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ABSTRACT

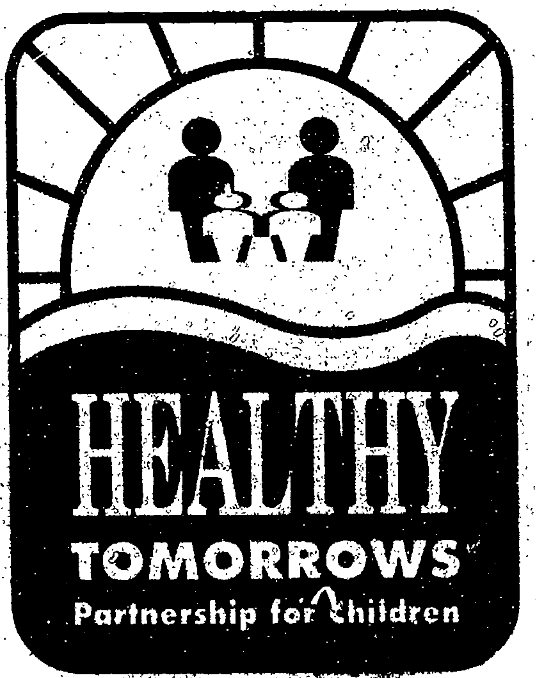
The Healthy Tomorrows Partnership for Children Program (HTPCP) was developed to support special projects demonstrating how states, local agencies, organizations, and communities can work together to improve health of mothers and children. The HTPCP supports a coalition that includes the federal and state governments, professional organizations, foundations, corporate leaders, and families. The HTPCP grant projects described in this document encourage community-based approaches, strengthening the ability of communities to build public-private preventive health strategies. For each of the 54 programs described the problem addressed by the program is given, along with the goals and objectives, methodology, and an evaluation statement. This document details Healthy Tomorrows projects in the following states: (1) Alaska; (2) California; (3) Colorado; (4) Connecticut; (5) District of Columbia; (6) Georgia; (7) Hawaii; (8) Idaho; (9) Illinois; (10) Louisiana; (11) Maryland; (12) Massachusetts; (13) Michigan; (14) Minnesota; (15) Missouri; (16) Nebraska; (17) New Mexico; (18) New York; (19) North Carolina; (20) Ohio; (21) Oregon; (22) Pennsylvania; (23) Rhode Island; (24) South Carolina; (25) Texas; and (26) Wisconsin. (HTH)

Healthy Tomorrows Partnership for Children

A PROGRAM SPONSORED BY THE MATERNAL AND CHILD HEALTH BUREAU
IN COLLABORATION WITH THE AMERICAN ACADEMY OF PEDIATRICS

Abstracts of Active Projects

FY 1995



National Center for Education in Maternal and Child Health
MCHB
Maternal and Child Health Bureau

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PREFACE

This publication provides information regarding the Healthy Tomorrows Partnership for Children Program (HTPCP), an initiative which began in 1989 to stimulate innovative children's health care efforts designed to prevent disease and disability and promote health and access to health services in local communities across the United States. The HTPCP assists children and their families to achieve their developmental potential through a community-based partnership of pediatric resources and community leadership. This partnership promotes efforts to meet the health and developmental needs of pregnant women, infants, children and adolescents, and children with special health needs and their families.

The HTPCP is a collaborative venture between the American Academy of Pediatrics (AAP) and the Maternal and Child Health Bureau (MCHB), and is part of the Maternal and Child Health Improvement Projects (MCHIP) grant program authorized under Title V of the Social Security Act. The initiative utilizes the AAP's network of health professionals, including 59 State chapters and 48,000 child health experts across the United States.

The HTPCP grant program was developed to support special projects which demonstrate how States, local agencies, organizations, and communities can work together to improve the health status of mothers and children. Specifically, the program supports the development of community-based initiatives which: (1) Plan and implement innovative and cost-effective approaches for focusing resources to promote community-defined preventive child health and developmental objectives for vulnerable children and their families (especially those with limited access to quality health services); (2) foster/promote cooperation among community organizations, agencies, individuals, and families; and (3) build community and statewide partnerships between families and professionals in health, education, social services, government, and business in order to achieve self-sustaining programs to assure healthy children and families.

The projects supported by the HTPCP and detailed in this monograph build upon and further encourage community-based approaches which have successfully demonstrated the willingness and the capacity to establish unusual, imaginative, and targeted health initiatives for children and their families. These projects also strengthen the capability of communities to build effective public-private preventive health strategies. The HTPCP brings together local communities to form a unique coalition which includes the Federal and State governments, professional organizations, foundations, corporate leaders, and families. By collaborating and sharing their knowledge and expertise, this coalition for children creates a critical set of resources and a commitment sufficient to establish a framework for mutual problem solving. By combining public and private resources, the coalition achieves a lasting effect upon the health care of America's children by enabling communities to utilize existing resources in the most effective manner possible.

MCHB supports 54 HTPCP projects at a commitment of $17 million over the 10-year period of the initiative. The 54 HTPCP projects described in this document represent a small sample of the more than 800 active projects that MCHB supports in all areas of maternal and child health. It is hoped that the wisdom gained from the projects supported by the HTPCP will be translated for the purpose of enabling the development of prevention programs, compassionate care, and societal reforms that will enhance and protect the health of mothers and children throughout our Nation.

New Beginnings
Southcentral Foundation
670 West Fireweed Lane
Anchorage, AK 99503
(907) 265-4900

MCHIP
MCJ-028030
10/01/94–09/30/99
Project Director(s):
David ThunderEagle
Evelyn Tunley, M.A.

PROBLEM: Alaska Natives and American Indians in the Anchorage area make up less than 10 percent of the total population. Statistics from the State of Alaska Division of Family and Youth Services show that Alaska Natives and American Indians consistently make up 33 to 40 percent of the caseload involved with child abuse and neglect.

Phase I of an Indian Health Service (IHS) study on child abuse and neglect being conducted by the National Indian Justice Center (NIJC) has provided the first national profile of Alaska Native and American Indian child maltreatment. The study notes that child abuse and neglect is a persistent problem in Alaska Native and American Indian communities that is not being adequately addressed. Preliminary results of case statistical analysis found that 70 percent of offenders were parents and that almost 80 percent of all cases occurred in the child's home. This indicates a greater need to focus on child abuse and neglect as a family problem in Alaska Native and American Indian communities. Cases of neglect constituted the greatest proportion of reported cases (48.9 percent). Cases of sexual abuse (28.1 percent) and physical abuse (20.8 percent) constituted most of the remainder of the reports. Substance abuse was a factor in 70 percent of cases in which such data were collected. Victims ranged in age from 0 to 18, with a disproportionate number of victims (39.5 percent) less than 5 years old and a substantial number (9.5 percent) under age 1. Other childhood problems include increasing rates of adolescent pregnancy, high rates of fetal alcohol syndrome, high rates of postneonatal mortality, and school readiness issues. Yet these are problems that can be prevented. NIJC noted in its recent national study that child maltreatment is a persistent family problem that is not being adequately addressed in the Southcentral Foundation service area of Anchorage. The vast majority of offenders are parents, but most current programs do not address family dynamics or the need for offender intervention. Substance abuse is a significant factor in a majority of cases. The mental and social health of Alaska Native families is at serious risk of disintegration. While a variety of victim-oriented intervention programs and agencies exist, such as shelters, foster care, and incarceration of offenders, the scope of the problems can no longer be adequately addressed by intervention alone. The lack of a systematic approach to preventive intervention becomes particularly important in light of studies suggesting that those most in need of services are most likely not to receive them.

GOALS AND OBJECTIVES: The goal of the program is to reduce child abuse and neglect in Alaska Native and American Indian families in the Anchorage area. Year 1 objectives are to:

1. Identify 20 at-risk families;
2. Provide home visits to 20 families to assess needs;
3. Promote positive family functioning within 20 families;
4. Promote healthy child development within 20 families;
5. Link 20 families to a medical home and community services; and
6. By the end of the year, place each of the 20 families within Levels 1 through 4 for continued monitoring until the infant is 5 years old. The objective for the end of the 5-year period is to reach approximately 200 families, resulting in a 50-percent reduction of child abuse and neglect in the Anchorage area.

METHODOLOGY: The prevention of child abuse and neglect will be facilitated by a family service worker who will be responsible for coordinating screening of medical records by Southcentral Foundation fetal alcohol screening case managers at Alaska Native Medical Center and referrals to different agencies while monitoring the services provided. Further support for the program will include the IHS child psychiatrist, the Southcentral Foundation prematernal substance abuse and mental health treatment center, and Head Start staff. Home visit family support services will include crisis intervention, emotional support to parents, informal counseling, role modeling of family relationships, communication skills, life coping skills, and linkages to other services.

EVALUATION: The goals and objectives require a 10-percent reduction of known child abuse and neglect within year 1. During the remaining 4 years of this project, the frequency of home visits to the initially identified families will decrease and other families will be identified to meet the objective of targeting an estimated 200 families for a 50-percent reduction of child abuse and neglect over a 5-year period. A management information system will be used to monitor and assess accomplishment of the goals and objectives.

Advocates for Children Project
Pediatric Diagnostic Center Associates
3400 Loma Vista Avenue
Ventura, CA 93003
(805) 652-6124

MCHIP
MCJ-068913
10/01/92–09/30/97
Project Director(s):
Paul Russell, M.D.

PROBLEM: Prior to the Advocates for Children Project, no early intervention program existed in Ventura County, CA, to identify high-risk families and prevent child abuse and neglect. This had devastating consequences for thousands of children every year. More than 6,000 families representing more than 12,000 at-risk children were reported to Children's Protective Services last year. Approximately 70 percent of children currently receiving services from the Ventura County Mental Health Department—more than 16,000 emotionally or behaviorally disturbed children—have a history of abuse or neglect. Collaboration among public and private agencies in order to identify the at-risk child before maltreatment occurs has been nonexistent. This lack of a formal early intervention program within the county is a health systems problem that has catastrophic effects on the emotional development of thousands of children every year.

GOALS AND OBJECTIVES: The Advocates for Children Project will reduce child abuse and neglect in a targeted population of families. Specific objectives are to:

1. Develop and implement a formal assessment protocol at the Ventura County Medical Center;
2. Develop and implement a community-based home visitation family support program that will begin immediately following the birth of a child;
3. Improve overall family functioning and reduce the incidence of abuse and neglect in the targeted group of families to less than 5 children out of 100 receiving home visitation services;
4. Improve coordination and collaboration between public and private agencies in order to effectively expand prevention resources in Ventura County;
5. Provide a medical home for high-risk families and their children; and
6. Become an active participant in the statewide child abuse prevention program, Healthy Families California.

METHODOLOGY: Women giving birth at the Ventura County Medical Center will be screened and formally assessed for child abuse risk factors using the Kempe Family Stress Checklist. Families that reside in Oxnard and are identified as high risk will be offered voluntary participation in the Advocates for Children Project. Participation will be randomized. Home visitation family support services will be provided by five part-time family support workers (FSWs) recruited from the community. The FSWs will receive formal training from Child Abuse and Neglect, Inc. (CAAN), the participating private nonprofit child abuse organization, in conjunction with the County Department of Public Health Nursing. Training in the Head Start Home-Based Teaching Model will also be provided by our local Head Start agency, Child Development Resources. Case management is provided by field public health nurses who act as a link between the family and the participating primary health care medical homes. Initially, approximately 50 families will receive weekly visits for a minimum of 3 months. Subsequent home visit frequency will be adjusted according to family needs. Families will be tracked for 5 years.

EVALUATION: Three separate groups will be tracked during the 5-year project: 100 at-risk families receiving home visitation, 100 high-risk families referred to Public Health Nursing and not receiving Advocates for Children home visits, and a low-risk group. Overall family functioning and response to stress will be assessed every 6 months in both the home visitation and control groups using the Public Health Nursing Child Assessment Satellite Training (NCAST) and periodic rescoring of the Kempe Family Stress Checklist. Developmental progress will be evaluated using the Denver Developmental Screening Test (Denver II) biannually. Children's Protective Services reports will be tracked. The low-risk group will be tracked to evaluate the validity of the assessment instrument. A Community Advisory Committee has participated in the development of the program and meets monthly to review progress. A family visit coordinator maintains files on each participating family, meets weekly with each FSW, and reviews specific problems with the project director on a monthly basis. The project director also attends CAAN's Board of Directors meeting and the County Child Abuse Council monthly meeting. Updates are given to the County Children's Coordinating Council.

EXPERIENCE TO DATE: A full-time early identification (EID) worker interviews and assesses all new mothers from the target area. The FSWs have been recruited and trained. Thirty-five at-risk families are currently receiving home visitation services. Advocates for Children has joined another early intervention program, Healthy Families Ventura Cooperative, and is now part of Healthy Families California, the State home visitation/child abuse prevention program.

Brighter Tomorrows: International Elementary School Family Center Health Project
Children's Clinic
2801 Atlantic Avenue
Box 1428
Long Beach, CA 90801
(310) 933-0430

MCHIP
MCJ-068904
10/01/92–09/30/97
Project Director(s):
Elisa Nicholas, M.D., M.S.P.H.

PROBLEM: In order to achieve a brighter tomorrow, children must receive a sound education. To obtain this education, children must receive proper food, clothing, and health care. The staff at International Elementary School (IES), a public school serving low-income children from many cultures in downtown Long Beach, noted that children were unable to learn adequately because of untreated illnesses, behavioral problems, and psychological problems. They invited The Children's Clinic (TCC), a nonprofit community clinic, to develop a program for health services at the school site. Collaborative partners—TCC, IES, the local YMCA, Greater Long Beach Child Guidance Center, the local university, and the Long Beach Department of Health and Human Services—planned the project with input from children, parents, teachers, and community leaders. Baseline interviews and surveys revealed that only 21 percent of the children had been adequately immunized by age 2 and that there was inadequate access to primary health care services, acute care services, mental health services, and physical or recreational activities.

GOAL AND OBJECTIVES: The 5-year project has the following goals:

1. Reduce the risk of disease and disability through improved immunization rates and well-child care;
2. Reduce the risk of preventable disease through improved lifestyle behaviors;
3. Reduce the rate of sequelae from delayed diagnosis and treatment of treatable diseases; and
4. Increase the timeliness of medical and mental health care obtained.

This project will be a model for other schools as a collaborative, culturally sensitive, accessible system of improving health care.

METHODOLOGY: The Brighter Tomorrows project provides onsite health services to students and their siblings in two half-day sessions each week. In order to create a seamless health care system, all children are registered as TCC patients and have easy access to all services on the days the school clinic is closed. Bimonthly immunization clinics are held at the school. Screening and treatment of behavioral and developmental problems are also provided onsite. Physical fitness and drowning prevention are taught at the YMCA. An extensive health education program is being developed, focusing on eight health themes selected by parents and students.

EVALUATION: Project staff track the number of clinic sessions; patients seen; Early and Periodic Screening, Diagnostic and Treatment visits; diagnoses; referrals; immunizations; health care educational activities; parent meetings; psychosocial evaluations and treatments; and physical fitness activities.

Project evaluation includes both process tracking and outcome evaluations. Baseline data are obtained by reviewing the immunization records, parent-completed health history forms, and parental surveys. Health education evaluation occurs through pretests and posttests for each theme. Baseline physical fitness and exercise data are collected at the beginning of the YMCA program and at its completion. A matching grant funds formal evaluation. Evaluation of year 1 will be formative in nature, followed by summative evaluation. A control group is being sought.

EXPERIENCE TO DATE: Provision of onsite health care began in February 1993, with an open house attended by over 300 parents and guests, including the school superintendent, the mayor, and city council members. As of June 22, 1994, 887 patients had been seen at the school site during clinic sessions. Seven children required hospitalization and 195 were referred for dental and specialty care. Eight immunization clinics occurred.

New funding this year allowed after-hours phone access to medical staff, parental health care, and family planning. Educational packages for first aid, drug abuse prevention, and safety were developed, with interactive teaching sessions held for parents and facilitated by Latino and Cambodian community workers. Classroom teaching and homework regarding these themes occurred, and students produced videotapes for each theme. Educational materials were distributed to the parents of all 700 students. Yearly health fairs have been held with over 300 parents and children attending.

Mental health services began in March 1993, with weekly consultations with teachers and staff and evaluation and treatment of students heeding help. The physical fitness component, including drug prevention, occurs year round. A total of 256 children have received drowning prevention lessons or physical fitness education. Material produced includes handouts on the Brighter Tomorrows Project, first aid, well-child care, safety, drug abuse prevention, and immunizations. These handouts are produced in English, Spanish, and Khmer.

East County Healthy Tomorrows Partnership for Children Project
East County Community Clinic
855 East Madison Avenue
El Cajon, CA 92020
(619) 440-7615

MCHIP
MCJ-068903
10/01/92–09/30/97
Project Director(s):
Bronwen Anders, M.D.

PROBLEM: The eastern part of San Diego County has a large population of low-income families with limited access to health care. A single community health center, the East County Community Clinic, provides the only pediatric program with a sliding-fee scale for services and is one of the few centers serving Medi-Cal and Child Health and Disability Program patients. Health problems and risk behaviors in the population include higher infant mortality rates for Latinos and no-care babies than occur in the general population in the region; poor compliance with family planning and preventive health protocols; low breastfeeding rates; a high number of drug-exposed infants; a long delay from birth to initial medical visit; a low immunization rate; a high tuberculosis conversion rate; lack of education regarding appropriate use of preventive and primary care services; and inappropriate use of emergency room facilities.

GOALS AND OBJECTIVES: The overall goal of this project is to improve health outcomes for a culturally diverse, indigent, underserved population. In this project period the following health status improvement goals will be stressed:

1. Improve immunization status by immunizing 100 percent of the children who receive group well-child care from the El Cajon clinic.
2. Improve parenting skills of participants by:
   a. Providing childhood safety education to 100 percent of the mothers presenting their children for group well-child care;
   b. Educating 100 percent of the mothers in the group well-child program about the appropriate method of taking their infant's temperature and having 90 percent of the mothers understand what temperature indicates a fever; and
   c. Educating 100 percent of the mothers enrolled in the group well-child program about the appropriate use of the emergency room.
3. Improve breastfeeding rates by promoting breastfeeding among mothers involved in the program so that 90 percent of the mothers breastfeed for an additional 2 to 3 months and 50 percent of the mothers breastfeed for an additional 9 to 12 months.

METHODOLOGY: Groups of four to six mother-infant (birth to 12 months) pairs meet for 75- to 90-minute sessions at standard well-child intervals (1, 2, 4, 6, 9, 12, and 18 months). The groups will be facilitated by a pediatrician and a bicultural health care educator. The infants' vital signs are obtained at each session. Parents take their own infants' temperatures in the presence of a health care provider. Next, with the parents' assistance, infants are weighed on portable scales, and their growth is plotted on charts.

During the first hour, the American Academy of Pediatrics guidelines for health supervision are used to offer anticipatory guidance and lead open discussions on various topics: Normal development; common problems such as fever, colic, bronchiolitis, and otitis media; and the importance of proper medical management using appropriate health care services. The last 30 minutes of the group session are dedicated to physical exams and immunizations. These exams are performed within the group setting so that parents can appreciate the normal variation of growth and development. At the end of each session, age-appropriate incentives are given (for example, cereal at 4 months, electric outlet covers at 6 months, tippy cups at 9 months, etc.).

EVALUATION: Parents involved in the program will be given surveys at the first, fourth, and seventh visits. Questions asked will include information on the educational topics discussed, and the responses will be evaluated to appraise the participants' understanding of the concepts presented. At the final visit parents will be asked to take their children's temperatures. The mothers will be given a list of temperatures and asked which are considered a fever. The number of emergency room visits made by those involved in the program will be tracked and evaluated for appropriateness. Immunization records for the group will be reviewed for completeness of immunizations. A chart review will be completed at 2, 12, and 18 months to log the numbers of mothers who are still breastfeeding.

EXPERIENCE TO DATE: Since the project inception there have been 226 well-child group visits, 128 for the period October 1, 1993, to June 30, 1994. There are 14 groups with three to six parent-child pairs in each group. Five additional groups were started during this period. Some mothers had already decided not to breastfeed by the time of their first visit. To overcome this barrier, the team is intensifying its efforts to meet with each mother in the hospital shortly after delivery. An evaluation of the program, *Group Well-Child Care in a Hispanic Population: A Cultural Study on the Improvement of Health Care Access and Outcome*, was written this year.

Healthy Tomorrows Partnership for Children
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California Chapter 4
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Orange, CA 92668
(714) 558-5861

MCHIP
MCJ-068908
10/01/92–09/30/97
Project Director(s):
Lucinda Hundley, M.A.

PROBLEM: Consider the observations of an American Academy of Pediatrics (AAP) physician examining a group of children. He remarked that he felt as if he were practicing Third World medicine, but he wasn't. He was in Orange County, CA, examining elementary school children in Santa Ana. The 26,000 elementary school children in the Santa Ana Unified School District have been without adequate health care and appropriate resources for followup care. Social service issues are also of great concern. As of 1992, the school district had the highest child abuse referral rate in the county and the second lowest Child Health and Disability Prevention (CHDP) compliance rate in the county (51 percent), with staff continuing to express concerns that parents lack the necessary skills to assume responsibility for their children's physical and emotional well-being. The Santa Ana Unified School District serves a total enrollment of 48,897 students; it is the eighth largest school district in California and the largest in Orange County. It serves the greatest number of minority students of all 32 school districts in Orange County. Of these minority students, 95.1 percent are from ethnically diverse populations, 87 percent are Hispanic (compared with 15 percent statewide), 72 percent are limited English proficient (compared with 22 percent statewide), 40 percent are immigrant, and 71 percent of the elementary students receive free or reduced-price lunches. December 1990 medical examinations of a representative sample of Santa Ana elementary students revealed that 88 percent manifested presenting health problems, some requiring immediate hospitalization. Most students have no health insurance or regular health care. Health care providers reported that health resources are inadequate to meet these needs, made more severe by barriers of language, limited access to facilities, ineligibility for some services, and lack of Medi-Cal coverage.

GOALS AND OBJECTIVES: In order to address the health and social services delivery crisis in Santa Ana, the school district has developed a comprehensive, collaborative effort with its 10 "partners," including Children's Hospital of Orange County, the County Health Care Agency, the local chapter of AAP, and other agencies. Together they have developed goals to target five elementary schools (3,700 students) based on a comprehensive needs assessment, including direction from parents, partner and advisory agencies, and service providers. These goals are to (1) provide preventive, accessible health care for the school district's elementary students; (2) provide school-linked social services; and (3) empower parents as primary caregivers through comprehensive health education. Objectives to meet those goals include:

1. Provision of a mobile medical van staffed with a full-time bilingual pediatrician and bilingual registered nurse (funded through this grant);
2. Provision of appropriate preventive and followup medical care;
3. Provision of a bilingual health insurance counselor/secretary/driver and five full-time school-linked social workers; and
4. Development of a comprehensive parent education program.

METHODOLOGY: Through outstationed staff redirected from the partner agencies, the program provides school-linked health and social services to children whose problems are judged by the school site team to be beyond their expertise. The goal of this effort is to address the needs of approximately 1,000 such children per year. The mobile medical van provides immunizations, well-child physical exams, treatment of minor medical conditions, and appropriate medical referrals for followup care, with emphasis on preventive health care. Dental services are also provided to students. Thirty-six area pediatricians have each committed to two or three pro bono cases per month for followup care, in addition to monthly pro bono dental care by a local comprehensive care provider. Five social workers are assigned to the five targeted schools, providing crisis intervention, small-group and individual counseling, and parent education, referral, and followup as needed. Additional services consist of parent education coordination, utilizing and expanding existing resources for culturally sensitive and language-appropriate parent education programs and leadership/mentor programs. Central to the program design is the concern that these minority families are not accessing needed and critical care; hence the program seeks to make services accessible through a coordinated, school-linked model. This program represents a remarkable commitment of more than $600,000 in redirected, in-kind services.

EVALUATION: Initial program evaluation was conducted in June 1993 and January 1994 using outcomes data collected on an ongoing basis from student and health agency intake and financial records, supplemented by (1) an assessment of quality of care, based on user, provider, and partner interviews; (2) parent focus group interviews and surveys; and (3) an assessment of institutional changes such as school practices, funding streams, and professional health and education linkages, based on interviews with practitioners from both sides of the relationship. Evaluation results indicate a strong approval of the program, providing confirmation that the program is greatly needed, is welcomed by parents, and will produce measurable results in academic achievement and family functioning as well as in general health conditions in children.

EXPERIENCE TO DATE: Between June 1993 and May 1994, the program exceeded its annual goal of serving 1,000 students by providing medical services to 1,116 students referred to the medical van and social services to 842 students receiving direct service interventions from the social workers. A total of 228 students have been referred for followup care because of significant health problems; 877 students received CHDP exams, bringing compliance to 78 percent from 51 percent in 1992; and 744 students received immunizations. Dental treatment services were provided to 240 students, with pro bono followup dental treatment provided to 5 students per month. Of the students seen, 40 to 60 percent have had no history of medical care; significant life-threatening medical conditions have been found in several of these children. More than 1,200 parents participated in 48 culturally appropriate and language-appropriate parent education programs in each of the five schools, with topics such as family roles and communication, modifying child behavior, child abuse laws, accessing Medi-Cal services, home health practices, nutrition, dental care, and preventive hygiene. The January 1994 evaluation revealed that 85 percent of the respondents reported that accessibility to services had improved, with 94 percent of that group attributing this improvement to the Healthy Tomorrows program. Four social work interns have participated 19 hours per week in small-group counseling and self-esteem programs. Eight of the original nine partners are in place (one agency lost funding and is no longer in business) and two additional partner agencies have joined the program, in addition to six area volunteer dentists and a local dental services provider.

San Diego Homeless Adolescent Health Care Project: Medical Outreach for High-Risk Teens and Their Families

Logan Heights Family Health Center
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San Diego, CA 92113
(619) 234-8171

MCHIP
MCJ-068918
10/01/93–09/30/98
Project Director(s):
Joseph Browne, M.D.

PROBLEM: Society in general and the health care system in particular have failed an extremely vulnerable, high-risk, medically underserved, and difficult-to-reach population: Homeless adolescents. An estimated 12,000 adolescents per year have run away from home ("overnight runaways") in San Diego County. Thousands more adolescents and their families are at significant risk for homelessness. Additionally, there are at least 1,115 runaway or "throwaway" homeless youth who have lived on the streets every night for an extended period of time, with little hope of reuniting with their families. Many have been physically or sexually abused, have been abandoned by their caretakers, have come from families of substance abusers, become substance abusers themselves, and engage in behaviors such as "survival sex" that place them at high risk for unplanned pregnancies and sexually transmitted diseases (STDs), including HIV infection. Their living conditions make them highly susceptible to tuberculosis and other communicable diseases. Medical problems go undiagnosed and untreated because of poor access to the health care system. An innovative, community-based approach is needed to bring comprehensive, case-managed primary care to places where homeless, runaway, and near-homeless adolescents gather.

GOALS AND OBJECTIVES: The 5-year project has the following goals:

1. Create a system of comprehensive, case-managed health care for the thousands of throwaway, runaway, and near-homeless adolescents in San Diego, bringing available services to places where adolescents and their families live and congregate;
2. Create a coalition of community agencies and pediatric professionals dedicated to providing services to homeless adolescents;
3. Collect and disseminate project data, including demographics, chronic and acute medical conditions diagnosed, and contagious diseases with significant public health ramifications, such as STDs, HIV, and tuberculosis; and
4. Obtain a detailed risk assessment to monitor clients' knowledge, attitudes, beliefs, and behaviors.

METHODOLOGY: A bilingual (Spanish) health care team—composed of individuals experienced with the special medical and psychosocial problems faced by homeless, runaway, and near-homeless adolescents—provides comprehensive, case-managed health care onsite in places where adolescents live and congregate. The Mobile Health Outreach Team (MHOT) is composed of a pediatrician/project director, a physician assistant, a registered nurse project coordinator/case manager, a medical assistant, and a patient services representative. The team is supported by an evaluation specialist and is closely linked with all health education and promotion programs at the Logan Heights Family Health Center (LHFHC), as well as with outreach and case management staff from the Health Care for the Homeless Project, for which the LHFHC is the lead agency.

EVALUATION: A project advisory committee has been assembled. Working with staff, the committee will evaluate data regularly to assess the impact of the interventions. Their evaluation will be used to modify the program as time goes on. Throughout the course of the project, data will be collected on the number of encounters; diagnoses; and demographics, knowledge, attitudes, beliefs, and behaviors of the patient population. Statistics collected in years 2 through 5 will be compared to baseline data from year 1. Data will be shared with local and State agencies to promote better planning.

EXPERIENCE TO DATE: MHOT provided services at two sites during year 1. The Place is an alternative school run by the San Diego County Office of Education, serving homeless and runaway adolescents in downtown San Diego and linked with shelters, halfway houses, and other facilities serving adolescents. The Place provides one examination room and space for nursing, registration, health education, and triage. Two more examination rooms are being added to allow an increase in clinical services and to improve accessibility. At Bandini Elementary School (in a low-income, inner-city neighborhood), MHOT and the school nurse practitioner provide case-managed care to children whose families are at risk for homelessness.

As of June 15, 1994, 204 individual patients were served by MHOT, and 385 patient visits occurred. MHOT treated 31 cases of STDs and noted a 17-percent rate of tuberculosis skin test conversion, along with other previously undiagnosed and untreated medical conditions. Family planning services were provided, and pregnant clients were referred to LHFHC for comprehensive prenatal care. One case of active tuberculosis was diagnosed, and two adolescents were murdered. Clients are linked with LHFHC, the "Medical Home," and have access to care and the case manager.

Procedures and forms, a master problem list, care plans, and a mini-medical record have been developed. The risk assessment tool has been administered to all adolescents seen by the project staff, with plans to repeat this survey of risk behaviors annually. The data collected thus far confirms that a high percentage of the adolescents engage in behaviors that place them at risk for STDs and unwanted pregnancies. These self-reported data are confirmed by the high rate of pregnancies and STDs encountered thus far. The risk assessment is being revised to make it simpler, more user friendly, culturally relevant and suitable for younger children. Additional offsite clinics at community agencies serving the homeless and near-homeless are being developed for year 2.

Healthy Tomorrows for Denver
Denver Health and Hospitals
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MCHIP
MCJ-088807
10/01/92–09/30/97
Project Director(s):
Jeffrey Brown, M.D., M.P.H.

PROBLEM: In cities across the United States, infants and children with or at risk for developmental delays are falling through the cracks of the existing service delivery system. In Denver, this gap is particularly evident in the pediatric population served by Denver Health and Hospitals (DHH), the heart of the city's public health care system and the primary provider of care to Denver's low-income and culturally diverse neighborhoods. This Federally Qualified Health Center serves approximately 2,000 infants and children with or at risk for developmental delays each year, many of whom are identified at birth. Fully 12.5 percent of the 2,939 infants born to DHH families in 1991 were low birthweight, and only 55.8 percent were classified as normal newborns. Ideally, DHH caregivers would routinely identify and refer these infants and children to Child Find of Denver Public Schools—Denver's single point of entry for families seeking access to early intervention services and supports. However, due to limited DHH caregiver knowledge of P.L. 102-119 (IDEA) and minimal Denver health and education system collaboration, only about 100 infants and children are identified and referred from DHH to Child Find each year. In addition, families that are referred from DHH to Child Find often fail to complete the evaluation process and to access services. Out of 77 children ages 0–5 identified by DHH and referred to Child Find in 1992, only 57 percent completed the Child Find evaluation process. This is largely the result of various motivational, financial, and cultural barriers to care, combined with fragmented service systems, lack of tracking and monitoring systems, and lack of service coordination and outreach. These conditions limit family access to services and supports guaranteed under P.L. 102-119.

GOALS AND OBJECTIVES: The goal of the Healthy Tomorrows for Denver (HTD) project is to increase access of children ages 0–5 with or at risk for developmental delays and their families to Denver early intervention services and supports guaranteed under P.L. 102-119. Specific goals are to:

1. Increase DHH outreach and child identification;
2. Ease and expedite the Child Find process;
3. Promote family use of early intervention services; and
4. Develop a tracking and monitoring system.

Five measurable objectives are proposed to achieve these broad goals.

METHODOLOGY: Two methods are employed by the project, including the institutionalization of DHH referrals to Child Find and service coordination for families referred. All DHH children ages 0–5 identified as having or at risk for developmental delays are referred to HTD for service coordination and referral to Child Find and services. A referral followup system from HTD/Child Find back to the DHH referral source has been established to promote caregiver involvement in the individualized family service plan (IFSP)/individualized education plan (IEP) and to encourage ongoing referrals. HTD service coordination uses professional and paraprofessional home visitors to assist families in identifying individual strengths and needs, providing support and parent mentoring, identifying evaluation and service options, collaborating with service providers, and coordinating care. Families are followed through the process of child identification, multidisciplinary assessment, IFSP/IEP development, service identification and implementation, and review and evaluation of plans. The average service coordinator caseload is 50 families. The targeted length of time for service coordination is 3 months for families fully involved with the IFSP/IEP, after which they are transitioned back to the DHH caregiver and/or community provider. An estimated total of 850 families will receive service coordination services throughout the life of the project.

EVALUATION: During the fourth quarter of years 2, 3, and 4 of the project, HTD will gather and analyze formative feedback from families, DHH staff, and community providers using focus groups and family and provider satisfaction surveys. The HTD data base will be analyzed and all data evaluated in collaboration with an evaluation consultant and used to refine the project as indicated. The internal management mechanisms used by HTD are the HTD data base and regularly scheduled meetings. The data base collects demographic, diagnostic, treatment, referral process, and system access data on all referred families, assisting Denver's health and education systems in tracking and monitoring family access to and use of services. Regularly scheduled meetings include monthly meetings of the HTD Executive Committee and quarterly meetings of the Advisory Board.

EXPERIENCE TO DATE: Project activities have been very successful to date. In 1 year, an unexpected 285 families were referred to HTD, with 93 percent completing the Child Find process and accessing services. Health and education system collaboration has greatly improved following a recent HTD grant award from the Colorado Department of Education. Also, the HTD data base has been chosen as a pilot for State of Colorado use.

Healthy Tomorrows for New Haven
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MCHIP
MCJ-098112
10/01/90–09/30/95
Project Director(s):
William P. Quinn, M.P.H.

PROBLEM: To meet the needs of adolescents and young children in the most disadvantaged areas of New Haven, health services must be both accessible and comprehensive. Because of social and environmental factors such as geographical or psychological isolation, family disorganization, and substance abuse, the needs of these groups have outstripped the capacity of the existing service delivery system to provide appropriate care—that is, genuinely accessible and comprehensive care. Each of the two institutional frameworks capable of providing preventive health services to children from low-income families (namely, the primary care facilities and school health services) offers a piece of the puzzle. The school nurse is accessible; the primary health centers are comprehensive. Yet the two systems operate on parallel tracks, with considerable costs in efficiency and effectiveness.

GOALS AND OBJECTIVES: Healthy Tomorrows for New Haven has focused on enhancing the long-term capacity of school health services to serve as access points and sources of continuity for appropriate health and mental health care for children; facilitating a coordinated approach by the Departments of Health and Education to meet the health, mental health, and health education needs of school children; developing a partnership between school health personnel and a health care provider in a model school-linked clinic program designed to provide access to comprehensive, preventive health and mental health services located near a primary care facility and to reduce barriers of understanding between the two institutions; and developing a partnership between school health personnel and a health care provider in a model program of expanded school health services designed to provide access to comprehensive, preventive health and mental health care for preschoolers and elementary school children in an isolated, underserved area of the city.

METHODOLOGY: The model, an expansion and strengthening of school health services with linkage to primary care facilities, has been adapted to the specific needs and opportunities of particular school communities. Both the school-based and the school-linked models ensure access to comprehensive, skilled, and personalized health and mental health care. For parents of young children, the availability of services at a familiar neighborhood site convenient for child and parent alike and from a consistent skilled practitioner is likely to make the difference between adequate and inadequate care. For adolescents, locating services in the institution where they are required to spend the bulk of their time is the most effective way to ensure access.

EVALUATION: Documentation of population served, services provided, and tracking of referrals and followups provides an evaluation of the school-based clinic and the school-linked clinic project outcomes.

EXPERIENCE TO DATE: During the fourth year of operation, permission slips were obtained or on file for 350 of the 379 students enrolled at K. Brennan School. The school-based clinic provided services to a total of 262 children. The pediatric nurse-practitioner, in collaboration with a pediatric consultant and a social work consultant, provided consistent health and mental health care to Head Start enrollees, students in kindergarten through sixth grade, and incoming Head Start students in fall 1993.

A Maternal and Newborn Outreach Services worker, trained to work with medically underserved women, assisted in identifying and advocating for women in need of prenatal care.

Testing for anemia and lead levels was performed in conjunction with kindergarten and well-child care physical exams. In addition, a social worker was available for counseling, support groups, and direct social services.

Contacts with parents stabilized at 300. Health-related early dismissals decreased overall by 10 percent, but chronic absenteeism continued to fluctuate between 17 and 45 students daily. The pediatric nurse-practitioner and the social worker are continuing their efforts to identify children who are absent frequently to determine if absences are health related.

Following the success of the health fairs held in 1992 and 1993, another health fair is planned to publicize the variety of free services available at the school-based clinic.

The school-linked clinic at Troup Middle School continues to refer adolescents to the Hospital of St. Raphael (HSR) Adolescent Clinic. The Troup-HSR partnership provided more than 3,000 encounters that did not exclude the child from school for the remainder of the day. This substantial improvement over prior years represents a major, positive outcome for this partnership.

Prenatal-to-Pediatric Transition Project
Fair Haven Community Health Clinic, Inc.
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MCHIP
MCJ-098125
10/01/93–09/30/98
Project Director(s):
Laurel Shader, M.D.

PROBLEM: The Fair Haven Community Health Center (FHCHC) is the sole source of health care in a neighborhood of New Haven, CT, that is isolated from the rest of the city. FHCHC provides primary care to 10,000 patients in 40,000 visits a year. FHCHC's prenatal and pediatric population is 83 percent minority, with 95 percent having incomes below the poverty level. Twenty-five percent of the prenatal women are adolescents and 4 percent are less than 16 years of age.

The City of New Haven has distressingly high rates of infant mortality and low birthweight, a low rate of immunization levels for children at 2 years of age, and increasing rates of substance abuse and HIV infection among pregnant women. Access to culturally sensitive medical, dental, and social service providers is fragmented.

GOALS AND OBJECTIVES: The goals of the Healthy Tomorrows Prenatal-to-Pediatric Transition Project are to increase coordination among health care resources and to provide enhanced health education, highlighting normal infant development, proper nutrition, and preventive pediatric care. The project will achieve these goals by meeting the following objectives:

1. Integrating a prenatal to pediatric transition model similar to those used in the private sector;
2. Providing enhanced prenatal and pediatric education;
3. Ensuring compliance with American Academy of Pediatrics guidelines for well-child care and immunizations;
4. Assisting parents with early detection of developmental abnormalities;
5. Reducing inappropriate emergency room visits by 15 percent per year for infants; and
6. Facilitating coordination between specialty and primary care providers.

METHODOLOGY: Several approaches were chosen to recruit families for FHCHC's enhanced programs:

1. A transition visit for women pregnant for the first time to meet with a midwife and pediatric clinician at 34 weeks' gestation to discuss relevant medical and social issues;
2. Childbirth education classes;
3. HIV counseling and testing;
4. A meeting with a nutritionist from the Special Supplemental Food Program for Women, Infants and Children (WIC);
5. Hospital care for all newborns delivered by FHCHC midwives;
6. Improved case management services;
7. Improved compliance with well-baby care and immunizations;
8. An effort to decrease inappropriate use of the emergency room through education; and
9. Parenting classes scheduled to begin in the fall.

EVALUATION: The following key activities of the project have been tracked for up to 9 months:

1. Compliance with and content of the transition visit;
2. Newborn admissions at the Hospital of St. Raphael;
3. Compliance with standards for well-baby visits and immunizations;
4. Contacts with social services; and
5. Use of the emergency rooms at both local hospitals.

Baseline data will be compared against data for the project cohort as the babies reach their first and second birthdays.

Project data should show that reducing perceived and actual barriers to access, providing Center-based case management, and improving overall continuity of care improves compliance with standards of pediatric care for infants. Project staff continue to focus efforts on developing baseline data, identifying cultural and language barriers that affect patients' ability to receive or follow through with care, and examining the health systems at FHCHC and linkages (or lack thereof) with providers that affect the staff's ability to coordinate care.

EXPERIENCE TO DATE: The experience of the first 9 months of the project shows success in meeting the objectives in most areas.

1. Staffing of the project has been successful. The project director continues in her role, and a data manager/policy consultant, a bilingual pediatric outreach worker, and a bilingual pediatric social worker have been hired. The capacity to provide case management translation, outreach, and social services to the Center's pediatric population has improved substantially with the hiring of these personnel.
2. Women enrolled in the enhanced prenatal education program have benefited from childbirth education classes, nutrition counseling, HIV testing and counseling, and the transition visit.
3. FHCHC pediatric clinicians are the physicians-of-record for all newborns delivered by FHCHC midwives.
4. Baseline data are being gathered, documenting both appropriate and inappropriate use of emergency room services.
5. Emergency supplies (such as portacribs, car seats, and diapers) have been received with tremendous enthusiasm and gratitude.

Accessing A Primary Health Care Home Through Case Management
District of Columbia Department of Human Services
Commission of Public Health
District of Columbia Linkage and Tracking System
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MCHIP
MCJ-118339
10/01/94–09/30/99
Project Director(s):
E. Elaine Vowels, Ph.D.

PROBLEM: In the District of Columbia, many low-income parents of at-risk and disabled children are not receiving coordinated, comprehensive health care. These children lack a "primary health care home" that provides continuity of care. Many lack financial access to health services; only about 40 percent of children receive appropriately scheduled immunizations, and it is estimated that a similar number are not tested for blood lead levels. Many children do not receive adequate primary care on a regular basis. Health education on preventable conditions and on acute and chronic illnesses is insufficient. Too many have too little knowledge of how to navigate the health and social services delivery system. The specific problems are (1) the systematic problem of access barriers to health care relative to medicaid enrollment and maintenance; (2) the health status problem of the underutilization of primary obstetrics and pediatric health care (physical network); (3) the health status problem of low immunization rates for preventable childhood diseases; and (4) the health status problem of inadequate lead poisoning screening of the District's children.

GOALS AND OBJECTIVES: The major goal of the project is to promote the concept of the primary health care home, wherein every child has one provider who ensures continuity of health care services. This can be accomplished through a collaboration with hospitals, private practices, and individual empowerment relative to primary health care and community-based services. These community outreach goals include in-depth and culturally sensitive health education activities and appropriate assistance in enabling parents to access the medical and social service systems. Specific measurable objectives to be met by October 1999 include:

1. An increase in continuous medicaid coverage for 90 percent of project participants for the duration of the project;
2. An increase in the proportion of children and families who receive recommended primary care services at appropriate intervals to at least 90 percent, in accordance with *Healthy People 2000* goals;
3. An increase of immunization rates for children less than 2 years old to 90 percent, in accordance with *Healthy People 2000* goals; and
4. An increase in lead screening rates to 90 percent for children who are at environmental risk.

METHODOLOGY: The at-risk population will be divided into experimental and control groups comprising 100 children each. Appropriate statistical randomization selection methods will be used to avoid self-selection that may adversely affect the outcome of the study. The experimental group will receive proactive, comprehensive care by identifying, tracking, and providing case management services (family-centered, community-based primary health care case management model) within the primary health care home concept, whereas the control group will continue to receive care currently available. This study is designed as a quasi-prospective random sample control intervention trial. It will be nearer to a factorial trial or survey, where two or more treatments are used singly and in unison so that possible interactions and their effects can be measured. Community members will be involved in the planning process for determining the methods and implementation of this project. The experimental group of children will receive recommended immunizations and an annual blood lead level screening with intensive followup in addition to the regular medical and health care service. The experimental group will be compared with the control group, which will continue to receive current services. The hypothesis is that children and families in the experimental group receiving more intensive care within the primary health care home model will maintain continuity of care as measured by appropriate health indicators such as immunization uptake, annual lead screening, annual number of primary care visits, successful breastfeeding practices, and progress of growth and development. This will improve the accessibility of primary care physicians network and medicaid services in accordance with *Healthy People 2000* goals.

EVALUATION: A comprehensive evaluation of the project will be undertaken using process outcome and impact methodologies. Summative data will be used to assess the overall impact of the project on the targeted populations, on utilization of services, and on case management practices in order to determine the relationship between project objectives and actual outcomes. Participating families will formally evaluate the project's reliability, relevance, and effectiveness through the use of self-sufficiency and parenting empowerment surveys before and after entry into the project. The evaluation plan will track six elements: (1) Eligibility and referral progress, (2) effectiveness of case management intervention, (3) followup data, (4) management of project activities, (5) quality control, and (6) project objectives. Reports will be produced with specific recommendations to aid planners and policymakers in developing programs that will ultimately translate into improved health status for mothers and children in Ward Six and the District of Columbia.

Making Dreams Possible for Hispanic Teens
Mary's Center for Maternal and Child Care, Inc.
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MCHIP
MCJ-118337
10/01/94–09/30/99
Project Director(s):
Elida Vargas, M.S.

PROBLEM: Adolescent pregnancy and sexually transmitted diseases (STDs) are growing at an alarming rate in the District of Columbia's burgeoning, newly immigrated Hispanic community, reflecting national trends. Between 1986 and 1991, while the adolescent birth rate increased 19 percent among whites and 13 percent among blacks, it rose a dramatic 34 percent among Hispanic adolescents. In general, too-early childbearing exposes an adolescent and her baby to poor pregnancy outcomes such as low birthweight, diminished educational opportunities, and poverty. This is especially true in the District of Columbia, where Hispanic adolescents and their infants lack basic access to prenatal, pediatric, and primary health care services; face a multitude of psychosocial and economic stressors; and experience difficulties in school (a 45-percent high school dropout rate among Hispanics). Once Hispanic adolescents drop out of school, they tend to become isolated from the health and social service system, which places their children at increased risk for vaccine-preventable diseases, developmental delays, child abuse and neglect, and other adverse health outcomes.

GOALS AND OBJECTIVES: The goals of this project are to:

1. Develop a system that links Hispanic adolescents in the community to essential bilingual, community-based services that prevent pregnancies, STDs, and other adverse health outcomes for adolescents; and
2. Provide bilingual, comprehensive, supportive services to 200 hard-to-reach Hispanic pregnant adolescents and their infants enrolled at Mary's Center, with a focus on the prevention of repeated pregnancies and adverse child health outcomes.

Year 1 project objectives are to:

1. Increase from 50 percent to 90 percent the percentage of Hispanic adolescents seeking primary health care services who agree to be screened for STDs during their physical exam;
2. Prevent pregnancies among 85 percent of 180 Hispanic adolescents seeking primary health care services (no baseline, since primary health care services for adolescents started only in November 1993);
3. Reduce the low birthweight rate to no more than 3 percent among the infants born to 40 Hispanic adolescents (baseline: 7 percent over 4 years);
4. Increase from 60 percent to 90 percent the percentage of the 40 Hispanic adolescents and their partners who receive HIV testing and counseling by the second trimester of pregnancy;
5. Increase from 70 percent to 95 percent the percentage of infants born to the 40 Hispanic adolescents who receive timely immunizations;
6. Increase from 60 percent to 90 percent the percentage of infants born to the 40 Hispanic adolescents who are screened for developmental delays and referred to appropriate services; and
7. Reduce the rate of unintended repeated pregnancies to no more than 8 percent among the 40 Hispanic adolescents (baseline: 14 percent over 4 years).

METHODOLOGY: Mary's Center will collaborate with The Latin American Youth Center to provide bilingual, culturally competent, community-based, family-centered, comprehensive services to Hispanic adolescents (ages 13–21) and their young children (ages 0–13) residing in the District of Columbia. A project director and a case manager will assess the needs and knowledge of adolescents, provide them with basic education on STDs and family planning, and enroll them in the Saturday Teen Clinic (STC) for primary health care. The case manager will provide continuous and individualized case management to pregnant adolescents and their infants to increase compliance with services and to facilitate access to educational, vocational training, and other programs that will help them to avoid repeated pregnancies and adverse child health outcomes. In addition to Mary's Center's routine one-stop shopping services, pregnant adolescents and their infants will receive (1) nutrition education; (2) a six-part "Strengthening the Family" series; (3) home visits; (4) developmental screenings and referrals; and (5) parenting training on child development, stimulation, and abuse and neglect. These services will be provided by a health educator, four home visitors, and a child development specialist. Partners and parents will be encouraged to participate in all interventions.

An outreach worker will conduct outreach/education in the community to facilitate access to the STC and Mary's Center's one-stop shopping services. Project staff will also participate in media advocacy and community networking to increase public awareness about health issues and to expand services for Hispanic adolescents and their families.

EVALUATION: Data will be collected from the adolescents, their partners, and their parents at four focal points: At entry, at 6 months, at time of delivery, and at 12 months into the program. These data will provide information about participants' satisfaction with services provided and about increases in access to services, knowledge, and skills. Printouts from a central computer and a review of medical charts will compare outcomes with baseline data. Project monitoring will include weekly meetings and monthly case conferences. Data collection and organization will be conducted by staff, and analysis will be done by the Catholic University School of Social Work.

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MCHIP
MCJ-138420
10/01/93–09/30/98
Project Director(s):
Frances Crutcher, R.N., M.P.H.

PROBLEM: Within Cobb County there is limited access to comprehensive primary care for children and youth (0–21 years) with medicaid or who are uninsured. As of January 1994, more than 9,000 children and youth in Cobb County were medicaid eligible, and access to primary care services for them was limited to hospital emergency departments or hours pediatric clinics. A total of 44 pediatricians and 38 family physicians were informally surveyed. From this survey it was found that only 12 physicians accepted medicaid and only 2 took new medicaid patients. Primary care clinics in other parts of metropolitan Atlanta were used for primary care, but lack of transportation makes access to them difficult. Some families were using the Cobb County Human Services Coalition Clinic, a volunteer clinic established to serve some of the health needs of the homeless, for their primary care. Well-child services offered by the Cobb County Board of Health had waits of more than 2 months for appointments. Hospitals and private physicians took emergency referrals, on a rotation basis, for a specific followup visit or a specific hospitalization. After providing initial followup care, the physicians had the option of continuing to provide comprehensive or episodic care or discontinuing care and allowing the child to reenter the "lottery" system of care. Children with chronic illnesses such as asthma and heart disease had no medical home. Because many children seen in the clinics could not afford prescribed medications, definitive therapy was delayed or never followed through on. No agency or provider served as the "gatekeeper" or primary care home. In January 1993, the Cobb Health Futures Alliance (the Alliance) began enrolling children.

GOALS AND OBJECTIVES: The goal of this project is to expand and extend access to the Cobb Health Futures Alliance comprehensive primary care services. To accomplish this goal an additional pediatrician is needed. This addition will allow expansion of clinic hours and 24-hour coverage for the target population. These activities will help the Alliance build capacity in order to provide high-quality single-site primary care.

The objectives are as follows:

1. By October 1994, hire a pediatrician. The pediatrician will be able to provide for more children, extend hours, and increase the ability to enroll children in the Alliance.
2. By December 1994, establish extended afterhours services, which will provide additional coverage for customers.
3. By January 1995, develop and complete protocols to follow for hospital admissions. This would provide nurse-practitioners with procedures to follow when acting in the role of physician extender. A precertification process for hospital admissions will also be developed.
4. By July 1994, complete structure for integration of services through the Alliance (e.g., dental, outreach, mental health).
5. By December 1994, establish baseline measurements of health status indicators for Alliance children, using *Healthy People 2000* as the model.
6. By September 1994, enroll 60 percent of the eligible newborn medicaid population prenatally.
7. By October 1994, conduct three focus groups of parents to discuss customer satisfaction and develop ways to improve services.
8. By October 1998, secure funding for expansion to a permanent site that provides comprehensive primary care for children.

METHODOLOGY: Each Alliance partner brings to the table a specific part of the system and works to coordinate its services with the other partners. Each partner plays a specific role. Parents enroll their children and ensure that they receive important preventive and health maintenance care. The hospital partners provide the majority of the acute episodic care for sick and injured children. The Cobb County Board of Health provides well-child checkups, immunizations, and health education classes for parents. Private sector pediatricians provide a single-site medical home for children with chronic illnesses. Marketing and referrals from partners and school systems inform families of the Alliance.

EVALUATION: The work plan that has been established lists each program objective, strategies for completing the objective, date to complete each strategy, and the staff members responsible for each strategy. Objectives will be added to the work plan as needed. Core staff meet monthly to report progress. All medical records on Alliance children are computerized. Periodic data analysis is conducted on records to monitor progress on process and outcome indicators. Changes in health status indicators will be assessed from these data. Reports on analysis are provided to core staff at monthly meetings. Parents of the Alliance children are partners in the evaluation process. Parents participate in focus groups and are surveyed for customer satisfaction. Changes in hospitalization and emergency room visits will be assessed. The program evaluation includes a model that will be used to assess changes in school absenteeism and performance.

EXPERIENCE TO DATE: The principal stumbling block of the project has been the inability to obtain a second pediatrician. A second pediatrician will be coming on board in October 1994. Even with this delay, 2,582 children have been enrolled in the Alliance since January 1993. The goal was a minimum of 3,000 children within 2 years. Children with chronic conditions are being referred to private physicians, hospital partners, and Children's Medical Services. Collaboration is the key component of the project.

Grady First Steps to Healthy Families
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MCHIP
MCJ-138412
10/01/92–09/30/97
Project Director(s):
Kay H. Jones, L.M.S.W.

PROBLEM: In 1990, Grady Memorial Hospital in Atlanta, GA. referred 1,435 cases of suspected or potential child abuse or neglect to Child Protective Services. These numbers are, in large part, due to the prevalence of risk factors associated with child maltreatment among inner-city families. Child abuse and neglect are most likely to occur when family and social stressors outweigh supports. Published studies indicate that in order to decrease these devastating rates of child abuse and neglect, families demonstrating high-risk factors for these problems must receive an intensive, home-based intervention that begins at birth and continues throughout the child's early development. Grady Memorial Hospital provides services in an urban population, with many of its patients exhibiting one or more of these risk factors. More than 60 percent of families served by Grady have incomes below the poverty level. Between June 1993 and May 1994, 933 infants were born to first-time mothers under age 21 at Grady Memorial Hospital; in approximately 98 percent of these cases, the mother was the only parent. Although these at-risk pregnant women often receive comprehensive prenatal services from the Grady Health System, they very often leave the hospital following delivery with few, if any, services that address the risk factors for child abuse and neglect.

GOALS AND OBJECTIVES: The goals of Grady First Steps to Healthy Families are to:

1. Reduce the risk of child abuse and neglect in overburdened families with first-time parents under age 21 who receive prenatal care and/or deliver at Grady Memorial Hospital and reside in Atlanta;
2. Preserve the family unit;
3. Effect change in a multiracial/multiethnic, multicultural environment by promoting culturally aware, sensitive, and competent services and educational materials within the program; and
4. Provide a voluntary, community-based, comprehensive, universal, systematic program in collaboration with public-private agencies.

Seven specific and measurable objectives are to be achieved by 1997.

METHODOLOGY: Grady First Steps to Healthy Families addresses both primary and secondary child abuse and neglect prevention. Both involve community collaborations between Grady Memorial Hospital, neighborhood clinics, public health departments, social service agencies, and neighborhood/community groups. First-time mothers under age 21 who deliver at Grady Memorial Hospital will be identified and/or screened and assessed at the time of delivery by an early identification specialist to determine the intensity of risk factors associated with child abuse and neglect. New families at low risk are eligible for primary services and may receive telephone contact and/or limited home visitation for a minimum of 3 months. Families assessed to be at high risk for child abuse and neglect are eligible for secondary services, which provide intensive family support services in the home for 3 to 5 years. Primary services use volunteers and student interns, while the secondary component employs paid professional and student interns in the positions of family support workers. The program uses culturally competent personnel to offer family support services to new families.

EVALUATION: The program will be evaluated on both a micro and macro level. Statistics will be compiled monthly, quarterly, and annually to record the number of clients served by race, age, marital status, income level, and geographic location. Annual comparisons will be made between Child Protective Services referrals of families enrolled in the program and referrals of nonenrolled families. Client and volunteer satisfaction will be measured on a biannual basis using a satisfaction survey. The program will participate in the formal statewide evaluation of Healthy Families Georgia sites to be conducted by an independent research firm. The formal evaluation begins July 1, 1994. Participating families will be evaluated during the child's first year of life using six measures of change focusing on child abuse potential, maternal social support, parental stress, child development, home environment, and parental expectations of child development. An attempt to publish this information will be made at the time of evaluation completion. All program activities are monitored with the assistance of the Paradox Database system, which produces a monthly statistical report. All identification, screening, and assessment documents are monitored randomly on a monthly basis by the program director. Volunteers and family support workers use forms to record client contacts; these forms are reviewed by volunteer supervisors and the program director during monthly supervision sessions.

EXPERIENCE TO DATE: From June 1993 to May 1994, Grady First Steps to Healthy Families identified 933 first-time mothers under age 21, screened 633 of these new families, and assessed 345 of these families (using the Family Stress Checklist). During this period the program provided 341 families with family support services; 315 families received primary services, and 26 families received secondary services. The program served 54 percent of the families in its identified target population/geographic area during this period. Through the use of Spanish-speaking volunteers and student interns, the program has expanded its ability to serve Hispanic clients. The program has completed the first phase of the Grady Medical Passport pilot project and has distributed 60 passports to new parents to help them track immunizations and child development information. Staff members have been trained during this period in the Nursing Child Assessment Satellite Training Feeding and Teaching Scales as well as Effective Black Parenting. Problems encountered to date have included the inability to serve our projected 60 percent of families in the target population/geographic area. This is due in part to a delay in the beginning of the statewide Healthy Families Georgia evaluation and our need to reserve spaces for families to be placed in the evaluation groups.

Improving Health Care Access for Hispanic Families

Mercy Mobile Health Care
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MCHIP
MCJ-138425
10/01/91–09/30/96
Project Director(s):
Noemi A. Carcar, M.D.

PROBLEM: Hispanic families living in metropolitan Atlanta lack access to a coordinated, culturally competent system of prenatal and pediatric care. The Hispanic population of Atlanta has grown dramatically in the past decade and now numbers more than 57,000. The number of Hispanic families in the three target counties—Fulton, DeKalb, and Cobb—has increased 77 percent, 109 percent, and 231 percent, respectively, in the past 10 years. The rapid demographic changes have placed burdens on the health care system and on service providers, who are often unprepared to handle the health care needs of these new residents. Hispanic families need assistance to bridge the barriers of language, information, economic, and cultural differences that may limit their access to health care.

The Asian population has also risen dramatically in the past 10 years—more than 300 percent. The Asian population, like the Hispanic population, is also faced with barriers to accessing health care services.

GOALS AND OBJECTIVES: Working in collaboration with local, county, and State health providers, Mercy Mobile Health Care will implement a comprehensive program that will:

1. Identify at least 50 Hispanic or Asian children with special health needs who require assessment, treatment, and followup services;
2. Improve the awareness and usage of coordinated health care services by at least 50 Hispanic, Asian, or African-American families with children with special needs;
3. Assist 50 pregnant Hispanic women in receiving a comprehensive range of assistance, including access to early prenatal care;
4. Develop a project evaluation plan that will provide needed baseline data; and
5. Improve the cultural awareness and sensitivity of health care providers regarding health issues affecting Hispanic and Asian families.

METHODOLOGY: The primary approach to identifying children with special health needs will be the use of mobile community-based children's screening and family primary care clinics. Children identified as having chronic medical care needs will be provided comprehensive referral assistance and support, including home visiting, transportation, and interpretation for appointments. A network of bilingual community health promoters (both Hispanic and Asian) will assist these families in accessing all needed health and social services. Health promoters will also assist pregnant women in enrolling in appropriate prenatal care and will carefully monitor women identified as being at high risk. Education that promotes healthful behaviors within the family will be provided through formal classes and regularly scheduled home visits.

EVALUATION: Careful records will be maintained on the number of clinics held and the number of patients seen. Individual patient intake forms will be used to monitor demographic information, special health needs, referrals made, and referral outcomes. Health promoters will maintain detailed activity logs on home visits made, type of referral assistance provided, and mileage. Information from the individual patient forms and the record of clinic activity will be tabulated monthly to determine (1) number of children screened; (2) number of children identified with special needs; and (3) number and source of referrals.

The evaluation plan will measure success in meeting specific process objectives that indicate the number of women and children who are provided health-related services and education. A plan to develop baseline data based on the result of activities since the start of the project will be implemented this year.

EXPERIENCE TO DATE: Since the project began in October 1991, the program has been successful in reaching and, in some cases, exceeding the project objectives. Mobile clinics are being conducted at two community sites. A total of more than 1,266 children have been seen, and more than 175 have been identified to date as having special health needs. There are now six health promoters providing outreach and linkage for Hispanic families in the three counties. Through matching funds from the Woodruff Foundation, one Asian health promoter is now assisting Asian families. A total of 455 pregnant women have been assisted in receiving prenatal care; at least 78 percent enrolled during their first trimester. At least 23 cultural sensitivity workshops have been conducted for area health providers.

Enhanced Community Health Options
Hawaii Department of Health
Maternal and Child Health Branch
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MCHIP
MCJ-158938
10/01/94–09/30/99
Project Director(s):
Loretta J. Fuddy, A.C.S.W., M.P.H.

PROBLEM: The health of children and their families is at risk in the community of Ko'olauloa on the island of Oahu, HI. Residents in this community are faced with many of the factors that are associated with poor health outcomes, including poverty, ethnic minority, undereducation, and barriers to access to health care services in the community. Barriers to health care for residents of Ko'olauloa include lack of health care providers, fragmentation and lack of coordination of services for children, language and cultural barriers, and reluctance of many Ko'olauloa residents to seek assistance from anyone other than family or community. The Ko'olauloa Coordinating Interagency Team, composed of six community-based health service agencies, identified the following problems in the existing health care system: (1) Limited child health resources and lack of coordinated care; (2) low level of paternal involvement in the care of children and the resultant overburdening of mothers; and (3) lack of developmental/psychological assessments available in the community.

GOALS AND OBJECTIVES: The Ko'olauloa Healthy Tomorrows project seeks to address the system problems that currently exist and to improve access to child health services for families residing in the area. This goal will be realized through increased and coordinated outreach services, promotion of an integrated system of comprehensive health care, improved continuity of care through home visiting, increased paternal participation in accessing health care, and provision of developmental/psychological assessments of at-risk children. The project will work with the existing health care system and the community to provide a community-based, family-centered, comprehensive, and culturally relevant system of care.

METHODOLOGY: The project will increase and improve outreach services to families by coordinating with existing outreach programs. Project staff will work with families by providing case management, home visits, and linkages to medicaid and health services in a culturally relevant manner. A male social worker will work with the Enhanced Community Health Options (ECHO) Team. This social worker will help fathers to increase their participation in caring for the health of their families by providing culturally relevant health promotion and education, outreach, home visits, and positive role modeling. Children identified as at risk for developmental delay will be offered developmental/psychological assessments through contract services of a psychologist. To ensure continuity of health care, home visiting and care coordination services will be provided to at-risk families that are not accessing the health care system or are not maintaining followup care. The Maternal and Child Health Branch will provide the services of the ECHO Team—which consists of a program coordinator, medical social worker, public health nutritionist, nutrition aide, and clerical support staff—in collaboration with Public Health Nursing, Medicaid, Special Supplemental Food Program for Women, Infants and Children (WIC), Kahuku Hospital, and private physicians.

EVALUATION: The Ko'olauloa Healthy Tomorrows Project will conduct process and outcome evaluation. The process evaluation will provide an overall assessment of the number and types of services provided, consumer satisfaction, number and types of referrals, number of and reasons for home visits, education provided during home visits, number of developmental/psychological assessments conducted, and demographics of the participating families and family members. The outcome evaluation will assess health status indicators of children, number accessing early and continuous family health care, immunization rate of 2-year-olds, number of child abuse reports, number of children screened for developmental delay, number of children receiving a developmental/psychological assessment, number of children participating in WIC and Early and Periodic Screening, Diagnostic and Treatment services, and paternal participation in family health care.

Malheur Maternity Project
Valley Family Health Care, Inc.
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Payette, ID 83661
(208) 642-9376

MCHIP
MCJ-168029
10/01/91–09/30/96
Project Director(s):
Royalynn Case, M.S.

PROBLEM: Although access to perinatal care has been increased through the operation of the Malheur Maternity Project (MMP), many pregnant women in Malheur County, OR, and Payette County, ID, are still not receiving prenatal care early in their pregnancy. Over the past 7 years, the number of first trimester enrollees in the service area has declined by 20 percent to 55 percent overall.

GOALS AND OBJECTIVES: The Malheur Maternity Project seeks to increase access to comprehensive MCH care, to provide individualized and continuous case management to pregnant and postpartum women and their newborns, and to implement planned and systematic educational programs to stress the importance of early and adequate prenatal care and child care.

METHODOLOGY: MMP has employed three certified nurse midwives to increase the capacity of the existing perinatal care system. MMP continues to participate with other community efforts to recruit new health care professionals who will provide maternity care. MMP promotes linkages and coordination among regional, State, and local resources and provides bilingual and bicultural case identification, risk assessment, and ongoing case management to pregnant women. To encourage early and adequate prenatal care, MMP maintains a high profile among service-providing agencies, promoting early entry into care. Networking is a continual process. Individual educational activities are focused toward each woman and her support system. A full-time case manager promotes and tracks followup care of both mother and child.

The participation and variety of individuals and agencies who make up MMP is the very strength of the project and concept. These members include the seven area physicians who have obstetrical privileges, Holy Rosary Medical Center, the Malheur County Health Department, Valley Family Health Care, Inc., and the Lewis and Clark Chapter of March of Dimes. The expertise and concern of the individuals involved and the existing spirit of cooperation have enabled MMP to succeed in improving the quality and quantity of MCH services in Malheur and Payette Counties.

EVALUATION: The MMP board of directors meets monthly and monitors MMP activities and utilization. Demographic data of MMP patients are reviewed annually, including trimester of entry, age, county of residence, ethnicity, education level, and payment status. These data are compared with parallel information on the general population in the service area. Any changes are also monitored and appropriate modifications are made.

Overall project evaluation will look at both outcome and process. Outcome will be evaluated using objective data. Vital statistics from 1989 for both Malheur and Payette Counties will be used as baseline data. MMP patient data as of December 31, 1990, will also be used as baseline data against which to evaluate specific outcomes. Specific health indices to be evaluated include trimester of prenatal care entry, birthweight, infant mortality, and neonatal and postneonatal deaths. A system has been implemented to track postpartum followup of mothers and infants. Baseline data are being collected on the number of women and infants who secure care at a local physician's office or clinic.

Process evaluation will be accomplished through key informant interviews of patients, policy board members, project staff, physicians, advisory committee members, elected public officials, and personnel of community agencies. This evaluation will analyze the procedures, protocols, public education campaigns, personnel effectiveness, and project mission and goals.

EXPERIENCE TO DATE: Since October 1991, when the Healthy Tomorrows Partnership for Children Program at the Malheur Maternity Project began, through May 31, 1993, 905 women were accepted into care at MMP. MMP clients delivered 566 babies. Of these 566 deliveries, 72 percent were by certified nurse midwives: 88 percent were normal spontaneous vaginal deliveries and only 12 percent were cesarean sections. The average birthweight was 7 pounds, 8 ounces. Thirty-five percent of the women accepted into care were age 19 or younger, and 15 percent were age 17 or younger. Thirty-three percent of the women were migrant or seasonal agricultural workers.

AAP/MCHB Collaborative Agreement to Promote Pediatric Provider Participation in the Healthy Tomorrows Partnership for Children Program

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MCHIP
MCU-176057
10/01/91–09/30/96
Project Director(s):
Sherry Lyons, M.A.

PROBLEM: Although America's children and their families are generally healthier today than they were 50 years ago, millions have not benefited equally from advances in medicine because of inadequate access to appropriate medical care. Efforts to address health care problems among the populations at highest risk are hindered by the fact that more than 11.8 million children under age 21 lack health insurance. Medicaid is the largest program in the United States to provide medical care to women and children who lack private insurance and live in poverty. However, while program expansions continue to increase the number of eligible children, low reimbursement and administrative burdens are responsible for a continuing decline in pediatrician participation in the program.

GOALS AND OBJECTIVES: The American Academy of Pediatrics (AAP) will establish a functional collaboration with the Maternal and Child Health Bureau (MCHB) by assisting with administrative and technical assistance activities related to the Healthy Tomorrows Partnership for Children Program (HTPCP). AAP goals for this collaboration are to (1) promote problem solving at the community level; (2) encourage and facilitate pediatrician involvement in community-based programs that provide comprehensive, family-centered, culturally relevant care for underserved children; and (3) encourage private sector and other support for improved coordination of and access to health resources at the community level.

Program objectives are to (1) assist communities in establishing new community-based programs that provide comprehensive, family-centered, culturally relevant care to underserved children; (2) provide ongoing consultation and guidance to HTPCP projects; (3) advocate for replication of successful public-private partnership models demonstrated; (4) inform AAP members of opportunities to apply for HTPCP grants; (5) facilitate the involvement of AAP chapters in HTPCP projects; (6) assist in assessing the impact of HTPCP projects in the communities; (7) provide pediatric consultation and assistance to the MCHB as requested; (8) provide public relations assistance to HTPCP projects; and (9) facilitate coordination of health resources in communities in which HTPCP projects are located.

METHODOLOGY: HTPCP is a collaborative AAP–MCHB grant program that provides financial support and technical assistance to innovative community-based projects that use cost-effective approaches, foster cooperation among public and private community organizations, involve pediatric health professionals, and ensure access to comprehensive health care for underserved children and their families. AAP was intrinsically involved in the development of HTPCP and has been collaborating with MCHB on program activities since it was established in 1989. The primary activities AAP will carry out during each HTPCP application cycle are to assist MCHB in providing technical assistance and in disseminating the Grant Application Guidance; publicize the cycle among AAP members and others who have expressed an interest; encourage AAP chapters to participate in developing application proposals; and provide MCHB with logistical support for review panel meetings.

In providing technical assistance to funded HTPCP projects, AAP will: Under the direction of MCHB, arrange/participate in technical assistance visits to HTPCP projects as an expert resource to achieve program goals; provide logistical support for meetings of the HTPCP Advisory Committee and the project directors; encourage collaboration between HTPCP projects and local AAP chapters; and disseminate information about successful public-private partnership models demonstrated by HTPCP projects. All AAP activities will be conducted under the oversight of the AAP Project Advisory Committee on Community-Based Programs, composed of AAP members who are recognized nationally as having expertise in planning and implementing community-based programs.

EVALUATION: Evaluation activities, to be implemented under the guidance of the Project Advisory Committee, will focus on assessing (1) whether AAP collaboration on HTPCP has involved pediatricians in community-based efforts for the first time; (2) the level of AAP chapter and member involvement in HTPCP projects; (3) whether AAP collaboration on HTPCP has been beneficial for those who participated in the application process; (4) whether the technical assistance visits conducted by AAP were beneficial to HTPCP projects; and (5) whether HTPCP addresses the barriers pediatricians cite as preventing them from participating in community-based child health service programs.

EXPERIENCE TO DATE: Since October 1, 1991, AAP has responded to 680 technical assistance requests from potential HTPCP applicants and has distributed more than 2,300 copies of Grant Application Guidance. AAP also has responded to 49 technical assistance requests received from HTPCP projects and has provided onsite assistance during seven national AAP meetings. Project Advisory Committee members and AAP staff have attended the HTPCP project directors' meetings held in 1992, 1993, and 1994 and have provided public relations information to new projects and individual consultations in conjunction with the MCHB program officer. Technical assistance visits were conducted to 7 new HTPCP projects in 1992, 16 new projects in 1993, and 10 new projects in 1994 (8 followup visits to 5th-year projects were also made in 1994). Reports that include recommendations for the projects have been developed by the technical assistance visit teams that conduct these visits.

A letter from the AAP president was sent to a targeted group of about 8,000 AAP members and other health professionals to announce the start of the 1992, 1993, and 1994 application cycles. Program information was sent to AAP national and chapter leaders at the same time to encourage their involvement. Presentations on HTPCP have been held during four national AAP meetings. Four HTPCP project directors gave presentations during the 1992 AAP Spring Session.

A survey of 1989 and 1990 HTPCP applicants was conducted in 1992. Data obtained from the survey have been analyzed, and a manuscript has been developed and submitted for publication in a peer-reviewed journal. A survey of HTPCP project directors was conducted in 1993. This survey asked project directors to assess the impact of HTPCP technical assistance visits and the level of pediatrician involvement in their programs. All respondents indicated a pediatrician was involved in their project in some capacity. In addition, a survey of 1,627 AAP Fellows was recently conducted. Responses received numbered 1,060; 9.5 percent of the respondents were very, somewhat, or vaguely familiar with Healthy Tomorrows, and more than one-half of respondents (56.1 percent) said they participated in community-based activities. About 40 percent of respondents said they would like to spend more time in community-based activities; the most frequently mentioned reason for limiting participation was lack of time (83.6 percent).

Infant and Family Followup Program
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Woodlawn Maternal and Child Health Center
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Chicago, IL 60637
(312) 702-0040

MCHIP
MCJ-178531
10/01/91–09/30/96
Project Director(s):
Karen Walsh, M.D.

PROBLEM: Low birthweight infants often suffer from a variety of problems, including mental retardation, cerebral palsy, epilepsy, learning disabilities, and other significant disabilities. The most severely affected are those infants born weighing less than 1,500 grams. For our population, as many as 80 percent are born to families without health insurance or other financial resources to care for their special needs.

The importance of preventive medical care for high-risk families is well documented. Unfortunately, the economically disadvantaged are the least likely to sustain participation in preventive health care or social service programs. There are many reasons for this failure, including lack of trust in health care providers; failure to recognize or understand the benefit of such a relationship; inadequate transportation; poor communication skills; and the fragmented nature and confusing array of social and health services. In order to overcome these barriers, families and service providers need extensive education, and effective partnerships must be forged between health care and social service agencies.

GOALS AND OBJECTIVES: The Infant and Family Followup Program (IFFP) is designed as a comprehensive medical and social intervention model for families to improve the outcome for very premature, very low birthweight infants, to actualize the maximal potential function of these children in family units later in their lives, and to prevent the birth of low birthweight infants in the future by encouraging family planning. Its objectives are to (1) coordinate services of the major health care and social institutions and services interacting with eligible infants and families in the program; (2) identify, enroll, and provide comprehensive intervention and preventive care to at least 90 percent of all eligible infants born within the network and their families; (3) ensure attendance of enrolled families at an average of two or more support and education group sessions per year; and (4) implement a computerized system to track and monitor the visits made by infants and their families, the attendance of individual families in the parent group activities, and program attrition.

METHODOLOGY: The IFFP identifies and enrolls all eligible infants. These infants are born in the University of Chicago Perinatal Network and either (1) have a birthweight below 1,500 grams, or (2) are documented with or at high risk for neurobehavioral deficits. Annually, about 200 very low birthweight infants and 100 other infants at high risk for poor neurobehavioral outcome are entered in the program with their families. These infants are identified while in the neonatal intensive care unit (NICU) by the social worker or parent educator.

Clinic appointments are made by the social worker, parent educator, or program clerk prior to the infant's discharge from the hospital. The program clerk makes reminder phone calls 1 to 2 days before the appointment, and missed visits are rescheduled immediately. Primary, medical subspecialty, and developmental followup care are provided. Primary care is performed soon after discharge, as indicated (at 1, 3, 4, 12, 15, 24, 30, 36, 42, 54, and 60 months). Medical subspecialty care referrals are also made as indicated, with followup after such visits.

Developmental assessments include the following: Bayley Scales of Infant Development at 4, 12, 24 months adjusted age; speech at 9 and 18 months adjusted age; Stanford-Binet at 3 and 4 years of age; and the Wechsler Intelligence Scale at 5 years. Nutritional assessment is provided in every clinic session and supplemented by the parent educator in exit sessions with the family. A parent support group is available for parents to increase opportunities to share their experiences, foster healthy family relationships, and empower them to be better parents. Topics discussed in these sessions are selected by the parents.

EVALUATION: Program outcome objectives are monitored continuously and reported annually. These objectives include outcome indices for system use, health status, maternal reproductive behavior, collaboration among agencies, and commitment from the families. A computer data base tracks and monitors clinic and subspecialty visits, and sociodemographic information is entered into the data base. Monitoring efforts include review of monthly enrollment and clinic visit statistics, an annual report, weekly case review, monthly administrative meetings, and an advisory council that oversees program implementation and ensures continued participation of all partners.

EXPERIENCE TO DATE: Fifteen Parents' Night sessions were held, with an average attendance of five persons per session. These meetings provided parents the opportunity for informal discussion with health care professionals while their children were in the NICU. A total of 168 eligible infants were identified, of whom 60 were seen in clinic. Of those not seen in clinic 48 died, 29 have private physicians, 16 are still in the NICU, and the parents of 15 were sent reminder letters. The social worker conducted family interviews using the Family Profile Questionnaire to obtain sociodemographic background information and maternal pregnancy histories. A total of 59 clinic sessions were held; the participation rate was 57.3 percent. The advisory council, University of Chicago Children Adult Resource Education and Support (UCCARES), was formed.

Luz del Corazón
Children's Memorial Hospital of Chicago
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MCHIP
MCJ-178502
10/01/92–09/30/97
Project Director(s):
Kathryn Stevens, L.C.S.W.

PROBLEM: Prior to the creation of Luz del Corazón, no bereavement services were available to Hispanic families who were having difficulty resolving their grief following the death of a child. Unresolved grief can lead to psychosocial problems that can affect family members' well-being throughout their lives.

GOALS AND OBJECTIVES: This preventive project is expected to decrease the incidence of dysfunctional physical, emotional, and social changes that arise in surviving Hispanic siblings and their families after the death of a child. It will also increase the accessibility and use of bereavement services for Hispanic families in the metropolitan Chicago area by developing a program that is culturally sensitive and that can be replicated in the Hispanic community.

Activities to accomplish these goals include the following:

1. To develop collaborative strategies with staff from Hispanic community organizations to identify existing bereavement services and deficiencies;
2. To create and implement a culturally sensitive bereavement program;
3. To secure long-term funding;
4. To evaluate the program and report findings;
5. To document changes in the health status of grieving children; and
6. To offer to train representatives from Hispanic organizations to replicate the program.

METHODOLOGY:

Objective 1: A community advisory committee has been created that meets quarterly and includes representatives from the Hispanic community, social agencies, families, pediatricians, and other health care providers. This committee reviews program progress and provides input on program development.

Objective 2: Systems have been created to identify, serve, and monitor appropriate families. A training model for volunteers who work with children's and parents' groups has been developed and implemented. Families joined the program in July 1994.

Objective 3: Funding has been secured from corporations and foundations. Long-term funding is still being sought.

Objective 4: Evaluation instruments have been identified or created, and they have been translated into Spanish as needed. These instruments reflect the impact of the program on the health status of participating children and reflect the appropriateness of program content.

Objective 5: Preliminary reports will be prepared after the data collected have been analyzed. Information will be shared with professional and local communities.

Objective 6: Training of interested community agency staff to replicate this model will be conducted in FY 1996.

EVALUATION: The principal and co-principal investigators and the executive board are responsible for tracking project activities and assessing the extent to which the project objectives are being met. The community advisory committee provides the project with input into program content and appropriate cultural modifications.

The extent to which the program's intervention helps decrease the incidence of psychosocial changes in surviving Hispanic children after the death of a sibling will be assessed by administering three evaluation instruments (the Hogan Sibling Inventory of Bereavement, the Child Behavior Checklist, and the Volunteer Observation of the Child). These instruments will be administered at three points in time: Before entering the program, after 6 months, and at the time of completion. In addition, monitoring of program content appropriateness will be conducted semiannually by using two instruments completed by parents and volunteers. Data analysis will be performed by compiling a descriptive profile that includes the following data: Demographic information, behavior trends (according to parental and volunteer observation), and children's grief experiences. As the sample size increases, analyses will be directed toward correlations of time spent in the program and increase in positive behavior, as well as differences across test administrations.

EXPERIENCE TO DATE: The following activities regarding program development have been completed, rendering the program operational: Cultural adaptations have been implemented, volunteers have been selected and trained, families have been identified, program protocols have been created, program materials have been translated, supplies have been purchased, evaluation instruments have been selected and approved by the Children's Memorial Medical Center Institutional Review Board, matching funds for FY 1994 have been received, and the contract with the program site has been negotiated. Now that the structural components of the program are in place, the active interaction with the children and families is in the beginning stages, involving meetings every other week and the administration of evaluation instruments.

First Steps Primary Prevention Program
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MCHIP
MCJ-228613
10/01/90–09/30/95
Project Director(s):
Jacinta Settoon, B.A.

PROBLEM: In 1993 there were more than 27,000 investigations in the State of Louisiana for allegations of child abuse and neglect. More than 3,000 investigations involved children under the age of 4. Intervention through support programs to parents of very young children is crucial in preventing abusive cycles from beginning. Currently, Louisiana lacks statewide programs or services that offer support and education to new families challenged with the responsibility of caring for young children.

Lack of cooperation and coordination of efforts among State agencies that provide services to children has been identified as a barrier to providing optimum care. Training opportunities to improve communication and cooperation are needed to strengthen prevention efforts within each agency. Making educational materials available to the populations served by these agencies is also seen as a way to reinforce prevention efforts and encourage collaboration.

GOALS AND OBJECTIVES: The goals are as follows:

1. To encourage an environment that reduces stress and promotes a nurturing relationship between parents and their children by offering education, personal support, and referrals to community resources during the high-risk weeks and months surrounding the birth of a newborn;
2. To assess the needs of public health nurses and offer training opportunities required; and
3. To research home visitation and define the role of the Louisiana Council on Child Abuse (LCCA) to implement the Healthy Start model in Louisiana.

The objectives for the developmental and outreach years at the end of the 5-year project period are as follows:

1. The First Steps program will be developed, implemented, and maintained in East Baton Rouge Parish;
2. LCCA will provide ongoing training and support of public health nurses and provide training sessions and educational opportunities to enhance their knowledge and skills in child abuse and neglect detection;
3. Program components will be refined and replicated statewide;
4. Evaluations that measure the program's effectiveness and outcomes will be made available to professional and academic communities; and
5. Home visitation will be researched and funding will be sought to coordinate with the First Steps program in developing pilot sites.

METHODOLOGY: First Steps volunteers are trained to provide individualized visits to first-time and adolescent parents in the hospital setting where they provide parenting information and emotional support. This is a community effort requiring cooperation among area hospitals, volunteers, social service agencies, and LCCA staff. Project staff collaborate with State-level MCH personnel to assess the needs of public health nurses. Educational opportunities are offered at the LCCA Statewide Conference and the Public Health Conference. Home visitation has been researched and preliminary funding sought to begin implementing this model and coordinating with the First Steps program for identifying families in need of this service.

EVALUATION: The First Steps Advisory Board meets bimonthly to monitor all project functions. The board is composed of representatives from interested health and social service organizations as well as from the medical community. Program staff provide inservice training to lay volunteers on a quarterly basis to review problem cases and provide additional training. All volunteers maintain daily attendance and client information records. Project staff are supervised by the director of programs of LCCA.

The efficiency and effectiveness of the First Steps program are evaluated by gathering information on client satisfaction for the service received and analyzed for impact on the family for stress prevention. Primary feedback regarding trends in reports of abuse for children under 1 year of age have been obtained through statistical information from the Louisiana Office of Community Services.

EXPERIENCE TO DATE: The First Steps program has been implemented in nine delivery hospitals around the State. More than 8,000 first-time or adolescent parents have been served by volunteers or hospital staff. Program refinement has taken place, as has expansion to other hospitals through orientations. Site visits by project staff and Advisory Board members are scheduled to begin later this year.

Collaboration has taken place on a local and regional level with the Office of Maternal and Child Health by facilitating trainings for public health nurses and child protection workers in investigating cases of child abuse and medical neglect of children under 3 years of age. Educational and networking opportunities at the LCCA Statewide Conference and Public Health Conference are made available as well.

Home visitation has been researched, and a task force has been formed at the State level. A statewide conference was held February 2 and 3, 1994, in which the Hawaii Healthy Start model was defined and demonstrated for the purpose of expanding existing home visitor programs. LCCA will provide home visitation training later this year to two local sites through a grant from the Children's Trust Fund.

Families in Transition
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MCHIP
MCJ-248327
10/01/91–09/30/96
Project Director(s):
Wayne Holden, Ph.D.

PROBLEM: Families with children constitute the most rapidly growing segment of the homeless population. Data for FY 1993 from the Department of Human Resources in Maryland indicate growth of the population of sheltered homeless children from 6,956 in 1991 to 12,770 in 1993. This age group accounts for 25 percent of the homeless served by shelters in Maryland. That health care specifically targeted toward homeless children is necessary is evidenced by literature suggesting these children have (1) an increased prevalence and severity of health problems; (2) substantially decreased opportunities for preventive health care; and (3) competing needs among their parents and family, which make preventive care a low priority.

It is the premise of Families in Transition (FIT), formerly known as Comprehensive Health Care for Homeless Children, that a focused yet encompassing interdisciplinary approach that allows for identification and treatment of the medical, psychosocial, and environmental needs of the child and family is an effective method for addressing the health status of homeless children.

GOALS AND OBJECTIVES: The goals of the FIT program are as follows:

1. To provide a centralized health care source that employs a core management team skilled in eliciting and managing the multiple problems of homeless families as well as aggressive outreach and tracking of these families;
2. To help parents negotiate barriers that impair access, and to facilitate parental management of family needs to empower parents to attain self-sufficiency; and
3. To create a knowledge base concerning the health status of homeless children in Baltimore City.

METHODOLOGY: A collaborative effort with Health Care for the Homeless (HCH), Inc., has been established to draw on the expertise of that organization and to avoid duplication of services for the parents of patients enrolled in the FIT program. Children living in 10 family homeless shelters and transitional housing in Baltimore City and children referred from the University of Maryland Pediatric Emergency Room, Nursery, and Pediatric Ambulatory Center comprise the patient population. The children remain in the system 1 year after stable housing is established, at which time families are referred to a health care site in close proximity to their home.

Patient care activities begin with an initial two-visit intake during which the patient and parent are interviewed and/or evaluated by a pediatrician, a psychologist, and a social worker. On the basis of intake results a problem list is generated from which all case management activities stem. Children may receive onsite individual or family counseling with a behavioral pediatrician. Parents in need of support services or health care receive care from HCH, Inc., or medical specialists on the University of Maryland campus. These services are coordinated by each family's social worker or nurse-practitioner.

EVALUATION: Tracking of project implementation occurs via a number of quality assurance measures to document chart completion and effective case management. Evaluation of the success of the project occurs through (1) the extent of the data base of medical and social problems of the children; (2) changes in parameters of child health status (immunization rates, hospitalization rates, and emergency room visits) and family functioning (ratings of stress indices, parental satisfaction, and the child's mental health and the percentage of appointments kept); and (3) assessment of the program to deliver the services proposed (attrition rates of clients, enrollment of all eligible families into Aid to Families with Dependent Children, parental satisfaction with the program, and lower rates of emergency room use and hospitalization).

Evaluation of the effectiveness of the FIT program has primarily relied on the close monitoring of clinical measures. Both medical data and psychosocial data indicate that the program has been successful in achieving its goals and objectives. A small subset of families exiting the program have completed a standardized exit interview with data indicating decreased parenting stress levels and reduced behavioral problems in their children. A former employee of the program is currently proposing a dissertation project that will attempt to identify family and individual patient variables at entry into the program that differentially predict both basic medical and psychosocial outcomes. Grant proposals will be submitted in an attempt to obtain extramural funding to support a more controlled evaluation of the FIT program in the future.

EXPERIENCE TO DATE: During year 3, additional funding has allowed the program to include a program coordinator and a data manager. Collaboration with the Baltimore City Health Department has resulted in delivery of immunizations to children in shelters in Baltimore City. Outreach continues to shelters for the purpose of health assessments, health education, and referrals. Any child found on outreach without an identified source of health care is referred directly to the FIT program.

The Advisory Board, formed during the planning phase of the project, consists of the project team and representatives from numerous city and State agencies providing services to homeless families. Problem solving has been focused on funding, public relations, linkages, and strategic planning.

Job descriptions have been revised, work plans written, policies and procedures established, a parent satisfaction form written and circulated, an intake questionnaire rewritten, data bases revised, a newsletter published and sent to FIT families and community, and presentations given in university settings as well as other health-related settings.

Healthy Tomorrows Parenting Program
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MCHIP
MCJ-248326
10/01/93–09/30/98
Project Director(s):
Lauren M. Jansson, M.D.

PROBLEM: The incidence of substance abuse in women of childbearing age is increasing. Consequently, an increasing number of children are being born to substance-abusing mothers. Children born to drug-abusing women are at risk for multiple health problems, developmental disabilities, and emotional/behavioral dysfunctions. Substance-abusing mothers often have multiple factors that prevent them from good parenting. Some of these factors are their origin from families with multiple problems, poor parental role modeling, sexual victimization, and poor self-esteem. Also, substance-abusing families often live in hazardous areas in abject poverty. It is evident that a combination of maternal and neonatal factors can seriously hamper the quality of the mother-infant relationship at a very early and critical stage in the child's development. The extent of the role of the environment in the disabilities suffered by substance abuse children remains unclear, but recent literature has shown that intensive intervention can reverse the effects of perinatal drug exposure.

GOALS AND OBJECTIVES: The Parenting Skills Training Program for Substance Abusers program will:

1. Improve parenting skills among drug-abusing women through the development and implementation of a parenting curriculum, group educational sessions, and individual intervention/instruction sessions;
2. Improve the drug-abusing mother's self-concept in the role of motherhood and enhance her maternal appreciation of the child's development by assessing the child's behavior and development in the presence of the mother;
3. Facilitate mother-infant interaction by teaching the mother to recognize the competencies and needs of the child by assessing the child in the presence of the mother; and
4. Improve the cognitive, emotional, and social development of the drug-exposed child by increasing the mother's awareness of at-risk situations.

METHODOLOGY: The parenting project will be integrated into the Center for Addiction and Pregnancy (CAP) of the Francis Scott Key Hospital, Baltimore. CAP is an urban, community-based center that integrates enhanced prenatal and other medical care onsite with specialized substance abuse treatment services. In addition. comprehensive pediatric care is provided, with preschool-age children enrolled in onsite developmental play programs. To achieve its goals and objectives, the project will:

1. Develop and implement a parenting curriculum, adapted to each phase of the drug-using woman's treatment, that encompasses areas affecting the child's physical, emotional, and intellectual growth;
2. Conduct group education sessions covering topics such as physical care, motor and sensory stimulation promotion of communication and language, enjoyment of the child, and consistent limitation and approval;
3. Administer various developmental and behavioral screening tools to the child in the presence of the mother during individual intervention/instruction sessions;
4. Instruct the mother to evaluate her child's development to enable early detection of developmental delays; and
5. Provide parenting evaluations and instructions during home visitations.

EVALUATION: Evaluation of the mother-child interaction will be performed using the Nursing Child Feeding Assessment Scale. Individual children's development will be assessed using the Neonatal Behavioral Assessment Scale and the Denver Developmental Screening Test. Baseline data collected during the first assessment will be compared with longitudinal data collected during followups. Comparisons between baseline and longitudinal data will be made to determine the effectiveness of the program in the mothers as well as the children. The parenting curriculum will be evaluated using the following outcome measures: (1) Attendance at sessions, (2) retention time in the program, (3) interest and participation in the activities, (4) acquisition of new knowledge, (5) level of awareness of child development issues, (6) changes in attitudes, (7) promotion to advanced phases of the program, and (8) reduction of drug use.

Deaf Family Clinic: Health Care Promotion for Deaf Youth and the Children of Deaf Parents
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MCHIP
MCJ-258116
10/01/92–09/30/97
Project Director(s):
Stephan R. Glicken, M.D.

PROBLEM: Through the Deaf Family Clinic (DFC), children who are deaf or hard of hearing or who come from families where one or both parents are deaf or hard of hearing are offered primary and tertiary care services in an environment sensitive to their communication needs. In the past, failure to recognize the linguistic, cultural, and technological needs of these children put them at risk for stigmatization, poor compliance, personal hopelessness, failure to comprehend medical information, and dissatisfaction with experiences within the medical system. In addition, infants born with significantly abnormal hearing may suffer needless delay in identification through gaps in implementation of recommended newborn screening programs. We estimate that in the greater Boston area there are approximately 1,500 to 2,000 children and about twice that number of adults with hearing significantly diminished to the point of posing a barrier to receiving optimal health care.

GOALS AND OBJECTIVES: The five major goals and principal objectives of the DFC project are as follows:

1. To improve access to all elements of the health care system for people in our target population who are deaf or hard of hearing. We will eliminate the need for outside or family-member interpreters by providing full access to foreign-language interpreters for all families and by opening a school-based program at a local school for the deaf.
2. To improve the health status of children who are deaf or hard of hearing or whose parents who are deaf or hard of hearing. Specific objectives here are to guarantee equal access to anticipatory guidance for these patients, measure functional health status reports from parents, and track progress of patients with chronic conditions such as asthma.
3. To improve the level of patient and parent satisfaction with the pediatric care delivery system. We have established representative advisory boards, improving communication and confidentiality and tracking serial measures of satisfaction objectively.
4. To enhance these families' understanding of their children's medical problems and improve their management and advocacy skills. We will provide both face-to-face education and innovative videotaped educational materials. We will monitor participation of family members in clinic visits and utilize community consultants to help us function best with our clients.
5. To improve access to and satisfaction with adjunctive treatments such as mental health consultations and educational testing units. Our social worker will provide direct mental health services and will make appropriate referrals to deaf-sensitive consultants.

Overall, we plan to achieve these goals by providing an environment conducive to comfortable communication between patients and project staff, including having staff fluent in American Sign Language (ASL), amplification devices for use by people who are hard of hearing, and general knowledge and sensitivity to cultural issues within our target groups.

METHODOLOGY: The project is open to families living in the greater Boston area and to the families of students attending the Learning Center for Deaf Children school in Framingham. Advertising for the service occurs through the deaf press, parent organizations, personal appearances, and word of mouth. A multi-disciplinary staff including deaf, hard-of-hearing, and hearing people delivers care in the communicative style preferred by consumers, with a staff interpreter to assist in situations where more than one language style is used. Emphasis is placed on patient education to bring the level of knowledge up to normal standards for our special populations. Detailed measures of satisfaction, health status, self-image, and interactive strategies will be conducted longitudinally. The community advisory boards will guide the efforts of DFC in directions most suitable for the concerned communities.

EVALUATION: Progress is discussed quarterly at our Advisory Board meetings and at least weekly with project staff. Staff collect data to demonstrate progress toward specific objectives and overall goals. A detailed set of evaluation instruments has been constructed and is currently being translated into ASL by media consultants and deaf communications experts. We will collect data for approximately 3 years to determine the efficacy and effectiveness of the DFC program.

Injury Prevention for Pregnant and Parenting Teens: A Home Visiting Model

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MCHIP
MCJ-258123
10/01/93–09/30/98
Project Director(s):
Rebecca F. O'Brien, M.D.

PROBLEM: Injury is the leading cause of death in children ages 1–19. Sixteen million children are seen in emergency departments each year for injuries, and injuries account for 20 percent of childhood hospital admissions. Unintentional injury and death are consistently related to young maternal age; however, injury prevention efforts have not been specifically targeted to adolescent parents. There may be aspects of adolescent parenting styles that place children at increased risk for injury. In young children, most injuries occur in the home. Massachusetts has collected the baseline statistics on childhood injury on which nationwide risks are based, and has been a leader in the development of injury prevention efforts through the Statewide Childhood Injury Prevention Program (SCIPP). This program documented an overall incidence of injury of one in five children per year by a surveillance system capturing emergency room visits and hospitalizations.

Previous educational efforts to reduce childhood injuries have typically been able to raise a parent's awareness of potential hazards in the household but have had only modest effects on actual reduction of potential hazards in the home.

GOALS AND OBJECTIVES: The 5-year demonstration project has the following goals: (1) To reduce the risk of injury in the children of adolescent parents in the Adolescent Prenatal and Family Clinic at New England Medical Center (NEMC) through a model of home-based injury prevention; and (2) to improve the delivery of services to pregnant and parenting adolescents at our affiliated community health centers, especially around the areas of outreach and injury prevention. The objectives to reach these goals include increasing adolescent parents' knowledge about injury risks and effective parenting skills coupled with increased use of safety devices and practices. The project will assess the current adolescent services for pregnant and parenting adolescents at our affiliated health centers and incorporate home-based injury prevention into the Parent-to-Parent outreach worker curriculum.

METHODOLOGY: We have developed a home-based injury prevention model for high-risk adolescent families who receive care at NEMC in our Adolescent Prenatal and Family Program. Our model expands on the SCIPP model by providing longitudinal, developmentally based home visits specific to the needs of adolescent parents. A full-time lay outreach worker provides the home-based visitation, using materials and resources from SCIPP and the Injury Prevention Program developed by the Academy of Pediatrics that have been modified as needed for the target population of adolescent parents. Home visitation begins prenatally and continues for 3 years after the birth of the child. Strategies to reduce the risk of childhood injury include safety counseling regarding hazardous household practices, distribution and installation of safety devices, and home inspections to identify hazards. The home visitor provides education and modeling of effective parenting skills and serves in a mentorship role to the young parents.

We hypothesize that this model will be effective in making the home environment safer, reduce the risk of injuries, and serve as an entree to discussions around broader injury issues such as physical discipline and child abuse and interpersonal violence, including family violence and sexual abuse. In subsequent years of this project we will work with the pediatricians and the Parent-to-Parent outreach workers in 10 affiliated community health centers to provide training and technical assistance to improve delivery of services to pregnant and parenting adolescents, particularly in the area of injury prevention. The NEMC Adolescent

Prenatal and Family Program and the community health center sites serve some of the most disadvantaged areas of Boston, and our target population can be described as young, low-income, urban, and minority.

The larger statewide community of pediatricians will receive updates about the project through articles published in the newsletters of NEMC referring physicians, Tufts Associated Health Plan (a large health maintenance organization affiliated with NEMC), and the Massachusetts chapter of the American Academy of Pediatrics.

EVALUATION: The project director will be following a timeline to determine whether the project activities are being accomplished in a timely fashion. The home visitor receives direct supervision from the program's social workers once or twice a week and reviews home visit logs and any problems identified that require referral. The home visitor meets with the project director monthly and, for assessing program quality, submits quarterly summaries of activities, including number of home visits accomplished, qualitative information on barriers to implementation of the planned service, training needs, adequacy of supervision, and accessibility of clients. The home visitor participates in the monthly case management meetings of all providers in the Adolescent Prenatal and Family Program.

At entry, young women enrolled in the Adolescent Prenatal and Family Program will be (1) randomized to home-based injury prevention intervention or to a comparison group that receives the standard office-based injury prevention education, and (2) followed prospectively. The expectation is 30 to 35 clients in each group per year. The process evaluation will focus on documenting that the home visiting intervention has occurred as planned, and it will assess strengths and weaknesses of the program implementation and assess client response to the intervention. The outcome evaluation will compare the two groups for knowledge of hazards, use of passive safety devices, safety practices, reported injuries, and use of physical discipline. Because the intervention may have broader effects on the parent's sense of effectiveness as a parent, measures of self-esteem, social competence, and quality of life will be performed. Because the home intervention may link these young women to the overall Adolescent and Prenatal and Family Program more effectively, we will also compare standard outcomes for adolescent pregnancy and parenting programs that relate to pregnancy outcomes, birth outcomes, infant outcomes, and compliance with scheduled prenatal and well-child visits. Data sources include program intake and followup forms, home visitor logs, home inspections, medical record reviews, and questionnaires administered to all clients at 12, 24, and 36 months postpartum. Improvement in the ability of the community health center sites to reach and engage adolescents will be measured by documenting adolescent client volumes. Attendance at workshops and satisfaction surveys will be used to measure effectiveness of educational efforts.

EXPERIENCE TO DATE: At the time of this report, three-quarters through our first program year, we have met our program objectives of hiring and training a lay community home visitor to provide the home-based injury prevention intervention. We have been developing the evaluation instruments and have submitted the evaluation plan to the institutional review board of the hospital and are awaiting approval. Since the home visitor was hired, 25 young women have enrolled in the program and been randomized to treatment or comparison groups. Project staff have received assistance from the Massachusetts Department of Public Health, Division of Injury Prevention and Control (formerly SCIPP), and other agencies providing home visitation and injury prevention efforts. Initial qualitative information suggests that home visitation is an acceptable intervention for adolescent parents.

Mothers' Mentors Project
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MCHIP
MCJ-258124
10/01/93–09/30/98
Project Director(s):
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PROBLEM: Infant health and survival are high-priority health status problems in the Boston, MA, neighborhoods of Roxbury, Dorchester, and Mattapan. In these neighborhoods, the infant mortality rate is more than twice that in the remainder of the city. Another indicator of the health status of the preschool-age children in these three neighborhoods is their immunization rate. Less than 40 percent of all children ages 0–2 are fully immunized. Failure of preschool children to have routine immunizations suggests not only that they are vulnerable to outbreaks of preventable infections such as measles but that they may also fail to receive other forms of well-child care, such as developmental assessments and anticipatory guidance. The prevalence and severity of these prenatal and infant health problems, combined with socioeconomic pressures, a lack of support services, and significant barriers to health care, mandated a focus on and mobilization of local community resources to positively impact infant health and survival in the Roxbury, Dorchester, and Mattapan communities.

GOALS AND OBJECTIVES: One goal of the Mothers' Mentors Project is to employ 24 trained community residents as mentors each year to promote primary health care, knowledgeable use of health resources, and increased parenting and nurturing skills to a minimum of 48 women and 144 infants each year who are at high risk for poor health status. A second goal is to improve the health status, functional ability, and developmental capability of 144 infants and children in three predominantly inner-city communities of Boston. Objectives are to:

1. Ensure the early and continuous participation of 100 percent of all project-enrolled pregnant women in prenatal care and other needed primary health care services;
2. Ensure that 75 percent of all enrolled infants receive regular developmental screenings, all age-appropriate immunizations, and other necessary preventive health services;
3. Ensure that 75 percent of all enrolled infants receive regular primary pediatric care;
4. Ensure that 100 percent of participants are informed about comprehensive family care, health care, reproductive health care, self-care, and infant care and safety;
5. Ensure the availability of an ongoing interdisciplinary advisory network during the course of the project; and
6. Provide 10 monthly Pregnancy and Parenting Support Group meetings for project participants.

METHODOLOGY: The Mothers' Mentors Project links pregnant and parenting women of Roxbury, Dorchester, and Mattapan with mentors—women from the same neighborhoods who have had successful pregnancies and parenting experiences. Through one-on-one relationships, home visiting, parent education/skills development, support groups, and recreational opportunities, the mentors will provide health education; facilitate linkages to primary health care, pediatric care, and family support services; conduct referrals and advocacy as needed; and provide skill development opportunities for the young mothers.

EVALUATION: The outcome evaluation will include a quantitative data analysis as well as a qualitative analysis of baseline data, data collected in exit interviews, interviews with a subset of participants, and observations of project activities. This analysis will profile the overall health status of each participant and child, will present in-depth case studies of the participants, and will identify project-related activities and processes that impacted the health status and overall development of participants. Mentors are monitored through ongoing direct supervision, weekly support group meetings of the mentors, and project staff observation. When participants leave the project, the evaluator will conduct an exit interview. Data will be collected on outcome of the pregnancy, health care, health status of the participant, and reasons for leaving the project.

EXPERIENCE TO DATE: The Mothers' Mentors project has trained and selected eight community residents who have served as mentors to 21 young women. One of the most significant experiences to date has been the healthy delivery of three babies to project participants. The mentors and project staff have built trusting relationships with one another and truly challenge and inspire each other. In addition, the mentors have formed a network among themselves. The project has been hampered in meeting its fullest potential only because of difficulties in identifying and hiring project staff.

Pediatric Family Violence Awareness Project
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MCHIP
MCJ-258101
10/01/92–09/30/97
Project Director(s):
Linda McKibben, M.D., M.P.H.

PROBLEM: Women in the United States are more likely to be assaulted and injured, raped, or killed by a current or former partner than by all other types of assailants combined. In Massachusetts alone, 32 women and 14 children were killed in 1992 in families with a known history of domestic violence. Children of battered women are at considerably increased risk for child abuse, and domestic violence and child abuse occur in the same family in 40 to 70 percent of cases. A child's witnessing the abuse of the mother also has important short-term and long-term psychosocial sequelae; for example, men who have experienced victimization of their mothers are 1,000 percent more likely to hurt their adult partners. Yet health care providers have typically received little or no training in appropriate responses to women and children affected by partner violence.

GOALS AND OBJECTIVES: The 5-year project will (1) enhance the quality of health care services provided to battered women and their children by increasing the knowledge of primary care providers about family violence, its impact on the pediatric population, and resources for referral and followup; and (2) provide increased access to an ongoing, innovative pediatric service, the Family Advocacy Clinic at Neponset Community Health Center (NCHC) in Dorchester, MA, which conducts comprehensive health and psychosocial evaluations of children of battered women and provides safety planning and advocacy services to battered mothers.

METHODOLOGY: The Pediatric Family Violence Awareness Project is a collaborative effort of the Massachusetts Health Research Institute, the Massachusetts Department of Public Health (DPH) Bureau of Family and Community Health, the New England Medical Center (NEMC), NCHC, Carney Hospital, Boston City Hospital, and the Massachusetts Chapter of the American Academy of Pediatrics. Trainings will be provided to approximately 1,200 pediatric and perinatal health care providers throughout Massachusetts. Half-day and full-day trainings address warning signs of abuse, screening and documentation, safety planning, and community resources. One-hour and 2-hour workshops focus on special issues, such as adolescent dating violence or domestic violence and child abuse. Practice guidelines are reviewed through use of the new statewide protocol "Identifying and Treating Adult and Adolescent Battered Women and Their Children: A Guide for Health Care Providers," which was developed by the DPH Women's Health Unit. In project years 4 and 5, a special intensive seminar will prepare trainers to implement the project curriculums in their own settings throughout the State. In year 5, the project curriculum will be prepared for statewide and national distribution. Technical assistance is provided by the multidisciplinary Project Advisory Board, composed of health care providers and battered-women's advocates from a variety of settings.

EVALUATION: The number of providers who receive training, including their professional and demographic characteristics, is monitored through a questionnaire administered at the beginning of each training. These data are summarized and presented at quarterly meetings of the Project Advisory Board. The number of patients seen at the Family Advocacy Clinic, the services they receive, and the number of referrals to the clinic by training participants are logged and summarized annually. Monthly administrative meetings provide a means to continually monitor progress toward stated goals and objectives.

Training effectiveness is assessed through pretraining and posttraining questionnaires measuring knowledge, attitudes, practice skills, and satisfaction with training, and through a 6-month followup survey measuring practice changes. The number of providers who reported screening more than 80 percent of mothers and female patients for domestic violence increased from only 12 percent before training to 30 percent 6 months after training.

EXPERIENCE TO DATE: The project has developed and piloted a versatile curriculum consisting of 1-hour, 3-hour, and 6-hour seminars for pediatric and perinatal providers. The project trained 260 providers in year 1 and 334 providers in the first 9 months of year 2. A pretraining and posttraining questionnaire has been developed to measure changes in provider knowledge and attitudes. NEMC has added new, hospital-based advocacy services for battered women and their children, and has conducted domestic violence trainings and technical assistance in affiliated community health centers. The clinical assessment services originally offered at NEMC have been strengthened and relocated to a community-based setting at NCHC.

Preschool Asthma Education Project
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Trustees of Health and Hospitals
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MCHIP
MCJ-258134
10/01/94–09/30/99
Project Director(s):
Suzanne F. Steinbach, M.D.

PROBLEM: Pediatric asthma is an increasingly prevalent and costly public health problem. Children living in inner-city, disadvantaged homes show a higher prevalence of asthma and are disproportionately affected by asthma morbidity, including ill health and hospitalization. Current preventive asthma management strategies should minimize symptoms and school absence as well as virtually eliminate the occurrence of acute severe asthma attacks requiring emergency care and hospitalization. Still, school absence and hospital-based care is common among inner-city children with asthma. We have documented that at least 12 percent of 2,000 children enrolled in an inner-city Head Start program have known asthma with frequent symptoms and activity limitation. Use of preventive asthma therapy among these children was low, and their absences were 30 percent higher than of nonasthmatic classmates. We have also shown that asthma emergency room visits and hospitalization rates for children in the Head Start age group are particularly high. Multiple factors contribute to high prevalence and excessive morbidity of childhood asthma in the inner city. High levels of airborne particulates (including industrial and traffic-associated pollution) and environmental tobacco smoke in the home are recognized asthma triggers. In the inner city, household allergens relevant to asthma extend beyond the ubiquitous dust mite to inhalant allergens resulting from infestation of poorly maintained urban housing—namely mold, roach, rat, and mouse allergens. The episodic nature of asthma care in the inner city contributes directly to asthma morbidity and results in deficient asthma education of families for cooperative care. Specific educational resources designed for inner-city families with preschool-age asthmatic children are lacking.

GOALS AND OBJECTIVES: The goal of the preschool asthma education project is to reduce the excessive morbidity experienced by young, inner-city children with asthma who are enrolled in a Head Start program. Specific objectives are to:

1. Increase asthma care knowledge among participating parents and teachers;
2. Increase asthma preventive care visits to primary care providers by the enrolled asthmatic children;
3. Decrease asthma symptom levels among these children;
4. Reduce excess health care utilization (emergency room treatment and hospitalization) among enrolled asthmatic children;
5. Reduce asthma-related Head Start absences;
6. Reduce exposure to asthma triggers in the home; and
7. Increase family use of adaptive behavior regarding asthma.

METHODOLOGY: The 2,100 children enrolled in Action for Boston Community Development (ABCD) Head Start will be surveyed for asthma using routine health forms completed by the primary care provider as well as an additional parent questionnaire. Initially, separate focus groups of parents, teachers, and primary care providers of these children will meet to define their perceived educational and support needs. The results of the focus group sessions will be used to modify existing asthma educational curricula developed for older inner-city populations. The project physician will provide comprehensive training to the team of Head Start nurses regarding pediatric asthma and project implementation. The Head Start family advocates and nurses will gather data on asthma symptoms and therapy, health care utilization patterns, family asthma knowledge, decision-making and adaptive behaviors regarding asthma, and exposure to asthma triggers in the home. Teachers will also be surveyed for asthma knowledge. The project physician and site nurse will meet with teachers at each site to discuss asthma and the educational project and to elicit their cooperation in reporting to the advocate any asthma symptoms observed in class. The nurse at each site will (1) meet with the family advocate each month to review absence data and asthma symptom levels, (2) meet with parents in a monthly asthma educational and support group, and (3) meet with asthmatic children in an asthma educational/hospital play session. The nurse, with physician backup, will be available through a daily "telephone hour" to the family of each asthmatic child. Primary care providers of enrolled children will be informed of the project and will be offered onsite continuing education about asthma management; for any child with excessive symptoms or apparent undertreatment, the project physician will visit the child's clinic for "academic detailing." The family advocate will gather data continuously regarding asthma absences, preventive clinic visits, and symptoms observed at school; for comparison, routine attendance logs for nonasthmatic children will be maintained.

EVALUATION: At the end of each Head Start year, family advocates and nurses will repeat data gathering from parents regarding asthma symptoms and therapy, family asthma knowledge, decisionmaking and adaptive behaviors regarding asthma, and exposure to asthma triggers in the home. Teachers will be retested for asthma knowledge. At least once a month, cumulative data on asthma absences and health care utilization will be entered into data analysis programs and reviewed. Information obtained will enable an assessment of the impact on asthma morbidity of a comprehensive, sustained asthma educational and support effort integrated into an inner-city Head Start system. The program will result in the creation of methods and materials suitable for wide use in Head Start systems.

Center for Healthy Beginnings
Region II Community Action Agency
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MCHIP
MCJ-268515
10/01/90–09/30/95
Project Director(s):
Molly Kaser, R.N., M.P.H.

PROBLEM: Jackson experienced a health care crisis during the 1980s and early 1990s, signified by a loss of obstetrical providers and a decrease in access to prenatal care for low-income women. Prior to the opening of our prenatal project, one woman per day presented in labor at Foote Hospital having had no prenatal care at all, and until last year, the local health department was providing maternal support services to an average of 900 high-risk women per year. The prenatal project is serving this population.

GOALS AND OBJECTIVES: The Center for Healthy Beginnings is a collaborative human services program designed to decrease the infant mortality rate and the low birthweight rate and increase access to prenatal and gynecological care in Jackson County. Our objective is to offer prenatal, postpartum, and gynecological care through a multidisciplinary approach. The major project goals are as follows:

1. Reduce infant mortality to 9.0 by 1998;
2. Reduce the rate of low birthweight infants;
3. Bring Jackson County into compliance with the Michigan Department of Public Health mandate that prenatal care be a basic right of every woman in the State; and
4. Provide prenatal and gynecological care to any woman in need.

METHODOLOGY: The center is providing full perinatal and gynecological services; women's services case management; intensive substance abuse day treatment; the Special Supplemental Food Program for Women, Infants and Children (WIC); infant mental health services; nutrition and social work counseling; ultrasonography; childbirth and parenting classes; Maternal and Infant Support Services; and assistance with medicaid prenatal applications. Because multiple services are offered in one location, more services are utilized.

We have two full-time and two part-time certified nurse-midwives and one full-time obstetrician-gynecologist. In addition, our full support staff includes two registered dietitians, two registered nurses, two medical assistants (one full time and one part time), a social worker, an assistant for program operations, a director, three infant mental health specialists, and three office support persons (two full time and one part time).

EVALUATION: Appropriate statistical data are examined each year to note implications of change in the general population and the minority population. This is a collaborative effort involving Michigan State University, State and local health departments, a prenatal advisory group, the Region II Community Action Agency, and the local hospital.

The evaluation component involves direct participation of the parents of infants served by the project. Data from prenatal clients are entered into our computerized agencywide program (PROBER) for tracking utilization of services. Discipline-specific evaluations are compiled annually. Our computerized clinical data base includes previous maternal history, course of current pregnancy, health history, and pregnancy outcomes. We also use client surveys (prenatal and postpartum) and tracking of emergency room utilization by the target population. The prenatal staff gathers, compares, and analyzes data on a quarterly basis. Survey questionnaires are used, and data collection is ongoing.

Michigan State University has completed a 2-year professional evaluation of our services, which looks at our outcomes as well as psychosocial variables that have an impact on utilization of prenatal services. Comparisons were made with a project similar to ours in population and services.

EXPERIENCE TO DATE: Since the center opened in February 1991, the staff has increased from one full-time certified nurse-midwife and no medical director to two full-time and two part-time certified nurse-midwives and one full-time medical director (an obstetrician-gynecologist). In recent months the center began providing its own maternal and infant support services and has added a part-time office support person and a part-time medical assistant.

The infant mortality rate in Jackson County per 1,000 births during the 3-year period of 1990–92 averaged 8.9, which is less than the State average of 10.4. The incidence of low birthweight per 1,000 births dropped from 75.2 in 1990 to 64.4 in 1992, versus 75.8 in 1990 to 75.5 for the State. The neonatal death rate in 1992 for the center was 4.4 per 1,000 (lower than the State or county average). The cesarean birth rate of our clients is 11.6 percent, well below the national average of 23.5 percent.

Prior to the opening of the center, approximately one woman per day presented at Foote Hospital for delivery having had no local prenatal care or no prenatal care at all. That rate is currently less than one woman per month.

Collaborative Developmental Clinic
Michigan State University
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MCHIP
MCJ-268514
10/01/90–09/30/95
Project Director(s):
Marsha D. Rappley, M.D.

PROBLEM: Professionals in the greater Lansing, MI, community have addressed the school and behavioral problems of preschool through adolescence in isolation from one another. A child presents to a pediatrician as a medical problem, to a mental health worker as a psychological problem, or to an educator as a classroom problem. The child is then treated with other issues unaddressed. This situation is of greatest concern within the medical community, where the pressure to medicate children for behavior problems is tremendous, originating from parents, teachers, and the medical model itself. This project brings together a pediatrician, a child psychologist, and a school consultant in a clinic that will comprehensively evaluate and offer treatment for families with children who have school-related learning and behavior problems. This project serves children and families from widely diverse cultural backgrounds and all socioeconomic levels. Children with behavioral problems that have an impact at school and at home are vulnerable to morbidity associated with school and social failure.

GOALS AND OBJECTIVES: The Collaborative Developmental Clinic will (1) improve access to comprehensive developmental evaluation; (2) specifically improve access for families at lower socioeconomic levels who have traditionally been underrepresented in developmental clinic populations; (3) in addition to the judicious use of medication in the management of behavioral problems, create opportunities for treatment modalities that are classroom and family oriented; (4) establish the economic feasibility of the comprehensive team approach to behavioral problems; and (5) provide educational activities for parents and professionals who live and work with children with attention deficit and hyperactivity disorder (ADHD).

METHODOLOGY: This project provides comprehensive assessment of children referred for behavioral or developmental problems by a pediatrician, a child psychologist, and a school consultant working as an interdisciplinary team. Each child has a complete history, physical and neurologic exam, and family and classroom assessment. Assessment, intervention planning, and evaluation of treatment are carried out at clinic conferences weekly with progress reports monthly. Other members of the team include a nurse-clinician, a reimbursement analyst, and an evaluation consultant.

EVALUATION: Evaluation is an ongoing process based on the achievement of stated specific goals that come before the project director and the team for review on a weekly basis. This method will allow revision of objectives and project management decisions based on the data acquired over both the short and the long term. Evaluation of the impact of clinic services on the family has been in interview and questionnaire format. The impact of the clinic on the community at large is assessed by the involvement of the clinic personnel as consultants and models for four community programs that have developed since this project began. The final year of operation will be in the mode projected for postfunding. A 25-percent effort will be directed at completing the final evaluation of the demonstration project.

EXPERIENCE TO DATE: New assessments are completed on approximately 60 children per year. Approximately 45 percent of new and followup patients are insured through medicaid or are without insurance. A parent training group was established to facilitate interventions recommended to families. However, very few parents were able to use this resource. Fifty hours of scheduled presentations have occurred for parents, educators, counselors, or physicians. An additional grant from Michigan State University has funded three regional conferences to provide access to information for professionals statewide. The Michigan Department of Education has provided funding along with funds from the University Outreach effort to provide cross-inservicing for professionals involved in ADHD, a model program of collaboration based on this program's success.

The major problem identified in the first year of service continues—namely, overwhelming demand for services. Efforts have focused on the education of classroom teachers and school support staff to assist in the school management of generic learning and behavior problems prior to diagnosis. The second major problem identified in the first year was a lack of funds to conduct a thorough evaluation of services. We now have the evaluation procedure described above. The problem of allowing more efficient communication between the clinic and the referring doctor will be addressed this year by a letter provided at the time of family feedback, to both the family and the referring doctor. An evaluation of this letter will be completed as well.

Consultation Service for Children with Severe Chronic Illness
Michigan State University
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MCHIP
MCJ-268509
10/01/92–09/30/97
Project Director(s):
Jane Turner, M.D.

PROBLEM: Children with severe chronic illnesses or disabilities represent 2 percent of all children; there are 35,000 to 50,000 such children in Michigan. A large majority of these children lack access to effective primary care because of the complexity of their problems, the time involved in assessment of the children's and families' needs, the difficulty in finding local support services, and the inadequate level of reimbursement. As a result, such children lack any semblance of coordinated, comprehensive care; they also lack basic immunizations, appropriate nutritional assessment, anticipatory guidance, and even office care for intercurrent illnesses. Thus, many children with severe chronic illnesses receive expensive but inadequate health care services (a systems problem) resulting in impaired health, increased stress on the child and family, disordered educational experiences, and delayed functional development (a health status problem).

GOALS AND OBJECTIVES: The project's goals are to (1) increase access to primary care for children with severe chronic diseases, (2) assist primary care physicians in providing quality comprehensive care for children with severe chronic conditions, and (3) improve health status for these children. The objectives of the project include measurable improvements in health status, functional abilities, and developmental/educational capabilities of project children.

METHODOLOGY: Children with severe chronic illnesses in an 18-county region served by Michigan State University's College of Human Medicine are the target population. The children are recruited from private physicians, social agencies, district health departments, and local school districts. A total assessment of the child (and family) is done by a team consisting of a pediatrician, a clinical psychologist, a social worker, a nurse clinician, a nutritionist, an education specialist, and a physical therapist. The assessment produces an individual health plan (IHP) that delineates the problems and needs of the child and family, the goals to be achieved in the ensuing 12 months, the resources needed, and their location in the child's locale. This IHP is sent to the primary care physician and the local based services (LBS) coordinator for children with special health needs. Followup telephone consultation with the physician is available. Reassessment is done annually and a new IHP is developed.

EVALUATION: Process and outcome evaluations for the physician, child, and family are measured with questionnaires on physician attitudes and satisfaction; on the child's use of emergency services, hospitalizations, and days absent from school; and on the family's functional state and satisfaction. Disease-specific objectives in health status, functional abilities, and developmental/educational capabilities are established for each child and incorporated in the IHP. Project activities are monitored at specific intervals by project staff. Team process and progress toward project goals and objectives are discussed at team conferences and retreats. Individual files are reviewed annually.

EXPERIENCE TO DATE: The consultation model has been modified to provide two or three visits with the assessment team to accomplish a comprehensive evaluation and to develop the IHP. Thirty-five children with a variety of chronic health conditions have been seen, involving approximately 90 visits in the first 1-1/2 years of the project. Development of a new standardized format for the IHP, including appropriate language for families and professionals, is underway.

Air Care: Improved Asthma Management for Young Children and Adolescents

Minneapolis Children's Medical Center
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MCHIP
MCJ-278510
10/01/92–09/30/97
Project Director(s):
David Aughey, M.D.

PROBLEM: Minneapolis Children's Medical Center is surrounded by an inner-city neighborhood that is characterized as the poorest neighborhood in the metropolitan area, with the highest rates of public assistance, infant mortality, and other indicators of poor health status. Overall, minority inner-city children living in poverty are affected at almost twice the rate of white children who live in larger, less crowded housing. Many of the children who are patients in the Children's Clinic and the TeenAge Medical Service (TAMS) have had excessive rates of hospitalization and emergency room use due to inadequate asthma management. The Air Care home care nurse augments the traditional medical staff by providing education and intervention efforts that deal specifically with the social and cultural factors unique to an inner-city population living in poverty.

GOALS AND OBJECTIVES: Over the 5-year project period, each participant in the Air Care project will show relative improvement related to his/her asthma condition. The project will:

1. Improve the appropriate use of health services, such as decreased visits to the emergency room and hospitalization, and the appropriate use of asthma management medication;
2. Increase the sense of well-being as perceived by the child, parent, and adolescent, including improved school attendance or decreased absenteeism;
3. Increase the skill and knowledge level of patients and their families about the disease; and
4. Address the social and environmental factors that contribute to the risk associated with asthma.

METHODOLOGY: In order to achieve the outcome objectives established for the project and for each participant, the following methodology has been followed:

1. Identify the inner-city children and adolescents most at risk. Enroll 25 participants, with 20 percent adolescents.
2. Integrate a home care nurse into a team of physicians, nurses, and social workers.
3. Continuously follow up in the homes of the families participating in the program.
4. Adapt program efforts to meet the needs of parents of young children with asthma and the unique characteristics of inner-city adolescents.
5. Use the "You Can Control Your Asthma" teaching materials developed by another federally funded project.

EVALUATION: Initially, a parent evaluation and advisory council was proposed as a means of providing feedback about the project's effectiveness. This technique did not prove workable, so a family feedback questionnaire has been developed that will be conducted one-on-one by nonproject personnel on a periodic basis. A community advisory council has been established that includes members from various health organizations with an interest in asthma management. A specially designed data base has provided the capability to monitor the progress of each participant and the overall extent to which the project is meeting the stated goals and objectives. The data base provides the mechanism to organize, maintain, and evaluate the baseline information collected for each enrolled participant.

EXPERIENCE TO DATE: While we still intend to enroll 25 participants, we have found it very difficult to maintain stable and continuous involvement. Currently, 14 children are actively enrolled, 50 percent of whom are adolescents. More adolescents have been referred than expected based on their extreme noncompliance with asthma management efforts. Thirteen other children were referred to the program, but the home care nurse had difficulty finding them initially at the addresses and telephone numbers given or could not obtain agreements to continue followup appointments.

North Star Elementary School-Based Community Health Center
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MCHIP
MCJ-278535
10/01/94–09/30/99
Project Director(s):
Edward P. Ehlinger, M.D.

PROBLEM: The health status of children in the Near North community of Minneapolis is among the worst in the city. This community has the highest percentage of low birthweight infants (11.5 percent) and the highest infant mortality rate (18.6 percent) of all Minneapolis communities. Only 50.9 percent of pregnant women in this community received prenatal care in the first trimester, and only 38.2 percent of 2-year-olds are adequately immunized.

The Near North community is one of the most diverse communities in Minneapolis. Nearly 60 percent of its residents are people of color, and more than 12 percent speak a language other than English at home. Poverty is a major problem in the Near North community; 62.5 percent of children under age 5 and 50.3 percent of children between ages 5 and 18 are below Federal poverty standards. Only two primary health care facilities are located in this area, and most of the community has been designated a Medically Underserved Area. Most health care efforts in the city of Minneapolis have focused on preschool children and adolescents. Elementary school-age children have been neglected and are one of the most underserved populations in the community. North Star School, which is located in the Near North community and has one of the largest kindergarten through third-grade student populations in the city, has felt the effects of this lack of care. More than 360 students (33.9 percent) had more than 10 absences during the 1991–92 school year, and 123 (11.5 percent) had more than 20 absences. Teachers report that many of these absences are due to lack of access to health care or to parents' inability to deal with the complexities of the health care system. Currently, no solution exists to this problem of lack of access to health care.

GOALS AND OBJECTIVES: To improve the health status of children and their families in the Near North community, the Minneapolis Department of Health and Family Support (MDHFS) intends to build on its lengthy experience with adolescent school-based clinics and other community partnerships to establish a multidisciplinary and multiagency school-based clinic in North Star School. The objective of this clinic is to serve the students in North Star School and also to serve as a community clinic for other school-age and preschool children and their families who live in the community. It will also be a colocation site for an array of social services. By providing comprehensive health services to more than 1,000 children and their families, the clinic aims to:

1. Increase the immunization rate of 2-year-olds to 70 percent;
2. Decrease to less than 5 percent the number of students who enter kindergarten inadequately immunized;
3. Decrease by 25 percent the number of students who are absent more than 10 days during the school year; and
4. Improve the use of community-based health services.

METHODOLOGY: MDHFS will collaborate with two community-based clinics to staff a multidisciplinary clinic at North Star School. Various human service providers will also be colocated in the clinic. The clinic will be in operation during school hours and after school so it can serve North Star students as well as other children living in the area. Services to be offered to children and adults at the clinic include primary medical, dental, nursing, nutrition, social work, developmental screening, health education, and pregnancy testing and family planning services. Outreach workers from the community will provide home visits to enhance family use of the services provided by the clinic. Backup services will be provided by the existing community-based clinics that offer X-ray and pharmacy facilities. Contracts with the managed care plans in the county that serve the medicaid population will be pursued as a way to fund the clinic long-term and as a demonstration of how to link school-based clinics and managed care. MDHFS is the local Title V agency for Minneapolis. The program will collaborate with the Minnesota Department of Health's Maternal and Child Health Program and the Department of Human Services in negotiating contracts with the managed care plans in the county. Close coordination with the State's Services for Children with Handicaps Program will be necessary to serve more than 100 children in North Star School and numerous others in the community who have special health needs. The clinic will work closely with the State MCH program in its efforts to improve school health services and to expand school-based and school-linked health services.

EVALUATION: The overall health status of children in the Near North community will be monitored annually by KIDSTAT (the health status monitoring program of MDHFS). Data will be obtained through vital records, public assistance data, various city agencies, and special studies. Monitoring of specific objectives will be done through encounter forms and routine enrollment attendance data collected by the school. Monitoring of improved linkages among community health and social service providers will be done through a specially designed referral and tracking form. Progress toward the immunization objectives will be measured by a retrospective study of kindergarten students residing in the community.

Partnership Project
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MCHIP
MCJ-278516
10/01/90–09/30/95
Project Director(s):
Donna Zimmerman, M.P.H.

PROBLEM: The physical and emotional well-being of young children is seriously endangered by suboptimal parenting, which is associated with an insecure attachment between infants and their mothers. Suboptimal parenting is a very serious problem affecting morbidity—and in extreme cases, mortality—in infants. Consequences of suboptimal parenting include increased incidence of child abuse, neglect, and failure to thrive, as well as later psychopathology. There is considerable documentation in the research indicating an increased incidence of these problems among children whose mothers are socially isolated, are highly stressed, have unmet personal needs, and lack knowledge of child care and development.

Closely spaced pregnancies (pregnancies less than 18 months apart) are another factor in poor infant outcomes. They are associated with an increased incidence of prematurity, low birthweight, and small-for-gestational-age infants, as well as increased maternal stress, which further compromises the attachment between mother and child.

Health Start, Inc., previously conducted a program designed to promote positive infant outcomes and child health among a high-risk, low-income population in Ramsey County, MN. Data indicated that while the program successfully addressed the problems of suboptimal parenting, the incidence of closely spaced pregnancies within that project's high-risk population was more than twice that of the overall client population. This program, through modification of the former model, seeks to continue to address the problems of suboptimal parenting while exploring effective methods for reducing the number of closely spaced pregnancies.

GOALS AND OBJECTIVES: The project has two goals:

1. To facilitate the development of secure mother-infant attachments among clients participating in the project; and
2. To minimize closely spaced pregnancies in the target population.

Measurable objectives are

1. To reduce the incidence of abuse of children under age 2 in the project population to less than the 3.5 percent currently seen in the overall client population; and
2. To decrease to less than 50 percent the number of repeat pregnancies within 18 months of delivery among targeted women.

METHODOLOGY: The Partnership Project is administered as part of Health Start, a program with 501(c)(3) status that began in 1967 as a Title V categorical program. Health Start is located at St. Paul-Ramsey Center, a county teaching and tertiary care center. Health Start has a subcontract with the Early Childhood Family Education program of St. Paul schools, and project services are provided through this partnership.

Through this project, 24 women at high risk for care-giving dysfunction receive intensive services for 2-1/2 years beginning in the last 4 months of pregnancy. The project is designed to enhance informal and formal supports for the mother, increase her knowledge of child care and development, and help her better meet her own needs so she can better meet the needs of her child. Efforts are directed at helping each woman recognize the value of adequate child spacing so that she will incorporate into her lifestyle effective methods of postponing subsequent pregnancies. Essential components of the project are medical services (prenatal, postpartum, family planning, and pediatric care); home visits; mother-infant education and support groups; and case management.

Regular staff meetings involving all project staff are held to communicate progress, assess needs, and update care plans.

EVALUATION: Project activities are monitored through a computerized data system. Data are reviewed by the project director, direct service staff, and the project consultant so that necessary modifications can be made. Participant satisfaction with the interventions is monitored informally through home visits and written anonymous evaluations.

Data on the incidence of child abuse or neglect and repeat pregnancies are collected for comparison with client tracking information, including documentation of well-baby visits, home visits, and group attendance. The quality of mother-child interactions is evaluated on an ongoing basis through staff observation and videotaping.

EXPERIENCE TO DATE: One group of mothers has completed the intervention, one will complete the intervention in July 1994, and a third will complete the intervention in September 1995. Child Protective Services has been involved with three families, all of whom entered the project with older children and ongoing protection concerns. There have been no reports of abuse or neglect incidents in the enrolled infants. There have been nine repeat pregnancies to date, one 12 months after the first child's birth, two after 18 months, and the remainder after 19 to 25 months.

Family Friends: Neighborhood Volunteer Corps
Children's Mercy Hospital
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MCHIP
MCJ-298719
10/01/93–09/30/98
Project Director(s):
Edward Hoffman, M.D.

PROBLEM: Health problems have been reported in families where substance abuse is a problem. These health problems can occur because of substance abuse during pregnancy, or they may be due to the substance abuser's chaotic lifestyle, in which child abuse and/or neglect are prevalent. In the Kansas City area, more than 40 percent of the infants born at Truman Medical Center, the hospital serving indigent women, tested positive for substances, with 15 percent positive for cocaine. The infant mortality rate in these inner-city areas is more than 15 to 18 per 1,000 births. These rates have evidenced an increase in recent years. Child abuse rates have also escalated recently. The State of Missouri Department of Social Services reported more than 17,000 confirmed cases of child abuse during 1992. A number of factors contribute to this abuse. Women and minorities respond differently to drug treatment than do white males. Mental health problems often accompany substance abuse, and these are correlated with child abuse. The social support networks of these individuals are usually confined to other individuals who use substances. This places the child in more danger of abuse and injury.

GOALS AND OBJECTIVES: Working in collaboration with the health community and grassroots neighborhood groups, the Kansas City Family Friends: Neighborhood Volunteer Corps will implement a comprehensive, family-centered program that will lower the prevalence of disabilities and infant mortality. Specific objectives are to:

1. Develop linkages between the community and health care agencies to strengthen their ability to enhance health outcomes for children where substance abuse is a problem;
2. Assist at least 20 families per year (100 total over the project period) with a trained weekly visitor who is a community member;
3. Ensure that the developmental care of each infant, child, and adolescent (100 total over the project period) is maintained through regular visits and immunizations;
4. Decrease by 50 percent the repeat pregnancies of these women within 18 months of delivery, and increase the birthweight of infants born to women who become pregnant during the project period;
5. Decrease the incidence of child abuse in the population as reflected by emergency room/hospital admissions, decrease abuse risk factors of participating families on the Kempe Family Stress Checklist by 70 percent, and increase parenting skill/knowledge on the Adult-Adolescent Parenting Inventory (Bavokil) by 20 percent; and
6. Decrease by 20 percent the needs of these families as reflected by the Family Needs Survey (Bailey and Simeonnson) through collaboration with community agencies.

METHODOLOGY: Collaboration between the health care professionals and the neighborhood groups is fostered through regular meetings and the conduct of this project. Family Friends is a model of trained volunteers who visit families on a regular basis. The families are referred by other ongoing professional programs and pediatricians. Through these friendship visits, a role model is set for the parent, and peer support outside of the drug network is established. The Family Friend encourages developmental visits and assists in making arrangements for these visits. Supplemental programs of The Children's Mercy Hospital will stress health care for the child or adolescent and family, as well as other health issues (e.g., sexually transmitted diseases, adolescent pregnancy). Referral to a network of social agencies by the Family Friend and supporting hospital staff should assist with obtaining needed services and agency support.

EVALUATION: Baseline data on emergency room visits and hospital stays are obtained for each child and adolescent served. The infant mortality rates for the ZIP Codes participating in the project are also obtained. Annual data will document changes. Annual pre/post measurements of immunization records and maintenance of clinic visits will also be performed. The spacing between children and birth outcomes of infants born after participation begins will be compared with the spacing and birth outcomes of previous children. Family needs are assessed using the Family Needs Survey (Bailey and Simeonnson). The Kempe Family Stress Checklist measures family stress. Parenting skill is measured by the Adult-Adolescent Parenting Inventory.

EXPERIENCE TO DATE: Families have been identified for the program by a variety of agencies. Sixteen volunteers have applied for the program, seven volunteers have been trained, and four volunteers are working with children in their homes or in a child care facility. One problem has been the ability to train and utilize volunteers who work full time. An evening training session has been planned, but these volunteers will not be available to families during the day. Volunteers who work nontraditional schedules will be recruited. Materials produced include the Family Evaluation Assessment Tool.

Rural Partnership for Children
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MCHIP
MCJ-318717
10/01/90–09/30/95
Project Director(s):
Jeannette Pergam, M.D.

PROBLEM: Children who live in rural Nebraska and have chronic and recurrent illnesses lack access to comprehensive, coordinated pediatric services. Pediatric consultation is not an easily accessible complement to the primary medical care provided by local family physicians; moreover, primary care physicians may be less likely to refer children with chronic illnesses when distance is a significant factor. In Nebraska only 17 percent of all pediatricians in the State practice outside Omaha and Lincoln. It is estimated that between 5 and 20 percent of the approximately 10,000 children (0–21 years old) in Box Butte, Dawes, Sheridan, and Sioux Counties in the Northwest Panhandle of Nebraska have chronic medical conditions. Owing to the lack of specialization in the area, alternative mechanisms to meet the health needs of rural children with chronic and recurrent illness, such as the Rural Partnership for Children, must be developed.

GOALS AND OBJECTIVES: The Rural Partnership for Children project continues in its efforts to increase access to, coordination of, and quality of health care services to rural children with special health needs who reside in Northwest Nebraska.

METHODOLOGY: The Rural Partnership for Children strategy is to create and sustain for children with chronic and recurrent illnesses in the targeted four-county area a general pediatric presence that complements and strengthens the health care provided by local family physicians. Through monthly pediatric consultation service clinics, a team of general pediatricians plus psychologists and a nutritionist (on an as-needed basis) have continued to spend 1 to 2 days per month providing consultation in the offices of local physicians. The pediatric consultation service clinics rotate among four sites to enhance geographic access. Locally based project staff (a child advocacy coordinator, a nurse, and a health services clerk) arrange all intake, registration, scheduling, tracking, referral, and care coordination.

EVALUATION: The monitoring methods that were developed early on will continue, including quarterly reports based on goals and objectives, regular staff conference calls between the project service site in Chadron and the administrative offices in Omaha, ongoing documentation of project match, clinic reports, and so on. Telecommunication capacity via laptop computer/modem and the university's statewide network has permitted electronic exchange of data and other project information as well as E-mail between sites. The project has also increased its usage of teleconferencing for joint meetings of the Local Advisory Committee and the State Steering Committee, subcommittee meetings, and consultations. Minutes are kept of all meetings. The Patient Information System (PIS), including customized dBase software managed locally on the project's portable computer, tracks all children and families referred. Clinic reports are generated at least quarterly. Information from the patient care plan compiled for each child has also been computerized.

The Nebraska Rural Health Research Center, in the University of Nebraska Medical Center's Department of Preventive and Societal Medicine, provides assistance with and consultation on the evaluation of the project. The evaluation design includes four major components: A descriptive analysis of services provided; an assessment of the project's impact on the provision of medical care to children; an assessment of the impact on participating children and families; and a description of the general community reaction to the project.

The evaluation process began during spring of 1994. Thus far, the host physicians and members of the communities have been interviewed by the evaluation consultants; a survey of the consulting pediatricians and other providers will soon be underway. In addition, the PIS furnishes timely, comprehensive, descriptive data on the status of individual children and the population served as a whole.

EXPERIENCE TO DATE: Monthly pediatric consultation service clinics have been held in the project area since May 1991. As of June 1994, 265 children have been referred and 248 children were served, generating [illegible] visits. All practicing family physicians in the four-county area have continued to refer children on a regular basis. Care coordination and patient followup are provided by local project staff. The majority of health problems identified or confirmed continue to fall within the categories of abnormal growth and development, behavior, and congenital/genetic abnormalities. The child advocacy coordinator has become an integral player on local and regional committees and in planning efforts of other State agencies that serve children with special health care needs and their families, offering services such as early childhood intervention and respite care coordination. The State Steering and Local Advisory Committees have continued to provide guidance to the project. The joint Long-Term Planning Subcommittee was formed to look at issues affecting the project, such as future funding, health care reform, and State-local linkages.

Healthy Families Santa Fe
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MCHIP
MCJ-358626
10/01/91–09/30/96
Project Director(s):
Carole Owens, M.S., R.N., P.N.P.

PROBLEM: On a per capita basis, the incidence of child abuse, neglect, and domestic violence in Santa Fe County is above the national average. Recent data indicate the risk of child abuse and neglect can be reduced significantly if a continuum of supportive educational and therapeutic service is made available to families during the first years after the birth of a child. The most effective child abuse and neglect preventive efforts are home visitation and followup services for families of infants. In *Starting Points* (1994) the Carnegie Corporation addresses the issue of ensuring good health and protection of young children. The article suggests that offering home visitation services to all first-time mothers with newborns is essential. Healthy Families will help reduce child abuse and neglect in Santa Fe County by providing home visitation for first-time parents who are at risk of mistreating their children. Volunteers and paid paraprofessionals will make these home visits.

GOALS AND OBJECTIVES: The program's goals are to reduce significantly the incidence of child abuse and neglect in Santa Fe County and to improve the home environment of families with children.

At the end of the 5-year period the following objectives will have been met:

1. Ninety-five percent of all new mothers in Santa Fe County (1,500 annually) will have received information about early childhood development and the community resources available to them.
2. The average number of first-time parents at risk for abusing their children in Santa Fe County will be determined, so public and private agencies will be better able to allocate money for child abuse and neglect prevention programs.
3. Of parents receiving home visits, 2 percent will have been reported for child abuse and neglect. Based on data from Hawaii's Healthy Start Program, Breakey and Pratt (1991), and the Olds (1986) studies, it is estimated that without intervention, at least 20 percent of this high-risk group would be reported for child abuse and neglect.
4. Of parents receiving home visitation, 60 percent will have improved their home environment as measured by Home Observation for Measurement of the Environment and will be capable of functioning without the assistance of the home visitor.
5. Of parents receiving home visits, 90 percent will show a statistically significant reduction of changeable risk factors as measured by the Kempe Center Family Stress Checklist.

METHODOLOGY: First-time mothers who reside in the county and who are referred to the program are interviewed by an early identification worker and given a community resource directory. The risk for child abuse is assessed during the initial visit and the need for intensive participation in the program is determined. Family support workers assist eligible parents in enhancing their parenting and home management skills and encourage positive parent-child relationships. Parents are introduced to community resources that support the family and are encouraged to form their own support network. All services are free of charge.

EVALUATION: The validated Kempe Center Family Stress Checklist is the pretest and posttest tool. County child abuse or neglect reports are monitored. Individual family support plans monitor family progress. The Revised Denver Prescreening Developmental Questionnaire is administered every 6 months to determine the child's developmental progress. Family support workers discuss individual cases with the project coordinator every 2 weeks.

EXPERIENCE TO DATE: The program has responded to 100 percent (359) of referrals since the program's inception in 1991. Of families who have had the comprehensive intensive home visitation for a least 1 year, only one client was reported for neglect. This case involves a developmentally delayed mother with four children. The target child was admitted to the local hospital with the diagnosis of medical neglect of atopic dermatitis. An early identification worker was hired in 1994. A clerical position was filled in 1992. A program brochure, community resource directory, and early childhood information brochures have been developed.

Helping Enable Indian Children of Albuquerque

All Indian Pueblo Council
Speech, Language, and Hearing Program
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MCHIP
MCJ-358633
10/01/94–09/30/99
Project Director(s):
Sandra Taft, M.S.

PROBLEM: Urban Indian children with disabilities residing in Albuquerque, NM, are not receiving the full continuum of care they require to promote optimal health and functional ability. These children are not being adequately identified to the health care system, are not effectively accessing available services, and are not fully utilizing health care and related social support services. For urban Indian children with special needs, access to services is impeded by (1) a lack of recognition of the needs of urban Indians; (2) the mobile nature of the population; (3) differences between reservation-based and urban health care delivery systems; (4) a lack of understanding of the health care system on the part of families; (5) a lack of awareness about urban Indians on the part of providers; (6) a frequent lack of basic services and resources for families, such as adequate housing, transportation, and child care; and (7) a lack of outreach. A year-long Census and Needs Assessment project provided baseline data, defined the target population, provided information about the interaction between service providers and urban Indian families, and provided the impetus for this project.

GOALS AND OBJECTIVES: The project has two major goals:

1. Improve access to and utilization of health care and related resources by urban Indian children and their families; improve the health care system that serves these children by facilitating access and promoting utilization by client families.
2. Improve the health status, functional ability, and developmental capability of urban Indian children with limiting conditions and special needs. This long-term goal, relevant to *Healthy People 2000* objectives, is a health status goal that is directly related to problems inherent in the current health system (i.e., inadequate access to and utilization of services).

Program objectives include:

1. Identifying children who need services;
2. Improving services coordination;
3. Providing families with case management and advocacy skills;
4. Helping families to negotiate the urban health care system;
5. Fostering parent-provider partnerships;
6. Increasing the ability of agencies to serve and assist Indian families; and
7. Creating a culturally appropriate linkage between urban Indian families with disabled children and the full expanse of local service providers.

Outcome objectives include:

1. A formalized plan for creative outreach, home visitation, and program participation for urban Indian children with special needs and their families;
2. The ability of all client families served to identify a medical home;
3. An individualized family service plan (IFSP) for all client families;
4. Completion of at least 12 hours of individualized advocacy and case management training for 75 percent of client families;

5. Acknowledged competency in advocacy and case management training for 75 percent of client families completing 12 hours of training; and
6. Achievement of formal written agreements of cooperation with 80 percent of key agencies serving urban Indians.

METHODOLOGY: The program approach is designed to address the needs of urban Indian children with disabilities and ultimately to help increase their physical, social, and emotional health and functional ability. The approach comprises five components:

1. Creative outreach to provide active and innovative ways to locate, recruit, and enroll clients;
2. Case management to ensure that clients with complex multiple problems and disabilities receive all the services they need in a timely and appropriate manner;
3. Family empowerment through skills building to draw on the natural strengths and abilities of families;
4. Parent-provider partnerships to reduce cultural and jurisdictional barriers, provide common ground for communication, and provide a comfortable atmosphere for the family; and
5. Community awareness to increase collaboration with State and local providers, coordinate activities with service agencies, and increase communication with the provider community and with the urban Indian community.

The target population for the project is composed of three segments of the Albuquerque population: (1) Children with special health needs, (2) their families, and (3) service providers. This program will provide case management activities for the child as well as support services, education, assistance, and training for the family. Local providers will be the focus of client services coordination, cultural awareness efforts, and informational activities about the urban Indian population in general and about urban Indian children with special needs. Program activities include (1) outreach and case finding, (2) linkage to services and services coordination, (3) establishment of a medical home, (4) development of IFSPs, (5) training and education for families, and (6) provider outreach. Implementation of the client family IFSPs will be facilitated by screening, assessment, referral, tracking, training, and data management. Client families will progress through five defined levels of service. Services will be provided at various field sites throughout the city to make the program accessible to a majority of the target population. Data collection and data management will provide documentation of program activities and progress and will provide information to the project's advisory board and to funding agencies. This program is a joint venture between several Albuquerque-area service providers. The program will be developed and housed through the All Indian Pueblo Council, Inc., Speech and Hearing Program and will serve the needs of disabled urban Indian children from all tribes. Project partners include State of New Mexico Children's Medical Services; Parents Reaching Out, a nonprofit organization of parents and professionals; local pediatricians from the U.S. Public Health Service Indian Hospital and the Lovelace Medical Center; and Indian parents of children with special needs.

EVALUATION: Program evaluation will be performed through the periodic measurement of outcome objectives, client progress, client satisfaction, and program objectives. Operational and management data will be collected and analyzed. Family interviews and provider surveys will be conducted periodically. A formative evaluation of the target population, program services, and client family progress will be conducted at 6 months. A summative evaluation of program objectives and program performance will be conducted at 12 months. Monthly, quarterly, and annual progress, statistical, and status reports will be furnished to the Advisory Board and to the funding agency.

Teen Parent Support Project
Taos County Maternal and Child Health Council
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MCHIP
MCJ-358631
10/01/94–09/30/99
Project Director(s):
Nicola Baptiste, B.A.

PROBLEM: The general health status problem in Taos County, New Mexico, is poverty. The economic and demographic changes of the last two decades have led to a significant increase in the proportion of adolescents who have lived in poverty for prolonged periods. The specific health status problem in Taos County is the increasing rate of births to girls 15–19 years old.

GOALS AND OBJECTIVES: The Teen Parent Support Project (TPSP) has the following goals and associated objectives:

1. Provide the means for adolescent parents to develop improved health and safety practices for themselves and their babies.
   a. By 1996, an accessible, comprehensive, coordinated services system will be established for adolescent parents;
   b. By 1996, at least 75 percent of program participants will have breastfed their babies for at least 2 weeks;
   c. By 1996, at least 50 percent of program participants will have prolonged breastfeeding their babies for at least 6 months;
   d. By 1996, at least 85 percent of program participants will have received their full schedule of well-baby visits, including immunizations, as defined by American Academy of Pediatrics (AAP) recommendations;
   e. By 1996, the majority of program participants will have responded adequately to their children's routine accidents and/or illnesses;
   f. By 1996 at least 66 percent of the program participants will not have a repeat pregnancy before age 19; and
   g. By September 30, 1995, a component will be developed to validate and document culturally traditional and developmentally appropriate methods of infant health care with program participants.
2. Provide opportunities for support for adolescent parents in developing positive child-rearing practices.
   a. By September 30, 1995, a component will be established to validate and document culturally traditional and developmentally appropriate methods of child rearing with program participants;
   b. By 1996, the rate of reported cases of child abuse and/or neglect in program participant families will be not more than 5 percent; and
   c. By the time of their graduation from TPSP, participants' interaction with their children will show evidence of increased and integrated knowledge of child care, child development, and appropriate developmental expectations for their babies.

3. Increase possibilities of long-term self-sufficiency for adolescent parents.
   a. By 1996, at least 85 percent of program participants will graduate from high school or obtain their General Equivalency Diploma (GED) by the time they are 20 years old;
   b. By the time of their graduation from TPSP, participants will show evidence of increased understanding of job possibilities and requirements for specific training and employment opportunities; and
   c. By the time of their graduation from TPSP, participants will show evidence of having set appropriate and realistic short-term and long-term goals for their future education, childbearing, marriage, housing, and employment.

METHODOLOGY: TPSP will identify first-time pregnant adolescents through referrals from various entities in the community. An intake process will be done by the program coordinator in the first appointment with the TPSP participant; a care coordination plan will be developed from this process. The program will also encourage intergenerational support and community involvement through documentation and oral transmission of traditional Hispanic and Native American health and parenting practices. The core of the program will be two weekly group meetings with the project coordinator and the part-time paraprofessional group facilitator. These groups will have three functions: (1) To provide direct services in the form of well-baby Early and Periodic Screening, Diagnostic and Treatment visits and immunizations for babies of the participants; (2) to provide education and information; and (3) to provide support and encouragement for the adolescent parent participants. Supplementing the group will be a limited home visitation program to build confidence and intimacy between staff and the TPSP participants and to monitor outcomes.

EVALUATION: A data analyst will (1) review model instruments and data collection software programs, consult with the State MCH epidemiologist, consult with the MCH and AAP technical assistance units, and discuss specific outcome data needs with Taos MCH Council members and providers; (2) develop the evaluation process and schedules, including pretests and posttests, specific monitoring instruments, and collection of data from existing sources; and (3) implement the evaluation process and perform data analysis. In addition to these evaluation measures, TPSP will agree to participate in independent evaluation by the Healthy Tomorrows Partnership for Children Program or a designee.

Fostering Improved Health Status for Foster Care Children
Kids Adjusting Through Support, Inc.
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MCHIP
MCJ-368218
10/01/90–09/30/95
Project Director(s):
Michael Henrichs, Ph.D.

PROBLEM: Studies document the high incidence of behavioral, emotional, and mental health problems in the foster care population. These studies note a lack of mental health services for these children. In the past, it has often been felt that the provision of a stable environment, in the form of a foster home, was adequate for many of these children. However, studies show that this alone is inadequate for many children, especially children who enter care at an older age.

Foster children often come from disrupted families with multiple problems. Separation from families, friends, and familiar surroundings can enhance feelings of isolation and rejection. A number of factors contribute to these children's sense that they have no control over their lives, including absence of normalcy; stresses of adjusting to a new family, peers, and school; uncertainty about length of placement; number of placements; and anxiety about the future. Children in care often feel angry, sad, and hopeless. Studies have repeatedly demonstrated that 40 to 45 percent of children in foster care have emotional and behavioral problems. Followup of young adults who have left foster care shows that even apparently well-adjusted individuals experience detrimental long-term effects. They have problems with their sense of well-being and identity, find it difficult to form deep attachments, and regard themselves as inadequate parents.

GOALS AND OBJECTIVES: The Kids Adjusting Through Support (KATS) Foster Child Program is an innovative service and evaluation project implemented to achieve:

1. The health status goal of reducing the incidence of physical and emotional symptomatology among foster children in the project;
2. The health system goal of increasing the usage of health and mental health services by foster children and foster parents; and
3. The health system goal of increasing the incidence of social support (networking) among foster care children and foster parents.

The objectives include realization of improved physical and mental health among foster children and an increase in their contact with health and mental health professionals, as compared to study control subjects on valid and reliable pre/post measures.

METHODOLOGY: Through the well-established KATS Inc. program in collaboration with the Monroe County Foster Care Pediatric Clinic and Department of Social Services (DSS), the authors have developed support groups for children in foster care (ages 0–18) and their foster parents. The children are stratified by age into groups, which meet separately with trained mental health counselors. Foster parents also will meet simultaneously in groups to deal with issues of child behavior, limit setting, differences in value systems, and the emotional aspects of parenting, attachment, and loss. The KATS-Foster Family groups will meet for 8 weeks. It is hypothesized that foster children who participate in these support groups will have fewer adverse emotional effects and demonstrate less anxiety, depression, and behavioral difficulties than nonparticipants. It is also expected that the foster parents will have improved understanding of the behavior of the children and will provide a more responsive environment for them.

EVALUATION: The necessary information to determine the efficiency and effectiveness of the project will be gathered from (1) directors' meetings; (2) analyses of monitoring data; (3) coordination and referral information from local community agencies, professionals, and foster parent associations; and (4) compilation of chart reviews.

Regular meetings of the principal team members are held to (1) direct and monitor the project's activities; (2) make management decisions and plan data collection and organizational tracking strategies; and (3) coordinate supervisory and liaison activities. Group leaders and evaluators are trained and supervised to a level of competence. Valid and reliable pre/post psychological measures and group evaluation forms are utilized and analyzed with appropriate statistical techniques to ensure proactive monitoring.

EXPERIENCE TO DATE: The project benefits from broad community support. Collaboration with community agencies, the Monroe County DSS, the county and New York State Departments of Health, American Academy of Pediatrics members, other professionals, and foster and adoptive parent associations has been achieved. During 1993–94 more than 727 volunteers, including 45 group leaders for the Foster Family project, have been recruited, trained, and supervised. A total of 202 foster children and parents participated in intervention groups during 1993–94. During the next year, program evaluation will be the major focus of the project. An additional objective to conduct a support group for the biological parents of foster children has been a 1993–94 initiative.

To date, the foster children and foster parents have evaluated the program very positively. As a result of this positive response and requests from parents, the Monroe County DSS initiated monthly foster parent support groups for all foster parents in each of the county's four quadrants.

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Pediatric Comprehensive Asthma Management Program
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MCHIP
MCJ-368214
10/01/92–09/30/97
Project Director(s):
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PROBLEM: During the 1980s nationwide hospitalization rates increased 4.5 percent annually for asthmatics less than 17 years old, while admission rates for other respiratory disease declined (unrelated to a shift in diagnostic coding). New York City, with less than 3 percent of the nation's population, accounted for approximately 6 percent of all asthma hospitalizations. Race is not a cause of the observed difference, but poverty is. Among New York City neighborhoods there is a 16-fold difference in asthma hospitalizations, with the highest rates in the poorest areas.

The Women and Children's Health Center is a State-funded primary care center in a Health Crisis Zone of western Queens where the highest hospitalization rates in the city have occurred for conditions sensitive for ambulatory care. This area has the highest admission rates for pediatric asthma/bronchitis in Queens. The Pediatric Comprehensive Asthma Management Program (PedCAMP) was established to address this health status problem of increased pediatric asthma hospitalizations.

The three major contributing factors identified for the problems currently observed are (1) inadequate access to specialty care for asthma and related conditions; (2) inadequate understanding and counterproductive attitudes about asthma, resulting in poor compliance; and (3) increased target population exposure to environmental allergens and/or irritants.

GOALS AND OBJECTIVES: The primary outcome goal of this project is to reduce the overall asthma/bronchitis hospitalization rates by 80 percent for children enrolled in this program over the first 36 months of enrollment and to maintain this lower level throughout enrollment. The secondary outcome goals, to be met within the same time frame, are to (1) reduce emergency room visits by 50 percent; (2) normalize pulmonary function; and (3) reduce school absenteeism due to asthma.

METHODOLOGY: In response to the health systems problem of inadequate access to specialty care, PedCAMP began providing onsite comprehensive evaluation and treatment for asthmatic children beginning in January 1993. Through two weekly outpatient sessions, physicians, nurses, and a social worker (1) provide neighborhood access to subspecialty evaluation, education, and treatment for asthma; (2) coordinate home and school care; and (3) facilitate procurement of prescribed asthma and allergy interventions for children with chronic moderate to severe asthma.

To accommodate our increasing patient demand, we will expand to two sessions per week beginning in July 1993 (our seventh month of onsite clinical activity). We are adding two new physician providers to our program in year 1, and the percent effort of the specialist nurse and social worker will increase commensurate with our increased patient care sessions. Our patient education outreach program brings PedCAMP providers into neighborhood schools to present asthma teaching seminars to parents and students. Our onsite patient education programs focus on improving medication compliance and allergen avoidance; in year 2 these programs will be expanded to include elimination of environmental tobacco smoke exposure.

EVALUATION: We track objective data on hospitalizations, emergency room visits, pulmonary function, and school attendance at each visit and compare these data with pre-enrollment levels. Subjective assessments of compliance and self-management skills are made at each visit by review of interim history and physical examination. As patients improve and self-management improves, program visits are scheduled less frequently until patients are returned to primary care management with only quarterly followup visits to our program.

We review success in community and patient impact and data collection in regular staff and community advisory board meetings. We specifically track patient compliance in keeping scheduled appointments. We use follow-through on scheduled tests and appointments as a reflection of patient satisfaction with our clinical program. We maintain a patient log book for data entry at each visit regarding the clinical parameters we are tracking. Quarterly data review is used to identify problems with data retrieval.

EXPERIENCE TO DATE: In the first 17 months we have had more than 1,800 patient visits and enrolled 61 asthmatic children in our long-term followup program. For clients enrolled for at least 1 year, there was a 100-percent reduction in hospitalizations and a 98-percent reduction in emergency room visits compared with the 24-month period prior to enrollment. For clients enrolled for at least 6 months, we observed parallel 100-percent and 93-percent reductions. We have established a neighborhood school outreach program to increase community exposure to our program and awareness of asthma. We established a high school externship program that accommodates up to six local high school students per year as interns in our other health care programs. This externship provides students the opportunity to experience community-based health care, and may draw more adolescent asthmatics into PedCAMP.

Mental Health Treatment for
Sexually Abused Children

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MCHIP
MCJ-378405
10/01/92–09/30/97
Project Director(s):
Thomas E. Frothingham, M.D.

PROBLEM: The mental health and behavior of sexually abused children often are poor, lasting into adult life. In the six-county project area in north central North Carolina, access to appropriate mental health services fails for more than half of the children identified (diagnosed) by the Child Protection Team as suffering from child sexual abuse. Current standards dictate that sexually abused children are especially in need of mental health services.

GOALS AND OBJECTIVES: This project will improve function of sexually abused children by improving access for these children and their families to appropriate mental health services. Measurable specific objectives are as follows: (1) Identification of family specific reasons for and relative importance of factors causing failure of access; (2) improved rate of access to and utilization of appropriate mental health services for identified children and their families; and (3) improved mental health and behavior of sexually abused children.

METHODOLOGY: A three-part methodology will be used: (1) A brief questionnaire will be developed with which to determine for each family the nature and relative importance of barriers to access to appropriate mental health services. (2) On the basis of this information and general information from each client's data base, family-specific strategies will be implemented to achieve access. (3) Evidence for improvement in mental health status will derive from periodic behavioral and mental health assessments.

EVALUATION: Each child will be tracked with the aid of a computerized data base. Tracking comprises periodic queries to the mental health service to which the child has been referred. Queries comprise questions about the degree to which the child has accessed services and about behavior and mental health status. Contact will be made with families and involved professionals where access has failed, in order to learn the reasons and to promote access.

Access will be measured in terms of the proportion of referred children attending the mental health services to which they were referred. Mental health and behavioral status will be measured by periodic screening questionnaires and global mental health assessments. Periodic gathering of data on these measures will provide evidence of the success of the project.

EXPERIENCE TO DATE: The tracking system is in place, and data collection is starting. Data on a preproject 1992 cohort of 150 children reveal that only 53 percent of sexually abused children accessed mental health services and that results of mental health assessment were available for only 35 percent. A more comprehensive examination of the societal response for this cohort is the subject of ongoing research. This project has catalyzed a significant communitywide effort to improve the societal response to child sexual abuse.

Collaborations for Healthier Children
Good Samaritan Medical Center
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(614) 454-5090

MCHIP
MCJ-398528
10/01/91–09/30/96
Project Director(s):
Debbie Wilson, R.N.

PROBLEM: Comprehensive health care services for infants and children are often unobtainable by the indigent and working poor populations in southeastern Ohio. Increasing unemployment, alcohol and drug abuse, and the incidence of adolescent parents exceeding the national and State averages all have impact on clients' ability to access primary health care for their children. Reluctance of private physicians to participate as primary providers for this population further complicates a system already lacking continuity of care. Fragmented care, inappropriate use of emergency rooms, and medical neglect are too often the results of not having a medical home.

GOALS AND OBJECTIVES: Collaborations for Healthier Children focuses on the timely delivery of health care services to children residing in an underserved rural six-county area. Project goals are as follows:

1. Improve access to health care for all indigent children ages 0–12 in our six-county service area;
2. Improve the coordination, quality, and continuity of care through the delivery of medical, nursing, education, and social services to the target population;
3. Increase availability of support services to the adolescent parent; and
4. Identify high-risk infants and children, providing necessary referral and followup for these groups.

METHODOLOGY: During its first year, Collaborations for Healthier Children developed its health care team, composed of eight area physicians, three pediatric nurses, one social worker, one pediatric nurse-practitioner, and support staff. Comprehensive health care is provided by team members. Preventive health care, education, and anticipatory guidance are paramount, having impact on the quality of life not only for the child but for the entire family.

Children in need of a medical home are identified by the inpatient obstetric and pediatric nurses; Good Samaritan's prenatal clinic; area physicians; the Special Supplemental Food Program for Women, Infants and Children (WIC); and the Physicians' Referral Service. Attempts are made to place high-risk children with a private physician.

EVALUATION: Project activities are monitored through statistical information as well as other methods. Monthly statistics are tabulated to monitor clinic productivity for the physicians and the nursing staff. These statistics also monitor the number of children who receive well-child care or ill-child care.

The Advisory Board consists of representatives from six county health departments, clinic physicians, three parent representatives, and the clinic nursing staff. The board has been established to monitor the progress of the Children's Health Center in meeting its stated goals and objectives.

Information from patient surveys is shared with the nursing and support staff for evaluation, recommendations, and action as needed. Team progress toward meeting project goals is discussed and reviewed at monthly nursing staff meetings.

Chart review is used as a method of evaluating the coordination, quality, and continuity of care. Access to health care is also monitored through chart review. The charts of children of adolescent parents are evaluated to ensure that needed support services are provided.

EXPERIENCE TO DATE: The Collaborations for Healthier Children program opened in December 1991, the Advisory Board having been established the month before. Referrals were initially received from local hospital nurseries and physicians and were limited to newborns for a short period of time. As growth was slow, the limit was quickly expanded to include children through age 12.

The number of children receiving care has steadily increased, and several have been able to access care through private doctors. Newborn referrals from physicians have also increased. The pediatric nurse-practitioner has expanded her services to include some minor ill-child care. Parenting classes have been provided, but specialized one-to-one education has proven more effective.

Healthy Tomorrows/Child and Family Health Services Pediatric Tracking Program
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MCHIP
MCJ-398511
10/01/92–09/30/97
Project Director(s):
Edward F. Donovan, M.D.

PROBLEM: Among 850 Cincinnati women who delivered following suboptimal prenatal care since October 1990, utilization of preventive child services and child health outcomes are poor. Infant mortality for this group of primarily African-American, inner-city children is 50 per 1,000 live births. More than 50 percent of these children do not keep their first well-child appointment, many are significantly underimmunized, and the emergency room is used frequently and inappropriately. Approximately 25 percent are born with low birthweight, and the associated health care costs are staggering.

GOALS AND OBJECTIVES: The goals of the Cincinnati Healthy Tomorrows program are to (1) improve health and early educational outcome for inner-city infants born to women with suboptimal prenatal care, and (2) improve the outcome of subsequent pregnancies of index families. Specific aims are to:

1. Increase appropriate utilization of preventive children's services in the first 3 years of life;
2. Reduce infant mortality, primarily by reducing the low birthweight rate;
3. Reduce inappropriate utilization of the emergency department as well as rehospitalization for preventable childhood illnesses; and
4. Reduce the cost of care for children and their mothers by implementing specific preventive strategies.

METHODOLOGY: A community-based, community-managed program employs and trains outreach workers who reside in the same neighborhoods as the identified at-risk families. Using a case management model, community outreach workers will identify family-specific barriers, empower families to overcome these barriers, serve as a liaison between families and preventive services providers, and work with a Community Advisory Board to identify and reduce other community-wide barriers.

EVALUATION: The project is nested within an ongoing longitudinal cohort outcomes analysis begun in 1990. Women with fewer than two prenatal visits who deliver at either of two Cincinnati hospitals and their children are enrolled. Children are tracked to age 3 using computer-based, mailed, and personal contacts with all Cincinnati health providers who care for medicaid-eligible children and with the Bureau of Vital Statistics. Information is collected regarding receipt of well-child care (American Academy of Pediatrics recommendations), emergency department and inpatient utilization, low birthweight, infant mortality, subsequent pregnancy outcome, and cost of care.

Families in the longitudinal outcomes analysis that receive community outreach worker services will be compared to those that do not in the areas of receipt of preventive services, incidence of preventable illnesses and injuries, infant mortality rate, rate of prematurity in subsequent pregnancies, and cost of care. We now enroll approximately 250 children per year, of whom 40 to 60 will receive community outreach worker services.

EXPERIENCE TO DATE: Two community outreach workers have been hired and a training and supervision program is in place. A 15-member Community Advisory Board provides input to program content and writes and modifies the community outreach worker job descriptions. Families in the target neighborhoods are now being assigned community outreach workers. We anticipate that data will be available within the next year to evaluate the impact of this program on outcomes in early infancy.

Funding has been secured to prepare permanent space for the program in the community, to begin tracking children born at a second hospital, to develop a community outreach worker training program, and to develop a program marketing effort. A brochure has been developed to assist families in their interactions with professionals.

Toledo Healthy Tomorrows
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MCHIP
MCJ-398536
10/01/94–09/30/99
Project Director(s):
Bernard J. Cullen, M.D.

PROBLEM: Maltreatment of children constitutes a major social and medical problem in Onio. Although child abuse occurs in all families regardless of structure or income, children born to adolescents are particularly vulnerable to abuse. Their parents often lack the emotional maturity and the personal and social support necessary to properly care for their infants.

In 1992, Lucas County Children Services of northwestern Ohio investigated 4,232 referrals, an increase of 18.8 percent over 1987. Compared with Ohio's eight largest counties, Lucas County ranks third in referral rates. In 1992, 35 of every 1,000 children were referred to Lucas County Children Services for possible abuse or neglect. Improving the caregiving skills of adolescents is of paramount concern because Lucas County has the highest unmarried adolescent pregnancy rate and the highest repeat birth rate by adolescents in the State. More and more adolescents in Lucas County are having children, and fewer and fewer have partners with whom they can share parenting responsibilities. As a result, a generation of children is being reared by undereducated and emotionally immature mothers who often lack the parenting skills and personal support system necessary to ensure their children's well-being.

GOALS AND OBJECTIVES: The goal of the project is to reduce the incidence of child abuse and neglect among children of adolescent families participating in the program. The outcome objective is to reduce the need for children participating in the project to be referred to Lucas County Children Services for possible abuse or neglect, such that close to 0 percent of participants require referral to Lucas County Children Services during the project period. The project's impact objectives are:

1. Improvement in parent-child interaction skills shown by 80 percent of participating families, as measured by the Home Observation Measurement of the Environment (HOME);
2. At least nine well-baby visits by 70 percent of children served by this program by age 24 months; and
3. Completion of age-appropriate immunization schedules by 75 percent of children participating in this program by age 2.

METHODOLOGY: The Toledo Hospital, together with a coalition of parents, pediatricians, and representatives of the Maternal and Child Health Bureau of the Ohio Department of Health and the Toledo Department of Health, designed and developed Toledo Healthy Tomorrows. Toledo Healthy Tomorrows will serve about 80 targeted adolescent families over the 5-year project period. The project will rely on the services of lay persons and professionals. Each participating family will be visited by one of four specially trained Visiting Moms who will be hired by The Toledo Hospital on a part-time basis. The Visiting Moms will initiate contact with the adolescents during their seventh or eighth month of pregnancy and will make at least two home visits before delivery.

Following delivery, the families will be visited every week for 6 weeks, every 2 weeks from 2 to 4 months, every 3 weeks from 4 to 14 months, every 4 weeks from 14 to 20 months, and every 6 weeks from 20 to 24 months. Family caseloads will never exceed 21, averaging about 12 families per month over the 5-year period. During the home visits, the Visiting Moms will counsel, support, assist, and educate the parents and link them with health and social service agencies in the community.

Visiting Moms will receive extensive training, including the Nursing Child Assessment Satellite Training and monthly inservice training regarding child health, development, and abuse prevention. So that the services will be provided in a sensitive and culturally relevant manner, all Visiting Moms will receive intensive multicultural competency training.

Nurses will also visit the families (and an equivalent comparison group of families) when the children are 1 month, 6 months, 1 year, and 2 years old. During these visits the nurses will (1) assess the child's health status, (2) answer questions about child health issues, and (3) administer the HOME inventory.

EVALUATION: To assess the effectiveness of Toledo Healthy Tomorrows, participating families will be compared with an equivalent group of adolescent families using two measures of parenting skills: (1) The HOME inventory, and (2) reported incidence of child abuse or neglect that can be confirmed by Lucas County Children Services. Toledo Healthy Tomorrows will also monitor the immunization rates of children participating in the project and the frequency and appropriateness of well-baby visits. It is anticipated that families that have been assigned a Visiting Mom will (1) score higher on the HOME inventory, (2) have less reported incidence of child abuse and neglect, (3) have better child immunization rates, and (4) bring their children to a pediatrician for well-child visits more often than families in the comparison group.

Kids' Clinic
Eugene School District 4J
200 North Monroe
Eugene, OR 97402
(503) 687-3348

MCHIP
MCJ-418017
10/01/93–09/30/98
Project Director(s):
Pamela Tibbitts, B.S.N.

PROBLEM: Many students from kindergarten through eighth grade in Eugene School District 4J have no medical care other than visits to the emergency room at Sacred Heart General Hospital. Many students are not immunized for common childhood diseases. Parents of younger indigent students who take care of medical needs at the emergency room frequently wait too long to seek care so that serious medical conditions result. Although the school district instituted school-based health clinics in two of its four high schools 2 years ago, younger students also need access to care.

An influx of Hispanic students into the district in recent years has highlighted the need of this group to have better access to health care. Hispanics often do not use a preventive approach to health care, due to economic constraints and cultural barriers; they need an opportunity to see the positive effects of preventive care. Although 51 local physicians, Sacred Heart Hospital, local laboratories, and other health services are eager to supply free care to indigent students, these students lack the access to services that could be provided by referrals from school-based health clinic staff.

GOALS AND OBJECTIVES: The 5-year Kids' Clinic project has the following goals and objectives:

1. Provide indigent kindergarten through eighth-grade students in the district with a medical home by:
    a. Extending preventive-maintenance medical care to indigent students in grades kindergarten through eight by enrolling 35 new students by 1998, thus providing continuity of care from a familiar health professional; and
    b. Ensuring that 10 percent of the students seen at the school-based clinics are in the target population.
2. Ensure that kindergarten through eighth-grade students will no longer be without medical care equal to that of insured students or students receiving medicaid benefits by:
    a. Ensuring that by 1993, all target population students enrolled in school clinic care will have access to previously unattainable services, including free physician laboratory services and hospital care when treatment is beyond the expertise of the nurse practitioner; and
    b. Ensuring that by 1998, 25 percent of referrals from the school clinics to private physicians, Sacred Heart Hospital, and other diagnostic agencies for free extended care are for students from the target population.
3. Reduce emergency room visits for childhood illnesses (e.g., ear infections, strep throat) through school-based clinic treatment services delivered to indigent kindergarten through eighth-grade students in the Eugene School District by:
    a. Increasing the ratio of targeted population students seen by the clinic compared to the ratio of targeted population seen by the emergency room for visits associated with acute childhood illnesses and chronic disorders (e.g., infections or asthma); and
    b. By 1998, decreasing by 10 percent the emergency room visits for treatment of childhood diseases and chronic disorders by Eugene School District students in the target population who have no insurance, medicaid coverage, or ability to pay.

METHODOLOGY: Eligible students and their families will learn about district school-based clinic services through marketing and referral from school nurses. Families will visit the clinic together, and transportation will be provided if needed. A nurse practitioner will see students and their families, referring them as needed to Sacred Heart Hospital or a network of physicians, laboratories, and other service providers. Hispanic families will see bilingual staff and receive materials in Spanish, and staff will receive heightened cultural awareness training from the district community minority liaison.

EVALUATION: The school-based health clinics are monitored by an advisory health council that will also conduct process evaluation for this project. Objectives of the project are stated in measurable terms to facilitate project evaluation. Clinic staff and school nurses will collect the data necessary to determine that progress is being made toward objectives. An evaluation plan for data analysis and summative evaluation will be developed and carried out by the Oregon Research Institute, a nationally recognized research center in Eugene.

Family Growth Center Pilot Project
Allegheny-Singer Research Institute
Resource Development
320 East North Avenue
Pittsburgh, PA 15212
(412) 359-3160

MCHIP
MCJ-428321
10/01/90–09/30/95
Project Director(s):
Richard Solomon, M.D.

PROBLEM: Approximately 500,000 adolescents have babies in the United States each year. Adolescent pregnancy and parenthood interrupt the physical, psychological, and social development of both the parents and their infants. The city of Pittsburgh's North Side community reflects national statistics and problems, yet resources for the majority of these adolescent mothers are essentially nonexistent.

GOALS AND OBJECTIVES: The overall goal of the Family Growth Center (FGC) Pilot Project, now in year 4 of services, is to link the major medical institution in the North Side, Allegheny General Hospital (AGH), to FGC, which offers a comprehensive social support system for adolescent parents who live on the North Side and their children. The project has several objectives:

1. Increase social support for young parents;
2. Improve the health status of both parents and children;
3. Enhance the educational status of families; and
4. Enhance neighborhood and local community growth.

METHODOLOGY: FGC addresses social support, life stresses, parenting abilities, risk factors, and family function through three components: The hospital-based component; linkage of the hospital with FGC; and the neighborhood or community component.

The hospital component includes newborn nursery and primary care services. In the nursery, primigravida adolescent mothers received perinatal coaching in a mother-infant interaction program. Baseline information was also collected. These families were then linked to the FGC located in their community and are referred back to AGH for pediatric, obstetric, and family planning services.

FGC services include a drop-in child care program, a parenting support program, counseling advocacy, and social recreation. These activities help families achieve the objectives listed above.

EVALUATION: At present, 34 adolescent mothers and their firstborn infants have received newborn nursery and FGC services. Twenty-nine families not located in the intervention neighborhoods serve as controls. Baseline measures obtained in the newborn nursery are repeated periodically. Behavioral measures—for example, mother-infant attachment and interaction—are obtained in a laboratory setting by independent researchers when the infants are 12, 18, and 24 months of age. A year 3 evaluation report was recently completed, indicating that highly statistically significant differences between the intervention and control group have been found in terms of both high school dropout rates and repeated pregnancy rates. Only 4 of 34 in the intervention group (versus 14 of 29 in the control group) had second babies, and only 3 of 34 in the intervention group (versus 12 of 29 in the control families) dropped out of school. Satisfaction surveys indicated universal satisfaction with the FGC services. Qualitative data (such as case management files) are also gathered.

EXPERIENCE TO DATE: In year 4 of the project, services have become well established, and FGC has become an integral part of the community, serving well over 300 families in addition to the intensive case management services offered to the adolescents. Recreational programming attracts adolescent mothers, and transportation assistance sustains participation in FGC services.

Long-term support and intensive case management of adolescent mothers appears to result in important gains, both in terms of delaying second pregnancies and reducing school dropout rates as described in the evaluation above.

Project staff continue to be actively involved in countywide and statewide efforts to develop family support centers in the context of the neighborhood setting. This supportive approach may be important in guiding families on a pathway to independence.

Primary Care for Children in Foster Care and Homeless Shelters
Children's Hospital of Pittsburgh
Family Intervention Center
3705 Fifth Avenue at DeSoto Street
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(412) 692-8664

MCHIP
MCJ-428319
10/01/90–09/30/95
Project Director(s):
Mary Carrasco, M.D.

PROBLEM: A high frequency of chronic untreated problems, including behavioral or developmental problems and inadequate immunizations, has been documented among both foster children and children in homeless shelters. While many children receive mandated physical examinations, health histories and records are often unavailable at the time. Thus, the accuracy and scope of the initial health appraisal are seriously deficient and appropriate plans for the child's health care cannot be made. The lack of case management for children and families going through multiple transitions makes it unlikely that the usual medical encounters will result in any significant change in their health status.

GOALS AND OBJECTIVES: The Allegheny County Healthy Tomorrows Project coordinates and implements case management plans for primary health care of a subset of children (ages 0–6 years) in foster care and homeless shelters. Specific goals and objectives are to:

1. Provide case management to coordinate and enhance primary health care for foster children;
2. Coordinate and provide primary health care for children in three homeless shelters;
3. Arrange for these children to have a permanent primary provider or medical home in health care environments in which they feel comfortable;
4. Make adjustments in the program, as needed; and
5. Evaluate the impact of case management on health outcomes for these children.

METHODOLOGY: Two part-time pediatricians deliver onsite health care to children at the three homeless shelters. Children going into or out of foster care are routinely seen for health assessments at Children's Hospital of Pittsburgh's walk-in clinic or emergency department, following placement proceedings held at the nearby Juvenile Court. The health appraisal is performed by a nurse practitioner; available records are requested and reviewed. Children are placed in one of three categories, based on health needs, and then randomized within these categories into "augmented" and "usual" care groups. The augmented care group receives tracking, case management, health care, and referrals. The usual care group receives the prevailing type and amount of care, which often does not include case management and tracking. At the end of 1 year, the differences in the health status of the two groups will be assessed. A special appeal will be made to private practitioners, asking each to provide a medical home to a small number of patients. Incentives include case management through this project and increased Early and Periodic Screening, Diagnostic and Treatment reimbursement.

EVALUATION: Staff will monitor the effectiveness of and guide the need for changes in the program by tracking patient numbers, willingness of shelter workers and caseworkers to assist in gathering data and facilitating health care appointments, and willingness of private practitioners in the community to provide a small number of these children with medical homes. Periodic staff meetings are held to review the project's progress toward goals and to identify and resolve problems within the program.

A computerized tracking system that follows patients facilitates monitoring and data analysis. The effectiveness of the project is measured annually by differences between children in the augmented care and usual care groups in the number of health care visits, immunizations rates, hemoglobin and lead levels, growth and development, and placement in a permanent medical home. The feasibility and usefulness of tracking and patient callback will be judged. Staff will observe the incidence of specific health problems, evaluating the program's adequacy for managing these problems and recommending possible changes.

EXPERIENCE TO DATE: The project has developed a system of case management and primary health care. Protocols have been established and are being implemented for studying the project's effectiveness. Solid relationships have been established with Child and Youth Services, foster agencies, and shelters so that the project can reach the target groups of children. Project staff have also tapped the resources available through other hospital, county, and social service agency programs. Project staff have developed a prototype that tracks medical records, linking the information from Healthy Tomorrows with that of foster care agencies. During the last program year, they developed an informational card that describes the program.

Foster Children's Assessment, Referral, and Care Coordination Project
Rhode Island Public Health Foundation
Cannon Building, Room 401
Three Capitol Hill
Providence, RI 02908
(401) 434-3400, ext. 213

MCHIP
MCJ-448132
10/01/94–09/30/99
Project Director(s):
Monica J. Schaberg, M.D., M.P.H.

PROBLEM: In 1992, the Rhode Island Department of Children, Youth and Families (DCYF) established a Task Force to assess the unmet health care needs of children placed by the department in substitute living arrangements (i.e., foster children). The Task Force determined that (1) 43 percent of foster children were "medically involved"; (2) 70 percent were placed in substitute living arrangements in a different community than their original home, breaking established relationships with a primary medical provider; (3) half of foster children caregivers had been refused physician appointments for their foster children; and (4) 40 percent of foster children used hospital emergency rooms for sick or urgent visits. As a consequence, these children were deprived of preventive health services, timely attention to acute conditions, and continuity of care, resulting in higher costs of short-term care and higher direct and indirect costs of complications of inadequate care (e.g., for preventable chronic conditions and disabilities). The Task Force also found that physicians were reluctant to accept foster children due to (1) low rates of medicaid reimbursement, (2) inadequate access to prior medical records, and (3) lack of access to a qualified source of medically indicated care coordination. However, the Task Force also found that these physicians would accept foster children on referral from DCYF, despite low rates of reimbursement, if the other problems could be resolved.

GOALS AND OBJECTIVES: The goal of this project is to plan and develop a permanent system of foster children's assessment, referral, and medically indicated care coordination that will assure all foster children of a "medical home" (i.e., a regular provider of pediatric primary care services in the child's community) that delivers (1) preventive, diagnostic, and therapeutic care; (2) appropriate referral (and followup) for special medical, developmental, mental health, and inpatient services; and (3) referral to a qualified provider of comprehensive care coordination for medically indicated social and support services. Specific objectives of the project are to:

1. Ensure that every child receives an initial health and developmental assessment;
2. Ensure that every child is referred to a medical home in his/her community, with results of the initial assessment and (where available) prior medical records; and
3. Ensure that primary care physicians are assisted in identifying a qualified community-based source of medically indicated care coordination.

METHODOLOGY: The Rhode Island Public Health Foundation is a nonprofit organization established by the Rhode Island Department of Health to facilitate development of public health interventions on behalf of the collaborating organizations that represent the community of solution for this problem: The Rhode Island chapter of the American Academy of Pediatrics, DCYF, and the Rhode Island Department of Health. In year 1 the project will:

1. Develop an initial health and development assessment protocol for children newly in custody of DCYF;
2. Identify a panel of pediatric primary care providers willing to accept referrals from DCYF;
3. Identify qualified community-based providers of care coordination services;
4. Contract with community-based providers (e.g., visiting nurse associations) to provide assessment and referral services and medically indicated care coordination for a pilot test of the system for a sample of DCYF children;

5. Provide information to primary pediatric care providers statewide on care coordination providers in their communities;
6. Evaluate results of the pilot test to revise the system and estimate average costs per child served; and
7. Develop an incremental plan for statewide implementation and funding.

In years 2–5, the plan will be implemented and evaluated. A Project Advisory Committee, with representatives from State agencies, foster parents, and the physician community, will guide the project, promote physician participation, participate in the evaluation, and promulgate and oversee implementation of the State plan.

EVALUATION: Medical and care coordination records of foster children will be reviewed to determine (1) level of improved access to primary care physicians; (2) timeliness, comprehensiveness, and continuity of care; and (3) reduction of preventable chronic conditions and hospitalizations. Participating physicians will be surveyed to determine effectiveness of the system in providing them with (1) adequate medical information on children at time of referral, and (2) access to community-based sources of care coordination. Foster parents and other caregivers will be surveyed to assess (1) access to care; and (2) timeliness, comprehensiveness, continuity, and cultural competence of care. The program as a whole will be assessed to determine (1) effectiveness in securing long-term participation of physicians, and (2) adequacy of long-term funding.

Second Chance Club: A Family-Centered Intervention for Adolescent Mothers

Medical University of South Carolina
Department of Pediatrics
171 Ashley Avenue
Charleston, SC 29425
(803) 792-3689

MCHIP
MCJ-458422
10/01/93-09/30/98
Project Director(s):
Janice Key, M.D.

PROBLEM: The pregnancy rate among adolescents is higher in the United States than any other industrialized country in the world; adolescents who already have one child have a particularly high rate of pregnancy. Infants born to adolescent mothers have many medical and developmental consequences, such as low birthweight, prematurity, developmental delays, and poor school performance. Adolescents who have a baby often drop out of school, have lower paying jobs, and have medical complications if they receive inadequate prenatal care. These medical and developmental risks are compounded if the mother has a second child while still an adolescent, close in timing to the first pregnancy. The Second Chance Club project will target adolescent mothers and their families by providing health education and counseling, both in their homes and in groups, in a culturally appropriate, multigenerational approach combined with medical services. The overall goal of this project is to reduce the rate of repeat adolescent pregnancy.

GOALS AND OBJECTIVES: The 5-year project has the following goals:

1. Increase effective use of contraception by:
   a. Increasing access to medical care, increasing medical funding; and
   b. Using skill-based education to improve decision making.
2. Increase effective discussion within the family about sexuality and family planning by:
   a. Increasing the parents' knowledge about these issues;
   b. Using skills-based education and counseling about communication; and
   c. Providing this education in a cultural context appropriate for the families being served.

METHODOLOGY: Approximately 80 to 100 parenting high school students and their families will participate. The project coordinator will serve as a case manager for all participants and will provide group counseling and education sessions. Eight peer educators (four adolescents and four parents) will be recruited from the participants and trained by the project coordinator and clinic staff. The peer educators will each visit 10 families in their homes monthly. They will develop and implement their own group and individual counseling sessions and materials based on existing materials. Medical care of the enrolled adolescents and medical insurance funding will be facilitated through affiliated school-based and adolescent clinics.

EVALUATION: Project activity is monitored through reports to the advisory board on a quarterly basis and an annual report. Ongoing monitoring includes completion of a signed informed consent prior to participation (signed by the student and parent or guardian); documentation of training of peer educators; documentation of each group meeting, attendance, and educational topic; and an annual structured interview of participants.

Intervention group data will be compared to two control groups:

1. Two hundred adolescents who delivered infants in other counties in South Carolina and matched for age, race, parity, and education will be tracked by MCH by using birth certificate data; and
2. Fifty-four matched volunteer controls who delivered infants in Charleston County will be contacted through a structured annual telephone interview.

EXPERIENCE TO DATE: The project is located in an urban high school as a component of a school-based clinic. Initial opposition to opening the school-based clinic caused some delay in the project but was overcome by strong support from the community. Both the clinic and the Second Chance Club project opened in March 1994. The project expanded to serve the Young Mother-Baby Clinic that provides care for the infants of many of the participants. The project coordinator has actively recruited students and now has 48 participants (47 girls and 1 boy) in the club and three mother-daughter pairs as peer educators. The club meets weekly during school. Club members have written their own brochure, operated a booth at a community health fair, and had a graduation awards ceremony that was televised locally and on CNN. Participants also designed and wrote a brochure promoting the Second Chance Club.

Health Education and Literacy Partnership

City of Dallas
Department of Environmental and
Health Services
1500 Marilla 7AN
Dallas, TX 75215
(214) 670-8267

MCHIP
MCJ-488606
10/01/92–09/30/97
Project Director(s):
Alice I. Pita, M.D.

PROBLEM: Low literacy among low-income adolescent parents is a problem that affects all areas of their lives and the lives of their children. For the increasing number of clients who cannot read and who speak no English, access issues become even more complex. Literacy begins in early infancy with language development and the parents' positive reinforcement of their offspring's developmental milestone achievements. Many parents lack the skills and self-confidence to be their children's first teachers. This impacts the health care received and the ability to access resources effectively.

The Health Education Literacy Partnership (HELP) is a coalition of experienced professionals who want to make a significant difference in literacy and access to care. This project uses multilevel literacy guidance to parents and encourages them to complete their own education. A waiting room reading program functions in all clinic sites, with volunteers modeling reading for parents. Staff and volunteers provide free books and guidance about family literacy.

GOALS AND OBJECTIVES: The goals of HELP are to:

1. Increase access to health and social support services for high-risk mothers and their children;
2. Identify barriers to access for high-risk families;
3. Increase the literacy rate among high-risk mothers and the emergent literacy of their children; and
4. Increase awareness in the community and among pediatricians of the importance of emergent literacy and of the critical role of parents in this early educational process.

Ten specific goals will be achieved by 1997.

METHODOLOGY: Community service aides (CSAs) continue monthly contact with HELP clients. Because some client mothers go back to school, monthly in-home visits sometimes have not been possible. These clients may be seen in clinics when they bring their babies in for well-child checkups, or even at their schools. CSAs query clients about their children's health appointments, remind them to keep their own, and (by the fourth month of contact) administer the Rapid Emergent Assessment for Literacy in Medicine (REALM). They teach mothers how to play with their children to foster learning and emergent literacy. The volunteer readers for clinic waiting rooms read to the children, sometimes giving them books. By example and discussion, the volunteer readers teach parents about the importance of reading and how to share a book with their children. They may help parents to apply for a Dallas Public Library card. CSAs provide input on ways to fine-tune how best to carry out the HELP mission. Age-appropriate children are selected at random at public health clinics for the developmental testing done there. During clinic, nurses will administer the Early Language Milestones Scale (ELMS) and Attachment, Interaction, and Social Support (AIMS) to at least one client child 9 to 15 months old per day.

For parental reporting of literacy activities with their children, different approaches are being considered, including questionnaires and the Receptive-Expressive Emergent Language Scale (REEL).

EVALUATION: The High Risk Case Management data on the mother's progress toward educational goals, use of the health care system, REALM scores, and report of activities with her infant will be analyzed and correlated with her literacy level. Parent questionnaires describing in-home literacy activities will be collected in pediatric waiting rooms to assess increases in reading to children and increases in library use. Clients will have developmental language evaluations during regularly scheduled health appointments.

At monthly visits, CSAs monitor the mothers' response to HELP parent education materials, progress toward educational goals, use of medical services, and (for English-speaking mothers) literacy levels as determined by the REALM. Volunteer readers sign in where they are to read. The numbers of books distributed and received are documented in forms designed by and for HELP. The numbers of parent and pediatrician surveys are documented. The number of children seen in pediatric clinics is documented. The questionnaires dealing with in-home literacy activities will be documented.

EXPERIENCE TO DATE: Volunteers are reading in all clinic sites. More than 2,500 books have been received, allowing HELP to give books to child health clinic and High Risk Case Management clients year-round. CSAs are using Spanish and English activity sheets with project mothers. The forms also were given to pediatricians who participate in BOOKSHARES, a Pediatric Society of Greater Dallas project to collect books for HELP. The survey of pediatricians' attitudes and practices toward literacy is underway. Multiple public presentations for community and professional groups have focused on the importance of celebrating a child's achievements and ways to use book sharing to strengthen the parent-child bond while nurturing cognitive development.

Pediatric Clinic for Denton County
North Texas Community Clinics
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Denton, TX 76201
(817) 382-5000

MCHIP
MCJ-488630
10/01/91–09/30/96
Project Director(s):
Melinda Mashburn, R.N., M.S.N., C.P.N.P.

PROBLEM: Denton County, TX, is a suburban and rural county situated in the northern portion of the Dallas-Fort Worth metroplex. It is one of the fastest growing counties in the United States, gaining almost 88,000 inhabitants during the last decade to reach a population of 273,000. In recent years this county lost its only public, nonprofit hospital, leaving medically indigent people with no source of health care other than the for-profit hospital emergency room.

Approximately 4,000 children in the county, ages 0–6 years, participate in the medicaid program; a similar number are eligible but not participating. No providers of primary care to children in the county accept medicaid, leaving them to be cared for at the local emergency room. These children do not get developmental assessments or health maintenance exams except for a few given at the Health Department. Immunizations are given at the Health Department, but the Department has proven only marginally effective. Thousands of children have no access to even the most basic pediatric health care.

GOALS AND OBJECTIVES: The goals of this project are twofold:

1. To improve the health of children by improving access to care through the use of pediatric nurse practitioners; and
2. To demonstrate this approach as a reasonable, replicable method of delivering culturally sensitive, family-oriented, comprehensive pediatric care.

The program has several objectives:

1. To decrease unnecessary emergency room visits among this population;
2. To provide case management services;
3. To attain a high rate of immunizations among the pediatric population;
4. To compare the cost per patient visit with other providers' costs to demonstrate cost-effectiveness;
5. To serve 300 patients during year 1, increasing to 800 in year 2; and
6. To provide 70 percent of the patient visits with the nurse practitioners, without consultation or referral.

METHODOLOGY: Primary pediatric care will be provided by pediatric nurse practitioners in a nurse-managed setting. Well- and sick-child care—as well as immunizations, case management, and any necessary referrals—will be offered to low-income, medicaid-eligible children, ages 0–14 years, residing in Denton County. The effectiveness of this approach will be demonstrated by capturing objective data from internal and cooperating external resources to show both improvements in the overall health status of the population and problems within the health system itself.

EVALUATION: A data base collection system specifically designed for this project will collect pertinent demographic data on each patient upon entry into the clinic system, as well as at each clinic visit. Immunizations, diagnoses, interventions, referrals, and outcomes will be tracked and evaluated at least every 6 months to provide information to providers and the project director about the efficacy of this approach to care. Weekly staff meetings and monthly chart review and quality assurance activities will also provide needed information in this regard. An annual evaluation of progress made toward goals and objectives will be compiled and disseminated.

EXPERIENCE TO DATE: During year 3, enrollment in the pediatric clinic has far surpassed the projected numbers, with over 4,000 active patients. A walk-in acute care clinic with extended hours has recently been added and has proven very effective and has been highly utilized. The pediatric nurse practitioners continue to provide comprehensive pediatric health care in over 94 percent of all visits, without consultation or referral. Creative liaisons with pediatric specialists have been developed this year, linking clinic patients with an otolaryngologist and a cardiologist who hold monthly onsite clinics. Staffing has increased to include a part-time pediatrician and more nursing staff. The clinic is a sought-after site for nurse and nurse practitioner student preceptorships, due to the unique concept of nurse-managed health care.

PediPlace
PediPlace
502 South Old Orchard #126
P.O. Box 294285
Lewisville, TX 75067
(214) 436-7962 or 315-5342

MCHIP
MCJ-488627
10/01/93–09/30/98
Project Director(s):
James Florez, B.S.

PROBLEM: Southern Denton County, TX, has a large, critically underserved pediatric population of children who are medically indigent, medicaid eligible, uninsured, or insured but denied access to health care because their families cannot afford out-of-pocket medical expenses. Medical services are fragmented due to a lack of pediatric providers. There are only six pediatricians to serve a pediatric population of more than 35,000 children. Although there are more than 1,200 medicaid-eligible families in the target population, no pediatricians in the area accept medicaid patients. These children do not receive developmental assessments except for the few given at the Health Department. Denton County has no public or nonprofit hospital to provide indigent care, leaving this population to be cared for at the local hospital emergency room. Thousands of children in this area have no access to generally accepted pediatric health care.

GOALS AND OBJECTIVES: The goals of PediPlace are to:

1. Remove barriers to health care by providing a medical home to the uninsured, underinsured (i.e., unable to meet deductibles or copayments), and medicaid-eligible pediatric population of southern Denton County. PediPlace will offer preventive screening and diagnosis as well as immunizations (in cooperation with other area immunization programs), and it will emphasize continuity of care for acute/chronic medical problems.
2. Deliver information and care with the expectation of patient and family responsibility and accountability. PediPlace will seek to empower parents with information and skills in anticipation of their assumption of responsibility for the child's home health management.

METHODOLOGY: The goal of improved access to health care will be accomplished by providing a pediatric center for sick-child and well-child care to be staffed by pediatric nurse practitioners. Extended hours will improve access for parents who work full-time. Continuity of care will be achieved through cooperation with local agencies and organizations also serving the target population in order to prevent gaps in care and overlap of efforts and resources. Local volunteer pediatricians will provide call support for patients who have more acute problems or who need inpatient or emergency room care.

EVALUATION: The effectiveness of this approach will be measured by internal data and by external sources. The efficacy of PediPlace will be measured by the reduction of emergency room visits for nonemergency situations, an increase in immunizations (measured by PediPlace), an increase in the number of children enrolled in medicaid, and an increase in attendance for followup care and well-baby/well-child visits.

EXPERIENCE TO DATE: In July 1994, the Board of Directors of PediPlace negotiated a lease for retail space in central Lewisville for office and clinic facilities. Also in July, PediPlace was granted 501(c)(3) status, which has helped to legitimize the project with regard to potential donations. An executive director began work in July and has since been coordinating efforts to open PediPlace sometime in October. PediPlace's Board of Directors voted to expand its membership from three to eight members in order to represent a broader cross-section of the community and to add more working expertise. The new board voted to expand the advisory board to further its commitment to community ownership of the project. The interview process for a nurse practitioner is ongoing. Recruitment of qualified medical, clerical, and social work volunteers is underway.

Project First Step
Parkland Memorial Hospital
Community Oriented Primary Care
5201 Harry Hines Boulevard
Dallas, TX 75235
(214) 630-0493

MCHIP
MCJ-488621
10/01/90–09/30/95
Project Director(s):
Susan Spalding, M.D.

PROBLEM: Low birthweight is a contributing factor in a majority of infant deaths. Infants born to low-income mothers are more likely to have low birthweight and be at risk of not having their needs met. Low birthweight infants are a particularly vulnerable population. They experience twice the rate of hospitalization as normal birthweight babies, and their survival rate is significantly less. Because of the increased morbidity and mortality associated with low birthweight, those children successfully discharged from the hospital require close medical and social followup.

GOALS AND OBJECTIVES: This project has several goals:

1. Establishing geographically targeted low birthweight clinics;
2. Establishing a referral network between hospitals delivering low birthweight infants and Project First Step;
3. Delivering a case management system of family-centered, culturally sensitive, comprehensive, coordinated care; and
4. Developing baseline morbidity data to longitudinally track the impact of the program.

Measurable outcome objectives include the following:

1. Reducing infant mortality in target areas;
2. Improving the immunization rate;
3. Increasing enrollment in the Special Supplemental Food Program for Women, Infants and Children (WIC) nutrition programs;
4. Screening for and treating iron deficiency anemia;
5. Screening for and responding to child abuse and neglect;
6. Reducing hospitalization;
7. Reducing emergency room visits; and
8. Increasing the number of infants at appropriate weight for height within 12 months of enrollment.

METHODOLOGY: The target population includes those infants residing outside the City of Dallas but within Dallas County who are not currently eligible for intensive followup services. Project First Step provides culturally sensitive, family-focused, comprehensive, coordinated care by:

1. Placing clinics so they are geographically accessible to all eligible infants;
2. Developing an extensive outreach program using community-based workers who are knowledgeable about and sensitive to the needs of their clients;
3. Using a case management approach and a multidisciplinary team; and
4. Providing continuity of care by enrolling eligible infants in the Community-Oriented Primary Care (COPC) program of Parkland Memorial Hospital, which provides extra clinic care and after-hours coverage.

EVALUATION: Data collection is accomplished through patient data flow sheets. Staff analyze the data, with the cooperation of COPC, using the information to make program adjustments.

Gathering of cumulative data concerning program objectives began near the end of year 1 of the program and is ongoing. Outcome objectives will be addressed at the end of the program, in 1995.

EXPERIENCE TO DATE: Staff established the low birthweight referral network with Dallas-area hospitals. In the spring of 1991, two community service aides were employed to conduct outreach activities. Several months of planning went into opening four low birthweight clinics operated in cooperation with the Dallas County Health Department. These clinics opened 3 years ago (in June 1991) in Garland (east Dallas County), Grand Prairie (west), Irving (northwest), and Balch Springs (south). With the opening of the clinics—which have the specific mission to treat and follow up low birthweight infants—program activities shifted to intensive followup of infants. Staff also emphasize strengthening the referral network from the hospitals to ensure that eligible infants do not slip through the safety net of the clinics' services. To date, 446 cases have been opened, with 305 cases currently active. Additional funding for a social work coordinator and a community service aide through a March of Dimes grant added an important dimension to the program. March of Dimes funding ended in December 1993; however, COPC has provided matching dollars.

Teen Clinic
Brownsville Community Health Center
2137 East 22nd Street
Brownsville, TX 78521
(210) 548-7400

MCHIP
MCJ-488615
10/01/92–09/30/97
Project Director(s):
Carmen Rocco, M.D.

PROBLEM: The Brownsville Community Health Center (BCHC) established the Teen Clinic in response to the many needs of its adolescent patient population. High-risk activities of adolescents identified as prevalent in the area include substance abuse, poor academic performance, and risky sexual activities. These activities have negative consequences, as reflected by the city's high adolescent pregnancy and dropout rates. Such problems are compounded by widespread poverty. Prior to the creation of the clinic, services for adolescents in the community were focused on single behaviors; coordination of care was minimal, and there were no health care providers explicitly interested in and committed to adolescents.

GOALS AND OBJECTIVES: The goal of the Teen Clinic is to reduce the adolescent pregnancy and school dropout rates in its patient population. In order to measure progress in these areas, process objectives have been established involving (1) delivery of comprehensive health care, (2) adolescent counseling, (3) an increase in the number of referrals from underserved schools, (4) an increase in the number of clients who apply and qualify for medicaid, and (5) improvements in adolescent knowledge about family planning. The clinic has established three intermediate outcome objectives:

1. Prevent 50 percent of sexually active female patients from experiencing a pregnancy over a period of 1 year or until high school graduation;
2. Prevent 75 percent of adolescent parents from experiencing repeat pregnancy over a period of 2 years or until high school graduation; and
3. Maintain the enrollment of 50 percent of patients identified with poor academic performance in school for 1 additional year or in an alternative educational program.

METHODOLOGY: The Teen Clinic offers comprehensive health care that addresses the special needs of adolescents, including medical care, health education, and counseling. In-depth risk assessments are completed on each adolescent and interventions are planned accordingly. The clinic has been held two afternoons each week and is currently staffed by a nurse practitioner, two physician assistants, and a social worker. For the upcoming 1994–95 school year, as a result of our project, two full-time teams will be stationed to service four school sites.

EVALUATION: In order to evaluate the intermediate outcome objectives, a periodic interview (every 6 months) will be undertaken with each adolescent. This structured interview will record not only the number of pregnancies and number of dropouts but also the adolescents' evaluations of how the Teen Clinic has affected their lives. It will be conducted by the social worker at the end of the visit. The project will also continue to monitor and evaluate the patient population risk statistics.

The clinic monitors the health status of patients and clinic activities in several ways. Each patient completes a risk assessment survey at the first visit. Based on the responses, a risk score is assigned to the patient over a range of categories. In addition, a patient information form is completed by the provider at each visit; the form enables tracking of demographics, diagnosis, services, referral, and payment source. The data from these two forms are organized in an electronic data base. In addition, information on the status of enrollment in medicaid will be maintained to assist the clerk in maximizing enrollment. The clinic staff will hold monthly case review meetings to monitor and improve coordination of services.

EXPERIENCE TO DATE: During this period, the project lost its director and was reduced from two providers to one per clinic day. It is anticipated that a replacement director will be found before the end of the calendar year, but her departure is a setback for the project. In the interim the project was directed by the BCHC planner until June, when the BCHC pediatric chief assumed the project director position. In addition, this reporting period began with no case manager. In January a social worker was hired, and she has seen 168 adolescents in a little over 5 months.

Teen Pregnancy Service: Adolescent Primary Care

Teen Pregnancy Service
2040 West Wisconsin Avenue
Suite 350
Milwaukee, WI 53233
(414) 937-8040

MCHIP
MCJ-558521
10/01/93–09/30/98
Project Director(s):
Jenise Dennee, M.H.A.

PROBLEM: The Teen Pregnancy Service of Milwaukee seeks to expand services to the high-risk population of adolescents, children, and infants it currently serves. The population initially targeted for services through this project consists of pregnant and parenting Teen Pregnancy Service clients ages 13–19. This high-risk population, though culturally diverse, is predominantly African American; 95 percent are of low-income status. During the second year of the project, the target population will be extended to include clients enrolled in our primary prevention program. This group comprises nonparenting males and females, ages 10–18, who are assessed as at high risk for becoming adolescent parents. As risk factors tend to cluster rather than occur in isolation, both populations exhibit a significant number of interrelated risk characteristics such as poor academic achievement, substance abuse, delinquency, poor parent-child relationships, and low self-esteem, in addition to the potential health risk associated with early parenting.

Adolescents generally tend to underutilize the health care system. Reasons given for this lack of use are inaccessibility, lack of confidentiality, unaffordability, and lack of perceived need for health care. In Wisconsin, 53,052 adolescents (ages 15–20) were eligible for a HealthCheck screen but only 3,017 (5.7 percent) had these screens. Approximately 50 percent of girls ages 15–19 have had intercourse. Of sexually active girls, more than half report inconsistent use of contraception. Rates of sexually transmitted diseases (STDs) among adolescents are rising, with syphilis at the highest level in 40 years. AIDS is now the seventh leading cause of death among adolescents and young adults 15–24 years old. Adolescent pregnancy rates are not declining. Because adolescents tend to participate in many experimental and risk-taking behaviors that lead to negative health outcomes, lack of preventive and primary health care may have costly societal and economic repercussions in the form of premature pregnancy and parenting, increase in STD/HIV infection, diminished potential for self-sufficiency, lost productivity, and academic or vocational failure. The expansion of services seeks to fill critical gaps in the accessibility of care, including coordination of case management services to address pervasive issues associated with adolescents and early parenting and comprehensive primary health care services designed to meet the needs of this population.

GOALS AND OBJECTIVES: The Adolescent Primary Care model will combine the effectiveness of care coordination/case management with the availability and accessibility of comprehensive primary health care in a community and familiar environment. The overall goal is to provide effective comprehensive primary health care to adolescents in a cost-effective and culturally relevant manner. Comprehensive health care in the context of this project builds upon prenatal services currently provided and an acute awareness of the special needs of this population to include not only medical but also social and psychological interventions.

Special consideration will be given to the goal of increasing community involvement and cultural sensitivity in the project design because of the critical effect of the community's makeup and problems on this population.

METHODOLOGY: Pediatric primary care teams at the Teen Pregnancy Service include a nurse practitioner, a pediatrician, and a social worker. A nutritionist is available for consultation. Services with a preventive and educational focus to be provided by the primary care team include assessment of nutritional status, general physical and mental health, oral health, sexuality, risk-taking behavior, perinatal status, and other issues related to growth and development. Also to be provided is family (postnatal) care coordination that will utilize the concepts of the Parent Support Program, whose fundamental goals are to improve the parenting skills, daily life and self-advocacy skills, and support systems of adolescent parents at risk for child abuse and neglect. Community agencies will be contacted to (1) join an advisory board for program development, (2) develop and implement community outreach efforts, and (3) colocate services at the Teen Pregnancy Service.

EVALUATION: The number of clinic visits will be monitored and tracked to ensure that Teen Pregnancy Service clients have the opportunity to receive and are receiving comprehensive primary health care, family (postnatal) care coordination, and services from the Parent Support Program. Also, baseline data on the incidence of repeat pregnancy rate will be collected and compared to the same measures obtained after the new initiatives are implemented. Program recommendations from the advisory board and the implementation of the outreach workplan will be monitored.

EXPERIENCE TO DATE: All assessments, protocols, and care plan forms have been completed. Primary care services are being provided to adolescents. Care coordination services are being provided; however, due to the size of each social worker's caseload, the time spent with each individual is not as in-depth as ultimately desired. Additional funding is being sought from State and local sources. This funding will be used to hire additional social workers and to facilitate the advisory board.

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