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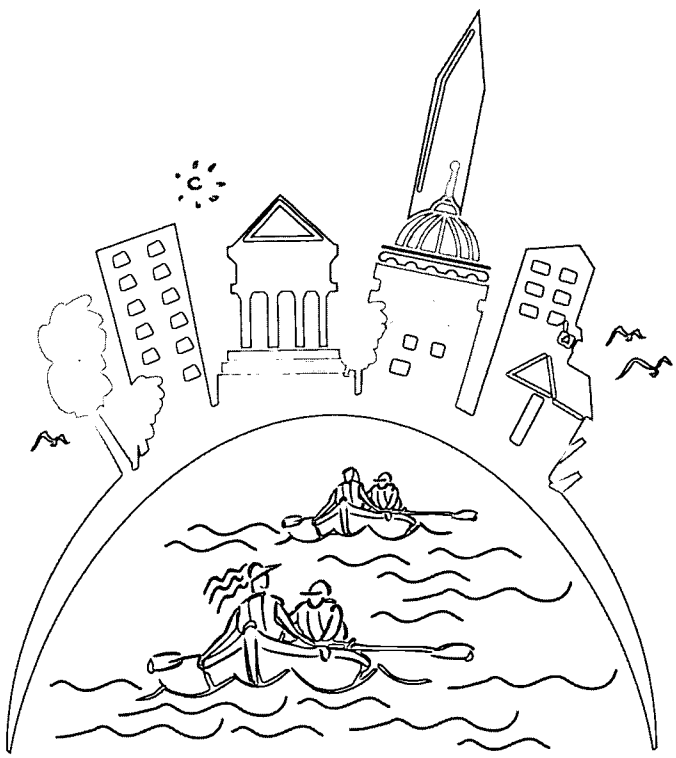
ABSTRACT

The designated leaders of maternal and child health (MCH) in more than 70 major urban city and county health departments submitted profiles of urban MCH efforts as a requirement for federally subsidized attendance. When these profiles were reviewed, eight broad themes were apparent as lessons from MCH practice. The lessons are: (1) drawing in people and organizations from other sectors is a resource for community connections; (2) never underestimate the role of the community in identifying possible solutions; (3) collaboration with other sectors requires communication skills and is enhanced by common policies and procedures; (4) work to break down language barriers; (5) time to find and secure funding is often disproportionate to the scope of work; (6) data and information offer new and greater opportunities for successful project outcomes; (7) staff is a health department's biggest asset; and (8) planning, persistence, and long-term efforts are necessary for successful, sustainable outcomes. (SLD)

LESSONS LEARNED 1999

Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health



HEALTHY CITIES:
Safe Harbors for Children and Families

From the 1999 CityMatCH Urban MCH Leadership Conference

Lessons Learned 1999:

Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health

From the CityMatCH
Urban MCH Leadership Conference
Baltimore, Maryland
September 1999

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City**MatCH** is a national organization of urban maternal and child health programs and leaders. City**MatCH** was initiated in 1988 to address the need for increased communication and collaboration among urban maternal and child health programs for the purpose of improving the planning, delivery, and evaluation of maternal and child health services at the local level. City**MatCH**, through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for addressing the health concerns of urban families and children. City**MatCH** also has developed a centralized information base about the current status of maternal and child health programs and leaders in major urban health departments in the United States.

For more information about City**MatCH**, contact Dr. Magda Peck, City**MatCH** Executive Director/CEO, Department of Pediatrics, University of Nebraska Medical Center, 982170 Nebraska Medical Center, Omaha, NE 68198-2170, Phone: (402) 595-1700 or visit us at our website http://www.citymatch.org.

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Acknowledgements

Lessons Learned 1999: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health is the fourth in the publication series from City**MatCH**, the national organization of urban maternal and child health (MCH) programs and their designated MCH leaders in local health departments serving America's cities. It is designed to facilitate easy access to selected urban public health practices and promote communication across communities about what works, what doesn't work and why.

The intent of this compendium of current practices is to put ideas forth for consideration, with the understanding that readers have the capacity and responsibility for following up on initiatives of interest.

While many of these urban MCH profiles have not been formally evaluated to assess impact or outcomes, they provide a starting point for further examination of what really works. Each City**MatCH** member health department attending the September 1999 Urban MCH Leadership Conference was requested to submit a profile describing what it judged to be its most successful MCH effort.

Every local health department submitting an urban MCH profile deserves special recognition for passing on valuable lessons learned and for trying to impact the health of children and their families in urban communities. Conference co-chairs Betty Thompson (Nashville, TN) and Linda Welsh (Austin, TX) did a fine job of steering a very successful conference experience. City**MatCH** staff – Jesica Christensen, Diana Fisaga, Maureen Fitzgerald, Kelly McIntosh and Joan Rostermundt -- deserve kudos for their hard work in producing a user-friendly tool for broader use. Final thanks to the Maternal and Child Health Bureau, HRSA, for providing essential funding to allow City**MatCH** to continue to serve as a partner for information and communication.

We hope this forthright peer exchange can plant seeds of change across cities struggling with similar MCH concerns. Please let us know if this publication has proven useful in your work in making a difference for women, children and families.

Sincerely yours,

Magda G. Peck, ScD
CEO/Executive Director, City**MatCH**

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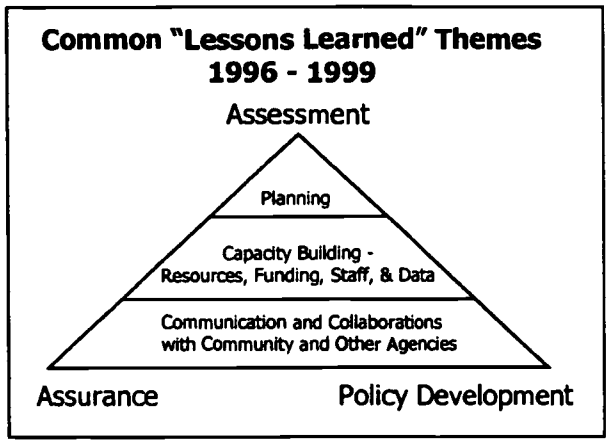
Mulling it Over: What Lessons Have We Learned?

Lessons Learned 1999 continues a journey begun in 1996, when the increased demand for "best practices" and "models that work" led to a new publication series, ***Lessons Learned: Profiles of Urban Health Department MCH Initiatives***. It was recognized then that beyond the call for new ideas was a need for replicable solutions to ongoing problems. Cities wanted to know how other cities were responding to similar challenges, and how those ideas and projects could be adapted for use in their own communities. City**Mat**CH agreed that lessons learned should be shared, thus planting seeds of change across America's cities. Four editions later, the need continues to grow, and with it the demand for this publication.



In September 1999, the designated leaders of maternal and child health in more than seventy major urban city and county health departments gathered in Baltimore, Maryland, for the 10th invitational City**Mat**CH Urban Maternal and Child Health Leadership Conference. The urban health departments they represent, whose jurisdictions include one or more cities with a population of 100,000 or greater, submitted a "Profile" of an urban MCH effort as a requisite for federally subsidized attendance. These profiles were exchanged at the conference to stimulate the exchange of both successful approaches and lessons learned among urban MCH leaders, and to foster peer technical assistance.

These profiles from the 1999 Urban MCH Leadership Conference, which have been edited and indexed, are designed to encourage urban health departments to go beyond reporting the technical details of what they have done. Health Departments were asked about their role, the barriers they encountered, the methods they used to overcome barriers, what they considered to be the significant accomplishments of the project, and any other lessons, positive or negative, that they might have learned along the way.

Eight broad themes came forth as the profiles were reviewed, reflecting the efforts local urban health departments have been making to meet the needs of their communities. They recognized that these families and children living in America's cities are more than a statistic for a particular social ill. They acknowledged that these families have complex lives, with complex needs, and that a variety of approaches will be required to effect positive change and growth. Projects continue to evolve toward greater cultural competence, recognizing the connectedness of people to place and to culture. Local urban health departments also recognized that in order to solve medical issues, they must address socio-economic issues outside traditional public health boundaries. This understanding displayed tremendous compassion and understanding for the publics they serve.

1. Drawing in people/organizations from other sectors is a resource for greater community connections.

Urban health departments have long understood that they can create dynamic change when collaborating with other community entities. They recognize the need for collaboration and also understand that the health issues facing urban families and children can be better addressed by engaging many disciplines, diverse community organizations, the faith community, and other sectors, all working in concert with the local urban health department. As the Albany County Health Department (NY) profile stated, *"Partnering with four organizations brings unique and exceptional strength, experience and*

expertise to the program." "Partnering with other organizations can broaden your focus and allow you to accomplish more than you could have alone," said the Kansas City Health Department (MO).

What is *different* is the discovery of many contributing health departments, that in utilizing these other groups, resources, and people, a greater sense of community has been fostered, resulting in a shared sense of responsibility for both problems and problem solving. Wayne County Department of Public Health (MI) reminded readers to *"Recognize that the community is all of us and that a synergy will emerge with long-term benefits."*

We recognized the importance of selecting planning committee members from various professional backgrounds in both the public and private sectors who possess varying beliefs, skills, and experience."
Houston Health and Human Services (TX)

"It is important to establish partnerships and collaborations with other agencies."
Richland County Health Department (SC)

2. Never underestimate the role of the community in identifying possible solutions.

How many times have we heard the adage, *"We're from the government and we're here to help,"* followed by chuckles and groans? City**Mat**CH member health departments are peopled with seasoned leaders and staff, who have dedicated their lives to making a difference in the lives of children and families in America's cities. Surely they know the best answers to contemporary problems facing these communities. This may be so, but as many health departments have discovered, if you try to tell someone what ***they*** are doing wrong, and what ***they*** need to change, you will surely be met with entrenched resistance.

A number of health departments submitting profiles over the years have recognized a better way to promote positive change: look to the community. *"Even coalitions made up of the most concerned community membership need their consumers to tell them what the community needs and which concern is a priority for them,"* wrote the Pinellas County Health Department (FL), in their profile submission. Several project profiles mentioned defining new problems, making new discoveries, and developing creative new solutions, simply by asking for community input. When project staff began asking questions, for example, asking consumers why they hadn't kept appointments, they began to recognize barriers outside the traditional realm of public health, i.e. transportation, language, lack of child care, cultural issues, fear.

Health departments who took problem-defining to the next step and sought input on possible solutions to these problems, were often able to accommodate consumers in ways that allowed public health goals of immunization, follow-up care, etc, to be met or exceeded. Additionally, community input was sought on such things as defining appropriate media campaigns, and the knowledge gained was utilized to make more effective promotions.

"It was learned that the communities knew the best routes of communication and education of their residents."
Vanderburgh County Health Department (IN)

3. Collaboration with other sectors requires communication skills and is enhanced when shared goals are developed and affirmed by common policies/procedures.

A common theme throughout *Lessons Learned 1999* was the incredible necessity for consistent communication. Tensions sometimes ran high as philosophically disparate groups struggled to find common ground and to reach goals. A number of health departments cited working with the faith

community as being essential to their project's success, and yet labeled working with the faith community as a significant barrier to project success, in the same profile!

Health departments achieved success by recognizing the potential dividing issues and communicating clearly in ways that did not polarize. They worked hard at defining the issues and at developing strategies. They recognized this truth, as stated by the Orange County Health Department (CA), *"If you know where you are going, many roads will lead you there." "Finding a common ground that everyone can support...seems to have taken us past many traditional barriers..."* helped the St. Paul-Ramsey Department of Public Health (MN) in their quest to reduce gun violence.

Other projects required coordination with independent government entities. To do this effectively sometimes required learning a whole new lingo. Interagency collaborations thus presented health departments with a yet another set of challenges.

"Institutional partners must be clear in their expectations for community involvement, especially with regard to sharing decision-making power."
Multnomah County Health Department (OR)

"A full commitment to the mission is needed. Well defined communication channels are necessary at all levels."
Albany County Department of Health (NY)

4. Recognize the power of language, and work to break down language barriers to give back connections that count.

As the United States hurtles into the 21st Century, our population is rapidly becoming more culturally diverse. Health departments recognized this issue, and more and more were writing interpreters and multilanguage materials into their grant applications. Additionally, recognition of cultural differences and traits led to new ideas, methods and solutions to continually evolving problems. *"Health promotion starts within the community, and each community has its culture,"* said the San Antonio Metropolitan Health Division (TX) in their profile.

This recognition exemplified the desire of health departments to move beyond traditional public health boundaries, to get at the heart of issues that impact families and children. Lack of common language presents a significant barrier to good health, and health departments knew that interpreters and written materials produced in community-appropriate languages were necessary. They understood that if they could break through the language barrier, connections might be made that could lead to positive public health outcomes. Unfortunately, cracking language barriers is an expensive undertaking, and many health departments were held back by lack of funding to achieve this goal.

"We have a growing population of Hispanics in Forsyth County, but not enough interpreters, so it can be very difficult to teach dental education when they visit the dentist."
Forsyth County Health Department (NC)

5. Time spent finding, securing and juggling funding is often disproportionate to the scope of work.

Running through the submissions to *Lessons Learned 1999* were themes and variations of funding struggles. As some traditional sources dried up, the needs of urban families and their children continued to increase. Projects were sometimes hampered by categorical funding streams, and in an effort to alleviate this health departments worked overtime to secure funding from nontraditional sources. Efforts to secure these needed resources were sometimes elaborate and were undoubtedly the cause of

immeasurable headaches and sleepless nights. Peoria City-County Health Department (IL) said that *"An ongoing need to establish funding resources was a barrier in project implementation."*

True to form, City**MatCH** member health departments continued to be creative in their efforts to secure resources for their projects. El Paso County Department of Public Health and Environment (TX) sponsored a Breastfeeding Fair to raise awareness during WIC month. A lack of money to fund the fair resulted in needing more time to pursue donations and limited the size and scope of the fair. Their profile cited the time it took them to solicit business for donations as a significant barrier to the project's implementation, yet they were able to secure the resources required and put on an effective fair.

"In 1997, the Legislature expanded the activity, without appropriating any additional funding."
Hawaii State Department of Health (HI)

"The first and largest barrier was funding."
City of New Orleans (LA)

6. Data and information offer new and greater opportunities for successful project outcomes.

City**MatCH** focuses attention on the power of data and the need for increased data capacity. Use of data tools such as registries, geographic information systems, and linked computerized data systems increased in *Lessons Learned 1999*. Sonoma County (CA) Health Department reviewed breastfeeding data, which showed good initiation rates for breastfeeding. With further analysis they were able to determine that while initiation rates were high, duration rates were problematic. With that knowledge they developed their project, "Promoting Positive Images of Breastfeeding." Other submissions focused on collection, compilation and analysis of data as the theme of their projects. For example, Orange County Health Department (FL) submitted *"Health Evaluation, Assessment and Research Studies Division"* which was a team supporting the Health Department's programs and grant proposals as different needs for research and evaluation were identified. It is important to keep in mind that data is a tool for effective action, rather than an end result.

"Data and information offer new opportunities to approach smoking cessation."
Philadelphia Department of Public Health (PA)

7. Staff may be a health department's biggest asset; it is essential that they be active participants in the project development process.

With continued budget cuts, and increased recognition that the needs of urban families and children go beyond traditional public health boundaries, changes were a constant for urban health department staff. Successful project profiles indicated the need for open minds among staff and demonstrate the impact made when staff assumed new roles.

Never underestimate the difference that a few people can make when empowered with knowledge and when enabled to participate fully from the beginning. The opposite side of the coin was that staff could be a potential barrier, if they felt threatened, did not understand or appreciate the goals, or felt terribly overburdened. *"Leadership needs to take an active role in managing workloads so that staff members do not become discouraged,"* said the Lincoln-Lancaster County Health Departmen (NE).

The Douglas County Health Department (NE) provided ongoing staff in-services to reinforce a common vision for their profiled program and to address staff nonparticipation. They were experiencing staff resistance to sharing data, to their perception of added workload, and to the change in the workflow as they integrated two programs. A key lesson learned is to make staff an integral part of the planning and project development process.

"Once they understood and agreed to the goal, they were empowered to come up with creative approaches and innovative strategies."
Orange County Health Agency (CA)

"Staff who work directly with clients are in a much better position to hear about the needs of the community."
Portland Public Health Division (ME)

8. Planning, persistence, and long-term efforts are necessary for successful, sustainable outcomes.

The Orange County Health Care Agency (CA) described a four-year comprehensive strategic planning process. This process resulted in identification of a department vision, mission and goals, specification of existing statutory mandates, determination of strategic priorities, identification of current local status for key health indicators and benchmarks, and development of local objectives to measure progress toward the achievement of its vision, *"Orange County: The Healthiest Place on Earth."*

Not all submissions were this specific, but most did indicate that the success or failure of projects hinged on careful research, planning, implementation and evaluation. Thoughtfully approached activities were more likely to bring about the intended result than haphazard, hurriedly thrown together projects. Tenacity when faced with obstacles such as the funding obstacles discussed above, creativity when faced with non-traditional barriers of language, child care and transportation, and persistence when projects were slow to get off the ground are hallmarks of health departments who submitted projects that worked.

Twenty-six profiles have already undergone formal evaluation processes. The first lesson learned by the Multnomah County (OR) Health Department was that *"It is critical to define the nature of the activity, its desired outcomes, its decision-making authorities and processes, and provide the staff and leadership resources to keep the process true to its intended goals and desired outcomes."* They went on to describe that this is particularly important when community activists are invited to be part of the process.

"If you don't know where you are going, any road will take you there."
Orange County (CA) Health Care Agency

It has been said that wisdom is the gift given by experience, and that experience is gleaned from taking risks and occasionally from making mistakes. These 1999 Profiles of Urban Health Initiatives are a chronicle of risk, experience and wisdom. Policymakers, community leaders, parents and providers have an opportunity here to build on these *"Lessons Learned"* and to continue the journey to insuring the best for families and children in American cities.

How to Use Profiles

What is a "profile"?

The annual City**MatCH** Urban Maternal and Child Health (MCH) Leadership Conference is a working meeting of invited urban MCH leaders representing member city and county health departments whose jurisdictions include one or more cities with populations of 100,000 or more (or the largest city in states not otherwise represented). A requirement of each invited health department is to submit a written profile of one of the health department's most successful MCH initiatives during the past year.

The profile includes a description of objectives, activities, barriers faced and overcome, health department roles, funding, accomplishments, and lessons learned (see sample on page 6). The designated MCH representative to City**MatCH** may only receive federal subsidy for conference expenses if their profile is received prior to the Conference. Invited health departments are encouraged to submit a profile even if they are unable to send a representative to the Conference. Copies of profiles are included in the conference participant resource notebook to facilitate immediate peer exchange.

Why are "profiles" published?

Since 1992, in response to interest in and increasing demand for best practices in public health, City**MatCH** has published and edited urban MCH profiles as a core component of Conference Highlights. The profiles are published as a compendium of ideas to promote the exchange of information about perceived successful initiatives in urban MCH. City**MatCH** does not verify each profile, nor does it evaluate the initiative and efforts described. It is assumed that with the contact information provided, readers will follow up with the source health department to ask questions and secure essential additional information.

How are the "profiles" organized?

The profiles are presented in alphabetical order, by city and by state where the local health department is located. Each profile spans two pages, with standard headings boxed for easy reference. Contact information is listed at the beginning of each profile to allow direct follow up with the health department. The 72 city and county health departments submitting profiles for the 1999 Urban MCH Leadership Conference are listed on page 4. In 1993, City**MatCH** began to index the conference profiles using standard categories of MCH approaches and targeted MCH populations. This practice continues with the 1999 profiles. In addition, the 1999 profiles have been indexed by essential MCH program functions. Both Profiles Indexes, which appear on pages 10-21, are explained on the following page.

Using Profile Index I: Target Populations and Approaches

Profiles are listed in alphabetical order on the left margin, by city and by state where the health department is located. Each submitted urban MCH profile has been coded by City**MatCH** staff for up to 49 categories of activity. Categories applying to a profile are shaded across the row corresponding to the health department's city/state. Population-specific activities appear on the left-hand page; systems-specific approaches are indexed on the right-hand page. To determine all categories within a given profile, read across both pages. To identify the range of initiatives within a given approach, read up and down.

Using Profile Index II: Essential MCH Program Functions

Profiles are listed in alphabetical order on the left margin, by state and by city where the health department is located. Using the "Ten Essential MCH Functions Framework" developed by a working group of public health organizations under the direction of the John Hopkins University Child and Adolescent Health Policy Center, each health department coded its profile for up to 49 categories of MCH functions. The full list of functions appears on the sample profile form on the following two pages. MCH function categories applying to each profile are shaded in Profile Index II. To determine all MCH functions within a given profile, read across both pages in the row for its city/state. To identify the range of initiatives within a given MCH function, read up and down the columns, which have been numbered on top to allow ease in reading the index vertically. These numbers also correspond to the MCH functions listed on the sample profile. More information about the MCH Functions Framework can be found in the publication, "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America", prepared by Holly Allen Grason, MA and Bernard Guyer, MD MPH at the John Hopkins University Child and Adolescent Health Policy Center, for HRSA/MCHB, AMCHP, ASTHO, City**MatCH**, and NACCHO.

Comments and Feedback Welcome

City**MatCH** needs feedback on how these profiles are used and how useful they are to public health practice. Tell us your comments and let us know of your experiences using the City**MatCH** *Lessons Learned 1999* via E-mail: citymch@unmc.edu, or you may complete the evaluation form located at the back of this publication and return it to: City**MatCH,** University of Nebraska Medical Center, Department of Pediatrics, 982170 Nebraska Medical Center, Omaha, NE 68198-2170.

Ten Essential Public Health Services to Promote Maternal and Child Health in America

1. Assess and monitor maternal and child health status to identify and address problems.

2. Diagnose and investigate health problems and health hazards affecting women, children and youth.

3. Inform and educate the public and families about maternal and child health issues.

4. Mobilize community partnerships between policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.

6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.

7. Link women, children and youth to health and other community and family services and assure quality systems of care.

8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs.

9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services.

10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems.

Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Listing of Successful Leading Urban Health Department Initiatives in Maternal and Child Health

CityMatCH members attending the 1999 Urban MCH Leadership Conference were required to submit a profile outlining successful MCH initiatives. The profiles described objectives, partnerships, accomplishments, funding sources, barriers, and measures of success. The initiative did not have to involve direct service provision. A committee reviewed submitted profiles and presented a *Spot*Light award to those cities who created outstanding, innovative, and successful MCH initiatives. The 1999 *Spot*Light recipients are: Philadelphia, PA; San Antonio, TX; and Santa Rosa, CA.

Instructions for 1999 CityMatCH Member Urban MCH Profiles

Each year CityMatCH members are asked to profile a successful MCH effort in their community. This year you also have the option of submitting a 'pearl' — something that started out as an irritant but you worked on it until it was a thing of beauty! A pearl may be a hard-learned lesson or a bad idea that did some good after all.

Any recent innovative program, activity or lesson learned *not previously submitted* which has strengthened your capacity to serve children and families can be submitted. There will be three awards this year: Most Innovative, Most Replicable, and the Alchemy Award for turning lead into gold! *Activities do not have to be a program or involve direct service provision.* While you are welcome to attach additional documents, we ask that you use the attached form. Profiles will be provided to all conference participants and reproduced in the CityMatCH publication, "*Lessons Learned 1999: Profiles of Urban Health Department MCH Efforts.*"

To receive financial assistance CityMatCH members must complete and submit a profile prior to or upon registration at the Conference.

Thank you for completing the 1999 Urban MCH Leadership Conference profile. If you have any questions or comments, please contact CityMatCH at the number listed below:

Please Mail, FAX or E-Mail Completed Profile by Friday, August 20 to:

CityMatCH at University of Nebraska Medical Center
Department of Pediatrics
982170 Nebraska Medical Center
Omaha, NE 68198-2170
Phone: (402) 559-8323 FAX: (402) 559-5355
E-Mail: CITYMCH@unmc.edu

Profiles received by Friday, August 20, 1999 will be included in conference materials & will be eligible for Spot*Lights* recognition. *Profiles must be typed. Handwritten submissions will not be accepted.*

Health Department: _____ City/State: _____
CityMatCH Representative: _____ Title: _____
Phone: (_____) _____ For more information contact: _____
(If other than CityMatCH Representative)

Activity Name: _____

Please consider my profile for (√ one): ☐ **Most Innovative** ☐ **Most Replicable** ☐ **Alchemy Award**

Please circle all "MCH Efforts*" that best apply to your "Activity", either Profile or Pearl.

Women's Health
1 Preconception promotion
2 Family planning
3 Breast/cervical cancer

Perinatal Health
4 Prenatal care
5 Expanding maternity services
6 Home visiting
7 Low birthweight/infant mortality
8 Substance abuse prevention
9 Breastfeeding/nutrition/WIC

Child Health
10 Immunization
11 Early intervention/zero to three
12 EPSDT/screenings
13 Expanded child health services
14 Injury (including child abuse)
15 Lead poisoning
16 Children with special needs
17 School-linked/based services

Adolescent Health
18 School-linked/based services
19 Violence prevention/at risk
20 Teen pregnancy
21 Teen parenting

Other
22 Communicable diseases
23 Family violence
24 Dental programs

Improving Access to Care for Urban Children & Families
25 Overcoming cultural barriers
26 Reducing transportation barriers
27 Expanding private sector links
28 Clergy & health connections
29 Schools & health connections
30 One-stop shopping locations
31 Mobile clinics for outreach
32 Other outreach activities
33 Increasing social support
34 Case coordination
35 Increasing access to Medicaid

Strengthening Urban Public Health Systems for MCH
36 Staff training
37 Strategic planning
38 Reshaping urban MCH
39 Securing MCH assistance
40 Managed care initiatives
41 Building coalitions & partnerships
42 Building MCH data capacity
43 Immunization tracking/recall
44 Infant/child death review

45 **Other** (please specify):
_____
_____
_____
_____
_____

1999 CityMatCH Urban MCH Profile

Activity Name: _____ Health Dept: _____

Contact: _____ City/State: _____

Please circle all "MCH Functions*" that best apply to your "Activity," either Profile or Pearl.

Assess MCH Status

1 Develop tools standardizing data collection, analysis, reporting
2 Implement public MCH program client data systems
3 Analysis of demographics, economic status, behaviors, health status
4 Community perceptions of health problems/needs

Diagnose/Investigate Occurrence of Problems & Hazards

5 Tracking systems
6 Population surveys (BRFS, PRAMS, PedNSS, YRBS)
7 Environmental assessments
8 Maternal, fetal/infant, child death reviews

Promoting Positive Beliefs, Attitudes, Behaviors

9 Hotlines, print materials, media campaigns
10 Culturally appropriate health education materials/programs
11 Implement/support education services for special MCH problems
12 Assessment of provider reports regarding process and outcomes

Community Partnerships

13 Prepare, publish & distribute reports
14 Public advocacy for legislation & resources

Research/Demonstration Projects

15 Special studies
16 Development of models

Assess Community Priorities & Action Plans

17 Develop & promote MCH agenda & YR2000 National Objectives
18 Newsletters, convening focus groups, advisory committees, networks
19 Promote compatible, integrated service system initiatives

Promote, Enforce Laws, Regulations, Standards, Contracts (LRSC)

20 Consistent, coordinated policies across programs
21 MCH input in legislative base for health plans & standards
22 MCH legislative activity
23 Development, promulgation, review, updating LRSC
24 Certification & monitoring provider compliance
25 Professional license & certification process
26 Monitor MCO marketing practices
27 Ombudsman services

Assure Capacity/Competency of Public Health Work Force

28 Provide infrastructure/capacity for MCH functions
29 Staff training
30 Support of continuing education
31 Support of health plans/provider networks
32 Health care labor force analysis
33 Laboratory capacity

Link MCAH Population to Services

34 Provide outreach services
35 Transportation & other access-enabling services
36 Referral systems, resource directories, advertising, enrollment assistance
37 Monitor enrollment practices for ease of use
38 Identify high-risk/hard-to-reach populations & methods to serve them
39 Provide, arrange, administer direct services
40 Universal newborn screening programs
41 Detention settings, foster care, mental health facilities
42 Prior authorization for out-of-plan specialty services
43 Review process for ped LT care admissions, CSHCN home services
44 Managed Care model contracts & access issues
45 Pediatric risk adjustment methods & payment mechanisms
46 Identify alternative resources to expand system capacity

Evaluate Effectiveness, Accessibility, & Quality of MCH Services

47 Comparative analysis of HC delivery systems
48 Profiles of provider attitudes, knowledge & practices
49 Identify & report access barriers

50 **Other** (please specify):

_____
_____
_____
_____

* Source: Grason, H. And Guyer, B. (1995) "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

1999 CityMatCH Urban MCH Profile

Activity Name: _____ Health Dept: _____

Contact: _____ City/State: _____

Please describe the activity:

Please describe the activity's objectives (specific, measurable):

Greatest barrier(s) facing implementation:

How are these barriers being overcome?

1999 CityMatCH Urban MCH Profile

Activity Name: _____ Health Dept: _____

Contact: _____ City/State: _____

How is the activity funded?

- ❑ City/County/Local government funds
- ❑ General state funds
- ❑ MCH block grant funds
- ❑ SPRANS funds
- ❑ Private source(s): Please specify:

_____

_____

- ❑ 330 funds
- ❑ Other Federal funds
- ❑ Third party reimbursement (Medicaid, insurance)
- ❑ Other: Please specify:

_____

_____

Approximate annual budget $_____

In planning, implementing and evaluating this activity, what has been the role of your health department?

Has this activity been formally evaluated?

- ❑ Yes
- ❑ No
- ❑ Don't Know

Has this activity been replicated elsewhere?

- ❑ Yes
- ❑ No
- ❑ Don't Know

What are the major accomplishments to date?

What are the lessons learned?

1999 Urban Health Department MCH Efforts

By type of initiative

Profile Index I

		Target MCH Populations																								
		Women's Health			Perinatal Health						Child Health								Adolescent Health				Other		
City, State	Page	Preconception Promotion	Family Planning	Breast/Cervical Cancer	Prenatal Care	Expanding Maternity Services	Home Visiting	Low Birth Weight/Infant Mortality	Substance Abuse Prevention	Breastfeeding/Nutrition/WIC	Immunization	Early Intervention/Zero to Three	EPSDT/Screenings	Expanded Child Health Services	Injury (including child abuse)	Lead Poisoning	Children With Special Needs	School-Linked/Based Services	School-Linked/Based Programs	Violence Prevention/At-Risk	Teen Pregnancy	Teen Parenting	Communicable Diseases	Family Violence	Dental Programs
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Akron, OH	24																								
Albany, NY	26						■																		
Albuquerque, NM	28									■															
Amarillo, TX	30																				■				
Austin, TX	32				■	■															■				
East Baton Rouge, LA	34				■	■				■															
Berkeley, CA	36										■	■													
Boise, ID	38										■														
Cheyenne, WY	40																		■		■	■			
Chicago, IL	42			■						■													■		
Colorado Springs, CO	44				■		■			■	■	■	■									■			
Columbia, SC	46																	■	■						■
Columbus, OH	48																		■		■				
Dallas, TX	50																		■	■	■	■			
Dayton, OH	52				■		■			■	■		■	■					■						
Denver, CO	54						■					■					■								
Detroit, MI	56										■												■		
Durham, NC	58																								
Englewood, CO	60						■													■				■	
Evansville, IN	62															■									
Flint, MI	64																								
Garland, TX	66										■												■		
Grand Rapids, MI	68																			■					
Greensboro, NC	70													■											
Hartford, CT	72															■									
Honolulu, HI	74														■										
Houston, TX	76				■			■				■													
Indianapolis, IN	78	■			■				■																
Jackson, MS	80									■															

Profile Index I	Urban MCH Approaches																								
	Improving Access to Care for Urban Children and Families											Strengthening Urban Public Health Systems for MCH									Other				
1999 Urban Health Department MCH Efforts By type of initiative	Overcoming Cultural Barriers	Reducing Transportation Barriers	Expanding Private Sector Links	Clergy and Health Connections	Schools and Health Connections	One-Stop Shopping Locations	Mobile Clinics for Outreach	Other Outreach Activities	Increasing Social Support	Case Coordination	Increasing Access to Medicaid	Staff Training	Strategic Planning	Reshaping Urban MCH	Securing MCH Assistance	Managed Care Initiatives	Building Coalitions and Partnerships	Building MCH Data Capacity	Immunization Tracking/Recall	Infant/Child Death Review	Other – STD, Drug, & Alcohol Prevention	Other	Other	Other	Other
City, State	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Akron, OH		■							■																
Albany, NY										■															
Albuquerque, NM			■														■								
Amarillo, TX																	■								
Austin, TX											■					■	■	■							
East Baton Rouge, LA	■											■					■								
Berkeley, CA											■								■						
Boise, ID																			■						
Cheyenne, WY																									
Chicago, IL																									
Colorado Springs, CO			■					■		■							■								
Columbia, SC		■			■							■	■				■								
Columbus, OH																					■				
Dallas, TX																									
Dayton, OH										■	■					■	■								
Denver, CO	■	■			■				■	■							■								
Detroit, MI						■			■	■		■	■						■						
Durham, NC																									
Englewood, CO								■	■	■							■								
Evansville, IN				■	■			■									■								
Flint, MI											■														
Garland, TX				■	■		■					■					■								
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Greensboro, NC								■																	
Hartford, CT													■	■			■	■							
Honolulu, HI												■	■				■	■		■					
Houston, TX	■								■		■														
Indianapolis, IN																									
Jackson, MS																									

Profile Index I		Target MCH Approaches																								
		Women's Health			Perinatal Health						Child Health								Adolescent Health				Other		
1999 Urban Health Department MCH Efforts By type of initiative	Page	Preconception Promotion	Family Planning	Breast/Cervical Cancer	Prenatal Care	Expanding Maternity Services	Home Visiting	Low Birth Weight/Infant Mortality	Substance Abuse Prevention	Breastfeeding/Nutrition/WIC	Immunization	Early Intervention/Zero to Three	EPSDT/Screenings	Expanded Child Health Services	Injury (including child abuse)	Lead Poisoning	Children With Special Needs	School-Linked/Based Services	School-Linked/Based Programs	Violence Prevention/At-Risk	Teen Pregnancy	Teen Parenting	Communicable Diseases	Family Violence	Dental Programs
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Kansas City, MO	82															■									
Knoxville, TN	84				■	■															■				
Lakewood, CO	86				■	■															■				
Lexington, KY	88				■	■		■													■				
Lincoln, NE	90																								
Little Rock, AR	92		■		■		■	■	■	■	■	■									■	■			
Long Beach, CA	94												■	■											
Louisville, KY	96		■		■	■	■	■		■	■		■								■	■			
Madison, WI	98																			■	■				
Miami, FL	100	■																					■		
Milwaukee, WI	102										■														
Minneapolis, MN	104											■													
Missoula, MT	106													■			■								
Nashville, TN	108										■												■		
New Orleans, LA	110											■	■	■											
New York, NY	112													■				■	■						
Newark, NJ	114										■	■		■		■							■		■
Norfolk, VA	116				■			■														■		■	
Omaha, NE	118				■					■											■				
Orlando, FL	120																								
Peoria, IL	122		■					■													■				
Philadelphia, PA	124				■	■		■	■			■													
Phoenix, AZ	126			■																					
Portland, ME	128														■										
Portland, OR	130																							■	
Raleigh, NC	132																	■	■	■				■	
Rochester, NY	134	■																							
Rockford, IL	136										■														
Saint Paul, MN	138														■					■				■	

Profile Index I	Urban MCH Approaches																								
	Improving Access to Care for Urban Children and Families												Strengthening Urban Public Health Systems for MCH									Other			
1999 Urban Health Department MCH Efforts By type of initiative	Overcoming Cultural Barriers	Reducing Transportation Barriers	Expanding Private Sector Links	Clergy and Health Connections	Schools and Health Connections	One-Stop Shopping Locations	Mobile Clinics for Outreach	Other Outreach Activities	Increasing Social Support	Case Coordination	Increasing Access to Medicaid	Staff Training	Strategic Planning	Reshaping Urban MCH	Securing MCH Assistance	Managed Care Initiatives	Building Coalitions and Partnerships	Building MCH Data Capacity	Immunization Tracking/Recall	Infant/Child Death Review	Other– Identify/Overcome Barriers to Insurance	Other – Doing an Assessment of Child Health	Other – Linking Literacy and Health Care	Other – Comm. Needs Assessment, Incl Minority Health	Other – Child Mental Health
City, State	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Kansas City, MO																									
Knoxville, TN				■					■								■								
Lakewood, CO			■					■			■					■	■	■								
Lexington, KY	■	■								■	■		■		■		■								
Lincoln, NE													■												
Little Rock, AR	■	■		■	■				■	■	■														
Long Beach, CA	■							■									■				■				
Louisville, KY	■	■	■			■			■	■	■					■	■								
Madison, WI																									
Miami, FL	■			■								■	■				■								
Milwaukee, WI			■										■				■								
Minneapolis, MN																						■			
Missoula, MT								■				■					■		■						
Nashville, TN																			■						
New Orleans, LA	■				■									■									■		
New York, NY	■							■	■	■	■	■	■	■		■	■								
Newark, NJ	■	■	■	■	■	■	■	■	■	■	■	■		■		■	■	■	■						
Norfolk, VA	■			■																					
Omaha, NE						■											■								
Orlando, FL	■		■				■	■	■				■				■	■						■	
Peoria, IL			■			■		■				■					■								
Philadelphia, PA			■						■	■		■		■		■	■								
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Portland, ME								■	■																
Portland, OR													■	■			■								
Raleigh, NC	■	■	■	■	■	■	■	■	■	■		■					■								■
Rochester, NY										■															
Rockford, IL						■				■		■							■						
Saint Paul, MN								■						■			■								

1999 Urban Health Department MCH Efforts

By type of initiative

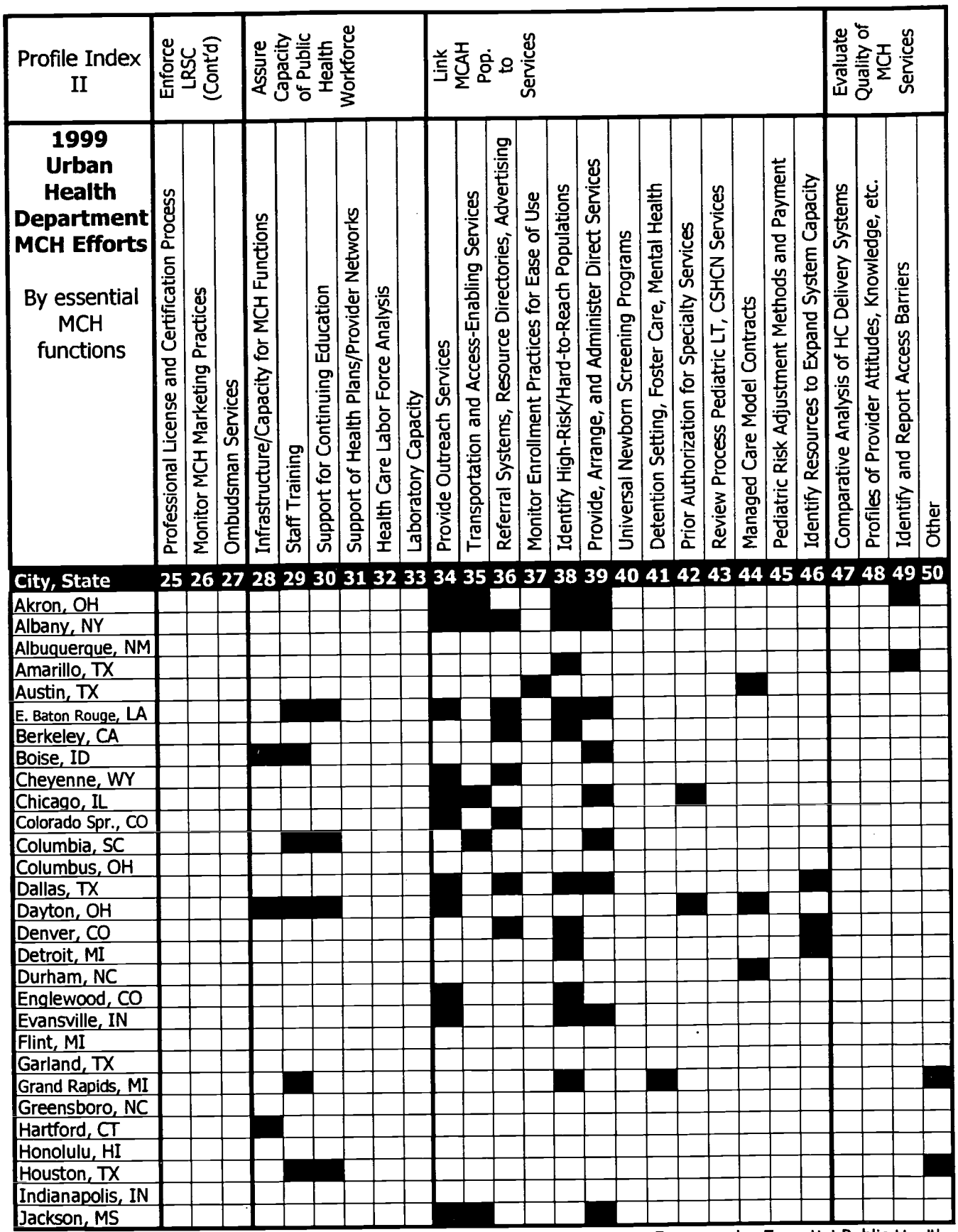
Profile Index I

		Target MCH Populations																							
		Women's Health			Perinatal Health						Child Health								Adolescent Health				Other		
City, State	Page	Preconception Promotion	Family Planning	Breast/Cervical Cancer	Prenatal Care	Expanding Maternity Services	Home Visiting	Low Birth Weight/Infant Mortality	Substance Abuse Prevention	Breastfeeding/Nutrition/WIC	Immunization	Early Intervention/Zero to Three	EPSDT/Screenings	Expanded Child Health Services	Injury (including child abuse)	Lead Poisoning	Children With Special Needs	School-Linked/Based Services	School-Linked/Based Programs	Violence Prevention/At-Risk	Teen Pregnancy	Teen Parenting	Communicable Diseases	Family Violence	Dental Programs
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Saint Petersburg, FL	140																								
Salt Lake City, UT	142				■	■		■		■	■														
San Antonio, TX	144	■			■																				
Santa Ana, CA	146																								
Santa Rosa, CA	148									■															
Seattle, WA	150																								
Spokane, WA	152											■	■	■											■
Stockton, CA	154															■									
Syracuse, NY	156		■		■		■	■	■	■										■	■	■	■	■	
Waco, TX	158																								
Wayne, MI	160									■															
Wilmington, DE	162																								
Winston-Salem, NC	164				■		■	■	■	■		■		■	■			■							■
Ypsilanti, MI	166				■	■	■	■	■	■															

Profile Index I	Urban MCH Approaches																								
	Improving Access to Care for Urban Children and Families											Strengthening Urban Public Health Systems for MCH									Other				
1999 Urban Health Department MCH Efforts By type of initiative	Overcoming Cultural Barriers	Reducing Transportation Barriers	Expanding Private Sector Links	Clergy and Health Connections	Schools and Health Connections	One-Stop Shopping Locations	Mobile Clinics for Outreach	Other Outreach Activities	Increasing Social Support	Case Coordination	Increasing Access to Medicaid	Staff Training	Strategic Planning	Reshaping Urban MCH	Securing MCH Assistance	Managed Care Initiatives	Building Coalitions and Partnerships	Building MCH Data Capacity	Immunization Tracking/Recall	Infant/Child Death Review	Other	Other	Other	Other	Other
City, State	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
St. Petersburg, FL	■												■				■								
Salt Lake City, UT	■					■					■						■								
San Antonio, TX	■	■		■				■				■					■								
Santa Ana, CA												■	■												
Santa Rosa, CA																									
Seattle, WA								■			■														
Spokane, WA	■		■					■				■	■		■		■	■							
Stockton, CA																									
Syracuse, NY	■	■	■	■	■			■	■	■	■	■	■			■	■	■	■	■					
Waco, TX													■				■								
Wayne, MI						■											■								
Wilmington, DE	■	■	■					■	■		■														
Winston-Salem, NC	■	■	■	■	■			■	■	■	■	■	■	■			■	■	■						
Ypsilanti, MI	■	■	■					■	■	■	■														

Profile Index II		Assess MCH Status				Diagnose Problems and Hazards				Promoting Positive Attitudes and Behaviors				Comm. Partners		Research/ Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
1999 Urban Health Department MCH Efforts By essential MCH functions	Page	Tools for Data Collection, Analysis, Reporting	MCH Program Client Systems	Analysis of Demographics, Health Systems, etc.	Community Perceptions of Health Problems	Tracking Systems	Population Surveys	Environmental Assessment	Maternal, Fetal/Infant Child Death Reviews	Hotlines, Print Materials, Media Campaigns	Culturally Appropriate Health Education	Services for Special MCH Problems	Assess Provider Reports on Outcomes	Prepare, Publish, and Distribute Reports	Public Advocacy for Legislation and Resources	Special Studies	Development of Models	Promote MCH Agenda/Year 2000 Objectives	Newsletters, Focus Groups, Advisory Comm.	Integrated Service Systems Initiatives	Consistent, Coordinated Policies	MCH Input in Legislative Base for Health Plans	MCH Legislative Activity	Develop, Promulgate, Review, Update LRSC	Certification, Monitoring Provider Compliance
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Akron, OH	24				■						■	■													
Albany, NY	26																								
Albuquerque, NM	28										■				■										
Amarillo, TX	30			■	■														■						
Austin, TX	32														■				■	■		■			
East Baton Rouge, LA	34					■				■	■	■						■	■	■	■				
Berkeley, CA	36				■	■					■														
Boise, ID	38	■	■			■							■	■		■	■				■				
Cheyenne, WY	40																								
Chicago, IL	44										■		■			■									
Colorado Springs, CO	42			■	■					■	■	■			■				■						
Columbia, SC	46			■										■											
Columbus, OH	48																								
Dallas, TX	50											■													
Dayton, OH	52			■	■					■									■						
Denver, CO	54										■	■			■					■					
Detroit, MI	56	■				■											■								
Durham, NC	58																								
Englewood, CO	60																			■					
Evansville, IN	62							■		■	■	■	■	■					■						
Flint, MI	64		■			■									■										
Garland, TX	66																								
Grand Rapids, MI	68										■	■							■						
Greensboro, NC	70							■																	
Hartford, CT	72										■	■		■			■								
Honolulu, HI	74	■		■		■			■					■	■										
Houston, TX	76			■						■									■						
Indianapolis, IN	78	■		■		■									■			■			■				
Jackson, MS	80																								

* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD



* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Profile Index II		Assess MCH Status				Diagnose Problems and Hazards				Promote Positive Attitudes and Behaviors				Comm. Partners		Research /Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
1999 Urban Health Department MCH Efforts By essential MCH functions	Page	Tools for Data Collection, Analysis, Reporting	MCH Program Client Systems	Analysis of Demographics, Health Systems, etc.	Community Perceptions of Health Problems	Tracking Systems	Population Surveys	Environmental Assessment	Maternal, Fetal/Infant Child Death Reviews	Hotlines, Print Materials, Media Campaigns	Culturally Appropriate Health Education	Services for Special MCH Problems	Assess Provider Reports on Outcomes	Prepare, Publish, and Distribute Reports	Public Advocacy for Legislation and Resources	Special Studies	Development of Models	Promote MCH Agenda/Year 2000 Objectives	Newsletters, Focus Groups, Advisory Comm.	Integrated Service Systems Initiatives	Consistent, Coordinated Policies	MCH Input in Legislative Base for Health Plans	MCH Legislative Activity	Develop, Promulgate, Review, Update LRSC	Certification, Monitoring Provider Compliance
City, State		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**
Kansas City, MO	82	■			■					■	■	■			■				■						
Knoxville, TN	84				■					■	■	■													
Lakewood, CO	86	■	■	■	■	■							■	■						■					
Lexington, KY	88			■	■	■				■	■	■	■					■			■				
Lincoln, NE	90			■	■			■										■							
Little Rock, AR	92																								
Long Beach, CA	94				■					■	■							■	■						
Louisville, KY	96										■	■													
Madison, WI	98											■													
Miami, FL	100										■														
Milwaukee, WI	102				■					■	■	■		■	■						■				
Minneapolis, MN	104			■			■							■											
Missoula, MT	106				■						■	■					■		■						
Nashville, TN	108																								
New Orleans, LA	110			■			■			■	■	■				■	■								
New York, NY	112	■		■	■	■		■		■	■		■	■			■		■	■	■				
Newark, NJ	114	■	■	■	■	■				■	■	■		■				■		■					
Norfolk, VA	116	■			■	■				■	■			■		■	■		■						
Omaha, NE	118																			■					
Orlando, FL	120	■		■	■					■	■		■	■		■	■		■						
Peoria, IL	122			■	■																				
Philadelphia, PA	124	■	■	■	■	■		■				■	■			■	■			■	■				■
Phoenix, AZ	126										■				■										
Portland, ME	128										■														
Portland, OR	130				■									■											
Raleigh, NC	132											■					■								
Rochester, NY	134	■		■							■					■	■								
Rockford, IL	136																			■					

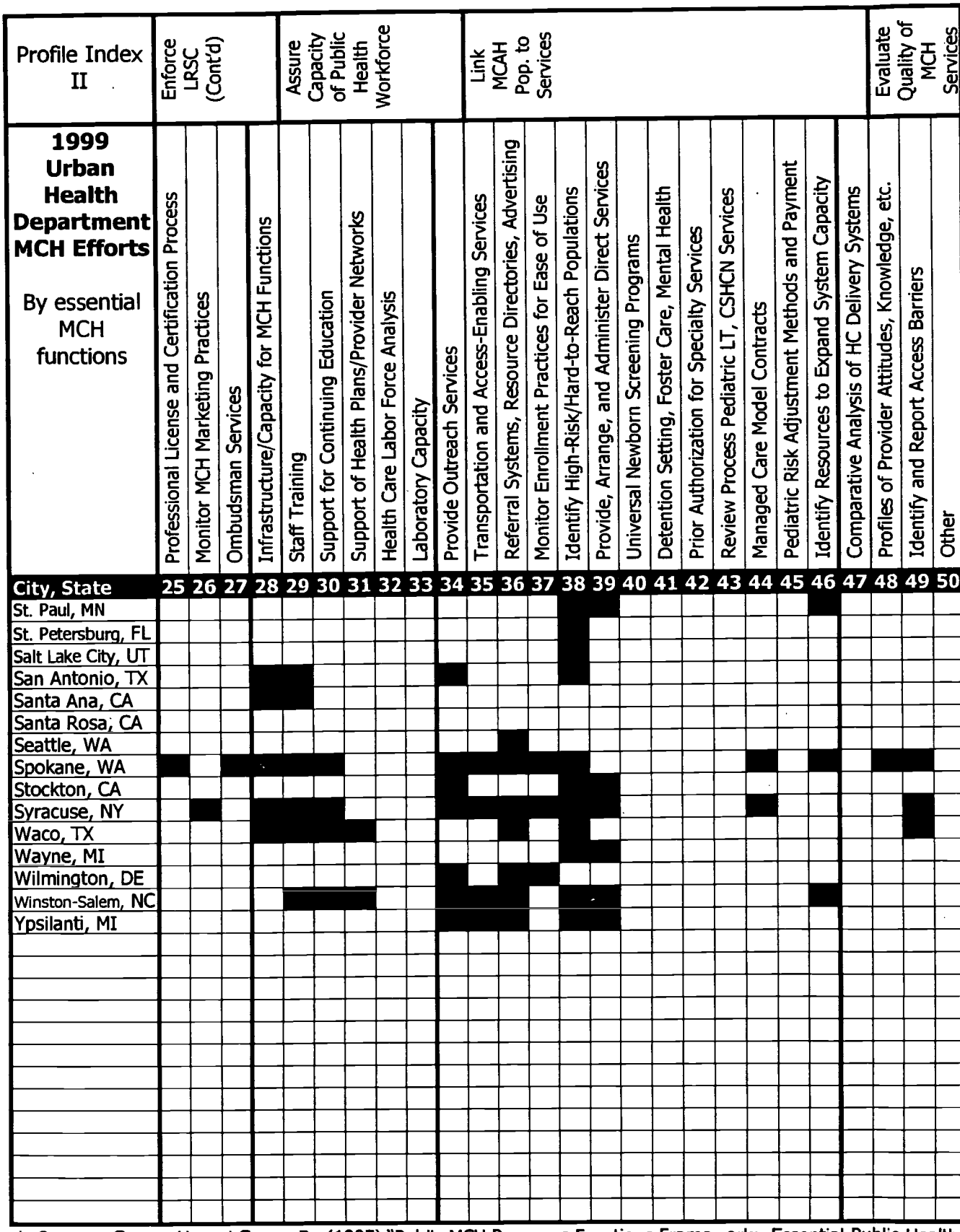
* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Profile Index II	Enforce LRSC (Cont'd)			Assure Capacity of Public Health Workforce							Link MCAH Pop. to Services												Evaluate Quality of MCH Services			
1999 Urban Health Department MCH Efforts By essential MCH functions	Professional License and Certification Process	Monitor MCH Marketing Practices	Ombudsman Services	Infrastructure/Capacity for MCH Functions	Staff Training	Support for Continuing Education	Support of Health Plans/Provider Networks	Health Care Labor Force Analysis	Laboratory Capacity		Provide Outreach Services	Transportation and Access-Enabling Services	Referral Systems, Resource Directories, Advertising	Monitor Enrollment Practices for Ease of Use	Identify High-Risk/Hard-to-Reach Populations	Provide, Arrange, and Administer Direct Services	Universal Newborn Screening Programs	Detention Setting, Foster Care, Mental Health	Prior Authorization for Specialty Services	Review Process Pediatric LT, CSHCN Services	Managed Care Model Contracts	Pediatric Risk Adjustment Methods and Payment	Identify Resources to Expand System Capacity	Comparative Analysis of HC Delivery Systems	Profiles of Provider Attitudes, Knowledge, etc.	Identify and Report Access Barriers	Other
City, State	25	26	27	28	29	30	31	32	33		34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Kansas City, MO											■												■				
Knoxville, TN											■			■									■			■	
Lakewood, CO				■							■				■	■	■				■						
Lexington, KY				■	■	■	■				■	■	■	■	■	■	■										
Lincoln, NE																											
Little Rock, AR																											
Long Beach, CA											■	■	■	■	■								■				
Louisville, KY					■	■	■				■					■					■		■				
Madison, WI															■												
Miami, FL															■											■	
Milwaukee, WI															■												
Minneapolis, MN															■												
Missoula, MT			■	■	■	■	■				■					■							■		■		
Nashville, TN															■	■											
New Orleans, LA					■								■		■	■											
New York, NY				■	■	■					■	■	■		■												
Newark, NJ					■		■				■	■	■		■	■										■	
Norfolk, VA					■						■	■	■	■		■		■								■	
Omaha, NE													■	■	■												
Orlando, FL														■	■								■		■	■	■
Peoria, IL				■	■											■											
Philadelphia, PA					■		■														■		■	■	■	■	
Phoenix, AZ											■			■	■	■							■				
Portland, ME											■				■	■											
Portland, OR					■		■																		■		
Raleigh, NC				■	■	■					■	■			■	■		■									■
Rochester, NY											■																
Rockford, IL					■											■											

* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Profile Index II		Assess MCH Status				Diagnose Problems and Hazards				Promoting Positive Attitudes and Behaviors				Comm. Partners		Research/ Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
1999 Urban Health Department MCH Efforts By essential MCH functions	Page	Tools for Data Collection, Analysis, Reporting	MCH Program Client Systems	Analysis of Demographics, Health Systems, etc.	Community Perceptions of Health Problems	Tracking Systems	Population Surveys	Environmental Assessment	Maternal, Fetal/Infant Child Death Reviews	Hotlines, Print Materials, Media Campaigns	Culturally Appropriate Health Education	Services for Special MCH Problems	Assess Provider Reports on Outcomes	Prepare, Publish, and Distribute Reports	Public Advocacy for Legislation and Resources	Special Studies	Development of Models	Promote MCH Agenda/Year 2000 Objectives	Newsletters, Focus Groups, Advisory Comm.	Integrated Service Systems Initiatives	Consistent, Coordinated Policies	MCH Input in Legislative Base for Health Plans	MCH Legislative Activity	Develop, Promulgate, Review, Update LRSC	Certification, Monitoring Provider Compliance
City, State		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**
Saint Paul, MN	138				■			■			■	■			■					■					
Saint Petersburg, FL	140				■						■									■					
Salt Lake City, UT	142										■														
San Antonio, TX	144				■						■														
Santa Ana, CA	146	■		■	■																				
Santa Rosa, CA	148				■					■	■								■						
Seattle, WA	150																								
Spokane, WA	152	■	■	■	■	■				■	■	■	■	■	■	■	■	■	■	■	■	■	■		■
Stockton, CA	154	■		■	■						■	■		■			■								
Syracuse, NY	156	■	■	■	■	■			■	■	■	■	■	■	■				■	■	■				■
Waco, TX	158	■		■	■	■	■	■		■	■	■		■	■			■	■						
Wayne, MI	160											■						■							
Wilmington, DE	162																								
Winston-Salem, NC	164			■	■	■				■	■	■	■	■	■				■	■					
Ypsilanti, MI	166																								

* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD



* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

1999 Successful Urban Health Department Initiatives in Maternal and Child Health

Early Start Program and Parent Meetings

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Family planning Prenatal care Home visiting Substance abuse prevention Immunization Early intervention/zero to three Children with special needs Teen pregnancy Teen parenting Family violence Reducing transportation barriers Other outreach activities Increasing social support	Community perceptions of health problems/needs Implement/support education services for special MCH problems Provide outreach services Transportation and other access-enabling services Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services Identify and report access barriers

Funding Sources:

City/County/Local government funds, Private source: per site

Budget: $49,000.00

Description:

Ohio Early Start requires parents who are enrolled in the Early Start Program to attend monthly parent meetings. Each Early Start site decides what kind of fun learning activity to provide. For the meetings, child care and transportation are provided and refreshments are served. The meeting may consist of a field trip, an informal group discussion of concerns that parents have at that time, or a presenter may come and speak to the parents.

Objectives of the activity:

Monthly parent meetings are required for parents in the Early Start Program. The meetings have the following objectives:

1. To provide peer support to the parents.
2. To provide group learning experiences.
3. To provide social, but structured, interaction for the parents.
4. To discuss/present interesting topics which will benefit the parents.
5. To observe parents and children and their interactions away from home.

Barriers encountered in implementation:	Strategies to overcome barriers:
The barriers included poor attendance at required parent meetings as well as the lack of a meeting environment conducive to full participation and interaction. The meeting room needed to be reserved in advance and did not allow flexibility; if a room was available, it was often not very "user-friendly" (cold conference rooms, hard chairs, no place for children to be occupied, etc.). Also, the beginning and ending times posed problems because parents arrived and left in a "staggered" manner due to the fact that each outreach worker had to make at least two trips each way to transport attendees	We decided to use a private residence as our meeting place. This allowed for staggered arrivals and departures more readily and made the waiting time more fun for the parents. In addition, the meeting at the house allowed for seating on couches and regular chairs, resulting in easy socialization and interaction as well as easy access to bathroom facilities. Bottles can be refrigerated/heated readily, food was prepared by popular request and eaten family style, and toys were available for all the children. Socialization during the first hour, allowed staff to fully observe the parents and children during normal activities. The second hour of the meetings were devoted to some form of learning activity. The format of the meetings was group activity as opposed to a lecture format,. Attendance and participation were better if separate meetings were held for the under twenty and over twenty groups. Once a year, during the holiday season, we held a festive sit-down meal of turkey with all the trimmings. The house was decorated and everyone enjoyed this occasion.

Role of health department in implementation, planning, and evaluation:

Early Start began in January 1996 in Summit County as a result of collaborations among Akron Children's Hospital, Decher Developmental Center, Children's Services of Summit County and the Akron Health Department. The initial four sites were Children's Hospital, the Akron Health Department, LifeLink (a prenatal outreach program) and Twinsburg Community Center. The monthly parent meetings are required under the grant funding Early Start.

Accomplishments:

The Akron Health Department has serviced over 500 young mothers children by providing intensive home visitations, training outreach workers, and holding monthly parent meetings. The accomplishments of the program include:

1. Increased levels of immunizations.
2. Parents remaining in and completing school; parents getting their GED
3. Parents obtaining and retaining gainful employment.
4. Children benefiting from improved parenting skills.
5. Improved parental social skills resulting from well attended parent meetings.

Lessons Learned:

A more personal touch was required to attract our clients to the parent meetings. Clients were tired of "being lectured to." Despite themselves, teens and young mothers do respond more in a warm personal environment which allows them to feel welcome and on equal footing with those who provide services for them. School-like activities are more likely to be "tuned out."

Bright Beginnings

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Home visiting Children with special needs Case coordination	Provide outreach services Transportation and other access-enabling services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
General state funds

Budget: $0.00

Description:

Bright Beginnings is part of the New York State initiative called Healthy Families America. Bright Beginnings is a primary prevention home visiting program whose aim is to reduce the incidence of child abuse and neglect within high risk areas in Albany County. The program provides voluntary home visits to new or expectant parents to reduce the stresses associated with pregnancy and the birth of a child. It offers support, nurturing, information and education that can lead to improved health and safety for the child and family. Family support workers assist families by providing parents with information about and linking them to available resources.

Objectives of the activity:

The Bright Beginnings Program objectives include:
1. Reduction in the number of indicated cases of child abuse and neglect and out-of-home placements.
2. Increased receipt of immunizations and lead screenings.
3. Regular medical care including prenatal care and well baby care.
4. Positive parent-child interactions and parenting skills.
5. Increased use of community resources.
6. Improved child development outcomes including readiness to learn in school.
7. Decreased infant mortality.
8. Initiation in preliminary steps to achieve self-sufficiency for all families on public assistance.

Barriers encountered in implementation:	Strategies to overcome barriers:
The development of policies and procedures that were suitable to all four very different and unique agencies working collaboratively on the project.	The Steering Committee is made up of program managers from each organization. This group is responsible for policy making decisions affecting the program. A Program Manager from the lead agency, which is the Albany County Department of Health, coordinates the daily operations of the program taking direction from the committee.

Role of health department in implementation, planning, and evaluation:

The health department is the lead agency in the collaboration. The department administers the grant funds, subcontracting with the three other organizations. In addition, the department has on staff a program manager who is responsible for oversight of the four-organization program. This individual works closely with the steering committee in carrying out their requests and in maintaining the collaborative nature of the program. All quality assurance activities are the responsibility of the health department. Also, screening activities to determine eligibility for the program are done by health department staff.

Accomplishments:

1. 94% of the nine-month-old children and 100% of the two-year-old children enrolled in the program are up to date on immunizations.
2. 88% of the children have been tested for lead poisoning.
3. 100% of the children have a primary care provider.
4. 98% of the children four months or older have demonstrated age appropriate developmental milestones or have been referred for future evaluations/services if delays were detected.
5. 89% of the primary care takers have not been the subject of a subsequent child abuse report by the child's first birthday.
6. 76% of families at the child's first birthday and 86% by their second birthday are enrolled in education/training or are employed.

Lessons Learned:

Partnering with four organizations brings unique and exceptional strength, experience, and expertise to the program. Collectively, the organizations offer expertise in health, child abuse, emotional disturbance, teen pregnancy, and drug abuse while decreasing any duplication of services. Without a strong committee to work together collectively, the program would not succeed. A strong steering committee with input and representation is vital. A full commitment to the common mission is needed. Well-defined communication channels are necessary at all levels.

WIC-Farmer's Market Nutrition Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Breastfeeding/nutrition/WIC Expanding private sector links Building coalitions and partnerships	Culturally appropriate health education materials/programs Public advocacy for legislation and resources

Funding Sources:
General state funds, Other Federal funds

Budget: $0.00

Description:

During the months of July through October, WIC participants can receive an additional $20.00 coupon booklet with their checks to be spent at local grower's markets. These coupons allow WIC participants to purchase fresh produce grown locally by area farmers. In addition to giving WIC clients the opportunity to buy the freshest fruits and vegetables, it also supports New Mexico's traditional small independent-farm agricultural base.

Objectives of the activity:

This program has two main objectives:
1. Increase the amount of fresh fruits and vegetables consumed by WIC participants.
2. Support local grower's markets and individual farmers. One of the measurements used is to compare the number of coupons issued with the number if coupons redeemed.

Barriers encountered in implementation:	Strategies to overcome barriers:
The federal government provides 70% of the financial support for the program. The state is required to provide 30% matching funds. This requires funding from the legislature and governor each year. During the last legislative session, WIC has strong support in the legislature, but the Governor vetoed funds for program expansion.	The WIC program overcame the financial barrier caused by the Governor's veto by using money from other discretionary funds. In the future, more work will be done with the Governor to educate him to the win-win nature of this program. Local growers have become very supportive of the program and are now organizing as a united political group.

Role of health department in implementation, planning, and evaluation:

The WIC staff has worked closely with the New Mexico Growers Association to recruit growers to participate in the program. The program is fully implemented by local WIC staff; it receives no administrative funds. Local staff educates WIC clients to the benefits of participating in the program.

Accomplishments:

Farmers are planning to increase production of next year's crop to meet the increased demand. The increase in revenue has brought together local growers to organize as a united political group. The coupon redemption rate by WIC clients has increased each year of the program. WIC has received a VISTA grant to start a community garden in one of the neighborhoods with a high percentage of Southeast Asian immigrants. This was due to the high demand for Southeast Asian varieties of fresh produce. Community garden participants can either consume the produce or sell it at the grower's market for extra income.

Lessons Learned:

Planning must start early. It is especially important to work with farmers before the start of the planting season to inform them about the program and increased demand for their produce.

Teen Pregnancy Prevention Coalition

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Has this activity been formally evaluated?
Evaluation will be based on the intervention component.

Has this activity been replicated?
Many coalitions exist; ours is not modeled after any particular coalition.

Essential MCH Functions:	MCH Initiatives:
Teen pregnancy Building coalitions and partnerships	Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Newsletters, convening focus groups, advisory committees, networks Identify high-risk/hard-to-reach populations and methods to serve them Identify and report access barriers

Funding Sources:
There is no designated funding for the Coalition.

Budget: $0.00

Description:

The Teen Pregnancy Prevention Coalition, serving Potter and Randall counties, was formed in May 1998. The goal of the Coalition is to help all young people become healthy, caring, and responsible individuals. The Coalition has a broad base of support from 90-100 members, representing schools, health care providers, social services, civic groups, and the media. The Coalition is co-facilitated by the City of Amarillo Department of Public Health and the United Way of Amarillo and Canyon. Organizationally, the Coalition has five "Interest Areas" and a steering committee made up of two representatives from each of those areas.

Objectives of the activity:

The Coalition's mission is to significantly reduce the number of school-aged pregnancies in Potter and Randall counties through community efforts. The role of the Coalition is to raise awareness of teen pregnancy, conduct a needs assessment, and propose strategies to impact adolescent pregnancy. The objectives of the Coalition are to:

1. Complete a needs/assets assessment by 9-1-99.
2. Conduct an intervention-focused brainstorming session by 9-30-99.
3. Incorporate an intervention component into the Community Action Plan by 11-1-99.
4. Engage key stakeholders to formalize their commitment to the Community Action Plan (no time identified yet).
5. Design a brochure that will describe the needs/assets assessment, vision and mission of the Coaltion. This brochure will aim to answer the community's question, "What can I do to Prevent Teenage Pregnancy?"
6. Host a community meeting to reveal the plan in January 2000.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Lack of resources (such as a dedicated staff and money) can be a barrier. 2. Engaging stakeholders.	1. Moving slowly and using the strengths of members/agencies is critical to developing trust, ownership, and a strong sustainable effort. 2. Maintaining openness and an inclusive environment is important. Constant outreach for new members through word of mouth, formal invitations, and the media assists with increasing our membership.

Role of health department in implementation, planning, and evaluation:

The health department served as a convener, facilitator, data assistant, and technical consultant to the coalition.

Accomplishments:

The Coalition's accomplishments include:

1. Forming the Coalition.
2. Heightening the community's awareness of adolescent pregnancy.
3. Completing the first draft of the needs/assets assessment.
4. Developing a close working relationship with a private foundation who has this issue as a priority; developing a relationship with a staff person from the National Campaign to Prevent Teen Pregnancy.

Lessons Learned:

Coalition development, once the grassroots formation has occurred, is much like managing an organization. The Coalition has maintained credibility by relying on sound facts and research.

Austin Area Perinatal Coalition

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Prenatal care Expanding maternity services Teen pregnancy Increasing access to Medicaid Managed care initiatives Building coalitions and partnerships Building MCH data capacity	Public advocacy for legislation and resources Newsletters, convening focus groups, advisory committees, networks Promote compatible, integrated service system initiatives MCH input in legislative base for health plans and standards Monitor enrollment practices for ease of use Managed Care model contracts and access issues

Funding Sources:
City/County/Local government funds

Budget: $3,000.00

Description:

The Austin Area Perinatal Coalition is a network of providers formed in 1993 to plan, coordinate, educate and advocate for comprehensive perinatal services. Participants are from Austin/Travis County and the surrounding area health and social service organizations, city and county agencies, Medicaid provider organizations, educational institutions and the community at large. More than 40 groups and 150 individuals are involved.

Objectives of the activity:

1. To reduce time for a pregnant low-income woman to access prenatal care.
2. To advocate for improved eligibility and enrollment processes for Medicaid Managed Care.
3. To improve access to Medicaid Managed Care services for low-income women and children.

Barriers encountered in implementation:	Strategies to overcome barriers:
Several barriers need to be eliminated to improve timely access to care. The first is lack of knowledge across providers, policy makers and the general community regarding the onerous process required for prenatal care entry through MMC. Another barrier has been the unwillingness of providers to use "presumptive eligibility" to expedite entry into prenatal care. Aside from the public clinics, most MCC providers are not regular Medicaid providers and will not see the clients who are not enrolled in STAR and in one of the managed care plans. The process of eligibility screening is long and frustrating, taking several appointments to complete.	The Austin Area Perinatal Coalition has documented the process required of non-insured, low income pregnant women to enroll in Medicaid Managed Care. Findings and recommendations for improvements have been forwarded to key staff at the Texas Health and Human Services Commission, Texas Department of Health and HRSA Auditors. The recommendations have resulted in an improved eligibility process for the Children's Health Insurance Program.

Role of health department in implementation, planning, and evaluation:

The health department serves as the convener of the Coalition. The chair of the coalition is a health department staff person. The health department provides for all mailings and associated costs.

Accomplishments:

The Coalition has formally documented the process required to access prenatal care, which has resulted in changes to the eligibility processes. The Service Delivery Committee meets regularly to identify and solve problems with specific women. One of the committees of the Perinatal Coalition has spun off to form the Austin Child Abuse Prevention Coalition, which has been raising public awareness of child abuse in the community. The Coalition's recommendations impacted the CHIP enrollment process to be more user friendly.

Lessons Learned:

Bringing a variety of partners to the table with different interests requires time to establish trust and an ability to work together. Improving access to care is very difficult when multiple bureaucracies are involved. Advocacy can be effective if there is qualitative and quantitative data to support specific recommendations.

Greater Baton Rouge Breastfeeding Coalition

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Prenatal care Expanding maternity services Breastfeeding/nutrition/WIC Overcoming cultural barriers Staff training Building coalitions and partnerships	Tracking systems Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Develop and promote MCH agenda and YR 2000 National Objectives Newsletters, convening focus groups, advisory committees, networks Promote compatible, integrated service system initiatives Consistent, coordinated policies across programs Staff training Support of continuing education Provide outreach services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
MCH block grant funds, Other Federal funds

Budget: $2,500.00

Description:

The Greater Baton Rouge Breastfeeding Coalition began as an outreach activity for the Office of Public Health-Region II WIC program. Professionals working in public and private hospitals were invited to the Office of Public Health-Region II to learn about the benefits WIC offers to breastfeeding mothers and infants who meet WIC financial guidelines. Contact phone numbers were distributed to link new mothers with local WIC breastfeeding nurses in each parish health unit.

Objectives of the activity:

1. To increase breastfeeding rates and number of referrals to WIC providers at the Region II Office of Public Health.
2. To increase the average duration of breastfeeding among the WIC population in Region II.
3. To increase the private sector's (MCH) knowledge of the WIC eligibility process and locations of services.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. The private sector's impressions of WIC providers and services were negative. 2. OPH WIC staff were resistant to tracking breastfeeding rates and duration. 3. No additional (OPH) manpower was available to assume more duties involving breastfeeding and nutrition education. 4. The technology for tracking breastfeeding rates and duration was very limited. 5. A lack of financial resources.	1. Meetings to discuss strategies are continuing quarterly; private institutional participation is on an ongoing basis. 2. Local staff receives recognition and praise for their contributions.

Role of health department in implementation, planning, and evaluation:

The health department served as a catalyst, organizer, gatekeeper, and major supporter of this initiative.

Accomplishments:

1. Private and public institutions operating in the area of breastfeeding education are working together to improve breastfeeding outcomes.
2. The Office of Public Health Nutrition Services was recognized by the private MCH medical community as a breastfeeding resource for clientele.
3. There has been an increased community awareness of breastfeeding.

Lessons Learned:

1. What is planned as a one-time WIC outreach meeting can blossom into a professional health education coalition.
2. People with genuine interests and commitments will do great things for little or no compensation. A pat on the back is often all we had to give.
3. Don't assume anything. Listen and learn.

Healthy Baby Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Immunization Early intervention/zero to three Increasing access to Medicaid Immunization tracking/recall	Community perceptions of health problems/needs Tracking systems Culturally appropriate health education materials/programs Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
City/County/Local government funds, MCH block grant funds

Budget: $100,000.00

Description:

A public health nurse goes to the maternity ward of the local hospital to acquaint all MediCal families with services available through the Public Health Department and outside services available for newborns. Some of the topics covered are immunizations, regular well baby exams, car seat safety, WIC, breastfeeding and hearing screening. The family is also told that here in Berkeley, the Public Health Department wants to assure that all of our children aged two are current with their immunizations; therefore a public health nurse will call at immunization intervals to discuss compliance and other needs.

Objectives of the activity:

1. To encourage compliance of timely immunizations amongst the MediCal population.
2. To assure that by 24 months all children known to the Public Health Department are complete and up to date with their vaccinations.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Obtaining complete information from various sources is difficult. We use the birth certificate data, WIC sign up lists, PHN referrals and delivery records. 2. Clients are not available during normal working hours for telephone calls. 3. Clients are very mobile.	1. Information sources are cross referenced. Letters are mailed to the homes of clients asking them to call the health department. 2. Telephone calls are made late in the evening between 6 and 7 p.m. and on weekends, attempting to reach a hard-to-reach population. 3. Surnames are cross referenced in the nursing data base to track families that move within the City of Berkeley.

Role of health department in implementation, planning, and evaluation:

1. Realizing the potential loss to follow-up experienced by many families and the fact that immunizations become a low priority in their daily hectic life, the public health nurses are instrumental in following up the "high risk" cases where families have growing needs.
2. This is a program within the health department. The implementation was somewhat bumpy because some of the players were not a part of the original planning phase. PHN became more instrumental in the program as the implementation got underway. This helped to facilitate a smooth transition for the new mothers.

Accomplishments:

1. Hospital statistics on the mothers are shared with the health department.
2. A number of PHN referrals have been made from the follow-up telephone calls.
3. We are aware of the strong partnership that can be built between Maternal, Child, and Adolescent Health and Public Health Nursing.
4. In conjunction with other immunization outreach programs, Berkeley has moved from being below the state averages in 1996, to surpassing the rising immunization rates of 1999.

Lessons Learned:

The immunization rates in the city of Berkeley were low compared to Healthy People 2000 goals. This Healthy Baby Program was conceived to provide public health nursing identification and case management follow-up to families in Berkeley. Coupled with decreased immunization rates, especially for African Americans and Hispanics, it was apparent that immunization follow-up by telephone calls, in an appropriate language, needed to be included in the protocol. The program is a successful one and will be continued.

Immunization Action Plan Service

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Immunization Immunization tracking/recall	Develop tools standardizing data collection, analysis, reporting Implement public MCH program client data systems Tracking systems Assessment of provider reports regarding process and outcomes Prepare, publish and distribute reports Special studies Development of models Consistent, coordinated policies across programs Provide infrastructure/capacity for MCH functions Staff training Develop tools standardizing data collection, analysis, reporting Provide, arrange, administer direct services

Funding Sources:
City/County/Local government funds, General state funds, MCH block grant funds

Budget: $15,587.00

Description:

Implementation of a program that links WIC with immunizations. The goal is to achieve the Healthy People Year 2000 goal of 90% immunization coverage rates for children two years of age and to assure continued high immunization coverage for children entering school. WIC and Immunization staff work together to identify participants' immunization status, make recommendations about immunizations, provide incentives, provide immunizations and track progress.

Objectives of the activity:

By December 31, 1999, Central District shall raise the two-year old immunization levels of children seen in Central District's Immunization, WIC and CHSP clinics to 90% by January 1, 2000.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. This activity requires more WIC time because clients must return to WIC monthly if their immunizations aren't up-to-date. WIC requirements allow a two-month span between appointments. 2. Some staff were reluctant to take on the additional work including research and printing records for WIC and updating records with data from WIC.	This was overcome by regular meetings, through encouragement including taking responsibility on performance evaluations and the development and implementation of a work plan.

Role of health department in implementation, planning, and evaluation:

The activity is a program of the health department. It requires the cooperation of the Immunization and WIC programs. The health department leadership team had been supportive and watchful of the process. The health department dedicated county and state dollars to this effort.

Accomplishments:

1. Improved immunization levels.
2. More complete, higher quality immunization data.

Lessons Learned:

1. The importance of programs working together.
2. Importance of including staff input from all levels of the organization.

Preconceptual Teaching

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
School-linked/based services Teen pregnancy Teen parenting	Provide outreach services Transportation and other access-enabling services

Funding Sources:
Private source: Wyoming Children's Trust Fund

Budget:

Description:

A presentation was given to junior high school girls regarding "preconceptual" planning. A handout was prepared describing what activities would have to be given up if the teen became a mother, as well as activities (such as middle of the night feedings) that are required of mothers. A teen mom accompanied the nurse to relate first-hand knowledge of the demands of teen motherhood.

Objectives of the activity:

That 90% of teens involved in the class would delay pregnancy until adulthood.

Barriers encountered in implementation:	Strategies to overcome barriers:
Obtaining schools' cooperation to allow the class.	Communication and perseverance.

Role of health department in implementation, planning, and evaluation:

The staff of the City County Health Department planned, implemented, and evaluated the program.

Accomplishments:

Two of the three junior high schools, plus a young mom's job training program, have asked for the class.

Lessons Learned:

Many of the topics need to be stressed over and over again. It is important that we try to address the girls at their learning level.

Mercy/CDPH Child Abuse Prevention Project

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Prenatal care Home visiting Breastfeeding/nutrition/WIC Immunization Early intervention/zero to three EPSDT/screenings Children with special needs Teen parenting Expanding private sector links Other outreach activities Case coordination Building coalitions and partnerships	Culturally appropriate health education materials/programs Assessment of provider reports regarding process and outcomes Special studies Provide outreach services Transportation and other access-enabling services Provide, arrange, administer direct services Prior authorization for out-of-plan specialty services

Funding Sources:
MCH block grant funds, Third party reimbursement (Medicaid, insurance)

Budget: $6,000.00

Description:

This program was first proposed in 1995 when it was still mandatory for women to be discharged from the hospital with their newborn infants approximately 24 hours following a normal vaginal delivery. This brief period allowed them little time to acquire skills in caring for their infants. The Chicago Department of Public Health's concern was based on studies which demonstrated that among high-risk women, early discharge was a contributing factor to the development of poor parenting skills, less than optimal child growth and development, inappropriate use of health care services, and child abuse and neglect. Consequently, in March 1996, the Chicago Department of Public Health (CDPH) and the Mercy Hospital and Medical Center (MHMC) entered into a collaborative agreement to develop, implement and evaluate a pilot project called the Child Abuse Prevention Project (CAPP).

Objectives of the activity:

The purpose of the Project was to evaluate the impact and cost of three designs of providing post delivery care on the following outcomes among high risk mothers and their newborn infants:

1. Enhancing parenting skills;
2. Preventing child abuse;
3. Promoting healthy growth and development in the child;
4. Promoting appropriate use of Early Periodic Screenings, Diagnosis and Treatment (EPSDT) services for the child; and,
5. Decrease IDPA expenditures for the use of emergency room and hospital services.

The three designs to be examined were:

1. Post-partum discharge of mothers and infants after 24 hours followed by routine home visits by public health nurses.
2. Post-partum discharge of mothers and infants after 24 hours followed by intensive home visits by a trained public health aide under the guidance of a public health nurse.
3. Post-partum discharge of mothers and infants after 72 hours followed by intensive home visits by a trained public health aide under the guidance of a public health nurse. Mothers were recruited by using the Healthy Families Stress Check-List. A total score of 25 or higher rendered the client high risk and therefore eligible to participate.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Loss of contact with Group A clients because of infrequent visits by public health nurses. 2. Reluctance of Group A clients to accept home visits. 3. Inability to obtain data on costs from Public Aid for Group A infants if the mother could not be located because the infant's name was often unknown at the time of discharge from hospital. 4. Difficulty in holding parenting classes at times because of gang activity. 5. Inability to make home visits because of inoperable elevators and dark stairwells. 6. Difficulty in recruiting Group C because mothers were unwilling to remain in hospital for more than 24 hours.	1. Sending letters and making phone calls as reminders to Group A clients. 2. Recruitment of women for Group C during prenatal period so they would be prepared to remain in the hospital longer. 3. Changing the location or time of the parenting classes 4. Providing more individual teaching.

Role of health department in implementation, planning, and evaluation:

Chicago Department of Public Health's Women and Children's Health Program worked with the physicians and nurses at the hospital to write the proposal and secure the support of the State to use Block Grant Funds for the project. The hospital obtained funding from Medicaid for the eightwomen who agreed to stay for the extra days. The department also obtained reports from the Department of Public Aid for emergency hospital services provided to infants. The public health nurse participated in the recruitment of clients in the hospital. All home visits were made by the department's public health nurse or the outreach workers under the direction of the nurse. Evaluation of the project was conducted jointly by the hospital and the department.

Accomplishments:

Between December 1996 and June 1998, a total of 33 Group A, 40 Group B, and eight Group C clients were admitted to the program. Contact was fairly well maintained with 18 Group A, 30 Group B, and five Group C infants. Among Group A infants, one was low birth weight, one died of SIDS, four were up-to-date on immunizations, and seven had visits to the emergency room. Denvers were performed on two of the infants and they were normal. Among the Group B infants, four were low birth weight, a set of twins did not survive, 23 were up-to date on immunizations, and eight had visits to the emergency room. Denvers were performed on 23 infants and they were normal. Among the Group C infants, there were no low birth weight infants, and no deaths. Four infants were up-to-date on immunizations, and two had visits to the emergency room. Denvers were performed on four infants, and they were normal. One infant in Group A was taken into custody due to child abuse, and one avoided in Group B as the mother received support.

Lessons Learned:

Collaboration between the hospital and the department's staff was excellent. We had assumed that the outcomes for infants admitted the Group B and C would fare batter, and this was so. The health professionals had assumed that mothers would want to remain longer in hospital, especially since the hospital had remodeled the unit. This did not happen. At a joint evaluation in June of 1998, it was decided to admit all eligible mothers to Group B and follow the infants for two years.

Breastfeeding Fair

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Breast/cervical cancer Breastfeeding/nutrition/WIC Communicable diseases	Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Public advocacy for legislation and resources Newsletters, convening focus groups, advisory committees, networks Provide outreach services Referral systems, resource directories, advertising, enrollment assistance

Funding Sources:
WIC funds

Budget: $100.00

Description:

The El Paso County Department of Health and Environment WIC Program held a breastfeeding fair during the WIC National Breastfeeding Month in August, 1998. The fair was held on the front lawn of the Health Department. At the fair, there were games, such as the "Price is Right," "Trivial Pursuit," and "Win, Lose, or Draw," coloring contests for children, baby races, and a raffle. In addition, a clown painted children's faces and snacks were provided. The prizes and food had been donated to the fair by community businesses. The prizes included Avalanche game tickets, a night at the Radisson Inn, pedicures, manicures, haircuts, facials, restaurant gift certificates, and tickets to area attractions. Over 70 different entities donated approximately $4,000 worth of services, gifts and supplies to the fair. Three information booths provided pamphlets and other resources on breastfeeding, child development and immunizations. Area lactation consultants, public health nurses, WIC nutritionists, a physician, and La Leche League representatives manned these booths.

Objectives of the activity:

To increase the breastfeeding initiation and duration rates in both women participating in the WIC Program and in the community. Also, to increase community support for breastfeeding women.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. The time it took to solicit businesses for donations (such as prizes, gift certificates, food, balloons, and other supplies) for the fair. 2. A lack of money to fund this fair resulted in needing more time to pursue donations, and limited the size and scope of the fair. 3. Getting word out to the breastfeeding community about the fair.	A core committee of six WIC staff organized the fair and solicited businesses for donations. Additional WIC staff volunteered to man the booths and help out at the fair. Lactation consultants and a community physician donated their time and expertise at the fair. We also used a Health Department Community Relations person to promote the fair.

Role of health department in implementation, planning, and evaluation:

The Health Department provided support from our community relations staff member for press releases and publicity. In addition, Health Department staff helped by manning the information and education booths. The Health Department allowed us to use the front and side lawns of the Department for the fair.

Accomplishments:

Over 300 pregnant or breastfeeding mothers and their families attended our fair. The fair provided a relaxing and fun day to honor breastfeeding women and attempted to increase awareness of the benefits of breastfeeding.

Lessons Learned:

This was a very time-consuming activity for the WIC Program. For future breastfeeding promotion activities, it will be important to form partnerships with other community lactation educators. Forming collaborations with other educators will ensure that we get additional manpower for future fairs and reach a larger segment of the community.

Children's Medicaid Dental Clinic

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Has this activity been formally evaluated?
Don't know

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
School-linked/based services	Analysis of demographics, economic status, behaviors, health status
School-linked/based services	Prepare, publish and distribute reports
Dental programs	Staff training
Schools and health connections	Support of continuing education
Staff training	Transportation and other access-enabling services
Strategic planning	Provide, arrange, administer direct services
Building coalitions and partnerships	

Funding Sources:

Private source: Sisters of Charity Grant $123,400, Third party reimbursement (Medicaid, insurance), in 1998- $300,000 in-kind dentistry, volunteers

Budget: $123,400.00

Description:

The Children's Dental Clinic was started in 1959 to provide dental aid for indigent children in the community. It is sponsored by the Family Service Center, a private nonprofit organization in Columbia. Referrals to the clinic are made by local school nurses. The Clinic is housed in the Health Department at no cost.

Through a Dental Health Initiative, the Children's Medicaid Clinic was started September 14, 1998 in Richmond County as an addition to the Children's Dental Clinic. Although Medicaid pays for some dental care, there are not enough dentists in the community who accept Medicaid to meet the need. The Clinic has four staff who coordinate the work and provide services along with volunteer dentists, dental residents and students, and hygienists.

Objectives of the activity:

Increased oral health skills, healthier teeth and gums, reduction of unnecessary dental emergencies, reduced time from school due to toothaches, higher self esteem, and free dental care.

Barriers encountered in implementation:	Strategies to overcome barriers:
Transportation.	We began providing transportation for Medicaid students from one school district at the end of the last school year. We plan to continue this when school begins this fall. It has also been helpful that the Dental Clinic/Health Department is located on the city bus line.

Role of health department in implementation, planning, and evaluation:

The Richland County Health Department provides space for the clinic at no charge. The Health Director has served as an advocate for the Dental Clinic in the community and in efforts to replicate the program in other counties. The Health Department recently chose this program to highlight at the South Carolina MCH Conference in Columbia.

Accomplishments:

The Children's Medicaid Program began on 9-14-98. In the first quarter of 1999, 110 children (ages 5-18) were seen as new and revisiting patients. Dental treatments were provided for 906 children in the Dental Clinic in 1998. The Dental Clinic received a $123,400 grant from the Sisters of Charity to increase our hours of service for Medicaid children and the adult program. Recently, we have started providing dental services to indigent adults one day a week.

Lessons Learned:

It is important to establish partnerships and collaborations with other agencies. Both private and public organizations can provide resources to meet a need that cannot be met by an individual entity. Although Medicaid will pay for some dental care, there are not enough private dentists accepting Medicaid to meet the need. Transportation is a barrier to receiving services.

Prom KIS

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Substance abuse prevention School-linked/based services Teen pregnancy Communicable diseases	Culturally appropriate health education materials/programs

Funding Sources:
None reported

Budget: $0.00

Description:

Two urban high schools were selected based on willingness to participate. A survey was administered to students in both schools the week before prom. School A participated in the Prom Keep It Safe (KIS) Program; a three part intervention that included information about HIV and STDs, skills for refusing/delaying unsafe behavior, and disease prevention methods. School B received no intervention. Students in both schools completed a post-prom survey.

Objectives of the activity:

1. To provide information on HIV and STDs to students and faculty.
2. To conduct activities that build self-esteem and also communication between students, teachers, and parents.
3. To conduct activities that help students learn the life skills necessary to prevent HIV/STD transmission.
4. To provide students and faculty with community resources.

Barriers encountered in implementation:	Strategies to overcome barriers:
It is difficult working with school systems when the topic is related to sexual health. There are state laws to abide by, along with parent/teacher associations, religious instruction, parental permission, and the like. It gets even more complicated when surveys are involved.	The program is currently being re-evaluated. Plans for the future to overcome barriers include educating parents and getting their initial support, as well as educating and collaborating with the school nurses, health curriculum coordinator(s), and the school board(s). Collaboration with a larger, nationally known agency for endorsement may be beneficial.

Role of health department in implementation, planning, and evaluation:

The idea for Prom KIS was conceived by public health nurses on the Sexual Health Team at the health department. They developed the concept after talking with high risk adolescents who identified Prom night as a "rite of passage" with pressure to have sex. The activity was planned by the public health nurses with core curricula for HIV/STD prevention, input from City Year (an adolescent work program), and input from the high risk teens. These same nurses implemented and evaluated this activity.

Accomplishments:

A major accomplishment was the collaboration that occurred between a city health department and the public schools in an area as sensitive as adolescent sexual health. Another major accomplishment was obtaining information from junior and senior high school students on their knowledge, beliefs and attitudes about HIV and STDs and their sexual risk behaviors.

Lessons Learned:

More thorough planning would allow for an enhanced program with increased participation from schools. It would also allow for better evaluation. Planning should start early, and should actively include student peers, either from the school or from organizations such as City Year. These same peers and young adults should be active participants in the program as well.

Summer Program for Adolescents

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
School-linked/based services Violence prevention/at risk Teen pregnancy Teen parenting	Implement/support education services for special MCH problems Provide outreach services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services Identify alternative resources to expand systems capacity

Funding Sources:
Private source: donations from various businesses

Budget: $3,000.00

Description:

The City of Dallas Adolescent Health Services (AHS) held a summer program for at-risk youth aged 11-18. All participants in the program were from the Dallas area, often from communities with high incidences of youth related crimes, gang membership, teen pregnancies and drop-out rates. Case workers on staff at AHS identified the youth from youth oriented service agencies and recreation centers throughout the City of Dallas.

Topics such as: hygiene, violence, anger management, substance abuse, tobacco prevention, peer pressure, sexuality/human growth and development, and HIV and STDs were covered during the six week program. At the end of the summer program, AHS held an event rewarding the participants for completion of the program. The Second Annual End of Summer/Back to School Blowout presented the participants with refreshments, school supplies and door prizes. Awards were also given to those who had had perfect attendance; in addition, each participant in the program received school supplies at this event.

Objectives of the activity:

1. To increase the awareness of at-risk youth about various relevant topics.
2. To identify and provide case management for those who needed additional services.
3. To increase participation from the previous year by 20%.

Results: Participants were given pretests before and posttests after each presentation to evaluate their level of awareness of relevant issues.

Barriers encountered in implementation:	Strategies to overcome barriers:
It was difficult to maintain participation throughout the six-week period of the program.	We used reinforcement by rewarding those who remained in the program for six weeks.

Role of health department in implementation, planning, and evaluation:

The AHS Program was responsible for planning, implementing and evaluating this activity.

Accomplishments:

Participation was increased to well over the targeted 20%.

Lessons Learned:

Incentives and positive reinforcement are still an effective means of getting youth involved in programs.

Children's Health insurance Program (CHIP)

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Has this activity been formally evaluated?
No (currently in progress)

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Prenatal care	Analysis of demographics, economic status, behaviors, health status
Home visiting	Community perceptions of health problems/needs
Breastfeeding/nutrition/WIC	Hotlines, print materials, media campaigns
Immunization	Newsletters, convening focus groups, advisory committees, networks
EPSDT/screenings	Provide infrastructure/capacity for MCH functions
Expanded child health services	Staff training
Children with special needs	Support of continuing education
School-linked/based services	Provide outreach services
Case coordination	Prior authorization for out-of-plan specialty services
Increasing access to Medicaid	Managed Care model contracts and access issues
Managed care initiatives	
Building coalitions and partnerships	

Funding Sources:
City/County/Local government funds, Private source: The Dayton Foundation, Other Federal funds, Federal Match Funds

Budget: $600,000.00

Description:

This program consisted of the development and implementation of outreach activities in Montgomery County to increase community awareness of the accessibility of health care through the Children's Health Insurance Program (CHIP). One of these outreach activities consisted of a consumer hotline which set appointments for clients with outreach agencies and answered clients' questions concerning CHIP. As another outreach activity, eight agencies in the community hired outreach workers to meet with clients either at the agencies' offices or in the home of the client. In addition, a marketing campaign through print media, billboards, television commercials, radio public service announcements, and posters was developed to increase the level of community awareness of CHIP.

Outreach staff and service providers were trained on the application process and eligibility requirements. During the application process, agencies maintained a relationship with each client for continual follow-up and education about CHIP.

Linkages in the community were created between many different service agencies to further promote institutionalization of the program after funding ends. In addition, an evaluation plan is in the process of implementation and will include interviews of agency members and phone surveys with clients to establish the level of client satisfaction.

Objectives of the activity:

1. To increase Medicaid enrollment by 2,000 children and pregnant women.
2. To increase community agency linkages.
3. To increase satisfaction with the Medicaid enrollment process.
4. To increase client satisfaction with accessing Medicaid services.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. A lack of awareness from the general population and service providers was a barrier to implementation. 4. A lengthy verification process was required to complete an application. 5. Clients were often unable to afford obtaining birth certificates as a verification of age. 6. High client mobility caused us to be unable to provide consistent follow-ups. 7. The confusion in the community concerning CHIP and Healthy Start eligibility was a barrier. 8. The clients were often confused with the process after acceptance to the program.	1. Educational materials were widely distributed in the community and the media campaign was launched to increase awareness. 2. Community leaders were educated about the verification process and provided with suggestions for improvement. 3. Agencies were provided with vouchers to obtain free birth certificates when clients could not afford them. 4. We conducted continual client follow-ups by phone and mail, offering incentives to keep appointments. We also provided community enrollment workshops. 5. We provided continual education for providers and employers about CHIP. We will maintain the consumer hotline for future questions for at least one year after funding ends. 6. The Medicaid Consortium will continue to address client issues.

Role of health department in implementation, planning, and evaluation:

The Health Department:
1. Established the consumer hotline.
2. Coordinated with other counties in the Southwest region of Ohio.
3. Hired a coordinator to implement our goals and objectives and to organize all activities.
4. Acted as a liaison between the Department of Human Services and agencies assisting clients in the community through outreach.

Accomplishments:

Since January 27, 1999 we have received 5,500 phone calls to the consumer hotline. Of those calls, approximately 4,000 have consisted of referrals to an outreach agency to begin the application process. Of those referrals, 1,600 applications have been turned in to the Department of Human Services. Over 1,000 children and pregnant women have been accepted into the program. Also, the Department of Human Services will maintain the consumer hotline for at least one year after federal funding ends.

Lessons Learned:

Two lessons stand out. The first is that Medicaid enrollment is difficult for families, and the enrollment process needs to be improved. The second is that, in order to consistently minimize the number of children that are underinsured or uninsured, the community needs to have continual education about the eligibility, enrollment, and accessibility of Medicaid after families have been accepted into CHIP.

Denver Healthy Children and Families Program

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Early intervention/zero to three	Culturally appropriate health education materials/programs
Overcoming cultural barriers	Implement/support education services for special MCH problems
Reducing transportation barriers	Public advocacy for legislation and resources
Schools and health connections	Promote compatible, integrated service system initiatives
Increasing social support	Referral systems, resource directories, advertising, enrollment assistance
Case coordination	Identify alternative resources to expand systems capacity
Building coalitions and partnerships	

Funding Sources:
City/County/Local government funds, MCH block grant funds, 330 funds, Kellogg Grant

Budget: $500,000.00

Description:

This program has a multidisciplinary staff of twelve that provides care coordination for families who have children with special needs in order to assure that the children receive needed services. The staff includes a medical director, program director, office manager, four nurse care coordinators, a developmental care coordinator, four family care coordinators, and a social worker.

As part of a family assessment to aid in care coordination, staff may perform a developmental screen on the child. These screenings, which frequently occur in the child's home, provide information which assists the primary care provider in developing a plan for the type and amount of services and therapies needed. To aid in care coordination, home visits may also be conducted to help caregivers identify needs related to the child's disability, provide information and education about their child's condition, and subsequently help make sure that the family is obtaining needed services.

Additional care coordination activities may include participating in visits with doctors and school staffing. Other efforts are directed toward the elimination of service barriers, such as assistance with transportation and language translation services which provide families with access to bilingual teams who have experience with children with disabilities. Some members of these teams are also parents of children with disabilities. The goal of this program is to create better access to and utilization of services from medical and community resources and, through home visits, to build strong relationships with families.

Objectives of the activity:

The goals of the Denver Healthy Children and Families Program (DHCP) are to:

1. Provide outreach, service coordination, family support, and education to assure that children with special needs have access to health care services, education, community resources, and support.
2. Assure that families have an understanding of the needs for health, education, and social services supports.
3. Increase the knowledge that families have about the services and supports they might be eligible for.
4. Provide individual and group support and training to 1,300 Denver County families of children with special needs.
5. Develop a comprehensive and coordinated service system for children with special needs and their families in Denver County and serve as the Denver Regional Office for the Health Care Program for Children with Special Needs.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. It was a problem dealing with multiple funding sources that had similar but not consistent expectations relating to activities and expected outcomes. 2. We were unable to charge third party payers for care coordination services. 3. Our funding sources expected evaluations of the program, but were unwilling to fund the development of an evaluation process. 4. Community collaboration to minimize duplication and improve access to services. 5. The program size was not adequate to meet the needs of the community.	1. We sought more stable and permanent funding sources from the community. 2. We developed contracts for receiving reimbursement for care coordination activities. 3. We participated in interagency teams to develop a system of service for children with special needs in Denver County. 4. We worked with the new HCP statewide database to collect data to meet the evaluation criteria expectations. 5. We participated with a community needs assessment to determine a direction for the program.

Role of health department in implementation, planning, and evaluation:

The Health Department completed a needs analysis and designed, implemented and oversaw the development of this program. The Department also sought out funding sources, provided administrative support, and provided continued support for the program by helping to minimize the barriers to program growth. In addition, the Community Health Section provided support for program development and community provider outreach. In-kind support, such as for administrative personnel, office space, and other indirect support, has provided some stability for the program as well.

Accomplishments:

1. We succeeded in developing a program that provides families and health care providers with the support necessary to assure that children with special needs will be able to access services recommended by care plan developed by the PCP, the family, and a care coordinator.
2. We experienced positive results in our attempts to collaborate with other agencies to develop a system of services for children with special needs.
3. We created a successful, multidisciplinary team model for care coordination that is accepted and respected by the community.

Lessons Learned:

1. If you provide good service delivery, you will face an increased demand, often beyond your funded abilities.
2. Program evaluation is expensive, so the cost needs to be built into the program budget. If you do not develop a good evaluation framework at the onset of the program, it will be difficult later on to find the time and resources needed for the program evaluation.
3. Programs can not live on seed money - they need some type of ongoing funding support.
4. Developing a team that includes parents of children with special needs is a win/win proposition. The expertise and experiences of these team members is invaluable when attempting to develop a trusting relationship that supports families learning about community resources and child advocacy.

DHD Immunization Improvement Project

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Immunization Communicable diseases One-stop shopping locations Increasing social support Case coordination Staff training Strategic planning Immunization tracking/recall	Develop tools standardizing data collection, analysis, reporting Tracking systems Development of models Develop tools standardizing data collection, analysis, reporting Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
Other Federal funds

Budget: $63,567.00

Description:

Through a process of continuous quality improvement, the Detroit Health Department developed and implemented an internal initiative to raise the immunization rates for the 0-3 year old population seen thorough the DHD Primary Care Clinics and the WIC Sites located throughout Detroit. This program has a twofold purpose:

1. To target children who are not up-to-date with their immunizations and to subgroup them into categories of priority based on age; and,
2. To collect "any and all" immunization information for entry into the regional immunization registry, regardless of where immunizations may have occurred.

Objectives of the activity:

The anticipated outcomes and the projected impact of the immunization improvement project on the DHD immunization coverage rates of the 0-3 population were:

1. 90% of DHD clinic clients age 0-35 months-of-age will have complete and up-to-date immunization status by September 1999;
2. To improve the documentation and management of immunization information in the DHD clinics;
3. To assess the immunization status of every 0-35 month-old child who presents to a DHD clinic of WIC site for services; and,
4. To populate the regional immunization registry.

Barriers encountered in implementation:	Strategies to overcome barriers:
The most significant barriers were internal. Existing service areas were functioning independently of each other, thus causing duplication of an already scarce resource: staff. Furthermore, the current state of documentation regarding immunizations and general services encounters was in disarray and many months behind. Thus at any one time it was impossible to obtain an accurate and current assessment of the clinic's and the overall DHD immunization coverage levels.	Through the use of the Americorps VISTA Program, it became possible to accomplish the immunization improvement goals. Each of the VISTA workers, trained as immunization specialists, was deployed to the DHD primary care clinic and WIC sites throughout the city of Detroit. These individuals functioned within the parameters of clinic operations, with the specific focus of improving the immunization coverage levels of the children 0-35 months-old. By supplying the added staff power, the lines of communication and multiple immunization efforts merged to accomplish a significant improvement in the immunization coverage rates both within the DHD clinics and the city of Detroit.

Role of health department in implementation, planning, and evaluation:

The DHD provided the overall leadership and management of the project, with the collaboration of the State Americorps Program Office. Although the project function within the clinics and WIC sites, it remained under the guidance and direction of the DHD immunization program. An internal evaluator measured the attainment of the project goals.

Accomplishments:

1. The immunization coverage levels within the DHD clinics and overall for the DHD improved significantly from previous levels to a range of 37% to 92.3% in July 1999;
2. The immunization registry had loaded over 100,000 immunization records and at least 75% of the time the clinics and the WIC sites to assess the child's immunization status used the registry;
3. In 1997 only 37% of the 11,703 WIC enrollees in Detroit were up-to-date in their immunization status when assessed. In July 1999 this rate increased approximately 32%.

Lessons Learned:

1. The efforts between the immunization program and other DHD services need to be coordinated, to decrease the ineffective duplication of services and paperwork.
2. A key strategy was to focus on improving the processes involved in the delivery of immunization services rather than intensifying the parallel effort of fragmented service areas.

Durham Community Health Network

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Building coalitions and partnerships	Managed Care model contracts and access issues

Funding Sources:
Other Federal funds

Budget: $360,000.00

Description:

The Durham Community Health Network is Durham County's response to a state-issued request for proposal to create demonstration projects to build on the state's managed care initiative, Carolina Access. This demonstration project brings together three primary care practices and supports wrap around services from the health department and the Department of Social Services. A care management team funded by the "per member per month allocation" provides case management services to most vulnerable, those who are likely to make intensive inappropriate use of the ER and those from whom a small investment in case management can produce a much better outcome. Most of the 10,500 patient pool are women and children. A risk assessment score determines the need for case management services.

Objectives of the activity:

1. Increase the number of children who are age appropriately immunized by age 2.
2. Decrease the inappropriate ER utilization by 5%.
3. Decrease the asthma-related school absenteeism.
4. Decrease the asthma-related work absenteeism.
5. Reduce no-show rate to primary care providers by 20%.
6. Reduce hospital length of stay by 3%.
7. Increase the number of pregnant women receiving case management services through the Health Department Baby Love Program.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Getting the employees of the practices to share patient information with the care management team without believing confidentiality breached. 2. Standardizing the practices and approaches to asthma management. 3. Standardizing membership so that revenue stream would support the care management team. 4. Balancing activities of social workers so that the federal matching funds could be drawn down to help support the budget. 5. Difficulty tracking utilization activities due to different information systems.	1. Educating staff at each of the involved agencies. 2. Establishing a clinical services committee with representation from each of the agencies involved. 3. Marketing services in an effort to stabilize population and attract new members. 4. Social workers are learning the federal guidelines and tracking time spent in various program activities being sure to have the appropriate hours for the matching funds. 5. Concentrating focus on information system that provides real time data on patients encounter activity along the continuum of care.

Role of health department in implementation, planning, and evaluation:

Several health department employees were involved in the planning process for this project. Once it was implemented, the health department continued to provide care management services to pregnant women and children with special needs. The health department will be auditing the immunization compliance rates of each of the practices. Health department nutritionist and health educator also provide on-site services for the practice groups. Health department director and division directors serve on the major committees governing the program's operation.

Accomplishments:

1. Establish a referral base for health department patients who are no longer eligible for health department case management programs.
2. Facilitated team building while utilizing a primary care community oriented model.
3. Development of integrated information system.

Lessons Learned:

1. Line staff needed to be involved in planning phase to develop program that could easily be made operational.
2. Process is an evolving one.
3. Learned to define integrated information system requirements to support care management of a community.

Adams County Colorado Social Service's TANF Home Visit Project

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Home visiting Children with special needs Violence prevention/at risk Family violence Other outreach activities Increasing social support Case coordination Building coalitions and partnerships	Promote compatible, integrated service system initiatives Provide outreach services Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
City/County/Local government funds

Budget: $45,000.00

Description:

Welfare reform in Colorado, following the national trend, has led to new and innovative approaches to helping families return to the world of work. In May 1998, the Director of Social Services for Adams County Colorado approached the Tri-County Health Department with a request to assist families who had not been able to complete their Individual Responsibility Contract (IRC) and were about to have their Temporary Assistance to Needy Families (TANF) benefits reduced. TANF caseworkers had observed that some of the issues interfering with these families' ability to participate were health related. Therefore, the director of Social Services wanted public health assessments conducted on these families in order to be certain that Social Services was not overlooking needy families. Social Services expected that the families would view a visit by a Public Health Nurse as helpful instead of threatening. During this visit, the nurse would do an assessment of health issues, family dynamics, and the availability of basic needs (such as adequate nutrition and housing), all of which could affect their ability to complete the IRC.

Objectives of the activity:

To assist "sanctioned" families in complying with their IRC:
1. By reconnecting sanctioned families with their Social Services Caseworker.
2. By connecting these families with the resources that would allow them to resume work on their IRC.
3. By advocating for families who have public health issues that should eliminate their requirements for participation.

Barriers encountered in implementation:	Strategies to overcome barriers:
Of the many difficulties Tri-County Health Department (TCHD) encountered in the development of this contractual relationship with Social Services, the one that presented itself first was the need to learn a new language. The terminology used in the Social Services arena is entirely different than the medical jargon used in a health care agency. In addition, Tri-County Health Department staff needed to become intimately familiar with the requirements of the TANF program.	From the beginning, TCHD and Social Services met regularly at all levels to exchange ideas and make plans. Each agency provided inservice training for the other to explain their department's philosophy, mission, and most important, their language. The Social Services staff had a luncheon for the nurses as an ice breaker so they could talk face to face in an informal setting.

Role of health department in implementation, planning, and evaluation:

TCHD took the lead in defining the scope of the work to be done by the Community Health Nurses who visited and conducted assessments on the sanctioned families. We also developed most of the forms used for reporting, established the time frames for client response, and defined the criteria used to measure success.

Accomplishments:

To this point, approximately nine months into the project, we have seen a 27% return to non-sanctioned status by the over 300 families referred to us. We have also advocated for numerous families who needed to be excused from the work requirements because of serious health related issues. In addition, the positive results of this project have led to two other contractual relationships with the county social services agency. Having the two agencies work together to aid the same families has had a very positive effect, and we believe that it has greatly improved the program's outcomes.

Lessons Learned:

TCHD staff now have a changed attitude about social service workers and their commitment to helping families. Working together has decreased duplication of efforts and services and increased the trust of our clients. We have also found a new way to locate and interact with the families for whom we have traditionally provided services. There is opportunity for new services and additional face-to-face contact with high-risk clients.

Community Lead Awareness and Education

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Lead poisoning Clergy and health connections Schools and health connections Other outreach activities Building coalitions and partnerships	Environmental assessments Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Prepare, publish and distribute reports Newsletters, convening focus groups, advisory committees, networks Provide outreach services Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
General state funds

Budget: $20,000.00

Description:

In 1998, Vanderburgh County was listed as one of the top five counties in Indiana that was identified to have a high incidence of lead poisoning in children six months through six years of age. We applied for and received a grant from IDEM (Indiana Department of Environmental Management). This grant was used to develop a plan to increase community awareness and education about lead poisoning. Three zip codes were further identified as high lead level areas within the county, and the outreach and education was targeted for these communities.

Objectives of the activity:

1. A community task force was organized and met quarterly.
2. Lead Awareness booths were provided at five of the targeted schools. Also, lead packets were given to each kindergarten family at these schools, reaching 500 students.
3. Lead information packets were provided to families of children who attended ten targeted daycare centers. This endeavor reached 2,870 families.
4. Ten targeted churches were contacted and provided lead information booths to set up on Sundays for their congregations
5. Five health fairs were participated in to promote lead awareness, successfully reaching 1,000 residents.
6. Guest speakers were provided to various agencies, groups and neighborhood associations.
7. In May 1999, a half-day seminar was provided to the community.

Barriers encountered in implementation:	Strategies to overcome barriers:
The lack of concern and cooperation form the medical community. Many of the physicians in our community do not believe that there is a problem with high lead levels and many do not screen their own patients. Our MCH/WIC clinics have been responsible for most of the screenings done in our county. These clinics continue to screen, identify high levels, and do the follow up.	The WIC/MCH clinics continue to do yearly lead screenings on all clients six years and under. A copy of the results is sent to their physician to be placed in their chart. If the lead level is ten or above, the follow up procedure is also sent to the physician, in hopes of educating him/her. The public health nurses are also available to the doctor for home visits of further education on lead as needed.

Role of health department in implementation, planning, and evaluation:

The health department was responsible for writing and implementing the grant that was received. The Health Educator took on the responsibility for setting up the meetings and coordinating the scheduled activities. The MCH/WIC clinics have played a vital role in being available 45 hours a week to do lead levels on any child under six years of age and for the dissemination of information to physicians.

Accomplishments:

The increased awareness in our community of the high incidence of lead, where it is found and what role the community can play in the identification and treatment of high lead levels in children. The collaboration between the health department and the community has also been a positive outcome of this endeavor.

Lessons Learned:

When there is a problem in a community, the community needs to be made aware of it and should have a role in identifying solutions. It was learned that the communities knew the best routes of communication and education of their residents.

MISSing Links

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Increasing access to Medicaid	Implement public MCH program client data systems Tracking systems Public advocacy for legislation and resources

Funding Sources:
None reported

Budget: $0.00

Description:

MISSing Links stands for Maternal and Infant Support Services Integrated Network Group. MISSing Links was formed in 1995 to be a collaboration between local maternal and infant support service providers and Early On (early intervention) representatives. The collaboration was formed to address issues related to infants and high-risk pregnant women who received Medicaid benefits. MISSing Links works to increase interagency coordination of services, address service gaps, and avoid duplication of services.

Objectives of the activity:

1. To maintain communication and coordination of services among M/ISS providers.
2. To create a database that facilitates information sharing, referrals, feedback, and process evaluation.

Barriers encountered in implementation:	Strategies to overcome barriers:
The 1997 implementation of mandatory enrollment in Medicaid managed care and the need for prior authorization by a managed care plan before M/ISS can be delivered have both served as barriers.	Four Medicaid managed care plans in Genesee County were invited to participate in MISSing Links meetings.

Role of health department in implementation, planning, and evaluation:

Health department staff chaired the committee and provided clerical support for meetings, data input, and report generation.

Accomplishments:

1. A common database for all women/infants enrolled in M/ISS is maintained at the health department.
2. We have developed and implemented common forms.
3. There has been a coordination of efforts to utilize enabling services (i.e. transportation).
4. Communication with state legislators by MISSing Links partners and others has resulted in changes for FY2000 to improve M/ISS.

Lessons Learned:

M/ISS providers and the Medicaid managed care plans have come to understand more about each other's frame of reference and rationale in regards to services to "high-risk" populations. Areas of common ground have been identified.

Hepatitis B Vaccination Program to GISD 7th Graders

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Immunization Communicable diseases Clergy and health connections Schools and health connections Mobile clinics for outreach Staff training Building coalitions and partnerships	Provide, arrange, administer direct services

Funding Sources:
City/County/Local government funds, Private source: Health Facilities Development Corporation

Budget: $250,000.00

Description:

To promote and implement a vaccination program to all Garland Independent School District (GISD) 7th graders against Hepatitis B, which would be at no cost to the parents and offered during school hours at thirteen middle schools. Because the city has a small staff of nurses, the Garland Fire Department (GFD) agreed to provide paramedics to help administer the program under the City Health Officers (MD) standing orders.

Objectives of the activity:

1. To build partnerships in the Garland community to help promote the program
2. To attain an 80% completion rate for all three doses of the Hepatitis B vaccine.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Making sure all the parents were notified of the program--most forms were sent by US Mail, and the forms were in both English and Spanish. 2. Encouraging school nurses, who already have many tasks, to promote the program at their school. 3. Completion of the series of the Hepatitis B vaccine.	1. Forms were sent by US Mail and the school nurses had extras for parents. 2. A dinner at a local restaurant was provided by one of the vaccine manufacturers to kick off the program for the nurses and paramedics. A community-wide appreciation banquet was held in the Spring. 3. Students not able to finish the series during the school year could come to the health department and the vaccine would be provided at no charge.

Role of health department in implementation, planning, and evaluation:

The program was initiated by the Garland Health Department and letters and information was given to GISD administration and the Garland Fire Department. The proposal for funding was presented to the Health Facilities Development Corporation by Victoria Yeatts. All the consent forms and letters to parents were put together by the health department who also staffed all vaccination clinics at 13 sites. Continued with "catch-up" doses during the summer months when school has ended.

Accomplishments:

The program was completed in the spring of the 1998-99 school year. 1,436 students participated in the program and a three dose completion rate of 88% was attained, with one school having a 99% completion rate. The GFD paramedics participated in 90% of the clinics and if hesitant at first, were administering vaccines without difficulty by the end of the clinic. GISD school nurses were very positive and praise the health department for offering this program.

Lessons Learned:

This was a major undertaking for a small local health department. Coordination and implementation, along with keeping regular clinic schedules and well child services was acheived. The students who participated were able to get additional health education and information and cooperated each time.

Project Respect

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Violence prevention/at risk	Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Newsletters, convening focus groups, advisory committees, networks Staff training Identify high-risk/hard-to-reach populations and methods to serve them Detention settings, foster care, mental health facilities

Funding Sources:
City/County/Local government funds, Michigan Dept of Community Health funds

Budget: $60,000.00

Description:

The Project Respect Programs are funded through a grant from the violence prevention section of the Michigan Department of Community Health. Two programs were developed by the Kent County Health Department; one was intended for high-risk youth, and the other was culturally and linguistically appropriate for Hispanic youth. The goal of the programs was to reduce the risk of youth in Kent County becoming victims or perpetrators of sexual assault. The Project Respect curricula and related educational materials were intended for use in school classrooms or other organizations serving youth. The curriculum and educational materials targeting Hispanic youth were available in both English and Spanish. Both programs consisted of six one-hour classes that were adaptable for use with either middle or high school aged students.

Objectives of the activity:

Upon completion of the Project Respect/Projecto Respeto Program, we hoped to see:
1. A 25% increase in the number of participants able to define sexual assault and identify ways culture promotes sexual violence;
2. A 25% increase in the number of participants able to differentiate myths from facts related to sexual assault;
3. A 25% increase in the number of participants able to understand that sexual assault and abuse are acts of power and control;
4. A 25% decrease in the number of participants indicating victim culpability for sexual assault;
5. A 25% increase in the number of participants able to name at least one community resource for someone who has been sexually assaulted.

Barriers encountered in implementation:	Strategies to overcome barriers:
A lack or racial/ethnic and gender diversity among health department staff working on the project has been identified as a barrier to program effectiveness. Another barrier to program effectiveness has been that the target audience is extremely transitory, and obtaining good attendance for a six-week program has proved difficult.	Health department staff recruited individuals from the targeted community and trained them to facilitate the Project Respect Program. Program facilitators were paid for implementing the program. To increase attendance of all six sessions of the program, many times the six classes were scheduled over a one-or two-week time period.

Role of health department in implementation, planning, and evaluation:

In planning the Project Respect/Projecto Respeto Program, the Kent County Health Department conducted focus groups with adults and youth from the Hispanic community. In addition, the health department formed community partnerships with local sexual assault service providers. In implementing the programs, health department staff presented the program to youth in juvenile detention, foster care and alternative high schools. Health department staff recruited and trained bilingual facilitators to implement the program with Hispanic youth. To evaluate the programs, pre- and posttesting was conducted and an outside evaluator from a local university was hired to analyze the data.

Accomplishments:

The major accomplishment of the Project Respect Program in 1999 was collaboration with local schools and agencies that serve youth to implement the program at eight locations serving high-risk youth and six locations serving Hispanic youth. In addition, evaluation data analyzed so far has indicated a significant change from pre- to posttesting in participants' knowledge and attitudes about sexual assault prevention.

Lessons Learned:

The Kent County Health Department has made a strong commitment to the delivery of services to diverse populations. Through the Project Respect Program and other similar initiatives, the health department established relationships with organizations serving at-risk youth and created ties with the Hispanic, African American and Native American communities. The community partnerships created throught these ties greatly enhanced the success of the Project Respect Program.

Asthma-Healthy Home Initiative Grant

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Expanded child health services Other outreach activities	Environmental assessments

Funding Sources:
City/County/Local government funds, General state funds

Budget: $14,000.00

Description:

The Guilford County Divisions of Environmental Health and Child Health designed a pilot program to launch an Asthma Healthy-Home Initiative. This initiative is composed of collaborating community partners involved with asthma management. The initiative provides for the implementation of referral-based, in-home, environmental investigations to determine indoor asthma triggers and assist in the remediation of those triggers.

Collaborating partners will refer children diagnosed with asthma to Community Nursing. Nurses will then serve as a "clearing house" for all referrals, having asthma-related information regarding the child entered into a database and forwarding completed referrals to Environmental Health. Following this, an EHS and Environmental Child Health Educator will visit the family and conduct an environmental investigation of the child's home to determine probable asthma triggers. In addition, parents and guardians will receive verbal education and basic supplies to help remove these triggers from the child's environment.

Upon completion of the assessment, a checklist and brief summary will be returned to the community nurses to enter information in the database and both the referral and the summary will be returned to the primary physician and referring agency. Approximately six months after the investigation, a follow-up with the families will be conducted and results will be used to assess the degree of effectiveness of the program. Education of staff and the community is ongoing.

Objectives of the activity:

1. To identify and coordinate existing local resources through the formation of a community-based coalition to address asthmatic children in Guilford County (This goal was met May 17, 1999 i.e. HHIC).
2. To increase community awareness of asthma, its contributing factors, and the services available for asthma treatment and intervention (EH has been providing ground level ozone awareness efforts in Guilford County for the past three years, addressing the contribution of ambient air factors on asthma).
3. To increase the awareness of the triggers and contributing factors of asthma possessed by the EH Specialists in Guilford County who inspect schools, day care centers, and institutions.
4. To provide an environmental in-home assessment to identify triggers and provide supplies to control triggers to a minimum of 100 families in the upcoming fiscal year.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Finding funding for supplies, printing, and office supplies for program. 2. Reallocating existing staff time to do the home assessments.	1. We received grant funding from the NC Department of Environment and Natural Resources, Children's Environmental Health Branch. 2. We trained Community Health Nurses to assist in providing the in-home assessments.

Role of health department in implementation, planning, and evaluation:

Environmental Health and Child Health staff conceived the idea for the initiative, planned the initiative, captured the interest of community partners, wrote the grant for the initiative, and conducted the interventions.

Accomplishments:

1. We were awarded $14,000 in grant funding.
2. Staff are being educated to do the assessments.
3. The database is being created.
4. Referrals are already flowing in after one presentation to pediatricians.

Lessons Learned:

Many asthmatics need this service. Doctors are willing to refer for this service.

Lead Poison Prevention Awareness Program for Day Care Providers

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Has this activity been formally evaluated?

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Lead poisoning Strategic planning Reshaping urban MCH Building coalitions and partnerships Building MCH data capacity	Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Prepare, publish and distribute reports Development of models Provide infrastructure/capacity for MCH functions

Funding Sources:
Other Federal funds

Budget: $19,870.00

Description:

The Hartford Health Department, in conjunction with the University of Connecticut Cooperative Extension System (UCONN CES), will utilize Community Environmental Educators and a Community Liaison to educate and train staff of the day care centers in high-risk areas on issues of lead and lead poisoning.

Objectives of the activity:

1. Recruit and train Community Environmental Educators from UCONN CES to participate in the project. The University of Connecticut Cooperative Extension System developed a train-the-trainer program to prepare local leaders to be "community environmental educators."
2. Identify at risk daycare programs and develop contact with them.
3. Conduct Lead Poisoning Prevention training sessions with daycare providers.
4. Evaluate overall success of the project.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Daycare providers with personnel constraints. 2. Providers with scheduling conflicts. 3. Part time vs. full time centers.	Having identified conflicts to participating in our educational initiative, the process was streamlined. The educational program was conducted during staff meetings and a limit was placed on the training time.

Role of health department in implementation, planning, and evaluation:

The health department has provided data and staff resources to this collaborative initiative. The department's role has been to provide assessment, assurance, and policy development relating to this educational program. We will continue to review the data and evaluate the overall success of the project.

Accomplishments:

1. Four community environmental educators have been trained.
2. The training completed by the Community Educators has been presented to 37 child care providers from fifteen sites. These providers represent approximately 3,701 children in the City of Hartford.

Lessons Learned:

Review of our preliminary questionnaire revealed that this type of educational program was an effective educational program to daycare personnel. The data also revealed a heightened awareness pertaining to the issues surrounding lead and its effect on young children were an important message to convey to parents and children. The project is still underway and a full analysis of data will not be undertaken until later in the fiscal year.

Child Death Review

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Has this activity been formally evaluated?
No

Has this activity been replicated?
There are many models of CDR but none review deaths to the degree of this program.

Essential MCH Functions:	MCH Initiatives:
Injury (including child abuse) Staff training Strategic planning Building coalitions and partnerships Building MCH data capacity Infant/child death review	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Tracking systems Maternal, fetal/infant, child death reviews Prepare, publish and distribute reports Public advocacy for legislation and resources Develop tools standardizing data collection, analysis, reporting

Funding Sources:
Private source: Hawaii Community Foundation, Other Federal funds, In-kind state match from various agencies

Budget: $0.00

Description:

Injuries, both intentional and unintentional, are the leading cause of death for children ages 0-18. In 1995, Hawaii had 181 child deaths (DOH Office of Health Status Monitoring). At that time, there was no uniform, systematic system for the investigation of child deaths in Hawaii. In 1996, the Hawaii Department of Health, Family Health Services Division, Maternal and Child Health Branch (MCHB) initiated a statewide Child Death Review (CDR) process. With the support of the Director of Health, the MCHB facilitated the creation of a voluntary multiagency, multidisciplinary CDR Council to recommend the procedures necessary to implement such a system. In 1997, when Chapter 350B of the Hawaii Revised Statutes was signed into law, the authority to conduct child death reviews to reduce the incidence of preventable child deaths was given to the Department by the Legislature.

Currently, local teams are completing the 1996 retrospective reviews of all child deaths in the state. These teams have met regularly on all islands since December, 1998. A forensic nurse specialist has been hired on contract to work with all local teams, complete chart and record reviews, and facilitate data gathering.

Objectives of the activity:

By September 30, 1998, the State CDR Council, five local CDR teams, and one Department of Defense team will have been established. By September 30, 1998, standard protocols, guidelines, and surveillance data systems will have been developed.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. It was difficult to obtain initial legislative and community buy-in. 2. In 1997, the Legislature expanded the activity without appropriating any additional funding. 3. Developing the funds and resources needed to support the program. 4. Sustaining physician input and support for the local teams.	The DOH and other agency supporters worked with this issue for several years to break down barriers. The lack of funding was solved by applying for grants, piecing together different sources of funds, and providing a large amount of in-kind support. These outside funds has enabled the program to hire personnel and provide training activities. DOH has continued to work with the physician community to develop ongoing support.

Role of health department in implementation, planning, and evaluation:

The Department of Health took a leadership role in the establishment of the CDR program. The MCHB Chief chaired the State CDR Council. In addition, MCHB personnel provided the staffing resources necessary to move the program forward and to seek and obtain grants. In the absence of grant funded personnel, MCHB staff provided support for the program activities.

Accomplishments:

1. The passage of legislation authorizing child death reviews.
2. The development of the policies, procedures, and protocols to be used in the CDR program.
3. We received buy-in from all major agencies in the State and County.
4. Local CDR teams were formed in each county.
5. A surveillance database system was developed.

Lessons Learned:

Collaboration, collaboration, collaboration. Planning, persistence, and long-term efforts are necessary for successful outcomes. Legislative mandates are critical to gaining the acceptance and cooperation of others. All stakeholders are necessary to the program and must be brought in early in the planning process.

Reducing Infant Mortality in Houston: Practical Steps and Ethics

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Prenatal care Low birthweight/ infant mortality Early intervention/zero to three Increasing social support Increasing access to Medicaid Building coalitions and partnerships	Analysis of demographics, economic status, behaviors, health status Hotlines, print materials, media campaigns Newsletters, convening focus groups, advisory committees, networks Staff training Support of continuing education

Funding Sources:
None reported

Budget: $0.00

Description:

The Houston Department of Health and Human Services (HDHHS) and the University of Texas-Houston Medical School jointly sponsored a four hour interdisciplinary and interagency CME program entitled "Reducing Infant Mortality in Houston: Practical Steps and Ethical Issues." This activity provided four hours of Category 1 credit toward the AMA Physician's Recognition Award, and contained one hour of ethics and professional liability content as required by the Texas State Board of Medical Examiners. In certain areas of Houston the infant mortality rate approaches that of some developing countries. Because of this fact, the Houston Infant Mortality Task Force, comprised predominantly of HDHHS staff from various programs, conceived the activity and targeted physicians and clinicians in the private sector of Houston. Prior to this meeting, there had not been a medical meeting update on infant mortality in Houston in five years.

Objectives of the activity:

At the conclusion of the conference, the participant would be able to :
1. Utilize knowledge, strategies, and resources to improve birth outcomes and infant vitality during the first year of life.
2. Summarize infant mortality trends.
3. Discuss the psychosocial needs of mothers during pregnancy and parenting.
4. Discuss best practices in prenatal care.
5. Discuss different approaches to improving parenting skills.
6. Describe ways to reduce the number of preventable infant deaths.
7. Identify resources for pregnant women and their families.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. The Task Force did not have expertise in planning a Category 1 CME event. 2. HDHHS lacks accreditation as a CME provider; joint sponsorship was therefore required. 3. The CME provider that usually co-sponsors with HDHHS was unavailable for this activity, and a new relationship had to be formed to find a co-sponsor. 4. The joint sponsor and planning committee were confirmed six months prior to the targeted activity date; this created a very tight schedule to complete all tasks. 5. HDHHS's CE coordinator was committed to other activities and did not have full support from her bureau to devote time to this activity. 6. The individual in charge of publicity left the planning committee	Task Force members now have experience planning a Category 1 CME activity and will be more skilled in planning future activities. HDHHS has now established relationships with at least two accredited CME providers we could collaborate with for future activities.

Role of health department in implementation, planning, and evaluation:

HDHHS and the Infant Mortality Task Force provided ongoing attention to the problem of infant mortality, evaluated HDHHS programs designed to reduce infant mortality, generated a needs assessment, and initiated planning to provide continuing education about infant mortality to public health professionals. HDHHS provided approximately 75% of the resources (staff time and monetary) for planning and implementation of this activity. Evaluation of the program was paid for by participant registration fees.

Accomplishments:

1. This was the first Category 1 CME activity on infant mortality (jointly) sponsored by HDHHS.
2. HDHHS introduced department programs and public heath issues to private providers, encouraging collaboration between the public health department and the private sector.
3. A large number of private physicians were included in the program mailing list. These physicians had not been previously included on HDHHS mailing lists.
4. In a formal evaluation of the activity, we received a score of 4.18 on a 5.0 scale. This indicated that we had exceeded the expectations of physicians and other clinicians in meeting their needs.
5. At least one partnership arrangement has been established between HDHHS and a private physician (a mobile practice and a WIC site) as a result of this activity.

Lessons Learned:

1. We realized that there is a need for greater communication between the public and private sectors.
2. We recognized the importance of buy-in from the private sector.
3. We recognized the importance of selecting planning committee members from various professional backgrounds in both the public and private sectors who posess varying beliefs, skills, and experience. We recognized the importance of selecting experienced planning committee members who possess the ability to negotiate resources through contacts.

Substance Abuse Treatment Provider Survey

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Preconception promotion Prenatal care Substance abuse prevention	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Tracking systems Public advocacy for legislation and resources Develop and promote MCH agenda and YR 2000 National Objectives Consistent, coordinated policies across programs Develop tools standardizing data collection, analysis, reporting

Funding Sources:
Private sources

Budget: $8,000.00

Description:

The program consisted of a written questionnaire sent to substance abuse treatment facilities to survey the availability of substance abuse treatment for women in general and for pregnant women in particular in Marion and surrounding counties.

Objectives of the activity:

1. To collect and compile detailed data about the availability of substance abuse treatment facilities for women in general and pregnant women in particular in Marion and surrounding counties. Fifty questionnaires have been sent; to date, data from 38 facilities have been received. Follow-up is in progress to obtain the remaining responses.
2. To compile the data received from the questionnaires into a resource book.
3. To disseminate this resource book on Substance Abuse Treatment for Women in Marion and surrounding counties to all women's health care providers and facilities, to members of the Indianapolis Healthy Babies Consortium, and to other interested members of the community.

Barriers encountered in implementation:	Strategies to overcome barriers:
Increasing the number of facilities completing and returning the questionnaires.	1. Second questionnaires have been mailed to all substance abuse treatment facilities which have not yet responded. 2. Those facilities who fail to respond to the second mailing will be contacted by phone and a personal interview to obtain the information will be arranged.

Role of health department in implementation, planning, and evaluation:

The health department:
1. Designed the questionnaire.
2. Is currently compiling the information received from the questionnaires.
3. Will do the follow-up interviews with non-responders.
4. Will compile the information and design the Substance Abuse Treatment for Women in Marion and Surrounding Counties Resource Book; will disseminate the book to women's health care providers, members of the Healthy Babies Consortium, and other interested members of the community.

Accomplishments:

1. The questionnaires were mailed to all substance abuse treatment facilities in Marion and surrounding counties.
2. Approximately 80% of the questionnaires were returned.
3. Follow-up has been conducted on non-respondent facilities.

Lessons Learned:

1. Feedback indicates that this is a much-needed and long-overdue project.
2. The Substance Abuse Treatment for Women in Marion and Surrounding Counties Resource Book will have to be updated at regular intervals to ensure its usefulness to providers, members of the Consortium, and community members.

Medical Mall WIC Distribution Center

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Breastfeeding/nutrition/WIC	Provide outreach services Transportation and other access-enabling services Provide, arrange, administer direct services

Funding Sources:
City/County/Local government funds

Budget: $0.00

Description:

The Jackson Medical Mall revitalized a decrepit retail mall in the "inner city" and surrounding communities, as previously reported in *Lessons Learned 1997*. The Jackson Medical Mall is a non-profit project designed to provide medical care to the MCH population in a "seamless" manner. Thus, in one location a maternity and child health patient can be certified and pick up appropriate WIC food at a modern distribution center. This inner city revitalization project has turned a decrepit retail mall into a modern complex of preventive primary and specialty services (including WIC).

Objectives of the activity:

1. To increase participation in WIC.
2. To decrease the costs to WIC.
3. To decrease the amount of fraud in participants of the WIC program.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barrier to be overcome was the Real Property Management bid process which mandates that rental space must be given to the highest bidder.	It took a great deal of persistence to convince the board that the mall, although at slightly higher rental price than other locations, is more cost effective for WIC and more convenient for patients.

Role of health department in implementation, planning, and evaluation:

The Health Department has been a coordinator for the "one stop shopping" concept of the Medical Mall.

Accomplishments:

1. Establishing a WIC Distribution Center at the mall that provides access to appropriate specialty centers and primary care centers for WIC Certification under one roof.
2. The Mall has an efficient distribution center of nutritionally appropriate foods.
3. The Mall provides clients with easy access to WIC services.
4. A very low fraud rate in the WIC program.

Campaign Lead-Safe KC

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Has this activity been formally evaluated?
No (but will be as data is collected)

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Lead poisoning	Develop tools standardizing data collection, analysis, reporting Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Prepare, publish and distribute reports Public advocacy for legislation and resources Newsletters, convening focus groups, advisory committees, networks Develop tools standardizing data collection, analysis, reporting Provide outreach services

Funding Sources:
Other Federal funds

Budget: $95,000.00

Description:

The program consists of a campaign to promote lead poisoning awareness and prevention. The project involves the Kansas City, MO Health Department, the Wyandotte County Kansas Health Department, and LeadBusters, Inc. (a community based organization).

Objectives of the activity:

1. To hold four community presentations each month in high risk neighborhoods.
2. To hold focus groups in Kansas City, MO and Kansas City, KS to assess community knowledge of lead poisoning and enlist their involvement in prevention activities.
3. To conduct a phone survey of 200 homes in high risk areas to assess the knowledge of lead poisoning.
4. To conduct a media campaign involving radio, TV, bus signs, billboards, and newsprint.
5. To introduce curriculum concerning lead poisoning into 25 elementary and Junior High/High School programs.

Barriers encountered in implementation:	Strategies to overcome barriers:
The agencies involved in the campaign have different philosophies and systems.	We hold monthly meetings to discuss issues and examine different approaches to implement the objectives of the grant. The agencies involved in the campaign are linked through contracts which clearly state each particular agency's responsibilities.

Role of health department in implementation, planning, and evaluation:

The Kansas City, MO Health Department identified funding sources for the campaign, designed the project, wrote the grant, collaborated with other organizations, and currently provides administrative oversight for the program.

Accomplishments:

The Kansas City, MO Health Department has a collaboration with another health department across state lines and also with a community-based organization called LeadBusters, Inc. The project covers the Kansas City metropolitan area, including three counties in Missouri and one county in Kansas.

Lessons Learned:

Partnering with other agencies can broaden your focus and allow you to accomplish more than you could alone.

KAPPI- "Gotta Be A Leader"

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Teen pregnancy	Community perceptions of health problems/needs
Clergy and health connections	Hotlines, print materials, media campaigns
Increasing social support	Culturally appropriate health education materials/programs
Building coalitions and partnerships	Implement/support education services for special MCH problems
	Identify alternative resources to expand systems capacity

Funding Sources:
City/County/Local government funds, MCH block grant funds, Private sources: hospitals and other local funds

Budget: $20,000.00

Description:

A. KAPPI Description (program sponsored by KAPPI for nine years): "Gotta Be A Leader" was created by the Special Projects committee of the Knox Adolescent Pregnancy Prevention Initiative. An average of 25 young people attend activities during the summer months which promote themes of goal setting and good decision making. The project, a collaborative effort with the Boys and Girls Clubs of Greater Knoxville, has included components that provide advice and guidance on everything from career opportunities and nutrition to resisting alcohol and other drugs and postponing sexual activity. The program has been held each summer since 1991. Through a Region IV Teen Pregnancy Reduction grant received by Florence Crittenton Agency, "Gotta Be A Leader" has expanded to become a year-round program at the Moses Teen Center. A coordinator was hired to implement this year-round program.

B. KAPPI Functions:
1. To create community awareness.
2. To solicit support from various sectors for prevention efforts.
3. To improve and coordinate services available to pregnant and parenting adolescents.

C. KAPPI Initiatives:
1. "Gotta Be A Leader" (Moses Teen Center)
2. Knox Teen Assessment Project (KTAP)
3. Baby Think It Over, infant simulators
4. Parent workshops
5. Teen Fairs (Knox County high schools)
6. Male Mentoring (Moses Teen Center)
7. Materials for the faith community
8. Teen Pregnancy/Teen Birth Rate
9. Teen Help Cards (resource cards)
10. Campaign- Don't Play that Game. . . Abstain!

Objectives of the activity:

1. To improve the self-esteem of the youth involved in the initiative.
2. To enhance youth knowledge, attitude and behavior related to personal health.
3. To improve the overall goal setting and decision making skills of adolescents.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Trying to collaborate with individuals who possess different viewpoints.	1. Developing common goals to achieve in the community.
2. Teen pregnancy prevention efforts have been addressed by only females.	2. Inviting males to be involved with KAPPI and to coordinate the "Gotta Be A Leader" program.
3. The involvement of the faith community with family life education.	3. Hosting community meetings for the faith community and providing materials for young people.

Role of health department in implementation, planning, and evaluation:

The KAPPI based at the Knox County Health Department is part of Tennessee's state plan to address teen pregnancy. KAPPI meetings are held the third Tuesday of each month at the health department.

Accomplishments:

Knox County, as well as the state of Tennessee, has seen a gradual decrease in the teen pregnancy rate since 1995. This decrease is the result of community collaborations between many agencies (including the peer education group, S.T.A.R.S. – Students Teaching and Respecting Sexuality) and individuals. The successful collaboration and commitment of such a wide variety of partners is a major accomplishment.

Another accomplishment was the administering of the Knox Teen Assessment Project (KTAP) in ten schools in 1998. Knox County Schools used the information gathered in the assessment for future program planning. Social service agencies found the results useful for program development and grant writing. Parent organizations can utilize the information to improve communications and interactions among parents and teens.

Other accomplishments include:

1. The Teen Help Card, developed by KAPPI and printed with funding from Baptist Health Systems, was distributed to 25,000 young people.
2. The Baby Think It Over simulator dolls were loaned to nine schools during 1998-99 and to several agencies during the summer months. The Knox Academy of Medicine Alliance (KAMA) has assisted with transportation of the babies this year and provided funding for 20 dolls.
3. Teen Fairs are provided to approximately five schools each year.
4. The multi-media campaign, "Don't Play That Game. . .Abstain!" was launched in May for Teen Pregnancy Prevention Month. The message was on billboards and KAT (Knox Area Transit) buses. Posters and other items will have the same message throughout the 1999-2000 school year. An 8th grade student at Vine Magnet School created the message for the campaign.

Lessons Learned:

The greatest lesson learned is that collaboration is the key to success in making changes in a community. Change is made possible through the coalitions, councils, or initiatives developed to utilize community assets appropriately.

Prenatal Care Assurance Initiative

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Prenatal care Expanding maternity services Teen pregnancy Expanding private sector links Other outreach activities Increasing access to Medicaid Managed care initiatives Building coalitions and partnerships Building MCH data capacity	Develop tools standardizing data collection, analysis, reporting Implement public MCH program client data systems Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Tracking systems Assessment of provider reports regarding process and outcomes Prepare, publish and distribute reports Promote compatible, integrated service system initiatives Provide infrastructure/capacity for MCH functions Develop tools standardizing data collection, analysis, reporting Provide outreach services Monitor enrollment practices for ease of use Managed Care model contracts and access issues Identify alternative resources to expand systems capacity Identify and report access barriers

Funding Sources:
City/County/Local government funds, MCH block grant funds

Budget: $55,000.00

Description:

In February 1999, our health department discontinued the provision of prenatal clinical services in our county. To assist women in accessing care in the private sector, a nurse case management program was developed. Pregnant women enrolled in our family planning clinic are given information about prenatal care, Medicaid, and providers. The nurse case manager is responsible for tracking these clients' access to prenatal services and satisfaction with their care. Birth outcomes data for these women will be obtained from the "Certification of Live Birth" records provided by the State Statistics and Vital Records Section. These data will then be compared with those of women who had previously utilized our prenatal clinic services.

Objectives of the activity:

By September 30, 1999, 75% of all clients with positive pregnancy tests confirmed by our agency will be contacted to determine their access to and satisfaction with their prenatal care. The birth outcomes data of these women will then be compared with women who had previously utilized the health department's prenatal clinical services.

Barriers encountered in implementation:	Strategies to overcome barriers:
Private providers were resistant to taking prenatal clients, especially the indigent. Media coverage of this event caused a conflict between the health department and county commissioners. Ongoing negotiations with State Vital Statistics for birth outcome data has been frustrating.	Negotiations with private providers and State Vital Statistics continues to assist in accessing care and birth outcome data. Communications with the county commissioners improved when they were invited to present awards for "Public Health Champions" at a luncheon planned by our agency. The media coverage of this event was very positive for the commissioners and the health department.

Role of health department in implementation, planning, and evaluation:

Our agency developed, implemented and funded this project. A proposal was written and submitted to State for MCH funding; this funding was awarded.

Accomplishments:

Preliminary satisfaction surveys show that clients are satisfied with their care. In August, the RN Case Manager implemented an "Initial Prenatal Visit" which is reimbursed by Medicaid. This funding will decrease the cost of the program and assist clients in accessing appropriate providers for high risk pregnancies.

Lessons Learned:

Communication with the private sector leads to improved understanding of referral resources; a collaborative effort has resulted in family practice residents working in our women's health clinic. Utilize MPH students to develop a client database.

Maternity Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Prenatal care Expanding maternity services Low birthweight/ infant mortality Teen pregnancy Overcoming cultural barriers Reducing transportation barriers Case coordination Increasing access to Medicaid Strategic planning Securing MCH Assistance Building coalitions and partnerships	Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Tracking systems Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Develop and promote MCH agenda and YR 2000 National Objectives Newsletters, convening focus groups, advisory committees, networks Promote compatible, integrated service system initiatives Consistent, coordinated policies across programs Provide infrastructure/capacity for MCH functions Staff training Support of continuing education Support of health plans/provider networks Provide outreach services Transportation and other access-enabling services Referral systems, resource directories, advertising, enrollment assistance Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services Universal newborn screening programs Managed Care model contracts and access issues Identify and report access barriers

Funding Sources:
MCH block grant funds, 330 funds

Budget: $446,575.00

Description:

Collaboration between the Lexington-Fayette County Health Department (LFCHD), Kentucky OB Clinic and the University of Kentucky Hospital was successful in arranging prenatal and postpartum medical, nursing, nutrition, social services, individualized and group prenatal education for Hispanic clients, via an on-site contract translator and an off-site hospital non-contract translator. The LFCHD worked with the Hispanic Association on a Hispanic Initiative to write a grant for funds to hire a second Spanish translator, Spanish educational materials and develop a system which allowed for easier access to more patient friendly services. In FY 1998-99, $60,000 and in FY 1999-2000, $74,400 was received from the State by the LFCHD to pay for prenatal/postpartum doctor visits only. However, these funds did not cover all prenatal costs. An agreement between the LFCHD and the Kentucky OB clinic was implemented so that the clinic OB residents could provide prenatal care for clients without a payer source. Collaborative efforts between the LFCHD staff and OB clinic staff allowed creation of a referral system to the OB clinic financial counselor to make payment arrangements. Ninety percent of the Non-Medicaid LFCHD Maternity Program clients are Hispanic non-US citizens, thus, not eligible for Medicaid. Hospital programs are available for which our clients may qualify. These programs will pay for hospitalization. These clients may also be eligible for an emergency medical card. Clients are encouraged by the LFCHD staff and the hospital staff to apply for the card, so that hospitalization costs can be covered.

Lexington, KY

Objectives of the activity:

1. To assist staff in communicating with Non-English speaking Hispanic clients when providing prenatal and postpartum services.
2. To provide easier access to more patient friendly OB care for Hispanic clients.
3. To increase the number of Hispanic clients who seek prenatal care in the first trimester.
4. To assist Hispanic clients in obtaining financial assistance to pay for prenatal care and delivery.
5. To increase the number of clients who continue care through the postpartum visit.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Lack of available funding, translators and transportation. 2. Non-US citizen Hispanic client's fear of the INS. 3. Hispanic clients would not initiate or continue to keep prenatal doctor appointments because they could not afford to make payments for prenatal care.	The LFCHD is working with the Hispanic Association on a Hispanic Initiative to write a grant for funds to hire a second Spanish translator, purchase Spanish educational materials and develop a system which allows for easier access to more patient friendly services. Funds obtained are used to assist prenatal clients who are without another payer source. LFCHD, OB clinic and hospital staffs refer clients to hospital programs for which our clients may qualify. These programs will pay for hospitalization. These clients are also referred for an emergency medical card to cover hospitalization costs. The hospital considers labor and delivery an emergency. Collaborative efforts between the LFCHD and OB clinic staff allowed the implementation of a referral system to the OB clinic financial counselor to make payment arrangements for OB care.

Role of health department in implementation, planning, and evaluation:

The Lexington-Fayette County Health Department is involved in continuous planning, implementing, provision and evaluating services provided for our Hispanic clients.

Accomplishments:

Since FY 1996-97, the number of Hispanic clients in need of prenatal care has steadily increased. A Spanish translator was hired via contract to provide needed translation services, so that staff can communicate with Non-English speaking Hispanic clients when providing services.

Lessons Learned:

Two years ago, shortfalls in funding to the LFCHD for the payment of prenatal care, delivery and newborn assessment occurred. This was another barrier for our clients in seeking prenatal care since they had no payer source and did not have the money to make payment arrangements.

Healthy People 2010 for Lincoln, Nebraska

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Strategic planning	Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Environmental assessments Develop and promote MCH agenda and YR 2000 National Objectives Newsletters, convening focus groups, advisory committees, networks

Funding Sources:
City/County/Local government funds

Budget: $0.00

Description:

The Lincoln-Lancaster County Health Department has provided the leadership for a Healthy People process for the past two decades. For Healthy People 2010 the department desired more input from the community at large from the beginning of the planning process. A steering committee was identified composed of leaders from a variety of community groups and organizations. Special attention was paid to participation from leaders of racial and ethnic minority communities and from persons with environmental health interests because these areas needed strengthening in the new plan. After the major topic areas were identified, 21 groups of persons with special interests began the process of requesting data and other information about health status related to the topic. Currently focus groups are being held with citizens from racial and ethnic communities. Input from all groups will be assembled into "white papers" from which issues will be identified and eventually prioritized.

Objectives of the activity:

1. Development of a Healthy People 2010 plan for Lincoln and Lancaster County to be presented to the community at the January 2000 Board of Health Annual Meeting.
2. The Steering Committee and Board of Health will maintain oversight of the process through the next decade, with regular "Report Cards" of progress toward selected objectives.

Barriers encountered in implementation:	Strategies to overcome barriers:
This is a time-intense activity, and finding time in busy schedules has been difficult.	Division Chiefs have had to prioritize activities to allow staff time to conduct committee meetings, research data and write "white papers." Staff have altered work schedules so that new and diverse community members can participate in focus groups and on work groups. Several strategic activities in the Department have been put on hold in order to achieve objective #1.

Role of health department in implementation, planning, and evaluation:

The health department, in collaboration with Community Health Partners and the Board of Health, has played a leadership role, convening meetings and providing staff resources to research and document the process. The vehicle for community distribution of the plan will be the annual Board of Health meeting which draws more than 400 citizens.

Accomplishments:

Major topic areas have been selected, draft white papers have been developed and currently focus groups are giving input. Next steps will be finalizing the white papers and convening a large community meeting to identify and prioritize issues.

Lessons Learned:

1. Be flexible about focus group times and locations. Staff can be present to observe, but should not be at the table, so that citizen dialogue is free and open.
2. It will always take more time than expected.
3. Department leadership needs to take an active role in managing workloads so that staff members do not become discouraged.
4. Learned from the Healthy People 2000 process. . . citizens raved about their involvement and the document was used by a variety of groups to seek funding from new sources.

The Arkansas Birthing Project at the Watershed

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Family planning Prenatal care Home visiting Low birthweight/ infant mortality Substance abuse prevention Breastfeeding/nutrition/WIC Immunization Early intervention/zero to three Children with special needs Teen pregnancy Teen parenting Overcoming cultural barriers Reducing transportation barriers Clergy and health connections Schools and health connections Increasing social support Case coordination Increasing access to Medicaid	Transportation and other access-enabling services

Funding Sources:
General state funds, Private source: Watershed Human Development Agency

Budget: $100,000.00

Description:

The Watershed Human Development Agency in Little Rock, Arkansas, in partnership with the Arkansas Department of Health and the National Birthing Project in Sacramento, California, launched the Birthing Project. This Project is a national African-American Maternal and Child Health Case Management Model known as "The Birthing Project". The project utilized volunteer case managers to mentor pregnant and parenting women. Women who are at risk of experiencing a high-risk pregnancy, birth or difficulty parenting due to poor social support systems, lack of resources to medical and other human services and lack of educational resources, are recruited for this project. They are matched with a mentor known as a Sister Friend. This mentor provides social-emotional support to her Little Sister in educating her about prenatal care and empowering her to function as an adult who can manage her own life.

Objectives of the activity:

The Birthing Project is a mentee-mentor case management model which utilizes volunteer mentors known as Sister Friends to provide one-on-one case management to a pregnant mentee known as a Little Sister. The program measures number of prenatal care visits, pre- and post-pregnancy smoking and drug use of little sisters, birthweight of project babies, family planning utilization of little sisters and immunization schedule appropriateness of project babies.

Barriers encountered in implementation:	Strategies to overcome barriers:
Funding to pay for program "Bunch" managers and managers as the project grows.	Soliciting funding from a variety of public and private funding sources.

Role of health department in implementation, planning, and evaluation:

To provide programmatic implementation and design assistance and support to the Watershed Human Development Agency's efforts to implement this project. We have loaned a public health employee to this effort at 20% time to provide program direction and support. In addition, local area VIII office staff have provided secretarial support and office supplies for the project. The State Health Department may give seed money support to this project to support local community growth in strategic communities statewide which could benefit from a grassroots recruitment and implementation of this project approach to case management.

Accomplishments:

1. A healthy 8lb 3oz baby girl was born to the Project a few weeks ago!
2. Several applications have been completed and sent to local potential funders.
3. A permanent program office has been established.
4. Ten Sister-Friends have been recruited to work with our first bunch of ten Little Sisters.

Lessons Learned:

Local community support is essential to the growth and sustenance of any community based program. Hard work pays off!

Healthy Families

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
EPSDT/screenings	Community perceptions of health problems/needs
Expanded child health services	Hotlines, print materials, media campaigns
Overcoming cultural barriers	Culturally appropriate health education materials/programs
Other outreach activities	Develop and promote MCH agenda and YR 2000 National Objectives
Increasing access to Medicaid	Newsletters, convening focus groups, advisory committees, networks
Building coalitions and partnerships	Provide outreach services
	Transportation and other access-enabling services
	Referral systems, resource directories, advertising, enrollment assistance
	Monitor enrollment practices for ease of use
	Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
City/County/Local government funds, General state funds, Other Federal funds

Budget: $0.00

Description:

The Healthy Families/MediCal Education and Outreach project is a cooperative project between several MCH-related programs in the department, utilizing staff from the Perinatal Outreach and Education project, CHDP Administration Program, and the MediCal Outreach Project. CHDP program staff receive an average of 5600 reports every month from 65 CHDP providers indicating whether or not a child is on MediCal, and whether any medical problems were found. CHDP staff contact the families of the children with medical conditions to offer assistance and ensure receipt of any necessary follow-up medical care. CHDP staff have also begun surveying families regarding their knowledge and experience with MediCal and Healthy Families, to provide information, and to determine barriers in enrollment.

Objectives of the activity:

Educate the potentially eligible population regarding the benefits of enrollment in MediCal and Healthy Families, and identifying and overcoming barriers to enrollment; with the overall goal of increasing health care coverage for children.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Finding funding to continue to pay for staff time in order for the program to continue.	1. Continue to apply for funding beyond that already secured.
2. Enrolling families who are distrustful of the system.	2. Continue to educate families on the value of health coverage for children.

Role of health department in implementation, planning, and evaluation:

All outreach, education, and referral activities have been conducted by Department staff. Enrollment activities are coordinated with staff from other agencies, such as DPSS and community based organizations, who are providing enrollment assistance.

Accomplishments:

On average, over 400 families are contacted by phone every month for education regarding Healthy Families and MediCal and offered assistance with enrollment. An additional 1,000 families per month are mailed letters offering the same information and assistance. The MediCal Outreach project is in the process of evaluating its effectiveness in terms of actual enrollment of children into a program.

Lessons Learned:

In order to be most effective, outreach and enrollment assistance are best done by personal, preferably face-to-face contact, which is labor-intensive and time-consuming. There continues to be a lack of information in the community regarding how and why to obtain health care coverage for children, and continued outreach and enrollment assistance activities are needed in order to overcome the barriers. It is frustrating to put in a huge amount of effort establishing collaboratives and community referral networks, only to come to the end of the funding cycle once you're begun to establish a presence in the community. Continuing to get community support to continue the activities once the funding is gone is not always easy.

Mommy and Me Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Family planning Prenatal care Expanding maternity services Home visiting Low birthweight/ infant mortality Breastfeeding/nutrition/WIC Immunization EPSDT/screenings Children with special needs Teen pregnancy Teen parenting Overcoming cultural barriers Reducing transportation barriers Expanding private sector links One-stop shopping locations Increasing social support Case coordination Increasing access to Medicaid Managed care initiatives Building coalitions and partnerships	Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Staff training Support of continuing education Support of health plans/provider networks Provide outreach services Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services Managed Care model contracts and access issues Identify alternative resources to expand systems capacity

Funding Sources:
Third party reimbursement (Medicaid, insurance)

Budget: $394,000.00

Description:

The Mommy and Me Program is provided through a contractual arrangement between Passport Health Plan (PHP), the regional provider of the Medicaid managed care program, and the Departments of Health in 16 counties of North-Central Kentucky. The Mommy and Me Program seeks to improve pregnancy outcomes and decrease infant morbidity and mortality in the region. The program provides home based services, such as prenatal and postpartum home visits and monthly to weekly phone calls. During these contacts, public health nurses, acting as case managers, assess the family to identify the family's needs and barriers to care. The nurse then assists families in accessing community resources, such as WIC.

Objectives of the activity:

Through collaboration with the Department of Health, obstetrical providers, and community agencies, activities will be developed to:

1. Identify members early in their pregnancy and provide an initial home visit within 30 days of identification;
2. Provide a home visit to conduct a comprehensive assessment of a family's psychosocial and health care needs and evaluate the home environment;
3. Conduct ongoing case management to monitor the expectant mother's adherence with prenatal care and appointments with her doctor; and,
4. Provide information and counseling on what to expect during the pregnancy and on the new baby's care and development.

Phone contacts will be made monthly until 32 weeks gestation, bi-weekly until 36 weeks, and then weekly until delivery. Also, post-partum visits will be provided within seven days following delivery and a post-partum phone call will be made six weeks after delivery. This telephone call will confirm the mother's medical post-partum visit and baby's well-child visit and immunizations. Additional home visits may be made to families determined to be in need of more intensive services.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. The timely identification of new prenatal Medicaid members has been a barrier. Our experience has been that by the time a woman determines she is pregnant, applies for medical care, and is reported to PPH, she is late in her first or early in her second trimester.	1. As new prenatal clients are identified at the Health Department's service sites (such as prenatal or WIC clinics), PHP is notified. Also, notification of pregnant women is provided through Health Department collaborative projects with other health and human service agencies.
2. A second barrier was the initial contact with the pregnant client. Initially, case managers attempted to contact the client by telephone to arrange home visits or make periodic contacts. Many of our families do not have telephones. Also, the information provided at the time of Medicaid application is often incomplete, making telephone contacts with the client very difficult and time consuming.	2. Case managers use other available databases (Health/WIC Clinic registry data, OB provider, human service providers) to obtain updated phone numbers, address, etc. Attempts to obtain additional means to contact is a part of any successful contact. When unable to make phone contacts, public health nurses make unscheduled "drop-in" home visits to plan future services. Health Departments are also working with other human service providers to assure more accurate information.

Role of health department in implementation, planning, and evaluation:

The Jefferson County Health Department served as the lead agency in negotiating the contract between the Medicaid managed care agency and the 15 other county health departments in the region. The Jefferson County Department also functioned as a liaison in efforts to coordinate program services.

Accomplishments:

We established private and public health partnerships and an excellent working relationship with the Medicaid managed care provider. We provided preventative health information and maternity support services to families who may be considered high risk based on income criteria and history of accessing health care.

Lessons Learned:

Public health nurses possess skills in case management, health education, and counseling that are invaluable contributions to the implementation of a managed care plan. Public Health Departments have established relationships with agencies and consumers that promote preventive health care services. Public health departments also have the experience needed to successfully work with the Medicaid population and providers of care to acheive improved health outcomes.

Public Health Nursing and Girl Neighborhood Power

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Has this activity been formally evaluated?
Planning for evaluation is taking place at the federal Madison level.

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Violence prevention/at risk Teen pregnancy	Implement/support education services for special MCH problems Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
Other Federal funds

Budget: $200,000.00

Description:

Girl Neighborhood Power (GNP) is a collaborative effort between Madison's Department of Community Services, the Department of Public Health, and two youth-serving nonprofit agencies. The program goals are to provide nine to 14 year old girls from four of Madison's challenged neighborhoods with healthy and stimulating daily after-school activities that build skills by providing experiences in community service, health education, career development, recreation, and positive interactions with peers and adults. The health education component is built on the needs and wishes of the girls without replicating the health education programs in their schools. The girls participate in fun-filled educational activities, including building communication skills, learning animal safety, exploring new foods, testing the senses, practicing good personal hygiene, and many more. The public health nurses also try to spend time with the girls doing "non-health-related" activities in order to build rapport and be available for "the askable moment."

Objectives of the activity:

Health related objectives include increasing the number of girls who report abstinence from risk behaviors, as well as increasing the girls' knowledge of healthy lifestyle choices, all while having FUN!

Barriers encountered in implementation:	Strategies to overcome barriers:
There are many issues that served as barriers to the project. These included recruiting girls and maintaining their participation, retaining site staff, and engaging the parents in programming. The greatest challenge to the public health nurses was finding new ways to present health education topics that engage girls aged nine to 14.	The public health nurses meet every one to two months to brainstorm, exchange ideas, look for new resources, and generally try to "think outside the box" of traditional health education programming.

Role of health department in implementation, planning, and evaluation:

Health Department staff assisted Community Development staff in creating the public health nursing roll and in developing a budget for personnel and educational materials. Health department staff also participated in reviewing the proposals submitted by neighborhood groups who were requesting selection as a Girl Neighborhood Power site. Public Health Nurses spend approximately eight hours a month at each site providing health-related programming. Staff also meets periodically with project partners for on-going planning and evaluation to assure the effectiveness of programming.

Accomplishments:

The projects have:
1. Been able to achieve moderately consistent program attendance even though the girls recruited for the program are from challenged neighborhoods with transient populations;
2. Identified what girls like to do in order to achieve program goals in a manner that provides both education and fun;
3. Helped girls develop close relationships with one another, as well as with the site staff; and
4. Maintained programming in spite of losing a neighborhood center and difficulties maintaining consistent staffing.

In addition, the young women have:
1. Helped to develop a business plan for GNP that will be incorporated into a master plan for collaborative fundraising;
2. Met with the editorial director of a local TV station to assist in developing a plan to involve the media;
3. Identified potential advisory board members to be recruited to assist in sustaining the program;
4. Presented to the board of a major Madison foundation, and received funding from that foundation; and
5. Requested and received several small grants.

Lessons Learned:

Girls have many ideas concerning how they might learn and grow best. Each site has a Girl Council that has been instrumental in selecting activities that meet their individual needs and desires. The girls are most interested in participating in learning experiences that include activities and physical participation with a minimum of sitting and listening to lecture style presentations.

Community Prevention Initiatives

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Preconception promotion Communicable diseases Overcoming cultural barriers Clergy and health connections Staff training Strategic planning Building coalitions and partnerships	Culturally appropriate health education materials/programs Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
General state funds, Other Federal funds

Budget: $50,000.00

Description:

To design, plan, develop, and implement HIV/AIDS/STD/TB prevention and education efforts for groups of populations, including the MCH population, in Miami-Dade County.

Objectives of the activity:

1. To increase community awareness of the risks for HIV infection, AIDS, STD, and TB.
2. To mobilize the community into taking an active role in the decision making process.
3. To empower the community to make informed decisions about safer behaviors.
4. To build partnerships and increase collaboration with new and existing community organizations.
5. To increase more HIV/AIDS/STD prevention and education services to the at-risk community and to special groups, such as the MCH population.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. A lack of funding. 2. The limited number of community partners. 3. Low socioeconomic status, a lack of housing, and unemployment among the target population. 4. Language barriers between public health professionals and the target population. 5. Problems with immigration status, ignorance and denial, and drug and alcohol abuse. 6. Religious beliefs. 7. A lack of cultural sensitivity and competency among caregivers. 8. Distrust of the Public Health System. 9. Limited access to primary care. 10. A lack of good data.	1. Utilizing volunteer workers (both individual and agencies). 2. Collaborating with new, non-traditional groups such as churches, other CBO's, elected officials, pharmaceutical companies, and members of the business community. 3. Tapping into other sources of funding. 4. Obtaining support from the media and enlisting specific media contacts. 5. Referring clients to social service agencies. 6. Educating potential partners.

Role of health department in implementation, planning, and evaluation:

The healh department served as the lead agency in this initiative, offered technical assitance, helped with skills building, amd empowered those involved in the initiative through training and education.

Accomplishments:

1. The initiative obtained commitment from community partners.
2. Community and business leaders participated in the initiative, as did non-traditional organizations such as the media, churches, elected officials, and schools.
3. We built relationships with new partners.
4. The initiative increased frequency of HIV testing.
5. Several churches established an AIDS ministry.
6. There is now better coordination and working relationships among community based organizations.

Lessons Learned:

1. Look at the community as a whole.
2. Use creative approaches to problem solving.
3. More funding is needed to properly address public health issues.
4. Collaborate with non-traditional health partners.
5. Provide the community with the tools they need, and they will be able to further stem the spread of HIV/AIDS in their community. Vulnerable groups in the community, such as adolescents, pregnant women, and children, need to be empowered to effectively fight HIV/AIDS.
6. Address both community issues and community risk indicators for effective public health measures.

Protect All Kids Coalition

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Immunization Expanding private sector links Strategic planning Building coalitions and partnerships	Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Public advocacy for legislation and resources Consistent, coordinated policies across programs Identify high-risk/hard-to-reach populations and methods to serve them Identify and report access barriers

Funding Sources:
City/County/Local government funds, Private sources: Vaccine manufacturers and private citizens, Other Federal funds

Budget: $20,000.00

Description:

Protect All Kids is a county-wide, cross-systems coalition dedicated to the health of all Milwaukee County children through immunization against vaccine-preventable diseases. It brings parents, educators, businesses, health care providers, public health, community, religious organizations, and others together to promote and maintain awareness of immunizations for the health of children, families, and the community as a whole.

Objectives of the activity:

1. Increase the number of children who have access to immunizations at no cost through a primary care provider.
2. Increase the percentage of children that are fully immunized upon entering daycare to 90% by 2003.
3. By Fall 2003, increase the percentage of children that are fully immunized upon entering school to 90%.
4. By 2001, establish sustained community awareness of the importance of immunizations.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Lack of understanding among the public and professionals related to the seriousness of vaccine-preventable diseases. 2. Opposition of some business and other payor groups related to the need for immunizations or immunization mandates. 3. Need for paid staff who are dedicated to and skilled in coordination and implementation of coalition activities.	1. Education events, such as a rally in April 1998, to inform public and professionals of the seriousness of vaccine-preventable diseases. 2. Participation in other local coalitions and groups. 3. Educational strategies designed to convey the philosophy that healthy, fully immunized children are essential to the well-being of the entire community. 4. Enlisting community advocates to staff the coalition and secure funding from various sources for operations and projects.

Role of health department in implementation, planning, and evaluation:

Immunization Program staff developed, organized, and currently chair the coalition. Start-up funds were provided by the Department in 1998 and 1999. In-kind services include technical and clerical assistance and assistance with securing operating funds.

Accomplishments:

1. Survey of daycare employees and parents regarding knowledge base and barriers to immunizations. Follow up report generated.
2. April 1998 event providing disease and immunization information to approximately 40 community-based agencies.
3. Technical assistance to sponsoring legislator and ongoing advocacy for state Senate bill to require first-dollar coverage for immunization in all Wisconsin health insurance programs.

Lessons Learned:

1. Establish formalized collaboration with an established non-profit organization as soon as possible.
2. Establish a balance between a tightly focused mission and a broad appeal.
3. Begin grant-writing and fund-raising immediately after establishing the collaboration with the Coalition.

Child Health Assessment and Monitoring Project (CHAMP)

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Early intervention/zero to three	Analysis of demographics, economic status, behaviors, health status Population surveys (BRFS, PRAMS, PedNSS, YRBS) Prepare, publish and distribute reports Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
City/County/Local government funds, Private source: Minneapolis Foundation

Budget: $300,000.00

Description:

The Minneapolis Department of Health and Family Support is developing the Child Health Assessment and Monitoring Project (CHAMP), a survey of current Minneapolis residents whose children are six to 24 months of age and were born in the city. The survey is being developed in partnership with both the Minneapolis Public Schools and "Way To Grow", a family resource and home visiting agency. In addition, input from several community agencies, health providers, and local and national maternal and child health experts has been sought.

Objectives of the activity:

1. To obtain quality data that exceeds the traditional health measures and examines dimensions such as parent involvement, day care, social networks of parents, and richness of the child's environment.
2. To provide neighborhood specific information.
3. To survey all eligible births between June 1 and August 30, 1999.
4. To look at the conditions of our youngest children and their parents, and to assess the strengths and weaknesses that underlie their formative years.

Barriers encountered in implementation:	Strategies to overcome barriers:
Finding telephone numbers and addresses based on birth certificate information.	We used different sources to find phone numbers from addresses and names. In addition, we sent letters to all parents involved asking them to call us if their phone numbers were unlisted or under a different name. We also publicized the project by using different media outlets in the Metropolitan area.

Role of health department in implementation, planning, and evaluation:

The Minneapolis Department of Health and Family Support was the lead agency in this endeavor.

Accomplishments:

Lessons Learned:

There is high mobility among the population with young children.

Healthy Child Care Montana

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Expanded child health services Other outreach activities Staff training Building coalitions and partnerships Immunization tracking/recall	Community perceptions of health problems/needs Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Development of models Newsletters, convening focus groups, advisory committees, networks Ombudsman services Provide infrastructure/capacity for MCH functions Staff training Support of continuing education Provide outreach services Provide, arrange, administer direct services Identify alternative resources to expand systems capacity Profiles of provider attitudes, knowledge and practices

Funding Sources:
City/County/Local government funds, Other Federal funds

Budget: $83,000.00

Description:

Over ten years ago, in response to the growing number of children in out-of-home care, MCCHD initiated a child care program in collaboration with the local child care resource and referral agency. The program is staffed by a public health nurse who visits each child care center and home at least annually, providing individualized health and safety education. In addition, this child care nurse consultant conducts group activities, including an orientation for new providers and workshops on a broad range of topics. Ongoing communication is maintained with providers through newsletter articles, phone consultations, and visits (upon request) to address specific health or child development issues.

The Healthy Child Care Montana project is a statewide effort based upon this successful community model. The state MCH Bureau, as the grant recipient, has been contracted with MCCHD to coordinate the project. Our goal is to facilitate the linkage of public health and child care resource and referral agencies throughout the state, as we have in the Missoula community. The program includes a training component to prepare local and tribal public health nurses to undertake the role of child care health consultants and to meet Healthy Child Care America's Ten Blueprint for Action Steps.

Objectives of the activity:

1. To organize a project advisory committee made up of key persons, including consumers, local resource and referral agencies, and public health and state agency representatives.
2. To survey RandR's and public health and tribal health departments to determine training and resource needs.
3. To develop materials and curriculum, including a tool kit for child care health consultants.
4. To conduct regional training seminars and on-site visits to counties and reservations.
5. To expand health links (PHN's serving as child care health consultants) from less than five to a total of 25 counties providing consultation services to child care providers.

Barriers encountered in implementation:	Strategies to overcome barriers:
Because the Healthy Child Care Montana grant can offer only nominal financial incentive to counties, the greatest challenge is gaining enthusiasm from local public health departments to undertake an additional service.	Presentations at various public health professional organizations and associated discussions have focused on the following: 1. The need to assure that children receive safe, quality and developmentally appropriate care, whether at home or out of the home. 2. Most PHN's are already responding, on an informal basis, to child care providers and to parents with child care concerns. HCCM can provide them with the tools and resources needed to respond more effectively. In addition, the Resource and Referral agencies will assist and support the public health nurses by distributing materials, scheduling visits, and providing a communication system with providers.

Role of health department in implementation, planning, and evaluation:

As with several other programs, MCCHD designed and implemented the child care health consultant model. MCCHD also reccommended to the state MCH Bureau that we should work together to seek resources for replication in other local health departments. Thus, the Healthy Child Care Montana grant proposal was prepared cooperatively. With MT DPHHS serving as grant manager, the Missoula City County Health Department served as the HCCM statewide project coordinator.

Accomplishments:

In addition to providing ongoing services, the local Child Care Health Program has:
1. Developed a comprehensive infant-care curriculum; developed guidelines for child care health promotion activities.
2. Documented increased immunization levels in child care settings.
3. Provided training for child care homes and centers to ensure proper care of children with special needs.

The Healthy Child Care Montana project accomplishments include:
1. Conducting the first round of regional training sessions. These sessions focused on defining the role of child care health consultants as well as team development between public health nurses and child care staff.
2. Conducting on-site visits to Montana's seven reservations to introduce the project and identify specific resource or training needs of this population.
3. Increasing the number of counties with child care health nurse consultations from five to ten counties by the second year of the project.

Lessons Learned:

Local health departments are more responsive to undertaking a new activity when it is presented by "someone who has been there, done that." Providing resources, guidelines (the Child Care Health Consultant Tool Kit), and onsite visits are key components of the implementation phase. Child care providers need and welcome the expertise of public health nurses.

Immunization Outreach Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Immunization Communicable diseases Immunization tracking/recall	Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
City/County/Local government funds, General state funds

Budget: $114,000.00

Description:

On February 1, 1998 the Metropolitan Health Department implemented an Immunization Outreach System to improve basic immunization coverage levels for children by 24 months of age. This system was implemented due to the results of a clinic assessment which indicated that coverage levels for 24-month old children were 34%. Immunization Outreach Workers were assigned to each clinic site. A reminder-recall system, which included phone and mail reminders as well as home visits, was implemented for all children 24-months and younger. Children with high-risk indicators were identified through computer generated reports and were outreached separately.

Objectives of the activity:

Our outcome objective is to attain the year 2000 goal set by the National Immunization Program which is set at 90% coverage for the basic immunization series by 24 months of age.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Funding for immunization outreach workers and the resources needed to complete the job. 2. Training the outreach workers to work consistently within the system. 3. Obtaining the "buy-in" of the clinic staff to effectively work on the immunization outreach system.	1. Funding was obtained through immunization grant money and local dollars to hire immunization outreach workers. Resources such as computers and auto-dialers were shared with already existing programs at no cost to this program. 2. An outreach manual was written and several inservices were given to the outreach workers to keep the outreach process on track and consistent among the various clinic sites.

Role of health department in implementation, planning, and evaluation:

The Immunization Management Team, comprised of two representatives from the Immunization Program, a WIC representative, an outreach worker and a clinic manager, planned, implemented, made numerous adjustments to, and evaluated this system. This team is comprised exclusively of Health Department employees.

Accomplishments:

1. All sites are performing outreach correctly.
2. All sites have the use of an auto-dialer and a computer.
3. Due to the immunization outreach, patients are also returning for WIC appointments.
4. An Immunization Outreach manual was developed.
5. The basic immunization level for 24-month old children in 1997 was 34%, in 1998, 40%, and in 1999, 74%. This indicates a 40% increase in the coverage level.

Lessons Learned:

Implementing a new system is a slow process, which requires constant assessment to keep the process fine-tuned. Written guidelines that are clear, concise, and accessible to all pertinent employees is vitally important. The greatest lesson learned is allowing those who are implementing the process to have input into the process and to be flexible when change is needed to improve the system.

Reach Out and Read-City of New Orleans

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Early intervention/zero to three EPSDT/screenings Expanded child health services Overcoming cultural barriers Schools and health connections Reshaping urban MCH	Analysis of demographics, economic status, behaviors, health status Population surveys (BRFS, PRAMS, PedNSS, YRBS) Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Special studies Development of models Staff training Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
Private source: Barbara Bush Foundation

Budget: $25,000.00

Description:

Early reading aloud to children has been found to be the most crucial factor in determining which children will become good readers. "Reach Out and Read" (ROR) is a program that utilizes the relationship between health care providers and parents to encourage parents to read to their young children. The program has three components:

1. Readers in the waiting room model age-appropriate reading to parents.
2. Health care providers, while being sensitive to barriers such as illiteracy, encourage parents to read to their children.
3. Tips are given for age-appropriate, culturally appropriate children's books to take home. Children receiving all of their well child visits will receive ten to 12 new children's books before they enter school.

When children are not read to, they do not reach the early literacy milestones needed for success in school and are at much higher risk for poor self-esteem, teen pregnancy, drug use, gang membership, school failure, and in turn, early school dropout and lower earning income potential. Our goal is to break this cycle.

A controlled prospective study is underway to determine the effectiveness of the ROR program. Surveys of parents of children age six to 11 months will be conducted before and after one year of the intervention in two of the intervention clinics and in one control clinic. Outcome variables will include frequency with which reading is listed as a favorite activity, frequency of reading to their child, and child language skills as measured by the MacArthur, a short parent survey of children's skills.

Objectives of the activity:

The objectives of the program are to increase the frequency of parents reading to children and to improve childrens' reading readiness skills.

Barriers encountered in implementation:	Strategies to overcome barriers:
The first and largest barrier was obtaining funding for the program. We began planning the intervention a year before implementation because we did not want to begin the program before it was certain that we would not run out of money for books. The second barrier was obtaining commitment from health clinic personnel to take on another project. Books are ordered from City Hall, but once they arrive in each clinic, they must be sorted, labeled, and inventoried each month. This is a lot of work, which is a problem because staff are already very overworked due to a 25% decrease in personnel over the past several years due to budget cuts.	The initial grant was secured through the Boston City Hospital Reach Out and Read program from the Annie E. Casey Foundation. However, we calculated that to implement the program in six clinics this initial grant would only last three months. To overcome this barrier, we secured funds from the Barbara Bush Foundation for a full year of books ($25,000 for 8,000 books, which are discounted for us). The second barrier was overcome by making inventory and labeling as simple as possible and providing a pizza party on a low volume clinic day to get the first month of books labeled. Once staff were trained and realized the potential impact they could have, how to counsel parents, and what to do with the books, resistance disappeared.

Role of health department in implementation, planning, and evaluation:

Our health department used materials from the Boston City ROR program and private foundation grant funds to plan and implement this program. The evaluation was designed by the medical director of the program in collaboration with Dr. Pam High from Brown University and Sharon Hutchinson, a graduate student in Early Childhood Education.

The health department also sought collaboration with other agencies to enhance the program's effectiveness. For example, YMCA Educational Services came and trained our clinic staff to detect parents who are illiterate and refer them to adult literacy programs. Also, VIGOR, our city hall volunteer office, recruited volunteer readers for the waiting rooms and our health department offered monthly training sessions for those interested in becoming volunteer readers. Private businesses were approached for donations to create a reading corner in each clinic waiting room for children. Donated items included area rugs, frames for reading posters for each corner, and a small table and chairs for each clinic. Donations of food and door prizes were secured for the big kick-off. NEA donated both new and used children's books which were used for parents to read to their children in the waiting rooms.

Accomplishments:

After a year of planning and grant writing, the program officially began on August 12, 1999. A combined "Community Immunity Day, KIDMED week, and Reach Out and Read Kick Off" celebration in each clinic was planned with high profile readers in each waiting room such as the mayor, the new school superintendent, city council members, and others. Other accomplishments include the scheduling of a press conference, the printing of brochures and press sheets, and the purchasing of file cabinets for each clinic for sorting and storing books. Books have been ordered and received by each clinic. Clinic staff were trained with a three hour workshop. Enthusiasm in the department was at an all time high at implementaion of the program.

Lessons Learned:

One year ago when the idea was introduced to the department, it was received with great enthusiasm and plans began immediately after securing our first seed grant. When we realized that there was the possibility that we would not secure additional funding and the new program could dry up in three months, the program was placed on hold until more funding was secured. After much frustration and grant writing, the project resumed. Knowing that we were set for a year was worth stopping everything and waiting. The lesson is, get your ducks in order before you begin and you will have a more successful, worry-free project. This program has united our health department as everyone has become involved in the implementation of ROR and the plans for the big kick-off. It is hoped that the books, like WIC, will be a drawing card for total preventative health care. This is definitely a "feel good" program, with the potential for a real impact.

New York City Childhood Asthma Initiative

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Has this activity been formally evaluated?

No. A request for proposals for an evaluation contractor has been developed and will be issued in Fall, 1999.

Has this activity been replicated?

No

Essential MCH Functions:	MCH Initiatives:
Expanded child health services School-linked/based services Overcoming cultural barriers Schools and health connections Other outreach activities Increasing social support Case coordination Increasing access to Medicaid Staff training Strategic planning Reshaping urban MCH Managed care initiatives Building coalitions and partnerships	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Tracking systems Environmental assessments Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Assessment of provider reports regarding process and outcomes Prepare, publish and distribute reports Development of models Newsletters, convening focus groups, advisory committees, networks Promote compatible, integrated service system initiatives Consistent, coordinated policies across programs Provide infrastructure/capacity for MCH functions Staff training Support of continuing education Develop tools standardizing data collection, analysis, reporting Provide outreach services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:

City/County/Local government funds

Budget:

Description:

The New York City Childhood Asthma Initiative (NYCCAI) was developed by the NY City Department of Health in 1997 to lower morbidity and mortality due to childhood asthma.

The NYCCAI is a multicomponent program which seeks to integrate medical care system components with community initiatives. The mission of the NYCCAI is to:

1. Work to strengthen the ability of families, schools, communities, health care institutions and city government to control and prevent asthma;
2. Build on existing research as well as educational and clinical efforts with the result of a coordinated and comprehensive effort to understand, treat and prevent asthma in NYC;
3. Develop linkages among health facilities, schools, communities and government agencies; and
4. Reduce hospitalizations due to asthma throughout the city, with special attention to high risk populations.

Objectives of the activity:

The objectives of the NYCCAI include:

1. To promote improved family management of asthma.
2. To control asthma by reducing the exposure to asthma triggers in both homes and communities.
3. Promote the practice of state of the art medical care.
4. To develop and implement effective surveillance methods.
5. To increase community awareness of asthma.

Barriers encountered in implementation:	Strategies to overcome barriers:
There is tension between service delivery and capacity building in local communities and organizations. Numerous studies have proven that case management of individual families will yield lower hospitalizations, emergency room visits and asthma morbidity. However, it is impossible to case manage all children with asthma in NYC. Therefore, capacity building in all areas of city life touching children (e.g. schools, day care centers, after school programs, housing programs, social service agencies, medical care systems, etc.) will ultimately yield greater results for the population as a whole. This long-range viewpoint can be difficult to maintain in the face of the need for immediate results. Additionally, the complexity and size of NYC means that the NYCCAI works on many fronts at the same time.	We brought together specialists in a variety of arenas (medical, managed care, media, community development, school health, etc.) to develop "best practices" approaches to asthma in particular settings; we then worked to implement those approaches. This has yielded, for example, a curriculum for training primary care providers to support the successful implementation of the national Guidelines for the Diagnosis and Management of Asthma (NHLBI 1997). We also funded community-based organizations in seven high risk neighborhoods to develop local community responses to asthma. In addition, we built relationships with a wide range of governmental and community-based organizations.

Role of health department in implementation, planning, and evaluation:

The NYCDOH was the lead agency in planning and implementing the program citywide. The DOH developed the partnerships and advisory committees (both interagency and intraagency) necessary for program development and implementation. The DOH also developed requests for proposals for community based organizations to develop local partnerships as well as for an evaluation contractor to evaluate the Initiative.

Accomplishments:

Much of the Initiative's work is still in the initial stages. However, several important accomplishments to date include:

1. We conducted a media campaign in the NYC transit system with the theme of "I have asthma, but asthma doesn't have me."
2. We developed a curriculum for the education of medical providers.
3. We developed conferences for nurses, social workers and respiratory therapists.
4. We created an asthma case management protocol using community health workers.
5. Using a community empowerment model, we collaborated with other agencies to develop programs for asthma control. These programs included an integrated pest management program in the NYC Housing Authority
6. The development of surveillance systems to monitor pediatric asthma.
7. We implemented "Open Airways", a six session curriculum for children with asthma in all NYC elementary schools sponsored by the Department's Bureau of School Health.
8. In the spring of 1999, we held a Family Asthma Day in each of the 32 school districts in NYC. This was sponsored by the Bureau of School Health and the Board of Education.
9. We developed an Asthma Action Plan, a written self-management plan for use by families and medical providers, which is available free of charge and in multiple languages.
10. We developed a Medicaid Managed Care Asthma Services directory.

Lessons Learned:

A public health approach to lowering childhood asthma morbidity may not yield immediate results, but will create the infrastructure needed for long-term changes to occur. In that spirit, the NYCCAI believes strongly in the importance of collaboration, in utilizing existing research and not reinventing the wheel, in the importance of linkages between systems (e.g. between schools and doctors), and in the importance of developing programs that can address internal systems in multiple arenas. Finally, it is clear to us that appropriate medical care is necessary, but not sufficient, to reduce asthma morbidity among children in urban environments. A comprehensive community approach which seeks to integrate medical care system components and link them to community activities is the key to successfully achieving our goals.

Newark WIC-Pediatric Health Van

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Immunization	Develop tools standardizing data collection, analysis, reporting
Early intervention/zero to three	Implement public MCH program client data systems
Expanded child health services	Analysis of demographics, economic status, behaviors, health status
Lead poisoning	Community perceptions of health problems/needs
Communicable diseases	Tracking systems
Dental programs	Hotlines, print materials, media campaigns
Overcoming cultural barriers	Culturally appropriate health education materials/programs
Reducing transportation barriers	Implement/support education services for special MCH problems
Expanding private sector links	Prepare, publish and distribute reports
Clergy and health connections	Develop and promote MCH agenda and YR 2000 National Objectives
Schools and health connections	Promote compatible, integrated service system initiatives
One-stop shopping locations	Staff training
Mobile clinics for outreach	Support of health plans/provider networks
Other outreach activities	Develop tools standardizing data collection, analysis, reporting
Increasing social support	Provide outreach services
Case coordination	Transportation and other access-enabling services
Increasing access to Medicaid	Referral systems, resource directories, advertising, enrollment assistance
Staff training	Monitor enrollment practices for ease of use
Reshaping urban MCH	Identify high-risk/hard-to-reach populations and methods to serve them
Managed care initiatives	Provide, arrange, administer direct services
Building coalitions and partnerships	Identify and report access barriers
Building MCH data capacity	
Immunization tracking/recall	

Funding Sources:
City/County/Local government funds

Budget: $0.00

Description:

The Newark WIC-Pediatric Health Van is not a new concept. Similar types of outreach services have been used elsewhere. The new concept here is to offer not only the direct services of immunizations, WIC and KidCare enrollment, but also health education related to all services provided by the health department, and to make appointments for follow-up in a medical home. The van is parked throughout the city at a prescheduled site which is advertised by flyers, ads, and word of mouth from community leaders, all arranged by the outreach coordinator. The driver is the health educator, who is available to directly counsel clients. It is citizen friendly, one-stop shopping, bringing health services to the community, advertising the resources available at the Newark Department of Health and Human Services, and enrolling eligible residents in a nutritional medical home.

Objectives of the activity:

1. To provide immunization review and immunizations.
2. To advertise and provide WIC services onsite in the neighborhood.
3. To enroll eligible children in KIDSCARE.
4. To offer a medical home to residents by making appointments at the Pediatric Practice of the Newark Department of Health and Human Services.
5. To provide health education on a variety of pertinent topics.
6. To make residents aware of the services offered by the Newark Department of Health and Human Services.
7. To compile statistical data to have a better picture of Newark's needs and strengths.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. State approval for van usage. 2. Funding. 3. Staffing.	1. Standard operating protocols are being developed for all activities. 2. Some staff is being hired and other reassigned on Van days from other duties. 3. Success in the first year on operation might allow its inclusion in the annual city operating budget.

Role of health department in implementation, planning, and evaluation:

The NDHHS is the sole conceiver and operator of this project.

Accomplishments:

The Van has only been in operation for two weeks. So far the response has been excellent. It has had a high profile in the media and excellent reception within the local communities.

Lessons Learned:

There has been too little time to determine the real success or failure of this activity. As a method of outreach to target pockets of real poverty and need in the city, it should have positive impact.

Norfolk Fatherhood Healthy Start Initiative

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Prenatal care Low birthweight/ infant mortality Teen parenting Reducing transportation barriers Clergy and health connections Schools and health connections Increasing social support	Develop tools standardizing data collection, analysis, reporting Community perceptions of health problems/needs Tracking systems Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Prepare, publish and distribute reports Special studies Development of models Newsletters, convening focus groups, advisory committees, networks Staff training Develop tools standardizing data collection, analysis, reporting Provide outreach services Transportation and other access-enabling services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services Detention settings, foster care, mental health facilities Identify and report access barriers

Funding Sources:
Other Federal funds

Budget: $20,000.00

Description:

The Norfolk Fatherhood Healthy Start Initiative (NFHSI) initially targeted fathers-to-be/fathers of children born to mothers who were followed by two Resource Mothers Programs in Norfolk. It later broadened its target population to include other fathers in the community who were interested, although the priority continued to be the first group. The program includes information and education through a process involving mentoring by the Resource Fathers as well as "rap groups." In the groups, information and educational topics are covered such as pre- and post-natal care, including the fathers role and support of this; relationship building between men and women; anger management; building better relationships with their fathers; growth and development, including need for medical care for children, safety and immunizations as well as nutrition. The participants are encouraged and supported in obtaining their GED, getting jobs, and establishing goals.

Objectives of the activity:

Goals:
1. Getting fathers involved in the lives of their children, especially during prenatal and newborn period.
2. Keeping fathers involved
3. Helping fathers become effective parents and "dads."

Objective: To reach annually, 50 fathers of children (whose mothers are aged 20 to 24 years of age) with priority given to those whose mothers are served by the Resource Mother's Program.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Reaching a very narrow target population. 2. Obtaining referrals from the Resource Mother's Program--many mothers reluctant to get fathers involved.	By one-on-one recruitment by program coordinator at every opportunity-going where young men are.

Role of health department in implementation, planning, and evaluation:

Norfolk Department of Public Health has taken the lead in recruiting and in utilizing creative ways of doing so.

Accomplishments:

1. Successful mentoring of many young men in their learning the importance of the father's role in their children's lives.
2. "The Talking Drum," a radio talk show.
3. Production of a fatherhood play, "The Fifth," having its world premier in San Francisco at the National Center for Strategic Non-Profit Planning and Community Leadership, International Fatherhood Conference.
4. Creation of the 2nd Colored Calvary reenactment troop-a touring troupe consisting exclusively of fathers who recreate this historical African American Civil War Union Army unit.
5. Numerous newspaper articles and media interviews.

Lessons Learned:

1. Value of staff training.
2. Importance of collaboration with other human service agencies.
3. Innovation attracts interest.

WIC MCH Integration in Metro Omaha

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Prenatal care Teen pregnancy One-stop shopping locations Building coalitions and partnerships	Promote compatible, integrated service system initiatives Referral systems, resource directories, advertising, enrollment assistance Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
MCH block grant funds, Other Federal funds

Budget: $0.00

Description:

In July 1998, Title V providers and the WIC Local Agency met to develop a program to reduce duplication and integrate services between these two programs. A facilitated enrollment in WIC through the high-risk maternal care providers program was established. The program uses an integrated data gathering tool to collect baseline demographic information, prenatal medical/nutritional history data, and identifying WIC nutrition risk factors. The data are then shared between the two programs to reduce duplication of client report, medical, demographic, anthropometric and hematological data. Additionally, nutrition and health education messages can be prioritized and reinforced. At the first prenatal visit, baseline information is entered into the data gathering tool, which simultaneously submits the information to the WIC program, thereby facilitating earlier entry into WIC services. Clients referred by this mechanism also experience a shorter and more focused WIC appointment at the client's preferred site. The initial form was modified for use in a second site. In this subsequent modification, the WIC services were incorporated into a second visit at the prenatal provider site.

Objectives of the activity:

Decrease the fragmentation of WIC and prenatal care; Early entry into WIC services; Improved prenatal outcomes relate to improved nutritional status of pregnant women.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Each medical home and population served has a unique level of ability to establish a singular universal model for the two programs (WIC and MCH). 2. The staff's resistance to sharing data and perceptions of an added workload due to the project. 3. Dissimilar definitions of data elements and nutritional risk existed between systems. 4. Duplication of data entry by clerical staff.	1. Initial meetings with decision-makers were held to establish a common vision; meetings with staff were held to develop a useable tool. 2. Using staff not only to review the use of the materials, but also to reinforce the vision of program and address nonparticipation in the program. 3. On-going collaboration with others committed to this integration approach. 4. Involving local agency decision makers and the state WIC director to address questions regarding regulations and capacity.

Role of health department in implementation, planning, and evaluation:

The Health Department housed both the WIC program and the MCH community coordination program. The health department was therefore instrumental in spearheading the initial meetings between these two groups, establishing the models of integration with medical homes, and implementing the program.

Accomplishments:

In the first 12 months of operation, 255 pregnant women enrolled in WIC via this program. 50% of these women were in their first trimester of pregnancy; in the local WIC agency, only 21% of all pregnant women were in their first trimester. Sixty-two percent of the women were seen within two weeks of their initial visit to a medical provider. Anecdotally, the second site is now requiring one less visit to enroll pregnant women into WIC because WIC services are now being offered during initial lab work by provider.

Lessons Learned:

1. One universal procedure is not workable for integration with multiple providers; each integration will be unique due to the unique needs of the medical providers.
2. Completion of the WIC risk data led to more uniform nutrition messages being provided to the women participating in both programs.
3. The opportunity exists to reallocate the use of WIC resources, such as staffing and dollars, in order to integrate nutrition screening and education within institutions that house WIC and medical services.
4. Each step of the program requires time, a flexible approach, and open discussions in order to produce results.

Health Evaluation, Assessment, and Research Studies Division

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Has this activity been formally evaluated?
No – in progress

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Overcoming cultural barriers Expanding private sector links Mobile clinics for outreach Other outreach activities Increasing social support Strategic planning Building coalitions and partnerships Building MCH data capacity	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Assessment of provider reports regarding process and outcomes Prepare, publish and distribute reports Special studies Development of models Newsletters, convening focus groups, advisory committees, networks Develop tools standardizing data collection, analysis, reporting Identify high-risk/hard-to-reach populations and methods to serve them Identify alternative resources to expand systems capacity Profiles of provider attitudes, knowledge and practices Identify and report access barriers

Funding Sources:
City/County/Local government funds

Budget: $270,000.00

Description:

The Health Evaluation, Assessment, and Research Studies Division (HEARS) of the Orange County Health Department is an evaluation and research team that will support County Health Department programs and grant proposals when different needs for research and evaluation are identified. The facility, including a state-of-the-art observation room, has been designed to support the use of focus-group students for the collection of health data. The Department plans to assist other local coalitions and associations by conducting evaluations and public health research.

Objectives of the activity:

The HEARS Division collaborates with local, state, and national partners to devise innovative approaches to assessing and evaluating the effectiveness, accessibility, and quality of public health services. We will accomplish this by using the highest ethical standards to analyze data gathered using proven scientific principles. The division works hand-in-hand with the Orange County Health Department in monitoring key health status indicators in our efforts to identify community health problems.

Barriers encountered in implementation:	Strategies to overcome barriers:
It was difficult finding consistent funding sources to fully realize activities.	We implemented effective grant-seeking and fund-acquisition programs.

Role of health department in implementation, planning, and evaluation:

The Orange County Health Department conceived and established HEARS based on a strategic planning process; HEARS supports internal department goals and objectives.

Accomplishments:

1. We created WIC focus groups to determine clients' opinions of new nutrition self-study modules.
2. We surveyed TB Clinic DOT services.
3. We conducted a statewide survey for the State Department of Health to determine attitudes about the privatization of care.
4. We completed a minority community needs assessment.
5. We conducted a client satisfaction survey for environmental health.
6. Clients are satisfied with the HIV counseling and testing efforts.
7. The immunization programs were evaluated.

Lessons Learned:

Orange County is a richly diverse community. Research, including focus groups, is one of the most effective ways to collaborate with the community, identify strengths and needed programs, and evaluate current programs. To find innovative solutions to health problems, it is important to develop policies and plans that can support individual and community health efforts.

Reduce Infant Mortality/Strategic Planning

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Family planning Low birthweight/ infant mortality Teen pregnancy Expanding private sector links One-stop shopping locations Other outreach activities Staff training Strategic planning Building coalitions and partnerships	Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Provide infrastructure/capacity for MCH functions Staff training Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
City/County/Local government funds, Third party reimbursement (Medicaid, insurance)

Budget: $274,000.00

Description:

Three years ago, in cooperation with the Peoria City/County Health Department (PCCHD) Board of Health, a strategic plan to address infant mortality was undertaken. One of the eight objectives of the plan is to reduce infant mortality to 5/1000 by the year 2006. The first strategy identified to begin to meet this objective was to establish family planning services at PCCHD. Guiding criteria for the program are:

1. We will develop programs and services which benefit the community by enhancing the quality and quantity of human life.
2. We will provide these programs and services through aggressive collaboration with the community and other health care providers and through efficient direct delivery of our services.
3. We will understand the health needs of our community and be dedicated to addressing those needs using our creativity, innovation, and expertise.

Using these criteria, a multidisciplinary team developed the infrastructure for family planning clinics. Two family planning clinics are currently in operation, one in a neighborhood settlement house co-located with a variety of other service providers to families (including Day Care, Immunization, and WIC), and the other at the PCCHD main facility.

Objectives of the activity:

1. To reduce the teen birth rate by 1% per year.
2. To increase the access of STD clinic clients to reproductive health care services.
3. To provide sexual health education and counseling to 100% of the clients accessing Family Planning services.
4. To broaden the skills of public health nurses and social work staff to include the education of adolescents and adults about safe reproductive health practices.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. It was difficult to establish partnerships with clinical providers who share our vision. 2. The tenuous nature of funding staff overtime hours. 3. An ongoing need to establish funding resources was a barrier in project implementation.	1. We built on existing partnerships with the University of Illinois College of Medicine at Peoria and the Methodist Medical Center to provide clinical family planning services at the two sites. 2. We enhanced the skills of public health nurses and social work staff to address the needs of women in high-risk, low income, STD clinic client, and Medicaid groups. 3. We utilized the strategic management process of continuous team learning in the areas of planning/forecasting, implementation, evaluation, and adaptation.

Role of health department in implementation, planning, and evaluation:

PCCHD has been the leader in all aspects of the collaboration. PCCHD served as a lead health department in Illinois to undertake the strategic planning process and manage strategically.

Accomplishments:

1. We established family planning services 12 hours/week at two sites.
2. We developed teaching tools for client education.
3. Staff were trained as a learning team.
4. The first year strategic team reviewed perinatal data and, as a team, recommended that a strategy to reduce infant mortality for the second year of the program would be to reduce smoking in pregnant women.
5. We continued to manage and address our objective to decrease infant mortality through strategic data-driven initiatives.

Lessons Learned:

1. Team learning is essential to individual and organizational growth and success.
2. When trying to enhance the public's health, establishing community partnerships is essential.

Smoking Cessation as an Avenue Toward Collaborative Partnership with Managed Care Organizations

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Prenatal care Expanding maternity services Low birthweight/ infant mortality Substance abuse prevention Early intervention/zero to three Expanding private sector links Increasing social support Case coordination Staff training Reshaping urban MCH Managed care initiatives Building coalitions and partnerships	Develop tools standardizing data collection, analysis, reporting Implement public MCH program client data systems Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Tracking systems Environmental assessments Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Special studies Development of models Promote compatible, integrated service system initiatives Consistent, coordinated policies across programs Certification and monitoring provider compliance Staff training Support of health plans/provider networks Develop tools standardizing data collection, analysis, reporting Identify high-risk/hard-to-reach populations and methods to serve them Managed Care model contracts and access issues Identify alternative resources to expand systems capacity Comparative analysis of HC delivery systems Profiles of provider attitudes, knowledge and practices Identify and report access barriers

Funding Sources:
MCH block grant funds, Other Federal funds, March of Dimes funds

Budget: $80,000.00

Description:

The recent implementation of mandatory Medicaid managed care in the five county Southeast PA region has provided an opportunity to create a smoking cessation collaboration between the Philadelphia Department of Public Health's Office of Maternal and Child Health, managed care organizations, public health officials, and advocacy organizations. This enthusiastic coalition has targeted smoking cessation as an important and cost-effective priority. The coalition meets regularly to develop standards of practice for prenatal smoking cessation interventions, and to strengthen the tracking, reporting, and evaluation systems of the managed care organizations that serve pregnant women.

Objectives of the activity:

The overall objective of the coalition is to reduce high-risk pregnancies and improve birth outcomes by diminishing prenatal smoking. A related objective is to encourage Medicaid managed care organizations to assume greater responsibility for smoking cessation among pregnant women. As leaders in the health care community, Medicaid managed care organizations are in a position to require smoking cessation interventions by all affiliated prenatal providers. Through the collaboration noted above, managed care organizations can:

1. Develop comprehensive policies to help prenatal providers counduct smoking cessation interventions;
2. Develop smoking cessation training and technical assistance programs for providers;
3. Provide prenatal teams with the support of smoking cessation specialists;
4. Modify clinical culture and practice patterns to ensure that every patient who smokes is offered a targeted treatment plan with regular follow-up.

Barriers encountered in implementation:	Strategies to overcome barriers:
Initially, it was a challenge to convince all coalition partners that it was in each of their best interests to unite around the issue of smoking cessation.	Collaboration is fostered through regular communication, relentless optimism, and an unyielding commitment to change.

Role of health department in implementation, planning, and evaluation:

The Philedelphia Department of Public Health initiated the collaboration; the Department of Health is responsible for coordinating this initiative.

Accomplishments:

Through this project, competitive managed care organizations are working together to solve a common problem. Also, joint efforts addressing smoking cessation among pregnant women are an important step towards achieving compliance with federal and state requirements. In addition, the County Health Directors of Bucks, Chester, Montgomery and Philadelphia Counties, as well as State representatives from Delaware county, have work together to improve maternal and child health across the Southeast region of Pennsylvania.

Lessons Learned:

For many organizations, the carrot of cost-effectiveness helps to offset the perceived stick of collaboration.

Well Woman Healthcheck Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Breast/cervical cancer Expanding private sector links Case coordination Building coalitions and partnerships	Culturally appropriate health education materials/programs Public advocacy for legislation and resources Provide outreach services Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services Identify alternative resources to expand systems capacity

Funding Sources:
Other Federal funds, CDC

Budget: $560,425.00

Description:

The Well Woman Healthcheck Program provides breast and cervical screening services to underinsured and uninsured women aged 50 and older whose income levels are at or below 200% of the Federal poverty level. The Well Woman Healthcheck Program monitors the activities of a provider network that is contracted to provide screening and diagnostic services to this population.

It has been established that there is a lower mortality rate among women receiving annual breast and cervical cancer screenings, as well as among women who are diagnosed and treated in the earliest stages of the diseases. Consequently, the program's goals are to detect breast and cervical cancer at the earliest stage possible and to provide follow-up care and appropriate treatment.

If, after a breast and cervical cancer screening, a woman is determined to be in need of further diagnostic procedures and/or treatments, the Well Woman Healthcheck Program attempts to locate the necessary resources for treatment. The provider network is able to conduct many of the diagnostic procedures needed on an outpatient basis. Follow-up for an abnormality is outlined in the clinical guidelines with specific timeframes attached to each procedure. The program relies on charitable trusts and grant funding to assist in the payment of procedures not performed by the provider network.

Objectives of the activity:

The goal of the Well Woman Healthcheck Program is to increase the percentage of women who return for their annual screening appointments to 52%. Through the efforts of the provider network and the County Well Woman Healthcheck staff, women are being educated on the need to keep appointments, follow up with necessary diagnostic procedures, and conduct monthly self-breast exams.

Barriers encountered in implementation:	Strategies to overcome barriers:
The Program received grant funding and began enrolling patients before a treatment network or a community-based coalition were established. As a result, the program does not yet have well-established treatment services for women with abnormal screening results. Most institutions will charge women with the Medicare Allowable for treatment procedures; this cost is often in the thousands of dollars depending upon the procedure needed. Many of the women enrolled in the program are not able to pay that much money and therefore do not obtain the necessary procedures.	The Well Woman Healthcheck Program has developed relationships with local community-based committees and local physicians to assist in the development of a treatment network. The coalition continues work towards expanding the treatment resources available. Coalition members have lobbied for legislation for treatment dollars on both a state and federal level.

Role of health department in implementation, planning, and evaluation:

The Maricopa County Department of Public Health has been involved with the Arizona Department of Health Services and the Centers for Disease Control and Prevention in all aspects of the planning, implementation, and funding efforts of this program since its inception four years ago.

Accomplishments:

1. The program has enrolled 2,185 women to date and continues to recruit women. In 1998, the program provided 1,358 cervical screenings and 1,560 mammograms. The program, in collaboration with the Provider and Treatment Network, has provided 199 cervical diagnostic/treatment procedures and 585 breast diagnostic/treatment procedures over the past four years.
2. Currently, the program has a rescreen rate of 41%. This is slightly lower than our goal of 52%; however, the program has had problems with staff turnover. These problems have since stabilized, and the staff has been focusing on assisting the provider network in achieving a higher rescreening rate.
3. The County Well Woman Healthcheck Program has been awarded treatment funds for the past two years through the Susan G. Komen Foundation. Through this funding, 11 women received treatment for breast abnormalities. The program will apply for continued funding with the Susan G. Komen Foundation for the year 2000.
4. The program staff members have been actively involved with local agencies that support the program's efforts. The staff has placed members in the Arizona Women's Cancer Network and the Arizona Latino Health Advocacy group.

Lessons Learned:

In implementing this program, coordinating between federal, state, and county agencies was difficult. The goals of the program were in place, but consensus on how to proceed was not. In addition, the department was involved with the establishment of another program while implementing the Well Woman Healthcheck Program; this caused a great amount of confusion within the department. As a result of the high confusion and low consensus, recruitment for screening initially became the primary focus of the program.

This focus on recruitment for screening caused the program to, upon its inception, have the ability to diagnose breast and cervical cancer without being able to refer patients with positive test results to a treatment facility. The County, as a result, has had to expend a tremendous amount of effort to develop a local coalition to take on the goal of locating treatment resources.

Another lesson learned related to the fact that the program did not have supervisory responsibility for the lay health workers hired to support the University's Wisewoman Project. Consequently, lay health workers were not trained to deal with the intricacies of the eligibility requirements for the Well Woman Healthcheck Program. The County Health Department has since applied for grant funding to assist the Well Woman Healthcheck Program with outreach workers who will be employed, supervised, and trained by the County.

CPR and First Aid Classes

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Injury (including child abuse) Other outreach activities Increasing social support	Culturally appropriate health education materials/programs Provide outreach services Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
City/County/Local government funds, Private source: a $10 fee for each class

Budget: $0.00

Description:

Through this program, MCH nurses certified in CPR through the American Heart Association and using a First Aid curriculum from the American Heart Association offer low cost infant and child CPR and First Aid classes to low income families. Regularly scheduled classes are offered on the second Thursday of each month from 3:00 pm to 6:00 pm on an alternating basis of CPR one month, and First Aid the next. A $10 fee is charged for classes, but scholarships are available.

Classes have become increasingly popular; some parents with child care issues have even sponsored classes in their homes for friends and neighbors. In addition, the nurses have just recently sought and won approval from the State Child Care Licensing Unit to be authorized to offer CPR and First Aid to child care providers, many of whom are small family daycare homes with little discretionary income.

Objectives of the activity:

1. Low income parents and child care providers will gain knowledge and skills in being able to manage childhood emergencies.
2. CPR participants will learn how to administer infant and child CPR by the end of the class.
3. First Aid participants will learn a least three first aid principles by the end of the class.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Schlepping supplies and equipment to the classes. 2. A prior inability to provide authorized classes to child care providers. 3. The large number of cancellations and no-shows for the classes. 4. Child care issues; i.e., there was no one to watch the kids during class.	1. Equipment and supplies kept on site when possible. 2. We requested and received authorization from the State Child Care Licensing Unit to offer classes to child care providers. 3. We place reminder calls to enrolled participants one day prior to their scheduled class. 4. We utilize creative child care methods – We held "at home" classes that allowed parents to be with their children or share responsibility for child care during the class.

Role of health department in implementation, planning, and evaluation:

This program is a direct service provided by the Health Department. The MCH staff at the Health Department implemented the pre-established curriculum used in the classes. Satisfaction surveys fulfill the evaluation component that guides the planning process.

Accomplishments:

Ten classes have been offered thus far with over 50 parents attending. The critical elements of the project include:
1. The low cost;
2. The non-threatening and low key atmosphere of the classes; and,
3. The "learn with your neighbor" supportive environment.

All of these have been key ingredients in encouraging low-income parents to take advantage of this opportunity. We expect the same will be true of child care providers.

Lessons Learned:

This is a program idea that was generated entirely by the health department's direct service staff and has proven to be both popular and successful. Staff who work directly with clients are in a much better position to hear about the needs of the community. Initiatives like this prove that projects do not have to be elaborate or expensive to work.

Employee Survey: Domestic Violence in Large Health Care Systems

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Has this activity been formally evaluated?

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Family violence Strategic planning Reshaping urban MCH Building coalitions and partnerships	Community perceptions of health problems/needs Prepare, publish and distribute reports Staff training Support of health plans/provider networks Profiles of provider attitudes, knowledge and practices

Funding Sources:
None reported

Budget: $0.00

Description:

In August 1998, the Multnomah County Health Department (MCHD) helped implement a survey of employees regarding domestic violence. Our partners for the survey were the hospitals, health systems, and insurers comprising the Oregon Health Systems in Collaboration (OHSIC): MCHD, Regence Blue Cross, Legacy Health Systems, Oregon Health Sciences University, Oregon Health Division, Providence Health Systems Kaiser Permanente, and the Portland Adventist Medical Center. OHSIC is an ongoing partnership whose purpose is to undertake collaborative projects to promote community health. Its member health systems cover about three-fourths of the population of the Portland Metropolitan Area.

This survey was part of an OHSIC initiative on domestic violence. The initiative focused on institutional policies and procedures, services and supports for employees, and domestic violence screenings and services for patients. The survey was intended to assess the readiness of the institutional partners to undertake more extensive domestic violence interventions for employees and patients. The survey was designed to measure employee knowledge, skills, capacities, beliefs, and personal and professional experience with domestic violence. The survey instrument was designed by representatives of the partners and community advocates, with input and refinement from a professional survey contractor. After a long development period, the survey was finally administered in August 1998. Results became available in November 1998.

Objectives of the activity:

The survey was successful in providing information about health care employees' knowledge, skills, capacities, beliefs, and personal and professional experience with domestic violence. Data concerning all of the organizations, as well as for each individual organization were available.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barrier to implementation was developing an acceptable "corporate" focus. In this activity, there was significant involvement and support from domestic violence advocates both from within OHSIC member organizations, and from the community-at-large. This involvement was a double edged sword. It brought much knowledge and energy to the process, but at the same time created confusion about the mission and goals of the activity. Questions arose about the focus of the activity, its ideological basis, and who was empowered to make decisions. This confusion spread into the design of the questionnaire, and into the survey implementation plan.	Ultimately, this barrier was addressed by rebalancing membership of the implementation group so that corporate interests were adequately represented. This was a delicate task that needed to ensure that the contributions of community partners were honored, and that member organizations' interests and concerns were addressed.

Role of health department in implementation, planning, and evaluation:

MCHD's primary role was to serve as a partner to the coalition developing the survey. In doing so, we provided substantial staff time for questionnaire development. The department was also an equal partner in the implementation process. The department provided leadership that was critical to re-balancing corporate and community interests.

Accomplishments:

1. The survey has raised awareness of domestic violence at all levels in the member organizations. It was particularly successful in raising awareness among the CEOs of these large organizations. It provided an opportunity for domestic violence to become a topic of discussion within the organizations. The CEO of one large private health system was particularly affected by e-mails he received from employees who shared their personal concerns and experiences with domestic violence.
2. The survey provided a baseline to develop employee training on domestic violence.
3. The survey strengthened the organizations' commitment to provide employees and clients service around domestic violence.

Lessons Learned:

It is critical to:
1. Define the nature of the activity, its desired outcomes, and decision-making authorities and processes; and,
2. Provide the staff and leadership resources to keep the process true to its intended goals and desired outcomes. This is particularly important when community activists are invited to be part of the process. Institutional partners must be clear in their expectations for community involvement, especially with regard to sharing decision-making power.

Sunrise Grief and Loss Support Groups

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
School-linked/based services	Implement/support education services for special MCH problems
Violence prevention/at risk	Development of models
Family violence	Provide infrastructure/capacity for MCH functions
Overcoming cultural barriers	Staff training
Reducing transportation barriers	Support of continuing education
Expanding private sector links	Provide outreach services
Clergy and health connections	Transportation and other access-enabling services
Schools and health connections	Identify high-risk/hard-to-reach populations and methods to serve them
Increasing social support	Provide, arrange, administer direct services
Case coordination	Detention settings, foster care, mental health facilities

Funding Sources:
City/County/Local government funds

Budget: $0.00

Description:

In accordance with the written memorandum of understanding, Wake County Human Services (WCHS) has established counseling services for Wake County Public School (WCPS) students from grades K-12 on school sites. The Sunrise Grief and Loss Support Group is a program for children and adolescents whose loved one has died. Sunrise groups are held for 6-8 weeks during school hours, rotating periods so students do not miss the same academic subject each week. The school setting is a familiar and non-threatening place for children to attend groups, and for parents to attend team meetings. Home visits are also possible when guardians lack transportation.

Objectives of the activity:

Sunrise groups offer children and adolescents ways to cope with the loss of a loved one or friend, reducing depressed and rebellious behavior. The group setting ensures an atmosphere of security and warmth vital for students whose lives feel out of control. Grief education validates all grief experiences and feelings. Interventions are age appropriate and enjoyable, including creative games, artwork, videos, and role play. Outcome data is gathered from pre- and post-Reynolds Children/Adolescent Depression Scales (mood), evaluation forms at the completion of the group, grades and suspension records, and reports of behavior in the classroom and at home. With incidents of violence and sudden death increasing in public schools and communities over the past decade, Sunrise groups have filled a need. Evaluation questionnaires distributed over the past two years indicate that the majority of students who have participated in Sunrise groups were glad they had attended, learned that talking about a special person who died can help them heal, and wished that the group would never end.

Barriers encountered in implementation:	Strategies to overcome barriers:
The WCHS School Based Mental Health Team has only 12 members serving 109 Wake County public schools. Team members provide daily coverage for Wake County's Evaluation and Emergency Services. They provide individual, group, and family therapy for children who are clients of WCHS as well as on-site training programs for school and agency staff such as the Substance Abuse program. One member of the School Based Mental Health Team has developed and implemented the Grief and Loss program for Wake County schools. In order for this effort to succeed, a collaborative effort was necessary.	All Sunrise groups are co-facilitated by a school staff support person. The child's needs are discussed weekly with the mental health clinician, and other in-school services may be accessed with permission from the legal guardian. When necessary, the clinical social worker on the School Based Mental Health Team may attend school meetings with the principal, teacher, and parent to advocate for the child. With parental consent, referrals may then be made to other area services if needed. Collaboration with Hospice of Wake County enables a two-way referral process through Hospice's Children's Reflections Program and the WCHS Child Mental Health clinics. For the past five years, the program has offered a training ground for undergraduate and graduate social work and psychology interns. Professional training is offered yearly to staff at WCHS, WCPS, and to other area houses of worship and programs to increase awareness of grief and loss issues. Community volunteers have been recruited to provide services for groups which help promote healing. Senior citizens from make comfort dolls; Project Linus supplies blankets and quilts for all ages; stuffed animals and prizes for games and greeting cards/magazines for collages are donated by churches and neighborhoods.

Role of health department in implementation, planning, and evaluation:

The School Based Mental Health Team is a part of the School Health Department which includes school nursing services under Child and Family Services, located in the Health Department building of WCHS. The Director of School Health has provided some funding for educational materials, supplies, marketing promotions, and educational materials as well as regular supervision for the Team leader and support for staff. The Director has made referrals to the Grief and Loss program, spent time with staff in the field, and has increased awareness at management meetings. Referrals have also been initiated by nurses and physicians working in the public schools and in the county's health clinics. Yearly data for evaluation purposes is submitted to the Director of School Based Services.

Accomplishments:

For the 1999 school year, 47 children and adolescents participated in the Grief and Loss program led by one mental health clinical social worker and co-led by school staff. 69.23% of children and adolescents who participated in the Sunrise groups showed a significant improvement in mood. The Sunrise Grief and Loss Program was presented at the "Advancing Mental Health Services in Schools" conference in Denver, Colorado, September 16-19, 1999. There is also interest at UNC in including this training in the course curriculum for the Spring class entitled "Care of the Dying and Bereaved."

Lessons Learned:

Symptoms of grief in children differ from symptoms in adults are often mistaken by school staff for other disorders (ADHD, clinical depression, even psychosis). Children don't always appear sad or withdrawn and are often viewed as "spoiled" or "aggressive". Death is not a comfortable topic for school staff, but as they gain understanding and onsite training, they are able to facilitate groups themselves and thus improve students' ability to function successfully in school. Education about grief and loss issues has also helped mental health clinicians with differential diagnosis in assessing symptoms to clarify the differences between normal grief reactions and other disorders. Statistics are not easy to obtain, but there is anedcotal evidence that classroom behavior and mood improves in many students this may have reduced suspensions and prevented placement in special education classes.

Family Support After An Infant Loss Home Visit Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Preconception promotion Increasing social support Case coordination	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Culturally appropriate health education materials/programs Special studies Development of models Develop tools standardizing data collection, analysis, reporting Provide outreach services

Funding Sources:
SPRANS funds

Budget: $75,000.00

Description:

The Family Support After an Infant Loss Home Visit Program seeks to reduce infant mortality by providing support and preventive services to families following the death of an infant. The program was developed in response to infant mortality review recommendations which addressed the lack of a universally available bereavement support/follow-up program and the lack of consistent preventive health information that could potentially affect future birth outcomes and infant deaths. This program provides targeted educational interventions to address preconceptual health and other family issues which impact the health and well being of mothers and children. The services are available to all women sustaining the death of an infant up to one year of age.

Objectives of the activity:

1. Utilization/participation rates for the overall program: total number of infant deaths, the number of families participating in the program, and the number of families who received certain services
2. Two specific objectives: seventy percent of women identified through the Family Support Program (FSP) would receive case management and preventive health information from the PHN to reduce risk in subsequent pregnancies, eighty percent of families identified as needing parenting education and support would receive case management to ensure preventive education, and linkage to appropriate resources.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Inability to locate some of the families. 2. The Family Support Program was developed as a PHN home visit program to provide specific services to a specific population. Thus, the progrm is unable to help those not within the target population.	The Maternal Child Health Division responded to requests for service but did not include the cases in the project populations. It would have been helpful to have a plan in place to address such requests before they began to occur.

Role of health department in implementation, planning, and evaluation:

The health department applied for and received the grant for the demonstration project. Development of this program was accomplished through the enhancement and expansion of the health department's SIDS Public Health Nurse Follow-up Program. The program coordinator for this project is the PHN coordinator of the the Infant Mortality Review (IMP) program and the home visiting PHN is an experienced nurse within the agency. The plan for evaluation was developed through contracting with the University of Rochester, Division of Public Health Practice. They will be assisting with the data analysis for the final report of this demonstration project.

Accomplishments:

Identification of cases through receipt of a death certificate or notification through the Medical Examiner. It is a program that reaches out into the community to families, it is not referral dependent. The program has become known to the community. The formation of a support group for parents whose infants have been in the Neonatal Intensive Care Unit. Prior to this, there was no support group specific for NICU parents whose infants did not survive.

Lessons Learned:

A few of the initial protocols were not as successful as originally planned. The plan for establishing contact with women not participating in the program for the purpose of monitoring their status, was more difficult and time consuming than anticipated. Few of the women responded to efforts to contact them by letter or telephone at three month intervals.

Coordination of WIC/Immunization Services

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Immunization One-stop shopping locations Case coordination Staff training Immunization tracking/recall	Promote compatible, integrated service system initiatives Staff training

Funding Sources:
None reported

Budget: $0.00

Description:

Winnebago County Health Department implemented a WIC Immunization Initiative in the Fall of 1998 in order to improve the immunization rates of WIC infants/children clients. WIC nutritionists were in-serviced by Clinical Service RN staff to provide accurate immunization status screenings to every infant/child at their certification/rectification WIC visit. RN Health Department staff from across multiple programs located at the WIC clinic sites have begun providing immunization services during WIC clinic hours to increase availability/accessibility of immunizations. WIC nutritionists offer the option to clients not up-to-date with immunizations to receive one month of food coupons vs. the usual three, receiving the balance when they return with their up-to-date shot record or are referred directly to an RN performing immunizations on the spot.

Objectives of the activity:

1. Increase WIC client accessibility to immunization services by providing immunizations in WIC clinics at four health department sites.
2. Assess immunization status of all infant/child WIC clients at recent visits.
3. Improve active WIC client up-to-date immunization rate from 42% to 90% by 2000.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Health department, specifically Clinical Services Division, lacking staff and funding to increase immunization schedule and coverage. 2. Many WIC staff lacked training to assess clients immunization status. 3. WIC clients lacked incentive to provide WIC with immunization records and/or has accessibility issues with immunization services. 4. No internal audit being conducted as to WIC client immunization rates.	1. Utilized existing RN's in other health department programs to provide immunizations during WIC clinic hours. 2. Provided training to WIC nutritionists as to current immunization schedule. 3. Developed/implemented new WIC policy to give out one month food coupons if client not up-to-date with immunization. 4. Developed QA protocol requiring monthly auditing of all WIC infant/child clients immunization records to determine a) immunization status b) if new policy being followed.

Role of health department in implementation, planning, and evaluation:

Health department supervisors responded to the low immunization rates noted in our annual program audit and initiated a collaborative effort across program lines within the health department bringing together WIC, Family Case Management, Health Works, Family Planning and Pediatric program staff. The health department planned, developed, and implemented this effort, and will also evaluate the success rate.

Accomplishments:

Immunization services are now available during all or some WIC clinic hours at three of the four health department sites. All infant/child WIC clients have their immunization status reviewed at every certification/rectification visit. Of the WIC clients not up-to-date, 90% are receiving one month food coupons per the new policy. Immunization clinic schedules are available to clients/handed out a every WIC visit. Immunization rates for clients keeping their WIC appointments is increasing.

Lessons Learned:

Cross training/utilization of staff can be effective in providing broader array of services without increase funding. Collaboration across health department programs can assist in more effectively achieving improved health outcomes.

Safe Gun Storage Campaign

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Has this activity been formally evaluated?
No

Has this activity been replicated?

Essential MCH Functions:	MCH Initiatives:
Injury (including child abuse) Violence prevention/at risk Family violence Other outreach activities Reshaping urban MCH Building coalitions and partnerships	Community perceptions of health problems/needs Environmental assessments Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Public advocacy for legislation and resources Promote compatible, integrated service system initiatives Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services Identify alternative resources to expand systems capacity

Funding Sources:
City/County/Local government funds, Private source: a private donation of $25,000, Joyce Foundation Grant

Budget: $45,000.00

Description:

The "Safe Gun Storage Campaign" is a prevention-oriented, education-based public health program that started in December, 1998. It was initiated by a Saint Paul city council member who wanted to address recent injuries and deaths caused by accidents with guns, and a private citizen who donated $25,000 to the program. Principal partners in the campaign include the Gun Violence Action Team in Ramsey County, St. Paul Children's Hospital, Regions Hospital, the St. Paul-Ramsey County Department of Public Health, the St. Paul Police Department, the St. Paul City Council, and the Ramsey County Board of Commissioners.

Objectives of the activity:

Goal: To decrease the number of injuries and death due to firearms in St. Paul-Ramsey County.

Objectives:
1. To provide, free of charge and with no questions asked, gun locks and education on safe gun storage for St. Paul-Ramsey County residents.
2. To develop effective educational materials for the entire St. Paul-Ramsey County population, including Southeast Asian, African American, and Latino/Hispanic residents.
3. To seek funding to help support the efforts of the campaign.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Political issues, such as the constitutional right to bear arms, have always been impediments to developing gun-related programs. 2. Financial resources are needed to maintain the program and to implement a desired expansion to suburban Ramsey County. 3. Keeping a "non-judgmental" attitude is required in order to prevent our message from getting lost in the heat of emotions about forearms. 4. Because we don't ask names, obtaining direct evaluation of the program is difficult.	1. Providing gun locks and education to bridge the gap. 2. We are seeking out additional funding to provide educational materials and gun locks. 3. We approach participants in a non-judgemental manner. We thank them for protecting both their families and their community by practicing safe gun storage in their homes.

Role of health department in implementation, planning, and evaluation:

1. The Public Health department saw this campaign as an opportunity to expand its already successful Home Safety Assessment/Educational Program. We had previously donated locks for cupboards to keep children away from poisons, so our idea was to lock up the guns too. As part of the initial planning/implementation team, Public Health brought its model of Primary Prevention, sharing those ideas with other community partners and sharing resources and staff.
2. The "non-judgmental" proactive approach of the Project is a part of the Public Health model.
3. As a coordinating team member, the Public Health Department helps to assess, implement, and evaluate the program.

Accomplishments:

1. After six months, over 2,600 locks were distributed (about 70% of our initial number).
2. The City of St. Paul, Ramsey County, local private hospitals, private businesses, and local citizens all came together to work on this campaign.
3. A new "door handle" type flyer was developed with input from the Director of the Thomas/Dale Block Club. Within a three week period, approximately 2,000 of the 4,000 fliers had been distributed to community residents.
4. An evaluation was developed to be mailed to the participating 12 organizations.

Lessons Learned:

1. Collaboration with our partners has been both exciting and challenging.
2. Outcomes may be difficult to measure because a "no questions asked" approach was used. To evaluate the Project, we will look at numbers of locks given out and the responses from the distributing organizations. In the long term, we can look at injuries and deaths related to firearms.
3. Finding a "common ground" using
4. a non-judgmental, educational support program with free distribution of materials seems to have taken us past many traditional barriers surrounding the prevention of gun violence.

Enhancing Healthy Start Services through Consumer Involvement

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Overcoming cultural barriers Strategic planning Building coalitions and partnerships	Community perceptions of health problems/needs Culturally appropriate health education materials/programs Promote compatible, integrated service system initiatives Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
Federal Healthy Start Initiatives, HRSA Funding

Budget: $62,130.00

Description:

The Pinellas County Health Department and collaborating community partners of the St. Petersburg Healthy Start Federal Project, starting in September, 1999, will be participating in their third year of an exciting four-year grant from the U.S. Department of Health and Human Services. As part of the grant requirements from the Division of Perinatal Health Systems, each Healthy Start Initiative project site reports on a set of common national performance indicators and data tables. One of the indicators for the nation is to increase the degree of consumer participation on programs and policy directions for the Healthy Start Initiatives.

The State of Florida created Healthy Start Coalitions across the State around the same time that Federal Healthy Start sites were being created in 1991. Since becoming a site, the Healthy Start Coalition of Pinellas County has learned how to enhance service delivery and build community partnerships through consumer participation. The Coalition was offered extensive technical assistance through mentoring conferences and open houses in Pittsburgh, Boston, and Baltimore. These conferences also provided the Coalition with the opportunity to network with others throughout the country who have been successful in their efforts.

During the first year of the grant, consumers who consistently participated in Consortium-related activities represented 8% of the active consortium membership. During the second year, a new Consumer Advisory Committee was created within the project area. Using the lessons learned from other project sites, this committee now has 54 consumers who have joined the committee. The number of consumers who consistently participate in Consortium-related activities has increased to 19.5% of the active Coalition membership.

Objectives of the activity:

The goal of the St. Petersburg Healthy Start Federal Project and the local Healthy Start Coalition is to enhance the degree of consumer participation in identifying program and policy direction for the local Healthy Start community. Five characteristics of consumer participation in Healthy Start Coalition activities were defined. These characteristics include: the average percentage of consumers over the total participation in Healthy Start Coalition meetings, advisory committees, and task forces; how the average racial distribution of consumers who consistently participate in Coalition activities is representative of the diverse cultures in the project area; the percentage of consumers who consistently participate in Coalition related activities (consumers who attend three or more meetings or other activities during the reporting period); the percentage of consumer members who participate in leadership positions on the Coalition; and, the percentage of decisions made by the Project and/or Coalition that have been affected by consumer feedback.

Barriers encountered in implementation:	Strategies to overcome barriers:
Initial efforts to obtain consumer participation included holding meetings in the evening, rotating meeting locations throughout the county and project area, and providing child care and transportation for participants. Despite these measures, obtaining consistent and continuing involvement remained a problem. The formality of the board and committee meetings somewhat frightened consumer participants, and as a result those who did participate had higher education or professional involvement in the community. These participants were not from the desired demographic; the Healthy Start Initiative clearly defines a consumer as a current Healthy Start participant, who is either pregnant or caring for a child less than one year old.	Based on the lessons learned through mentoring existing sites who had been successful in involving consumers, the Coalition planned its first Consumer Advisory Committee meeting within the project area as a "Holiday Celebration." The celebraton was scheduled several weeks before Christmas at a neighborhood center known to the majority of the project participants. Care Coordination staff were asked to attend and bring at least two participating families. Food and child care were provided. In addition to listening to several well known community speakers, the guests were asked to complete a survey regarding their interests and priorities concerning Healthy Start. Door prizes and incentives for participation were given. Over 54 Healthy Start participants, 70 children, and 73 community representatives, board members, and staff members attended. The Holiday Celebration was a great kickoff to regular monthly meetings.

Role of health department in implementation, planning, and evaluation:

The St. Petersburg Healthy Start Project received a performance supplemental award of new one-time-only funding for year two of the grant. The grant's Collaborative Management Team, and the Pinellas County Health Department as the grantee agency, allocated $62,130 to begin this Consumer Advisory Committee. A part-time program assistant and funding for transportation, childcare, incentives, Healthy Start promotional gift items, speakers, office supplies, and food was provided.

Accomplishments:

The "Holiday Celebration" in December was probably one of the most effective methods for recruiting consumers to be involved in Healthy Start Coalition activities. Since the committee was started, the number of consumers and community residents attending the monthly meetings has averaged 22 per meeting. Consumers identified issues thought to be barriers to positive birth outcomes in the target area, set priorities on these issues, and identified strategies to help reduce the number of poor birth outcomes in their community.

The top priority identified in the monthly meetings was obtaining "safe, low-income housing." The participants asked that a panel comprised of housing personnel be convened to discuss some of their issues. It is the goal of the Consumer Advisory Coordinator to continue to empower the group by educating participants on a variety of topics.

Lessons Learned:

Even coalitions made up of concerned community members need consumers to share community needs and concerns. The consumer's motivation to be involved depends upon their desire to help in addition to their consumer's ability to travel and find childcare. It is the challenge of the Coalition to build upon their new understandings of consumers and plan more appropriate interventions for the community.

University/Health Department Prenatal and Pediatric Clinic Collaboration

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Prenatal care Expanding maternity services Low birthweight/ infant mortality Breastfeeding/nutrition/WIC Overcoming cultural barriers One-stop shopping locations Increasing access to Medicaid Building coalitions and partnerships	Culturally appropriate health education materials/programs Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
City/County/Local government funds, MCH block grant funds

Budget: $2,000,000.00

Description:

The South Main Clinic is a collaborative effort between the Salt Lake City-County Health Department and the University of Utah School of Medicine. The purpose of this clinic is to provide increased access to prenatal care and pediatric care to the uninsured and underinsured populations.

Objectives of the activity:

1. To increase the percentage of women coming in for early prenatal care.
2. To increase and improve the Health Department's processes to insure that 90% of pediatric clients are routinely screened for Medicaid eligibility.
3. To increase the immunization rates in clinic children to 90%.
4. To identify the barriers which prevent women from receiving early prenatal care.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. The clinic has rapidly outgrown the current facility. There are more requests for appointments than can be easily accommodated. 2. The client population is 77% Hispanic. 3. County government and the data/financial system have been challenges.	1. The facility was used more efficiently; we employed adjusted time scheduling and provided Saturday appointments. 2. Spanish speaking staff from other areas of the Health Department were reassigned to the clinic. Hiring and recruiting practices were changed to reflect the population served by the clinic. In addition, cultural sensitivity classes were provided to staff. 3. The data systems have not been linked and this continues to be a challenge.

Role of health department in implementation, planning, and evaluation:

The Health Department recruited the University of Utah to enter into this collaborative effort to provide prenatal and pediatric services to the uninsured population. The Health Department provides the resources, staff, and supplies for the clinic; the University supplies medical care and oversight, and utilizes the clinic as a teaching site for medical residents. The Health Department evaluates this activity through surveys and quality assurance audits.

Accomplishments:

In 1998, the clinic had a total of 4,921 visits. The clinic serves approximately 550 uninsured and primarily Hispanic prenatal women each year. Many of these women are from a high-risk population.

522 children were served in the pediatric clinic during 1998. Largely due to the availability of health department "wrap around" services, the immunization rate for children attending this pediatric clinic is 90%.

Lessons Learned:

There seems to be a higher demand for services than the existing agencies are capable of providing. Maintaining good communication at all levels is very important to the success of the project.

Comenzando Bien Prenatal Education Program

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Preconception promotion Prenatal care Overcoming cultural barriers Clergy and health connections Other outreach activities Staff training Building coalitions and partnerships	Community perceptions of health problems/needs Culturally appropriate health education materials/programs Provide infrastructure/capacity for MCH functions Staff training Provide outreach services Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
MCH block grant funds, Private source: March of Dimes

Budget: $14,000.00

Description:

The Comenzando Bien Prenatal Education Program is a public-private partnership with the South Texas Chapter of the March of Dimes-Birth Defects Foundation. The goal of this program is to link women and their children with community, family, and health services.

Specifically, the San Antonio Metropolitan Health District's Comenzado Bien ("getting a good start") Prenatal Education Program addresses the critical needs of pregnant, low to moderate-income Hispanic women. Due to cultural practices, low educational attainment, low income levels, and a limited access to health services, Hispanic women in the program's target area have a high risk for poor maternity outcomes. Commenzando Bien reaches out to these women and provides a prenatal health education program specifically designed to connect with their social and cultural realities. The program acquaints pregnant Hispanic women, in terms familiar to them, with issues such as the importance of receiving early prenatal care, the danger of using home remedies and exchanging prescription drugs, and how to deal with a changing body, inter-personal relationships, and the stress associated with pregnancy.

The program consists of eight 1.5 hour sessions. The classes are held once a week at easily accessible locations throughout the city. Incentives, including new children's clothes, loaned child car seats, bicycle helmets, and other items, are distributed at the end of each program to the participants. Healthy snacks and a baby sitter are provided at the classes. Upon completion of the program, a certificate is awarded.

Objectives of the activity:

1. To inform and educate families about maternal and child health issues.
2. To mobilize community partnerships between policymakers, health care providers, families, the general public, and others in order to identify and solve maternal and child health problems.
3. To link women, children, and youth to health and other community and family services, and to assure that access to comprehensive, quality systems of care is available.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. The location of health education classes and the atmoshpere of the classroom were problems. 2. There were language barriers between the target population and health department staff; the literacy level of the target population was also a problem.	1. We provide an informal atmosphere, structured as friendly chats (or in Spanish, "platicas"). The program does not require participants to read books, take notes, or take tests. We provide participants with heavily illustrated brochures which are written at an appropriate reading level. 2. We hold the program at churches, libraries, and other locations within the community in order to provide easy access to the program. 3. At the meetings, we provide child care and healthy snacks for participants. 4. Upon completion of the program, we reward participants with a certificate of completion.

Role of health department in implementation, planning, and evaluation:

The curriculum for the eight-week Commenzando Bien program was developed by the March of Dimes. The SAMHD staff, who are trained to teach the curriculum by the March of Dimes, are responsible for promoting the program, recruiting participants, organizing the classes, providing additional training to trainers, teaching the classes, providing support services, and obtaining incentives used to encourage regular participation.

Accomplishments:

1. We are collaborating with community partners, including the March of Dimes and community churches.
2. This program is an effective vehicle for strengthening and extending linkages with community agencies.
3. Approximately 200 participants have graduated from the program.

Lessons Learned:

Health promotion starts within the community, and each community has its own culture. Informal "platicas" are an excellent vehicle to effectively teach prenatal and preconception topics.

Public Health Strategic Planning

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Staff training Strategic planning	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Provide infrastructure/capacity for MCH functions Staff training Develop tools standardizing data collection, analysis, reporting

Funding Sources:
Staff time

Budget: $500.00

Description:

Over the course of the past four years, the local health department has initiated a strategic planning process that identifies the department's vision and goals, specifies existing statutory mandates, determines priorities in the allocation of discretionary resources, identifies the current local status for key health indicators as well as other available benchmarks, and develops local objectives to assist the community in progressing towards the achievement of its vision – to make Orange County the "healthiest place on earth."

Objectives of the activity:

The objectives of the Public Health strategic planning process were to provide the Health Department with several important tools: a roadmap to utilize in developing the health department's budget, a framework for educating the community about the importance of Public Health, and objective criteria to be used to assess the performance of the health department.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barrier to the project was the large time commitment required of staff members to implement the project. The initial planning efforts involved the top leadership of the local health department and consumed an estimated 50 hours for each manager during the first three months. A four-hour "Vision, Missions and Goals" workshop, attended by all of the department's nearly 1,300 employees, consumed an estimated 1,200 management and supervisory hours plus 5,200 staff hours.	The top leadership of the local health department made a personal commitment to this effort and provided other managers, supervisors, and line staff with an example indicating that this effort was important. The department's managers and supervisors participated in an overview workshop and were responsible for developing the "Vision, Mission, and Goals" workshop which was the vehicle by which we conveyed imformation about the strategic planning program to all Public Health staff.

Role of health department in implementation, planning, and evaluation:

This strategic planning process was initiated by the local health department; health department leaders were responsible for implementating and sustaining these efforts.

Accomplishments:

The local health department in Orange County now has an explicit vision, a clear understanding of its role in the community, a mission statement, specific goals, and an understanding by each member of the staff of how he or she can make a direct contribution to the overall success of the organization and the achievement of its goals and objectives.

Lessons Learned:

The organization learned many lessons form this process. First, we learned the value of allowing staff at all levels of the organization to contribute to the organization's success by taking personal responsibility. Once staff members understood and agreed with the department's goals, they were empowered to apply creative and innovative problem-solving strategies. We validated the old adage, "If you don't know where you are going, any road will take you there." We also demonstrated that, "If you know where you are going, many roads will take you there." The latter has been proven time and time again when we involved the staff in looking for opportunities to make Orange County the "Healthiest Place on Earth."

Promoting Positive Images of Breastfeeding

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Breastfeeding/nutrition/WIC	Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Newsletters, convening focus groups, advisory committees, networks

Funding Sources:

City/County/Local government funds, Private source: special discount rates for film developing, donations from breast pump company and hospitals

Budget: $1,500.00

Description:

In preparing a five year MCH Plan, the Health Department and community members chose breastfeeding as one of twenty important health issues. In response to this, members held focus groups with mothers and lactation specialists to learn more about strategies to encourage breastfeeding. One strong message was that positive images of women successfully breastfeeding needed to be available in the public eye. These images would demonstrate community support for breastfeeding and illustrate the importance of breastfeeding children up through toddlerhood.

As a follow-up to this suggested strategy, several agencies sponsored a photo contest of positive breastfeeding images focusing on three categories: the family, the workplace, and toddlers. $100 gift certificates were awarded in each category to the winning mother and the photographer. Three sets of standing photo board displays were purchased and filled with the winning and other pictures. In addition, health messages and resource materials in English and Spanish were incorporated into the displays. The displays were placed in three different community settings (Board of Supervisors, Medi-Cal Office, and Wednesday Night Fair) and are scheduled to move to new locations monthly for six months. Surveys are placed at each site to measure attitudes and responses and will be tallied by gender, age, and site.

Objectives of the activity:

Goal: To provide access to prenatal care and improve the public image regarding breastfeeding.

Objectives:
1. During 5/99-1/00, to involve participants across the county who can contribute expertise, energy or funding to further our goal.
2. By 6/1/99, to structure a county-wide photograph contest to display positive images of breastfeeding.
3. Starting 8/1/99, to plan numerous exhibits strategically placed throughout the county to display the positive breastfeeding images.

Barriers encountered in implementation:	Strategies to overcome barriers:
An initial request was made for placement of the display at the Board of Supervisors to coincide with the start of Breastfeeding Week. Following this, we experienced a subtle, but strong, resistance to placing the pictures in public. Questions arose about whether or not the pictures would be offensive. For example, we received one statement that "not everyone has the same political beliefs about breastfeeding." An attorney was even brought in to research whether or not these pictures could legally be placed in a governmental building. This resistance took many other forms as well, such as delay tactics and the attempt to equate breastfeeding photos with sexual images.	The resistant parties were shown a California law stating that women have the right to breastfeed in public; therefore, public pictures of breasfeeding are also legal. Second, the Chair of the Board of Supervisors requested to serve as a judge for the photo contest, this support from an important community leader helped. Lastly, the subject of breastfeeding was introduced as a health behavior, not a political or sexual behavior. It was stressed that women have had the right to breastfeed for centuries, and that a return to breastfeeding as the norm would highly benefit both mothers and babies.

Role of health department in implementation, planning, and evaluation:

The Health Department led the effort to developing the five year plan for this project. The health department also set up and convened the focus groups regarding breastfeeding. Upon the recommendation of mothers and lactation specialists to hold a photo contest, the health department convened a short term (three months) task force to design, advertise, and hold the contest and to organize the placement of the photos and educational messages at various settings throughout the community. The health department provided logistics for the project such as keeping minutes of the meetings, creating the lay-out for the educational resources, and printing the materials. The department used donations and MCH funds to purchase the display boards and gift certificates for the winners. We also made the presentation to the Board of Supervisors and will tally all survey results from each display location.

Accomplishments:

The dialogue that was set in motion within the community about breastfeeding has been very valuable. The displays evoke a response and have caused many people to examine their own knowledge level about breastfeeding and the subtle reasons why they have difficulty seeing breastfeeding as a healthy behavior.

Lessons Learned:

Be well informed about the political, legal, and social ramifications of an issue and don't be afraid to hear disparate opinions.

Medicaid Outreach

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Has this activity been formally evaluated?
No

Has this activity been replicated?

Essential MCH Functions:	MCH Initiatives:
Other outreach activities Increasing access to Medicaid	Referral systems, resource directories, advertising, enrollment assistance

Funding Sources:
Private source: Robert Wood Johnson Foundation grant, Other Federal funds

Budget: $2,100,000.00

Description:

Building on existing Medicaid enrollment activities, the department is coordinating county-wide outreach activities to reach families with uninsured children to enroll those who are eligible in Medicaid, CHIP, and Washington Basic Health Plan, our state's health insurance for low-income people. The department is contracting with several community based agencies to conduct outreach to families and children not being reached through other enrollment activities, including: homeless and/or drug involved youth, homeless families and children, families in low-income areas, and potentially eligible people who are employed by small businesses.

Objectives of the activity:

The objectives of these outreach activities are to: increase access to health care by increasing the number of uninsured children applying for Medicaid and/or CHIP, increasing the number of Medicaid eligible children enrolled in Medicaid, increase the number of uninsured children enrolled in CHIP, and link those children to a health care provider. Each strategy has enrollment goals which vary depending on the target population.

Barriers encountered in implementation:	Strategies to overcome barriers:
Families experience a number of barriers to Medicaid enrollment, the most common of which are: complexity of the enrollment system, fear of immigration consequences, distrust, lack of awareness of eligibility, lack of awareness of how to use the managed care system, and lack of assistance in languages other than English. A further barrier actually relates to people remaining on Medicaid: in our state, many families that exit TANF are not told of their continued eligibility for Medicaid, and their Medicaid coverage is terminated.	Termination from Medicaid at the time of TANF exit is being addressed on a number of fronts, including: 1. Outreach workers inform families of their continued eligibility, and advocate for either another application for Medicaid, or for reinstating the family into Medicaid. 2. Advocates involved in the Medicaid Outreach project are advocating for individual clients and for system change so that families don't continue to get terminated from Medicaid coverage. 3. Most encouraging, the state Medical Assistance Administration is taking steps to educate their staff to continue families' Medicaid coverage. Language barriers are being addressed by hiring outreach workers who speak the languages of people most in need. Enrollment system complexity is addressed by outreach workers educating families how to navigate the system. We continue to advocate our state to simplify the process. People's fears of immigration consequences will be assuaged with the new INS guidance on "public charge."

Role of health department in implementation, planning, and evaluation:

The health department has been involved in Medicaid outreach for a number of years and initiated the development of a network of agencies to apply for the TANF outreach funds and to coordinate with other outreach efforts. A health department collaboration with hospital systems led to their decision to focus on and fund Medicaid enrollment activities and public health staff continue to play an active roll in the governance of that activity. All of the funding for these activities is channeled through the health department to claim Medicaid Administrative Match and we implement all of the contracts. Further, our department has developed a Client Activities Tracking System to track the outreach activities which are being conducted throughout the county. We maintain the data system, provide continuous training about how to provide the data, and provide periodic reports from the data. In addition, we are modifying the system to allow outreach workers to enter their own data via the Internet and produce reports for their own agency's planning purposes.

Accomplishments:

Twenty agencies are working together cooperatively, using the same message and materials, to reach uninsured children across the community through an agreed-upon series of strategies. This was very hard to accomplish, but is resulting in the whole being greater than the sum of its parts. Data is being gathered about barriers and strategies as well as numbers of people served. Approximately 2,731 individuals have been assisted with applications from October 1998, to June 1999, with 455 families receiving approval.

Lessons Learned:

Most of the families are eligible for Medicaid. We have found very few who will need CHIP. Because of the level of distrust in the hardest to reach families, outreach through trusted advocates produces the best results. It takes many contacts to yield an application. It may take contacts by many including mass media, to reach those who are hardest to reach. It would probably be cheaper to declare victory-say every child is eligible for health insurance- and focus our efforts on getting them into health care where they could then be enrolled. Providing insurance to those few who are not eligible for either Medicaid or CHIP would probably be cheaper than trying to convince families who are not seeking health care that they should apply for insurance.

Access to Baby and Child Dentistry (ABCD Program)

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Early intervention/zero to three EPSDT/screenings Expanded child health services Dental programs Overcoming cultural barriers Expanding private sector links Other outreach activities Staff training Strategic planning Securing MCH Assistance Building coalitions and partnerships Building MCH data capacity	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Implement/support education services for special MCH problems Develop and promote MCH agenda and YR 2000 National Objectives Provide outreach services Identify high-risk/hard-to-reach populations and methods to serve them

Funding Sources:
City/County/Local government funds, Administrative match funds

Budget: $121,223.00

Description:

The MCH population in Spokane has been drastically affected by a lack of access to oral health care. The goal of this program is to provide this population with access to routine diagnosis and treatment of dental problems and also to increase the awareness of preventive measures among the MCH population. In addition, the program hopes to decrease barriers to dental care and reduce the amount of dental disease and tooth loss.

In February, 1995, the ABCD Program began enrolling children. The program was designed to increase dental care access to children aged 0-4 who live in Spokane County and receive medical assistance coupons. Children enter the program at any time prior to their fourth birthday and remain in the project until their sixth birthday. The University of Washington and the SRHD are currently conducting focus group sessions with the ABCD caregivers to determine their perception of the ABCD program. A postcard reminder system is being studied as a method to enhance participation of the caregivers for routine oral health care.

Objectives of the activity:

Specific goals of the ABCD program are: to improve provider/client relationships, reduce the occurance of oral disease, increase the practice of healthy dental habits, increase family support for good dental hygeine, improve the dental health status of MCH children in Spokane, and increase consumer satisfaction with their dental care. Measurable projections of the program have been to recruit 1,000 clients for the program by July 1, 1995, and 5,000 by December 31, 1995. To date, the ABCD program has over 10,000 children enrolled.

Barriers encountered in implementation:	Strategies to overcome barriers:
A University of Washington study conducted in February of 1994 concluded that children living in poverty are far more likely to suffer from poor dental health than their more advantaged peers. For a variety of reasons, including transportation issues, cultual factors, parental fears of dentists, a lack of knowledge regarding dental care, and the overwhelming number of children needing care, fewer than 15% of Medicaid children are seen by a dental professional before they reach the age of three. The ABCD Demonstration program was developed and implemented in an effort to reduce these barriers to dental care.	After the caregivers are provided with a one-on-one dental session, they may choose a participating ABCD dentist. In order to increase the disparity in care experienced by MCH children, the program allows frequent visits to the dentist and the use of treatments previously not covered by Medicaid. As part of the project, care givers are given education on the importance of good oral health care. Topics include how to help their child/children to be cooperative patients, how to make and keep appointments, appropriate dental protocol, ways for caregivers to avoid transferring their own dental fears to their children, and other health education information.

Role of health department in implementation, planning, and evaluation:

The health department's involvement in this project includes hiring the needed staff for the program. They developed the implementation manual for the program which contains marketing and recruitment strategies, an orientation outline, various forms, client/provider conflict resolution guidelines, referral process guidelines, and a list of participating dentists.

The health department also provides outreach services for the program, and is developing and implementing an outreach service plan targeting dental providers, community agencies, the media, and potential clients. Additionally, the health department is responsible for orienting new clients to the ABCD program; conducting client orientation sessions at convenient times and locations within the community.

The health department also provides client and provider linkage and referral services and is developing a process to assess client and provider satisfaction, and serves as the "intervener of last resort" for resolving clients' problems with access to dental care. Finally, the health department fulfills the data requirements for this program by assuring completion of client surveys, submiting program reports, and maintaining the client database and tracking system.

Accomplishments:

The Health District uses various strategies to assure community involvement in the planning process for this program. Oral health issues are continually integrated into surveys or assessments being conducted in the community by the Health District Assessment Center, parent and dentist focus groups are conducted at various intervals, and the dental/oral health program is included in all health fairs, appropriate forums, and coalitions. ABCD Steering Committee meetings are held regularly, allowing for an exchange of ideas and planning strategies.

The ability to replicate and sustain the program are also major accomplishments. Recently, the ABCD program was recently awarded the most creative and innovative project within the MCH population by the National Association of City and County Officials.

Lessons Learned:

The ABCD program addresses the lack of oral health among the low-income and disadvantaged populations utilizing a collaborative, multifaceted approach with strong educational, assessment, and research components. The public health department, social services, local dental providers, and state and local dental associations have all participated in this program to develop life-long practices for optimal oral health among the MCH population. One lesson learned was the importance of the educational process. After four years, there were still differences cited by the dentists and the ABCD participants regarding dental protocol. The Spokane Regional Health District (SRHD) is conducting visits to all dental offices and producing a quarterly newsletter to those participating offices to enhance communication.

Lead Poisoning/Special Project

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Lead poisoning	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Prepare, publish and distribute reports Develop tools standardizing data collection, analysis, reporting Provide outreach services Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
None reported

Budget: $0.00

Description:

San Joaquin County (SJC) in California is known for its diverse multi-ethnic and multi-cultural population. Four Southeast Asian groups (Cambodian, Vietnamese, Laotian, and Hmong) live in the county. Slightly more than 23% of the county's total population is Hispanic; many of these families are emigrants from Mexico.

Frequently, when children are identified as lead burdened, their primary exposure is from lead paint in older houses. Our lead program staff often identified products utilized by certain cultural and ethnic groups as sources of exposure. The SJC Childhood Lead Poisoning Prevention Program in the Public Health Department was selected to implement a project to assess the relationship between cultural practices and lead poisoning in San Joaquin County.

Objectives of the activity:

To establish whether certain cultural practices can indicate lead poisoning in children by:
1. Developing a screening questionnaire.
2. Giving blood tests to at-risk WIC clients, ages six months to five years.
3. Cross referencing blood test results and questionnaire results.
4. Analyzing the findings and developing detailed reports on the methodology, findings, implications, and results of the Program; submitting results to the California Lead Poisoning Prevention Program to educate the community about links between lead poisoning and certain cultural practices.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Not being able to hire culturally and language appropriate staff for each ethnic group due to limited funding. 2. Set cultural beliefs, values and practices among the target populations.	1. Sharing staff with other programs and hireing part-time workers. 2. Strong cultural beliefs, values and practices are frustrating, but with patience and persistence, as well as adequate interpreters, they can be overcome.

Role of health department in implementation, planning, and evaluation:

The Public Health Department played a strong leadership role in the promotion of screening, identification, case management, and lead posoning prevention activities among children and families in the target populations. As a result of program staff efforts, a number of newspaper articles were generated to educate the community about lead poisoning and encourage lead poisoning screening.

Accomplishments:

1. Developing a culturally appropriate questionnaire and translating it into a variety of languages.
2. Hireing and training staff.
3. Assigning staff to the two WIC sites that are most likely to serve at-risk children to reduce the risk of mortality due to lead poisoning.
4. Visiting a high volume CHDP to encourage their participation and support.
5. Creating Su Salud, a community-wide education, screening, and referral resource to reach the Hispanic population.
6. Receiving positive feedback at an early stage.

Lessons Learned:

Most of the current tools to screen for lead poisoning are inadequate in assessing cultural practices. Many providers are only vaguely aware of the potential harm associated with lead poisoning. Families are also unaware of the risks and consequences related to their cultural practices, and are often unwilling to give them up.

Syracuse Healthy Start Risk Reduction Model

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Has this activity been formally evaluated?

Has this activity been replicated?

Essential MCH Functions:	MCH Initiatives:
Family planning	Develop tools standardizing data collection, analysis, reporting
Prenatal care	Implement public MCH program client data systems
Home visiting	Analysis of demographics, economic status, behaviors, health status
Substance abuse prevention	Community perceptions of health problems/needs
Breastfeeding/nutrition/WIC	Tracking systems
Children with special needs	Maternal, fetal/infant, child death reviews
Violence prevention/at risk	Hotlines, print materials, media campaigns
Teen pregnancy	Culturally appropriate health education materials/programs
Teen parenting	Implement/support education services for special MCH problems
Communicable diseases	Assessment of provider reports regarding process and outcomes
Family violence	Prepare, publish and distribute reports
Overcoming cultural barriers	Public advocacy for legislation and resources
Reducing transportation barriers	Newsletters, convening focus groups, advisory committees, networks
Expanding private sector links	Promote compatible, integrated service system initiatives
Clergy and health connections	Consistent, coordinated policies across programs
Schools and health connections	Certification and monitoring provider compliance
Other outreach activities	Monitor MCO marketing practices
Increasing social support	Provide infrastructure/capacity for MCH functions
Case coordination	Staff training
Increasing access to Medicaid	Support of continuing education
Staff training	Develop tools standardizing data collection, analysis, reporting
Strategic planning	Provide outreach services
Managed care initiatives	Transportation and other access-enabling services
Building coalitions and partnerships	Referral systems, resource directories, advertising, enrollment assistance
Building MCH data capacity	Monitor enrollment practices for ease of use
Immunization tracking/recall	Identify high-risk/hard-to-reach populations and methods to serve them
Infant/child death review	Provide, arrange, administer direct services
	Managed Care model contracts and access issues
	Identify and report access barriers

Funding Sources:

City/County/Local government funds, Other Federal funds

Budget: $200,000.00

Description:

On September 1, 1997, the Onondaga County Health Department was awarded a four year Healthy Start II grant from the Health Resources and Services Administration. Syracuse Healthy Start brings together eighteen community based and health care agencies. The overall goal of Syracuse Healthy Start is to improve health outcomes in Central Syracuse through the prevention of infant mortality and adolescent pregnancy. The Syracuse Healthy Start registry activities were initiated in April 1998. The Syracuse Healthy Start Registry is a population-based, computerized monitoring system that enrolls pregnant women in the Healthy Start project by either self referral or provider referral to ensure they receive preventive services.

Objectives of the activity:

1. Increase to 90% the enrollment of pregnant women in the project area who were enrolled in the SHS Registry.
2. Increase community awareness of infant mortality and SHS project activities.
3. Reduce infant mortality rate in SHS project area.
4. Decrease racial disparity in infant mortality.
5. Increase to 75% program participants beginning prenatal care in the first trimester.
6. Increase to 75% participants and all pregnant women in project area who receive adequate prenatal care.
7. Reduce to 3% the proportion of participants and all pregnant women in the project area who receive late or no prenatal care.
8. Reduce by 20% from baseline the proportion of VLBW, LBW, preterm, SGA and LGA among participants and in all project area births.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Flyers and posters were misleading to some who assumed that the promised help with obtaining supplies meant that they would be given away.	1. New flyers and posters will carry a disclaimer to avoid confusion.
2. Slow and problematic computer links for obtaining data.	2. Send for the information manually rather than electronically.
3. Fragmented documentation.	3. A Multidisciplinary Document Committee has streamlined and integrated all client record forms.
4. Trouble tracking births and outcomes for an ever-changing group.	4. A plan was developed to receive weekly status reports from home visiting activities and hospitals.

Role of health department in implementation, planning, and evaluation:

The health department's MCH Public Health Team, the Syracuse Healthy Start staff and the Syracuse Healthy Start Registry have been integral components of all aspects of planning, implementation and evaluation.

Accomplishments:

The Healthy Start Registry initiative and media campaign was kicked off in April 1998 and during its first year of operation the Registry reached 89% of all pregnant women in the project area. By December 1998, 85.7% of the infants in the project area were born to mothers enrolled in the SHS Registry. Infant deaths fell by over 30% in the project area and teen births fell by over 15% since mid-1997. All women are assisted with entry prenatal care and are encouraged to keep their appointments by the Registry coordinator. All eligible women are referred to WIC and are also encouraged by the Registry coordinator. Since 1997, WIC enrollment increased from 44% to 83% of eligible women by December 1998. There has also been a decrease in low birth weight that can probably be attributed, at least partially to WIC involvement. Lead tests are administered to women who had a childhood history of elevated lead levels. Healthy Start staff developed a social/public risk screening tool that identifies risks such as smoking, domestic violence, and substance abuse to name a few. Interventions or referrals are made if appropriate.

Lessons Learned:

1. Implementing the Syracuse Healthy Start Registry identified the need for continuous quality improvement activities. It also resulted in an improved telephone system, computerization system and the staff training necessary to ensure success.
2. The gaps in interagency communication are wide so direct presentations to health and human services providers and partners needs to be continuous and ongoing.
3. When you think you've thought of everything, think again.

Healthy McLennan County-Healthy McLennan Economy: A Joint Venture

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives:
Strategic planning Building coalitions and partnerships	Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Tracking systems Population surveys (BRFS, PRAMS, PedNSS, YRBS) Environmental assessments Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Prepare, publish and distribute reports Public advocacy for legislation and resources Develop and promote MCH agenda and YR 2000 National Objectives Newsletters, convening focus groups, advisory committees, networks Provide infrastructure/capacity for MCH functions Staff training Support of continuing education Support of health plans/provider networks Develop tools standardizing data collection, analysis, reporting Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them Identify and report access barriers

Funding Sources:
City/County/Local government funds

Budget: $0.00

Description:

The McLennan County Public Health Issues Collaboration was formed in the Spring of 1998 to explore a more equitable way to fund public health projects in McLennan County. As a result of this, the "Healthy McLennan County-Healthy McLennan Economy: A Joint Venture" project evolved (2/99) as an effort to promote healthy behaviors. One of the first activities of the Project is entitled "Promoting Healthy Behaviors-Tobacco Use." Other projects over a proposed three year timeline include "Promoting Healthy and Safe Communities" and "Improving Systems for Personal and Public Health". The Tobacco Use Project will target tobacco use prevention in youths, smoking during pregnancy, and adult tobacco use. The following factors have been determined:

Youth tobacco-use prevention:

1. Preventing first use of tobacco in young people will probably have the greatest long-term value in promoting healthy behaviors.
2. Most users begin at a young age.
3. First use often occurs as early as elementary school.
4. About 9% of McLennan County students are daily cigarette smokers at high school graduation.
5. Success at this stage has a high potential for long-term health benefits.

Prevention of smoking during pregnancy:

1. Smoking during pregnancy creates special health risks, such as pregnancy complications, premature births, low-birth weight infants, stillbirths, and infant mortality.

Prevention of adult tobacco use:

1. Adult tobacco use is the single most preventable cause of premature death.
2. Smoking cessation has health benefits for all age groups.
3. Medical costs associated with adult tobacco use exceed $50 billion per year. Members of the collaboration are determining the best possible ways to perform a county-wide needs assessment. After the completion of the assessment and based on other assessments that have been completed, programs will be enhanced and/or revised to target individuals in the three target groups.

Objectives of the activity:

Using 1998 data as the baseline, to reduce the number of students who use cigarettes for the first time by 3% by 2001. To reduce cigarette smoking in pregnant women by 5% by 2001, using 1997 data as the baseline. Reduce the number of people who report current cigarette use by 2.5% by 2001, using 1997 as the baseline.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Having designated staff for the project. 2. Because it is a collaborative effort, and it is sometimes difficult to convene all members, work has been slow. 3. Participants may vary from meeting to meeting.	1. Obtained funding from local and state governmental agencies. 2. Trying to meet with as many members as possible to continue toward the accomplishment of stated goals.

Role of health department in implementation, planning, and evaluation:

The Health District has taken the lead in convening local agencies and providers to develop action plans based on identified goals. The Health District also purchased software (Outcomes Toolkit) that will be used throughout the community for tracking data. A new program called the Health Education/Community Nursing is also being formed at the Health District. This program will focus on population-based health activities. Staff at the Health District are also leading the way to determine the best possible way to perform the community needs assessment.

Accomplishments:

Local community agencies to include hospitals, clinics, schools and universities, MHMR, American Cancer Society, America Lung Association, Education Service Center, Regional and State Health Department and citizens are participating. Staff (epidemiologist and Health Educator) have been hired to develop the project.

Lessons Learned:

Although it has been determined that a collaborative effort is the best route to take in this project, it is a slow process. It is best to have support from participants to have an effective collaboration. Even though the process may be slow, it is so much better to have others working *with* you rather than trying to be all things to all people.

WIC Partnership with Family Independence Agency (FIA)

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives:
Breastfeeding/nutrition/WIC One-stop shopping locations Building coalitions and partnerships	Implement/support education services for special MCH problems Develop and promote MCH agenda and YR 2000 National Objectives Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
City/County/Local government funds, Other Federal funds

Budget: $2,300,000.00

Description:

According to data from the Michigan Department of Community Health, there are approximately 39,000 families eligible for the WIC program in Wayne County, excluding the City of Detroit. Despite the fact that Wayne County increased its WIC caseload by 29% from 1997 to 1998, there still exists an unmet need for WIC services. The Health Department decided to initiate partnerships with the local Family Independence Agency (FIA) to address this unmet need.

Objectives of the activity:

The WIC Coordinator and other executive level staff contacted counterparts at the local Family Independence Agency for the purpose of increasing the department's WIC caseload by utilizing local FIA offices. The Health Department entered into an agreement to provide WIC services at three FIA offices beginning in October, 1999. A team consisting of a nutritionist, clerk, and lab assistant will provide WIC services at the FIA office.

Barriers encountered in implementation:	Strategies to overcome barriers:
Initially, staff at one FIA office were reluctant to offer under-utilized space for the WIC team. The space provided to provide WIC services is limited; renovations of the floor plan at the FIA office are needed.	The executive staff of FIA agreed to renovate the space needed for the WIC team; the Health Department covered the cost. The space is being made available at no charge. The Health Department is paying its own telephone charges and providing furniture. Several work stations have also been offered by FIA. We are curretly identifying staff to work at the FIA office via a realignment of health centers.

Role of health department in implementation, planning, and evaluation:

The health department has worked to assure FIA that a partnership with Public Health can be a win-win collaboration. Clients seeking services from FIA in many instances also qualify for WIC (and vice versa).

Accomplishments:

The Health Department established verbal agreements to begin the process of renovating the FIA offices to the specifications needed by the health department. Other FIA offices in Wayne County are also being considered as possible locations for WIC services.

Lessons Learned:

Community partnerships can be forged if key stakeholders share a common vision and do not become insecure about their roles and responsibilities. It is important to recognize that a synergy will create long term benefits and that we all make up the community.

Increasing Access to CHIP through Finders Fees

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Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Overcoming cultural barriers Reducing transportation barriers Expanding private sector links Other outreach activities Increasing social support Increasing access to Medicaid	Provide outreach services Referral systems, resource directories, advertising, enrollment assistance Monitor enrollment practices for ease of use

Funding Sources:
General state funds, Private source: Robert Wood Johnson Grant

Budget: $123,539.00

Description:

The Delaware Healthy Children Program (DHCP), Delaware's CHIP Program, started in January, 1999. In the first six months enrollment was relatively high, but after that enrollment leveled off. In July, 1999, a pilot project was initiated in New Castle County (NCC) to increase access to enrollment in both the DCHP Program and Medicaid. Fifteen community-based organizations, each having a well established record of providing services to children and families, were identified to become part of a Network of organizations that could provide application assistance to families enrolling in the DHCP of Medicaid.

Organizations were selected on the basis of their service provision to families within zip codes identified as having the greatest number of eligible children. In addition, their track record for reaching "hard-to-reach" populations was considered. Hard-to-reach populations include the Hispanic population and working families of all races and ethnicity with incomes in the higher bracket of eligibility (close to 200% of the poverty level) who may not realize their eligibility.

Organizations joining the Network agreed to guide clients through the application and enrollment process, as well as to provide follow-up to assure access to care. To facilitate this effort, the Division of Social Services, which approves applications, designated a case manager to approve applications from the Network. This process is easier than the traditional method of geographically distributing a case worker by the sip code of the applicant.

Network providers are responsible for contacting clients to resolve application problems. A "Finders Fee" of $50.00 will be paid to Network participants for every application that results in the successful enrollment of one or more children into either DHCP or Medicaid. Successful enrollment means that the child is eligible and the family has paid the monthly premium for DHCP, or that they have been enrolled in Medicaid Managed Care.

Objectives of the activity:

1. To enroll more than 3000 eligible children through the NCC pilot project over three years.
2. To enroll at least 1200 eligible children by March 2000 through the Network.
3. To enroll at least 225 eligible Hispanic children through the project by March 2000; to increase the proportion of working families earning between 150% and 200% of poverty guidelines through the project.

4. 90% of applications received through the Network pilot will be complete upon receipt and result in the enrollment of at least one child per application.
5. To decrease the time frame from the completion of application to enrollment to less than 45 days.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Financial support must be available to pay the finder's fees. 2. A tracking system and staffing needs to be in place to case manage applications and to evaluate the Project. 3. Cooperation and trust of the community and Network organizations are needed. 4. Full collaboration with Medicaid, including the sharing of data, is essential for success. 5. A simplified application to CHIP and Medicaid must be developed.	Both statewide and local coalitions have been developed. The Statewide Coalition focused on simplifying the application process and marketing the Program. Members also provided ideas and feedback on implementing the projects. Network organizations are a part of the Local Coalition and participate fully in the project. A Memorandum of Agreement was established between Public Health, the Division of Social Services Medicaid, the Medicaid-Contracted Health Benefits Manager, and the local lead agencies, Stand For Children and Delmarva Rural Ministries. The MOA defines roles and responsibilities of Project participants. A Network Participant Cooperative Agreement was also established and became part of a Deleware Health and Social Services, Division of Public Health contract with each Network provider receiving Finders Fees. A position was allocated to serve as a Network Coordinator, which would be liaison to Medicaid and Social Services and an educator to the agencies and the public. A tracking system is under development and a committee has been formed to look at linking existing data bases to provide the information needed to evaluate the project.

Role of health department in implementation, planning, and evaluation:

Public Health was approached by the community advocacy agency, Stand For Children, to apply for this RWJ grant "Covering Kids." A statewide Coalition and two local Coalitions were created to develop the ideas for the grant, and work on turing those ideas into a workable project. Public Health took the lead in developing the grant and providing the leadership to bring the Coalitions together. In addition, Public Health is the lead agency for the grant, and is responsible for implementing and evaluating the project. Locally, Public Health will be implementing the project and evaluating the project to determine the efficacy of involving local community-based organizations in the application process and in utilizing the Finders Fee approach.

Accomplishments:

1. The Coalition was established.
2. A Network of organizations is in place and contracts have been initiated.
3. The MOA and Cooperative Agreements have been signed.
4. Data systems are being developed.
5. Staff is being hired.
6. Full implementation will begin September 1, 1999.

Lessons Learned:

There is a tremendous amount of groundwork that needs to be put into place, but the community members have been very impatient and think that "the State" is not moving quickly enough. Keeping the Coalitions involved and maintaining trust are most difficult.

Community Partnership for Dental Health

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Has this activity been formally evaluated?

Has this activity been replicated?

Essential MCH Functions:	MCH Initiatives:
Prenatal care	Analysis of demographics, economic status, behaviors, health status
Breastfeeding/nutrition/WIC	Community perceptions of health problems/needs
Early intervention/zero to three	Tracking systems
Expanded child health services	Hotlines, print materials, media campaigns
Injury (including child abuse)	Culturally appropriate health education materials/programs
School-linked/based services	Implement/support education services for special MCH problems
Dental programs	Assessment of provider reports regarding process and outcomes
Overcoming cultural barriers	Prepare, publish and distribute reports
Reducing transportation barriers	Public advocacy for legislation and resources
Expanding private sector links	Newsletters, convening focus groups, advisory committees, networks
Clergy and health connections	Promote compatible, integrated service system initiatives
Schools and health connections	Staff training
Other outreach activities	Support of continuing education
Increasing social support	Support of health plans/provider networks
Case coordination	Provide outreach services
Increasing access to Medicaid	Transportation and other access-enabling services
Staff training	Referral systems, resource directories, advertising, enrollment assistance
Strategic planning	Identify high-risk/hard-to-reach populations and methods to serve them
Reshaping urban MCH	Provide, arrange, administer direct services
Building coalitions and partnerships	Identify alternative resources to expand systems capacity
Building MCH data capacity	

Funding Sources:

Private source: Forsyth Early Childhood Partnership, Third party reimbursement (Medicaid, insurance), Volunteer hours

Budget: $120,000.00

Description:

The Community Partnership for Dental Health, established in November 1997, is a collaborative effort that was funded by the Forsyth Early Childhood Partnership and initiated by the Forsyth County Department of Public Health. The Partnership has developed a strategy for addressing the unmet dental needs of children aged 0-5 and their immediate families by establishing clinics in different areas of the county. These clinics operate on the weekends and rely on volunteer dentists, dental hygienists, dental assistants, and community members. Our partners in this collaborative effort include Head Start, Healthy Carolinians Partnership, Reynolds Health Center, Living Water Family Resource Center, Triad Hispanic Ministries, Iglesia Cristiana Wesleyana, local volunteer dentists, dental hygienists, and dental assistants. To date, we have treated more than 2,000 children and over 600 immediate family members.

Objectives of the activity:

Goals: To develop, implement, and support a program providing increased access to dental care and preventive dental education for Forsyth County's children aged 0-5, and their immediate families.

Objectives:

1. To establish, by March, 2000, a fourth clinic that will provide free or reduced-fee dental treatment and/or screening for children aged 0-5.
2. By November 1999, to obtain brochures, videos, posters, and other educational materials in Spanish to reach out to our quickly growing Hispanic and Latino communities.
3. By January 2000, to hire a dentist that will travel between the four clinics and provide free or reduced-fee dental treatment and/or screening for children aged 0-5.
4. To continue to advocate for an increase in Medicaid reimbursements for dentists in order to increase the percentage of dentists who see Medicaid patients.

Barriers encountered in implementation:	Strategies to overcome barriers:
The number one barrier is the lack of dental manpower caused by a scarcity of dentists who accept Medicaid and N.C HealthChoice. The number of patients is growing rapidly; eventually people will have to wait months to get an appointment because there are not enough volunteer dentists to meet the need. We also face great obstacles when it comes to language barriers. We have a growing population of Hispanics in Forsyth County, but not enough interpreters, so it can be very difficult to teach dental education. Another challenge to the program is transportation. Many dentists who do not accept Medicaid and N.C. HealthChoice complain that patients do not show up to their appointments. The majority of the people who do not make their appointments cite a lack of available transportation as the cause.	To overcome the dental manpower problem $120,000 was requested and received from the Community Health Fund to pay for a dentist, dental hygienist and dental assistant for the Program. When they begin working, Medicaid and N.C. HealthChoice revenues will generate enough money to pay for their salaries. The pastor of Triad Hispanic Ministries has a van that takes patients to their doctor appointments. He has several interpreters at his clinic and he is fluent in Spanish. The health department is also working to obtain a van to pick children up from school and take them to their dental appointments. All of these efforts are really making a positive difference to the program.

Role of health department in implementation, planning, and evaluation:

The Forsyth County Department of Public Health initiated the Community Partnership for Dental Health by recognizing the desperate need for dental care in the community. The Health Department wrote the primary grant from Forsyth Early Childhood Partnership (Smart Start), laid the foundation for the Program, and continues to be a main facilitator in the Program. The program coordinator and the program assistant plan and implement the bi-monthly and quarterly reports and compile a mid-year and final evaluation for Smart Start each year.

Accomplishments:

Our greatest accomplishment is that the Program has enabled over 2,000 children to get dental care thus far; the Program continues to see more children every weekend. Another accomplishment is that the Program has received broad-based support from the community. In addition, development of community partnerships is ongoing and preventive dental health education in the County, as well as the community's awareness of dental care, has increased.

Lessons Learned:

We have learned to be persistent and determined in finding ways to meet the dental needs of our children. Networking is a key to meeting the dental needs in the community; what one program lacks may be another program's strength. It is important to incorporate creativity into educational programs to get the message across in a fun manner.

Maternal and Infant Health Advocacy Services Program (MIHAS)

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives:
Prenatal care Expanding maternity services Home visiting Low birthweight/ infant mortality Substance abuse prevention Breastfeeding/nutrition/WIC Children with special needs Overcoming cultural barriers Reducing transportation barriers Expanding private sector links Other outreach activities Increasing social support Case coordination Increasing access to Medicaid	Provide outreach services Transportation and other access-enabling services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations and methods to serve them Provide, arrange, administer direct services

Funding Sources:
General state funds, MCH block grant funds

Budget: $181,000.00

Description:

The Maternal and Infant Health Advocacy Services Program (MIHAS) in Washtenaw County provides in-home services to high-risk, low-income pregnant and postpartum women and their newborns. Six trained advocates provide referrals to health care and human services providers to promote healthy birth outcomes. In addition, clients are provided with support, information, advocacy with agencies, and help with basic needs such as cribs, car seats, food, and clothing.

Objectives of the activity:

The MIHAS program is designed to provide support and, through home visitation by the advocate, to reduce the isolation that may be experienced by the client. Advocates are hired from the target population because it is felt that someone who has had similar experiences can best provide support for the client. The majority of clients are young, single mothers who appreciate having someone who can answer their questions and assist with essential resources. Clients are also educated about resources in the community so they in turn can become advocates for themselves.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Our Hispanic advocate has to take more time with individual clients due to translations skills. This is positive, but finding enough time to do her work is a barrier. 2. Some clients, especially those who are Arabic or Middle Eastern, have not been receptive to having a male advocate. 3. Our one male advocate has to keep more rigid boundaries as a result of some young single women (who have lacked positive male role models in their lives) becoming attracted to him.	1. Reducing our Hispanic advocate's caseload so she is able to meet the needs of her clients. 2. This is a cultural issue, and when this has occurred, a female advocate is assigned. 3. When our male advocate begins getting signs that a client has become attracted to him, we usually assign another advocate to go with him. If it becomes more overt, he lets them know that he cannot cross this professional boundary and a female advocate will be assigned.

Role of health department in implementation, planning, and evaluation:

In July 1998 the MIHAS Program was implemented in the Washtenaw County Health Department. Applicants from a program called WorkFirst, which is a welfare-to-work program, were recruited for the Program. The strength of the Program lies in hiring advocates who have "been there." It was important to have staff with the ability to, through their experiences, relate well to the clients and use their successes to help others be successful. We hired six exceptional advocates; five African-American women and one man from El Salvador who is fluent in English and Spanish. During this year, one advocate moved into a higher County position and a former client was hired to fill her place. The other five advocates continue to provide a high level of services to their clients.

Accomplishments:

Our male advocate has been beneficial in connecting with the fathers in our Program, those who are with the mothers of their infants as well as those who are single fathers. He has been a great role model when presenting to teen groups, especially to young men at the crossroads of becoming responsible adults. Also, due to the outreach efforts of our advocate from El Salvador, we now have a better understanding of the barriers that many of our Spanish-speaking clients face. This advocate has been recruited to case-find at the migrant camp, where he also provides resources, assists with immigration papers, and translates information from health providers and other agencies. Two of the hospitals in the area have referred clients to the program as a result of translation services that the advocate provides to clients. All advocates have demonstrated the ability to use their own experiences to provide enhanced services to clients.

Lessons Learned:

Hiring advocates from the population that they serve has not only benefited the clients, but has also helped the advocates obtain training and resources to further their goals. Having a Hispanic advocate who can translate has greatly assisted our Hispanic clients with needs as well as increased the number of clients served. Having a male advocate has proven worthwhile not only because of the support he lends to other members, but also because of the example he shows to clients as a sensitive, caring, and responsible individual.

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Key

* CityMatCH Regional Representative - As of 9/1/99

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CityMatCH Publications Listing

Please send one copy of the publication(s) circled to:

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F-025 Forging an Urban MCH Partnership: Urban Maternal and Child Health 1991 Leadership Conference *(out of print) For reference copy, refer to library at the National Center for Education in Maternal and Child Health, (703) 524-7802*

G-004 Strengthening Urban MCH Capacity: Highlights of the 1992 Urban Maternal and Child Health Leadership Conference

G-005 What Works II: 1992 Urban MCH Programs - Maternal and Child Health Programs in Major Urban Health Departments: Focus on Immunizations *(out of print) For reference copy, refer to library at the National Center for Education in Maternal and Child Health, (703) 524-7802*

G-084 Improving Urban MCH Linkages: Highlights of the 1993 Urban Maternal and Child Health Leadership Conference

H-038 Changing the Rules: Medicaid Managed Care and MCH in U.S. Cities, City**MatCH** Special Report 1 *(out of print) For reference copy, refer to library at the National Center for Education in Maternal and Child Health, (703) 524-7802*

H-039 Effective Leadership During Times of Transition: Highlights of the 1994 Urban Maternal and Child Health Leadership Conference

I-022 What Works III: 1995 Urban MCH Programs - Focus on School Health

I-111 What Works III: 1995 Urban MCH Programs - Focus on School Health *(8-page Executive Summary)*

I-106 The Road to Community Partnerships: Highlights of the City**MatCH** 1995 Urban Maternal and Child Health Leadership Conference

J-068 Bridging Risk and Opportunity: Highlights of the City**MatCH** 1996 Urban Maternal and Child Health Leadership Conference

J-072 Lessons Learned: 1996 Successful Urban Health Department MCH Efforts

K119 Lessons Learned: 1997 Profiles of Leading Urban Health Department Initiatives in Urban Maternal and Child Health

L039 Lessons Learned: 1998 Profiles of Leading Urban Health Department Initiatives in Urban Maternal and Child Health

M019 Lessons Learned: 1999 Profiles of Leading Urban Health Department Initiatives in Urban Maternal and Child Health

Return this form to:
National Maternal and Child Health Clearinghouse
2070 Chain Bridge Road, Suite 450 ☐ Vienna, VA 22182-2536
Phone: (703) 356-1964 ☐ Fax: (703) 821-2098 ☐ E-mail: nmchc@circsol.com

CityMatCH Publications Listing

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Lessons Learned 1999: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health

❑ Yes, I would like a copy of this report. Enclosed is my payment for $15 per copy made payable to Department of Pediatrics, UNMC.
Federal ID #: 470491233

Return this form to:
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Omaha, NE 68198-2170
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Please take a moment to complete and return the following *"Lessons Learned 1999: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health"* Evaluation Form.

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LESSONS LEARNED 1999

CityMatCH

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Website: <http://www.citymatch.org>

MCHB Maternal and Child Health Bureau
U.S. Department of Health & Human Services HRSA Health Resources & Services Administration Maternal & Child Health Bureau
National League of Cities
University of Nebraska Medical Center Nebraska's Health Science Center

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Maternal and Child Health Bureau

Health Resources and
Services Administration
Rockville MD 20857

MAR 23 2000

Dear Maternal and Child Health Colleague:

I am pleased to send you the most recent CityMatCH publication *Lessons Learned 1999: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health.* There continues to be a call for innovative approaches and best practices to solve the public health problems facing families and children in America's cities. Urban communities want to know how to overcome barriers to implementation, how to go from "project" to scale, and how to sustain resources and commitment for long-term change. *Lessons Learned 1999* provides information about ongoing program and policy initiatives in urban maternal and child health (MCH) to address the demand for replicable solutions.

The Maternal and Child Health Bureau is pleased to continue its support for CityMatCH's annual survey of urban maternal and child health policy and programs under our Partnership for Information and Communication Cooperative Agreement. Through its studies, networking, and conferences, CityMatCH provides an essential link to MCH in cities.

For more information about the report or other CityMatCH activities, please call Magda G. Peck, Sc.D., CityMatCH Executive Director, at (402) 595-1700. Additional copies can be obtained for $15 directly from the CityMatCH Central Office at (402) 595-1700.

Sincerely yours,

Peter C. van Dyck, M.D., M.P.H.
Associate Administrator for Maternal
and Child Health

Enclosure