Healthy Start providers to community agencies serving high-risk populations (e.g., homeless shelters, substance-abuse treatment centers)
- Cooperate with other agencies in disseminating information
- Send mass mailings through utility bills or messages on the back of grocery receipt tapes
- Educate health care providers on factors contributing to low birthweight/infant mortality and publicize changes in state rules and regulations regarding the provision of services
- Use advertisements to convey public concern about infant morbidity and mortality

Oakland, CA

Men in the Oakland Healthy Start target area indicated that they did not feel welcomed or served by existing services, and women stated that they wanted male partners more actively involved in parenting. Therefore, Oakland Healthy Start responded with a commitment to family life empowerment and an array of male-centered services, including parenting classes, support groups, job referrals, counseling, and a male-focused mobile health van.
Steps for Implementing Risk-Reduction and Prevention Programs

Tools for Fiscal and Program Monitoring

For contractors or program staff, the following tools are useful:

- Integrated fiscal and programmatic monitoring database
- Protocol for FIMR interviews, including criteria for determining preventability, a classification method for cause of death, and criteria for determining adequate age-appropriate immunizations
- Checklist of possible interventions in FIMR cases
- Client consent forms for FIMR
- Protocol for FIMR case reviews from technical and community perspectives

Technical Assistance Needs

Risk-reduction efforts may require combining expertise in particular risk areas with expertise in perinatal health. For example, FIMR programs may also require assistance in research methods and bereavement counseling. In the Healthy Start demonstration sites, these combined technical assistance and training needs have been addressed by program staff, consultants, consortia members, and other experts. Assistance and training needs might include

- Assistance in developing and establishing relationships with specialized systems, such as the local departments of corrections, substance abuse prevention, and/or housing

Pee Dee, SC

The Pee Dee Healthy Start’s family intervention service program serves families at risk for child abuse, especially women of childbearing age and their children up to three years of age. Services include education and ongoing support to client families and links with such resources as guidance in parenting and coping skills, counseling, and career planning. Early results indicate that the program has helped reduce both postneonatal mortality and substance use (including tobacco) among mothers who have been clients.
The regional Pittsburgh/Allegheny County Healthy Start Consortium identified the need for short-stay housing with supportive services for postpartum women and their children. The risk prevention and reduction interventions focus on the provision of short-term, residential, community-based programs for select subpopulations of pregnant and postpartum women living in the Healthy Start communities. These women and their infants need short-term residential care because of their health and social needs related to homelessness, recovery from substance abuse, or risk of adverse birth outcomes due to high medical risk and little social support (e.g., low-income single mothers requiring a prenatal bedrest regimen, and those impacted by early hospital discharge practices). The residential programs are operated by Healthy Start, Inc., through subcontracts with three CBOs.

Steps for Sustaining Risk Reduction and Prevention

These services are often delivered as part of, or in concert with, other service systems (e.g., corrections, substance abuse services, child welfare). Working with these partners toward sustainability can open doors to resources that would not otherwise be available to Healthy Start programs. However, sustaining services for high-risk populations can pose special challenges (i.e., intensive services tend to have higher costs per case than other services).

Marketing and Resource Development

- Publicize the results of a valid and reliable evaluation of risk-reduction activities
- Demonstrate the continued need for risk reduction and prevention
• Foster legislative and corporate partnerships through targeted marketing activities
• Disseminate FIMR findings to policymakers and other key leaders who can help sustain FIMR and substantiate the need for prevalent specific risk-reduction activities
• Provide technical assistance and training to providers on risk-reduction topics (e.g., nutrition intervention, services to incarcerated women) for a fee
• Provide training to managed care organizations and other providers for a fee

Funding for Current Services
• Advocate the inclusion of specialized risk-reduction services in state Medicaid plans
• Market risk-reduction services directly to managed care organizations, local businesses, and industries, and develop contracts for providing these services to their members
• Reorganize services to be self-supporting through Medicaid and other third-party payer reimbursement
• Obtain the services of professional trainers as in-kind donations

Collaboration and Coalition Building
• Integrate risk-reduction services into existing community or state programs
• Integrate FIMR into core state or local public health surveillance functions
• Support contractors in their efforts to sustain risk-reduction services, and coordinate and oversee fundraising efforts of multiple contractors to ensure cooperation rather than competition
• Build partnerships with private foundations and other funders with missions similar to Healthy Start's
• Build relationships with businesses and industry
• Maintain linkages necessary for FIMR or service models
In many Healthy Start communities, services, even when available, were difficult to access. These difficulties arose from the consumers' lack of resources to reach services and/or by the services being in inaccessible locations. By facilitating access to existing and new services, Healthy Start sites are able to capitalize on many community resources and achieve greater use of care services.

**Model Definition:**
Provision of enabling services such as translation, transportation, and child care to help clients receive services and participate in infant mortality reduction programs.

**Purpose:**
To reduce logistical barriers to accessing and participating in services and activities.

**Anticipated Results**
- Increased access to services
- Increased community participation in Healthy Start services and activities
- Increased use of Healthy Start services
- Decreased number of missed appointments

**Key Components**
- Coordinated transportation to service sites, or provision of mobile services to increase the number of women, infants, and their families who are able to reach service locations
- Provision of on-site or drop-in child care that allows women to bring children with them to appointments, and to leave them in a supervised care setting while attending to their own needs or the needs of their other children. (Child care can be staffed in part by college students as a practicum for child development.)
- On-site access to bilingual staff, proficient in languages prevalent in the target community
Collaboration with existing community resources that provide facilitating services

Steps for Designing Facilitating Services

Key Partners

The most important partners for designing facilitating services are, without question, the members of the community. Consumers often identify logistical barriers as the key to their health-seeking behaviors. Often, facilitating services are lacking because providers have neglected to notice or address the barriers that consumers face.

Health and Social Services Providers

- Health and social service providers, including mental health and substance abuse services
- Medical providers, including hospitals, clinics, and physicians
- Public schools
- Local taxi companies and transit systems
- Child care providers

Systems Builders

- Medicaid, in order to be a certified transportation provider and eligible for reimbursement
- Transportation authorities and transit systems

Dallas, TX

Even Mom Mobile vans (with another one on the way) provide free transportation for women and children from their homes to health appointments, WIC services, parenting education classes, and related maternal and child care services. As word of the service has spread, the number of riders has increased steadily. This service is greatly improving the comprehensiveness of services to women and families. The program is only one example of the benefits of community collaboration: 77 percent of the funds for this service come from local foundations and corporations. In the future, Dallas Healthy Start will also take its services on the road, using a mobile medical van funded by Mattel and Exxon. The mobile clinic will serve five Head Start sites to provide immunizations, prenatal and postnatal care, health assessments and physical examinations for women and children, health education and parenting, and health referrals in the most underserved areas. Several community partners, including the Texas Woman’s University School of Nursing and Head Start, are helping to make this clinic possible.
• State and local departments of social services
• State MCH programs
• City, county, and state health departments
• Managed care organizations, requiring a formal memorandum of understanding

Grassroots Support
• Healthy Start Consortium and other coalitions
• Community residents
• Consumers
• Civic organizations
• Local businesses
• Local media

Role of the Healthy Start Consortium

To be effective, facilitating services must work as part of a system of accessible services. The consortium can play a crucial role in building collaboration and coordination among providers of all kinds of services. It is also the forum for community input into the planning process. Facilitating services, once implemented, strengthen the consortium by making participation by residents possible. Community residents face the same barriers to consortia participation as they do to service utilization.

Building Partnerships
• Build partnerships that bring services together into one communicating service system

• Represent the program to local civic and political bodies
• Address public community forums and engage in other public education activities

Identifying and Developing Resources
• Identify community needs, capacity, and available resources
• Conduct consumer focus groups to identify barriers and needed services
• Recruit and select staff
• Identify resources for referrals

Building Sustainability
• Build partnerships that lead to sustainability
• Identify resources for supporting the program
Detroit, MI

To bridge the gap between prenatal and other health care and the clients who so desperately need them, Detroit Healthy Start has expanded the Healthy Baby van service. Providing transportation to and from health care appointments, the van service uses the travel time to educate women about prenatal and infant care while providing an opportunity for the women to voice their concerns and problems. A joint effort of the Detroit and Wayne County health departments, the van service has increased the number of pregnant women making and keeping vital prenatal and other health care appointments. The van drivers are more than just transportation workers: 50 percent have been trained as maternal and child health advocates and are receiving college credit for their efforts. Detroit Healthy Start's goal is to have all of the drivers complete this training. Each of these drivers serves as another caring partner in the clients' lives and plays an important role in Healthy Start.

Resources Needed

Resource needs vary depending on what facilitating services are needed. A site may require personnel, equipment, and space/facilities necessary for transportation, child care, translation services, or any combination.

Personnel

- Program coordinator and administrative support
- Appropriately licensed drivers, cross-trained as clerks or outreach workers
- Appropriately certified child care providers
- Multilingual and culturally competent staff
- Transportation dispatcher

Office Space and Equipment

- Centrally located office and telephone number as hub for transportation
- Child care areas collocated with service delivery sites

Service Tools

- Vehicles (purchased, leased, or donated) that are equipped with maps, infant and child car safety seats, provisions/arrangements for people with disabilities, spill cleanup kits, vehicle maintenance agreement, and appropriate insurance coverage
- Safe parking area for vehicles
- Bus or subway passes
- Transportation dispatching system and log books
- Mobile telephones/pagers
- Vehicle maintenance logs
- Child care and related food service
- Child supervision supplies (e.g., culturally competent and age-appropriate health education materials, diapers, formula, books)
**Public Information and Outreach**

Facilitating services only increase access if consumers and providers know they are available.

- Distribute culturally competent posters and promotional materials at all service sites with facilitating services available
- Use an extensive, multifaceted marketing approach, including culturally competent and linguistically appropriate fliers, brochures, and radio and television public service announcements
- Have outreach workers publicize these services in the community
- Advertise to other service providers and coalitions
- Record phone messages and disseminate pocket guides to services
- Refer through hotlines
- Market to other agencies on a fee-for-service basis

**Steps for Implementing Facilitating Services**

**Tools for Fiscal and Program Monitoring**

For contractors or program staff, the following tools, which may be part of an integrated MIS, are useful:

- Data collection procedures and protocols
- Client tracking and data collection MIS
- Client contact reports/staff activity reports
- Fiscal monitoring database
- Transportation logs recording where and when clients are transported

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**Baltimore, MD**

On-site drop-in child care at each of Baltimore’s Neighborhood Healthy Start Centers (NHSC) is available for parents participating in Center-based activities, attending health care visits, meeting with case managers or other NHSC staff, or in need of a brief respite from parenting demands. The service is available from 8:30 a.m. to 6:30 p.m. 4 days per week and is staffed by trained child care assistants working under the supervision of an early childhood specialist. The infant/toddler activity areas are divided into four sections: fine and gross motor skills, soft play, and art areas. The infant room is equipped with six infant cribs, rocking chairs, and other items used to stimulate cognitive development.
• Client satisfaction surveys
• Service vouchers
• Daily mileage sheets for drivers
• Transportation dispatch/database system
• State child care reporting and licensure/certification requirements
• Review of sustainability plans

Technical Assistance Needs

For project and contractor staff members who are implementing the program, technical assistance needs may include

• Ongoing training in the service protocols and the procedures for data collection and submission
• Supervisory training
• Cultural competence training
• Parenting skills training and assessment
• Child care training, including health and safety in child care settings
• Child abuse and neglect reporting requirements and procedures
• Driver training, including safe and defensive driving
• Cross-training drivers to provide health education
• Sustainability and marketing training, including grant writing

Contractors can vary from large, complex organizations (such as hospitals or universities) to small CBOs. Some facilitating services contractors are small CBOs, while others may be state programs or other large, long-standing organizations. Contractor staff may need the technical assistance listed above, plus support for organizational capacity building. Organizational technical assistance may be provided on

• Operating a transportation dispatch system, including scheduling, routing, tracking, data collection, reporting, and backup systems
• Contracting for services and contract monitoring
• Fee-for-service administration
• Organizational development and strategic planning
• Staff recruitment, selection, and training
• Publicizing services and developing marketing materials
• Developing data management capability
• Managing budgets
• Building partnerships with other organizations for sustainability
• Designing and implementing evaluations of program performance
• Establishing resource development capacity

Role of the Healthy Start Consortium

• Identify problems and plan for their solutions
• Convene consumer focus groups to solicit opinions on proposed expansions or enhancements, and closely monitor consumer satisfaction
• Recruit and select staff
• Build partnerships that bring services together and/or lead to sustainability
• Build consensus and resolve conflict
• Secure donations of resources needed for the services (e.g., child safety seats, toys, diapers)

Steps for Sustaining Facilitating Services

Since facilitating services often supplement existing services, sustainability planning can be a joint activity between the project and providers. Often, if services are provided within an institution (e.g., child care in a hospital), the project can work toward institutionalizing the service. This is possible only if the project can demonstrate that the program benefits both the institution and the community.

Marketing and Resource Development

• Publicize the results of a valid and reliable evaluation of facilitating services
• Demonstrate the continued need for facilitating services
• Build name recognition and client satisfaction, with targeted marketing strategies for different audiences
• Garner media attention, and conduct media campaigns that include television and radio public service announcements, billboards, and newspaper articles
• Train staff, consortium members, and contractors in sustainability and resource development

Northern Plains, Aberdeen, SD

Employing trained community residents, Northern Plains Healthy Start provides services that have always been difficult to obtain, especially for women and children in American Indian tribal areas. Access to clinics, hospitals, and caring service providers is an important component of the project. Lack of transportation is a daunting barrier to care in Northern Plains' 19 tribal communities. Many families do not own cars, and some live 150 miles or more from the nearest medical provider. Healthy Start indigenous caseworkers provide transportation for clients, usually via automobile. The long drive to health care facilities gives caseworkers and clients the added opportunity to build trust and rapport, as the automobile becomes a virtual classroom on wheels.
Richmond, VA

Richmond Healthy Start's facilitating services model was developed to overcome clients' lack of access to services and facilities. Two initiatives, the Comprehensive Health Investment Project (CHIP) and the Memorial Child Guidance Clinic (MCGC), are interwoven and are designed to address the issue of accessibility. CHIP uses a team of nurses and paraprofessionals to provide in-home support to high-risk families with children under 5 years of age and to high-risk pregnant women. Home visitors work with the family to match interventions to the family's needs and concerns. MCGC provides transportation to prenatal care appointments and short-term child care so that pregnant mothers residing in public housing are able to keep their perinatal medical appointments. Both initiatives use community residents as liaisons to provide services within their own neighborhoods.

Funding for Current Services

- Market facilitating services directly to managed care organizations, and develop contracts for providing these services to their members
- Reorganize services to be self-supporting through Medicaid and other third-party payer reimbursement
- Become licensed Medicaid providers and pursue Medicaid reimbursement
- Become a licensed child care provider
- Identify agencies with facilitating service needs who can pay fees for services or contribute to the overall budget
- Seek in-kind donations for equipment, space/facilities, and training resources and other program materials

Collaboration and Coalition Building

- Integrate facilitating services into existing community or state programs
- Work with the Healthy Start Consortium to build relationships with potential supporters
- Build partnerships with private foundations and other funders with missions similar to Healthy Start's
- Support contractors in their efforts to sustain family resource centers
- Coordinate and oversee fundraising efforts of multiple contractors to ensure cooperation rather than competition
- Coordinate shared resources among contractors
- Build relationships with businesses and industry
Increasing a community's awareness of infant mortality, its contributing factors, and the strategies for combating it is essential for a Healthy Start project. Community events, media outreach, and other strategies have been creatively employed by each Healthy Start site. Once aware of the issues, Healthy Start clients and community members can access specific health education programs aimed at reducing infant mortality, including nutrition education, childbirth training, and parenting education.

In addition, Healthy Start projects have developed curricula on a variety of perinatal service components, including outreach worker training manuals, childbirth education and parenting education curricula, consortium training and community empowerment materials, and other audiovisual training and marketing aids. Linking this training with college credits or continuing education units encourages greater participation.

**Model Definition:**
Provision of planned education and public information to address risk factors associated with infant mortality and to improve individual and community health.

**Purpose:**
To educate the public, clients, and service providers about health issues and other topics that promote perinatal health and enhance the delivery of perinatal care.

**Anticipated Results**
- Increased community knowledge of and involvement in infant mortality reduction efforts
- Improved health knowledge and behaviors among clients and community members
- Increased job training and employment opportunities for community members
- Improved knowledge and skills in the health care work force
Key Components

- Public information and education campaigns (including creative communication strategies such as bus signs, radio talk shows on locally owned stations, and grocery bag advertisements) to elevate community awareness of infant mortality issues
- Collaboration with existing community resources, which can result in community service directories to address the ongoing need of identifying available providers and services
- Opportunities for education and training that enhance the economic development of the community
- Curricula that can be adapted to fit the specific needs of a community

Steps for Designing Education and Training Services

Key Partners

Comprehensive education and training initiatives require partners from a number of sectors. For public information campaigns, the media are key partners; for consumer education, consumers

District of Columbia

DC Healthy Start's Resource and Information Center produces and disseminates health fact sheets, brochures, maternal and child health statistical reference manuals, publications, and interactive multimedia presentations. The center also manages and searches databases, retrieves and disseminates information, provides access to the Internet/World Wide Web, and manages an audio-visual equipment loan service. The center is accessible to DC Healthy Start staff members and other providers who use these services on a daily basis. This component facilitates staff access to public information and educational materials and equipment.

The project has developed, tested, and produced Resource Parents' Training and Trainers' Manuals, Staff and Consortium Orientation Manuals, and a Male Outreach Workers Manual, using an Afrocentric approach. These manuals have been well received and are in high demand.

DC Healthy Start uses multi-pronged media campaigns to relay health messages to specific target populations and to increase public awareness of ways to combat the infant mortality rate in Washington, DC. Public service announcements air on local radio stations as well as on commercial and cable television stations. Feature articles are developed for publication in local print media and health-related trade newsletters. A newsletter is disseminated by direct mail and available at all public service centers.
and other CBOs agencies are key partners; and for staff training, staff members and other agencies are key partners.

**Health and Social Services Providers**

- Medical providers, including hospitals, clinics, and physicians
- Health and social service providers, including mental health and substance abuse services
- Outreach workers and supervisors
- Public schools, including administrators, teachers, counselors, and parents
- Libraries
- Local colleges
- Recreation programs, including the Boys and Girls Clubs
- Related community programs such as Cooperative Extension's Expanded Food and Nutrition Education Program, WIC, Planned Parenthood, and American Red Cross

**Systems Builders**

- State MCH programs
- City, county, and state health departments
- Managed care organizations

**Grassroots Support**

- Healthy Start Consortium and other coalitions
- Consumers
- Community residents
- Churches and other faith communities
- Civic organizations

- Universities, colleges, technical training schools, and parent-teacher associations
- Local businesses
- Local media

**Role of the Healthy Start Consortium**

Education and training programs allow the consortium to be active in a number of ways. Consortium members will all have been either creators or targets of public education campaigns, and all will have participated in health education and staff training activities.

**Building Partnerships**

- Build partnerships with local media
- Present at public community forums and conduct other public education activities
Northern Plains, Aberdeen, SD

Case managers working within the Northern Plains Healthy Start project prepare individualized culturally competent educational materials for clients and their partners, then review and discuss the materials in education sessions within the home. These sessions are supplemented by prenatal, parenting, and postpartum classes in the schools. Materials focus on the risk factors prevalent in this region: high alcohol consumption and domestic violence. Family planning is also a major component of the project’s health education efforts.

- Establish consumer-run educational groups
- Market by consumer word-of-mouth
- Conduct consumer focus groups to identify health education and awareness needs, and to learn where consumers will seek education and information

**Identifying and Developing Resources**
- Identify community needs, capacity, and available resources
- Review past campaigns and materials for their effectiveness
- Design a public education campaign
- Make recommendations on media messages and their placement
- Select or design health education materials
- Advise on cultural sensitivity of health education messages
- Provide health education and training

**Building Sustainability**
- Build partnerships that lead to sustainability
- Identify resources for supporting the program

**Resources Needed**

Resource needs vary depending on what training and education programs are implemented.

**Personnel**
- Public affairs specialist/media consultant or contractor
- Training and education coordinator and administrative support
- Trainers/facilitators and health educators
- Training consultants

**Office Space and Equipment**
- Training space located within the project area
- Health education space at sites where direct services are being delivered

**Service Tools**
- Health education materials and required audiovisual equipment (e.g., overhead and slide projectors,
television/VCR, audiocassette player, camcorder, projection screen)
• Access to research materials and established curricula
• Training manuals and participant workbooks
• Health education materials that are in languages used in the community and that are culturally competent
• Public service announcements, both video and audio
• Billboards and posters
• Incentive items (e.g., tote bags, key chains, magnets)

Public Information and Outreach

This model, along with the outreach model, provides the methods by which most other Healthy Start services are publicized.

Oakland, CA

The goals of the Oakland Healthy Start (OHS) public affairs program are to establish a positive image in the community, increase customer participation in OHS programs, and generate broad-based community support and recognition of infant mortality and healthy pregnancy issues. Prior to OHS, there were limited health and wellness advertising campaigns in East and West Oakland and the Fruitvale/San Antonio districts. OHS helped to improve the image of residents in these target areas by depicting positive images of African-American families. It also paved the way for private hospitals, HMOs, and community-based services to market their services in OHS target areas. OHS uses a wide variety of public education tools, including radio and transit advertising, outdoor billboards, a calendar, newsletter, brochure, posters, and cable TV public service announcements. Other media products include a home health handbook and a video series on reproductive health, fatherhood, and family themes.
• Use consumer and staff word-of-mouth
• Form a marketing committee
• Disseminate information and promotional items at places of worship, schools, and community events
• Distribute promotional items with Healthy Start and other relevant contact information
• Include male partners, siblings, and other extended family members in outreach efforts

Steps for Implementing Education and Training Programs

Tools for Fiscal and Program Monitoring

For contractors and program staff, the following tools are useful. They may be part of an integrated MIS.

• Fiscal monitoring database
• Session attendance sheets
• Minutes and notes of educational sessions
• Performance assessment tools for health education staff
• On-site reviews, by program staff, of educational sessions
• Session evaluation forms completed by participants
• Community assessment to gauge interest in the program and the penetration of media messages

Technical Assistance Needs

Education and training efforts may require health professionals to acquire new skills (e.g., in media relations, presentations, use of the Internet). In the Healthy Start demonstration sites, these technical assistance and training needs

Northwest Indiana

The Northwest Indiana Healthy Start’s Alternative Education Enhancement Project (AEEP) provides a comprehensive educational environment for pregnant and parenting female adolescents. Northwest Indiana Healthy Start developed this model for adaptation by school systems. The program incorporates both the local Healthy Start staff and the school system staff to meet the educational, social, emotional, and health care needs of the students. AEEP teachers are available to adolescents by telephone during difficult times. The ratio of 1 teacher to 20 students allows for individual attention and establishes a climate in which trusting and supportive relationships among students and staff can flourish. A school nurse is assigned to follow each student through her pregnancy until her infant’s first birthday. Other resources available to AEEP students include family planning and STD prevention.
have been met by program staff, consultants, consortium members, and other experts. Assistance and training needs might include

- Assistance in building media relationships
- Assistance with graphic design, including program identity, logos, and promotional items
- Training for trainers, including instructional skills and health information
- Staff development, including continuing education workshops and conferences
- Assistance in identifying or developing health education materials and curricula
- Cultural competence training
- Assistance with using the Internet for research and publicity
- Assistance in translating materials into multiple languages
- Training consumers to run self-directed groups

**Role of the Healthy Start Consortium**

- Identify continuing and emerging needs for health education
- Assist in developing education and training curricula
- Provide feedback on all educational activities, from media campaigns to staff training
- Convene consumer focus groups to suggest expansions or enhancements
- Build partnerships that bring health education services to the project or that lead to sustainability
- Continue or develop partnerships with local businesses and media
- Participate in training activities for direct observation, monitoring, and evaluation

### Steps for Sustaining Education and Training

Education and training services often offer a complement to existing services by providing health education to backup clinical services, by training staff members who implement other program components, or by publicizing Healthy Start as a whole. Therefore, education and training sustainability plans must be integrated with other, complementary components.

### Marketing and Resource Development

- Demonstrate the continued need for education and training through valid and reliable evaluation
- Build name recognition and client satisfaction, with targeted marketing strategies for different audiences
- Conduct targeted public awareness campaigns
- Sell education and training materials, including curricula, workbooks, and educational handouts
Chatham-Savannah, GA

The perinatal education component of the Chatham–Savannah Healthy Start project focuses on providing client-centered, culturally sensitive perinatal health education to women, teens, and families in the project area. The curriculum includes anatomy and physiology, information on bodily changes and possible discomforts, preparation for the hospital stay, labor and delivery, postnatal and baby care, and coping with becoming a new parent. Class sessions also discuss budgeting, household matters, and responsible parenting.

Classes are conducted at the Healthy Start office after school for pregnant teens and in the evening for working parents. Staff members from the Teen Age Pregnancy Program (TAPP) and the Health Department conduct the classes. Referrals are received from schools, agencies, and health care providers. Certificates for participation are presented at the conclusion of each session.

Funding for Current Services

- Market health education services directly to managed care organizations, and develop contracts for providing these services to their members
- Reorganize services to be self-supporting through Medicaid and other third-party payer reimbursement
- Provide training to managed care organizations and other providers for a fee
- Obtain the services of professional trainers as in-kind donations
- Seek in-kind donations for promotional efforts and materials

Collaboration and Coalition Building

- Build relationships with media outlets for in-kind donations of air time and support for, or sponsorship of, community events
- Integrate education and training services into existing community or state programs
- Build partnerships with private foundations and other funders with missions similar to Healthy Start's
- Build relationships with businesses and industry
A significant percentage of low-birth-weight babies are born to adolescents, making adolescents crucial allies in the fight against infant mortality. At-risk, pregnant, or parenting adolescents require the same services as older women, but the services must be designed to meet adolescents' special needs, engage the adolescents, and capitalize on the unique prevention opportunities adolescents present. Healthy Start sites provide information and activities that encourage healthy behaviors, improve self-esteem, promote abstinence, and help both male and female adolescents understand the risks of pregnancy as well as the challenges of parenting. Young people need to receive support and services that encourage abstinence and to feel involved in social interactions while empowered to postpone pregnancy.

**Model Definition:**

Provision of services focusing on the unique needs of adolescents to help them understand the complexities of childbearing as well as the need for pregnancy prevention.

**Purpose:**

To decrease adolescent pregnancy, promote healthy behaviors, and improve health care and parenting skills for pregnant and parenting adolescents.

**Anticipated Results**

- Development of adolescents' life skills
- Decreased numbers of pregnancies among adolescents
- Decreased birth rates among adolescents
- Improved birth outcomes for pregnant adolescents
- Increased birth intervals
- Increased intensity of intervention for those most at risk for infant mortality
- Increased community and institutional understanding and coordination of and collaboration on adolescent health issues
- Increased adolescent use of and access to services
Key Components

- Adolescent involvement in planning, guiding, delivering, and evaluating services
- Peer education and counseling programs through various activities, including artistic expression
- Involvement of adolescent males and females
- Collaboration with schools to implement school-based health and pregnancy prevention programs that promote healthy lifestyles

Steps for Designing an Adolescent Program

Key Partners

In many communities, adolescents are targeted by a number of health promotion programs. This array of social programs—some mandatory, some voluntary—can cause adolescents to avoid involvement in programs. Therefore, partnerships with youth-serving agencies and those concerned with youth development are essential to reaching adolescents. Coordination is the key to promoting comprehensive health for adolescents. Schools are a natural starting point, as are other places where adolescents congregate and socialize. On familiar ground, adolescents are less likely to be threatened by outsiders and more likely to respond to recruitment efforts. Because adolescent programs often incorporate several of the other intervention models (e.g., case management, outreach), many of the partnerships needed for other models are also needed here.

Health and Social Services Providers

- Public schools, boards of education, and school administrators

Dallas, TX

One of Dallas Healthy Start's priorities is to stimulate community ownership of Healthy Start strategies. Adolescents are crucial to this effort. The Dallas Teen Advisory Committee, composed of male and female adolescents, assesses the needs of its own age group and devises ways for adolescents to respond to those needs. The committee's mission is to increase adolescent awareness of factors harmful to health and to encourage role modeling of healthy behaviors. These adolescents meet monthly to plan an ambitious calendar of events, programs, and recruitment efforts, including health fairs, workshops on healthy behaviors, pregnancy prevention services at community sites and schools, adolescent court (a conflict resolution method that empowers adolescents to make wise decisions), and dramatic skits and panel presentations on appropriate health behaviors. Peer-to-peer information on healthy lifestyles and infant mortality has been shown to make a difference.
- Health, education, and social service providers, including WIC, family planning, and mental health and substance abuse services, especially programs or organizations where adolescents already congregate
- Medical providers, including hospitals, community health centers, clinics, and physicians
- Recreation centers, teen clubs, and city/county parks and recreation departments
- Boys and Girls Clubs
- Churches and other places of worship
- Law enforcement
- Planned Parenthood

**Systems Builders**
- State MCH programs
- City, county, and state health departments
- Juvenile justice system
- Infant mortality review panel

**Grassroots Support**
- Healthy Start Consortium and other coalitions
- Adolescent consumers and other community residents
- Parents and community volunteers
- Community-based organizations
- Civic and fraternal organizations
- Churches and other faith communities
- Advocacy groups, such as the Children's Defense Fund
- Local media
- Local businesses

**Role of the Healthy Start Consortium**

Adolescent pregnancy is a politically charged issue in many of the Healthy Start communities, as it is on the national scene. The Healthy Start Consortium's role in designing adolescent programs focuses on grassroots organization. The consortium can set up a forum for bringing the community together to design its own programs, whether the focus is abstinence, sexuality education, birth control education, alternate recreational activities, or parenting training. With programming for adolescents, this community decision-making can be particularly difficult; adults' views on appropriate programming may conflict with
adolescents' views of what they need or in which programs they will participate. For this reason, adolescents themselves, like other Healthy Start consumers, need to be vigorously recruited for direct involvement in the consortium and the decision-making processes that may affect them.

**Building Partnerships**

- Partner with adolescent providers and other adolescent services such as school-based and school-linked programs
- State adolescent coordinators
- Build consensus and resolve conflict, especially around issues of adolescent sexuality and pregnancy
- Promote a team approach to adolescent pregnancy that reduces duplication and "turf" issues
- Enlist community support for the program
- Partner with parent-teacher associations and other grassroots parent organizations

**Identifying Resources**

- Recruit and select staff and volunteers
- Recruit adolescent clients
- Use outreach, marketing, and information dissemination
- Provide technical assistance and training to community organizations that will implement the program
- Identify community resources for referrals

**Building Sustainability**

- Participate in resource development to promote sustainability after the funding period ends
- Evaluate and provide feedback to continuously improve the planning process and design
Resources Needed

Adolescent programs’ resource needs vary depending on the kind of program and who it aims to serve. Many programs find that locating themselves in public schools makes the program more accessible and acceptable.

Personnel

- Appropriate management and administrative personnel, including a program coordinator and administrative assistant
- Appropriate service personnel, possibly including a clinic coordinator, nurse practitioner, laboratory worker, social worker, case manager, and health educator
- Identified liaison in each school

Office Space and Equipment

- Program space, possibly in the public schools, which may include private examination rooms and appropriate waiting areas
- Confidential chart storage
- Conference/meeting space
- Space for rehearsals of adolescent performing groups and meetings of other adolescent groups

Service Tools

- Program van or other vehicles
- Culturally competent educational materials, including videos, tapes, and books, and the audiovisual equipment to use them
- Clothing and other items identifying adolescents as program participants

New York City

Adolescents are a major focus of Healthy Start/New York City (HS/NYC). To give teens alternatives to pregnancy and resources to improve their health and help them make constructive life choices, HS/NYC has funded student internships; peer mentoring; male involvement and leadership development; after-school programs; and prenatal care and family planning services for pregnant and parenting teens. The project has been particularly successful in attracting at-risk youth. One example is the Bedford–Healthy Start/Ellison Youth Initiative, which uses entertainment and talent development to attract the most at-risk youth. In order to participate, youths must enroll in health education and homework help programs. Serving more than 300 youths annually, this grassroots effort has received national attention for its innovation and ability to provide youth with an alternative to gang-related activity, violence, and teen pregnancy. Also successful was HS/NYC’s student internship endeavor, which provided high-school youths with health-related summer internships, job training, health education, and peer support.
Public Information and Outreach

Many adolescent programs rely heavily on health education through the media. In addition, communities often have multiple adolescent initiatives that need to work together to send consistent messages and to refer adolescents to each other's programs.

- Conduct public information campaigns with careful design and placement of messages, including television and radio public service announcements
- Use focus groups of target-population adolescents to design and refine messages
- Gain trust and support of potential participants, their families, and the community through community meetings and public awareness events held to discuss needs, concerns, and prevention strategies in a consumer-friendly environment
- Coordinate with other programs to enhance public information and outreach without duplication of effort
- Write letters to the editors of local newspapers and newsletters regarding sexuality education
- Print articles in organizational newsletters (e.g., Planned Parenthood, church bulletins)
- Partner with key personnel at targeted schools
- Disseminate information packets to principals, teachers, parents, and peer educators
- Disseminate brochures aimed at particular audiences (PTA, community, students, parents)
- Develop peer leadership
- Train and promote community and student spokespersons
- Disseminate program marketing materials through existing adolescent programs

Northern Plains, Aberdeen, SD

The Northern Plains Healthy Start project specifically targets adolescent pregnancy. One component of the model is the powerful photo exhibit "Diary of a Teen Mother." Adolescent American Indian mothers who volunteered to tell their stories and educate their peers are featured with their children and their personal statements on the realities of adolescent parenting. The exhibit now travels throughout the Northern Plains Healthy Start tribal communities and has inspired discussions on diverse issues in adolescent pregnancy, positive attitudes toward abstinence, and numerous requests by adolescents for more information and/or for panel discussions featuring adolescent parents.
• Develop a resource guide of providers to increase interagency communication and adolescent referrals

Steps for Implementing an Adolescent Program

Tools for Fiscal and Program Monitoring

For contractors and program staff, the following tools, which may be part of an integrated MIS, are useful:

- Client tracking and data collection MIS that is designed specifically for adolescent clients
- Client contact reports/staff activity reports
- Fiscal monitoring database
- Data procedures and protocols
- Monthly reporting format for all contractors
- Computerized, specialized adolescent medical records
- Adolescent clinical protocols
- Training roster and schedules
- Parental/guardian consent forms

Cleveland, OH

The Cleveland Healthy Family/Healthy Start School Outreach Team emphasizes abstinence and pregnancy prevention. Among pregnant and parenting teens, the program seeks to maintain both the parents' and infant's health and to support teen parents in their efforts to graduate from high school. Adolescents who are identified as either pregnant or parenting are eligible for enrollment (once parental permission is obtained) if they reside or attend school in the project area. A prevention specialist is then assigned to the adolescent, who is automatically considered to be a high-risk participant due to her age. The adolescent receives an intensive level of intervention in school as well as outside the school setting, if needed. For example, co-case management between the prevention specialist and a neighborhood-based outreach worker may take place when a student drops out of school or becomes lost to follow-up.

The School Outreach Team works under the direction of the Health Education Department of the Cleveland Public Schools. Two team coordinators are housed in a satellite administration site, which serves as a home base for 15 School Outreach prevention specialists. Each of these specialists is assigned to two or three secondary schools, spending approximately 1–2 days per week in each of these schools. Various professional development training opportunities have been made available to the School Outreach Team members, both internally (within the school district) and externally to ensure that prevention specialists have the appropriate knowledge and training to work with students.
• Evaluation forms for teachers, parents, and adolescents
• Reimbursement forms for mileage on personal vehicles

**Technical Assistance Needs**

For project and contractor staff members who are implementing the program, technical assistance needs may include:

• Ongoing training in the service protocols and procedures for data collection and submission
• Cultural competence training that focuses on issues specific and unique to adolescents
• Sustainability and marketing training, including grant writing
• Training in identifying behavioral risk factors and early intervention needs of adolescents

Contractors can vary from large, complex organizations (such as hospitals or universities) to small CBOs. Some adolescent program contractors are small CBOs, while others may be state programs or other large, long-standing organizations. Contractor staff may need the technical assistance listed above, plus support for organizational capacity building. Organizational technical assistance may include:

• Assistance with organizational development, including establishing goals and objectives, developing work statements, and preparing invoices for CBOs that had not been government funded
• Assistance with recordkeeping for some CBOs to develop filing systems, client charts, tracking forms for contacts with adolescents and providers, and tickler systems to remind workers to follow up on a referral. Some CBOs may also need training on federal fiscal reporting requirements.
• Guidance in conducting an environmental assessment
• Assistance in reviewing and adhering to statutory guidelines
• Assistance in increasing and sustaining community involvement
• Assistance in developing client recruitment systems to reach

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**Pee Dee, SC**

Pee Dee Healthy Start offers a unique approach to expanding the traditional role of the school nurse. Through this initiative, nurses offer student services such as pregnancy testing, health education, and care coordination and pregnancy prevention counseling for adolescents. Teen Life Centers are Pee Dee Healthy Start's major prevention strategy. Each county has a Teen Life Center designed as a supportive and educational environment for adolescents to learn about themselves and the health and family life issues that can present tough choices. Among the services adolescents can receive are counseling, tutoring, GED preparation, cultural enrichment, and mentoring.
recruitment targets, including help networking with sources of referrals
• Assistance in building partnerships with other organizations (particularly schools) for sustainability
• Assistance with properly training contractor staff, including training needs assessment, curricula development or selection, and training provision
• Help identifying a referral and resource network
• Help designing and implementing evaluations of program performance and collecting and analyzing data
• Help creating long-term strategic plans to sustain services after federal funding ends

Role of the Healthy Start Consortium

• Support an ongoing advisory committee of parents and students
• Monitor community impression of the program and its impact
• Advocate for community needs and perceptions, such as increased adolescent programs or programs for adolescent males
• Support credibility with important stakeholders such as the medical boards of health services partners
• Serve as volunteers or chaperones for program activities
• Provide technical assistance
• Include in consortium meetings staff members who are implementing programs, to hear community input firsthand and revise methods accordingly
• Help select health education materials that are appropriate for the target population
• Participate in public outreach and client recruitment initiatives
• Secure donations of incentive items for adolescent mothers (e.g., baby clothes, diapers)
• Develop resources and funding opportunities

Steps for Sustaining an Adolescent Program

Adolescent programs have the benefit of a high-profile issue to support their sustainability. Although this attention can prove to be a challenge, the heightened awareness among policymakers and funding sources create many opportunities.

Marketing and Resource Development

• Publicize the results of a valid and reliable local evaluation of adolescent services
• Capitalize on public information media campaigns that raise awareness of the program
• Train program staff, consortium members, and contractors in grant writing and resource development
• Increase options for community economic stability by creating youth entrepreneurial training
• Create videos and infomercials on health issues for fee-for-service workshop series in schools, churches, and managed care settings

Funding for Current Services
• Include third-party-reimbursable clinical services in the adolescent program model
• Reorganize services to be self-supporting through Medicaid and other third-party payer reimbursement
• Market adolescent pregnancy services directly to managed care organizations, and develop contracts for providing these services to their members
• Expand programs that have successful sustainability strategies
• Encourage the school system to adopt Healthy Start curricula for classroom use

Collaboration and Coalition Building
• Support contractors in their efforts to sustain adolescent services, and coordinate and oversee resource development efforts of multiple contractors to ensure cooperation rather than competition
• Partner with other federal programs in the local area, such as Empowerment Zones/Enterprise Communities, Community Integrated Service System grants, Early Head Start, state-funded Abstinence Education programs, and Drug Free Schools programs
• Integrate adolescent programs into existing community or state programs
• Create joint ventures with similar CBOs in the same geographic area to reduce program cost
• Partner with state initiatives, such as the state Title V MCH block grant and Title X family planning services, and state educational programs
• Work with the Healthy Start Consortium to build relationships with potential supporters
• Build partnerships with private foundations and other funders with missions similar to Healthy Start's
• Partner with the school system to seek funds from both health and education sources

The Healthy Start Initiative
In the early 1990s, the United States had an average infant mortality rate higher than that of 21 other industrialized countries in the world. The national rates of timely and adequate prenatal care also compared poorly with those of other industrialized countries. Furthermore, even within some U.S. communities, infants died at rates more than twice the national average.

Responding to this national crisis required innovation and change, especially in high-risk underserved communities. In 1991, the Healthy Start Initiative was funded by the federal Maternal and Child Health Bureau as a national program to develop, demonstrate, disseminate, and replicate strategies for reducing infant mortality.

The Healthy Start Initiative is unique in:

- Using a community-driven approach that relies on local leadership and broad-based collaboration to integrate the vast array of services needed to respond to the broad deprivations that adversely impact community health
- Using a holistic strategy that recognizes that infant mortality must be addressed within its broader family, community, social, and economic contexts, especially in communities where this problem is particularly pernicious.
- Emphasizing innovative approaches to developing coordinated, comprehensive, culturally competent models of health and other support services.

During its demonstration phase, the Healthy Start Initiative sought to reduce infant deaths in 22 urban and rural communities with some of the highest infant mortality rates in the nation. In designing community-based approaches, each of the Healthy Start demonstration sites has examined the factors contributing to infant mortality in its own locale and has identified the community's needs and resources. As a result, the Healthy Start communities have developed nine...
models of effective intervention and the unique strategies necessary to implement them. These models are a means of empowering communities to reduce low birthweight and infant mortality and to increase access to prenatal care.

In its replication phase, which began in 1997, the Healthy Start Initiative continues to look to the future. Healthy Start is disseminating the lessons learned and experiences gained during the demonstration phase to 55 additional communities across the nation, with more being added in fiscal year 2000.

The Healthy Start Initiative is supporting cooperative agreements in the 55 new communities to replicate and/or adapt successful Healthy Start models of intervention. Many of the experienced sites are now serving as mentors, helping new sites apply the practical knowledge and specific strategies developed during the demonstration phase. Healthy Start is continuing to support mentoring activities and individual programs already underway from the demonstration phase. Replication of a demonstration project provides the unique opportunity to use and refine the lessons learned by the now-mentoring project sites. Regional Mentoring Conferences and Open Houses have enabled new projects to experience and address design and implementation issues associated with each of the nine intervention strategies. These models of intervention will guide other communities as they seek to adapt programs and strategies to address their unique circumstances.

The lessons learned and the nine model interventions developed and refined during the demonstration phase are applicable not only to the active and planned sites funded by Healthy Start but to other communities throughout the nation. As noted in the Introduction, more than 300 communities in the United States still have an infant mortality rate greater than one-and-a-half times the national rate. The information in this volume can be used by all of these communities—regardless of whether they receive funding from Healthy Start. This publication will help to ensure that the Healthy Start legacy is preserved, not only for communities striving to reduce infant mortality but for any community-based program designed to improve the health of mothers, children, and families.