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ABSTRACT

This report contains selected presentations from the 1993 Urban Maternal and Child Health Leadership Conference. Following welcoming remarks by Carolyn Slack, two presentations discuss improving urban maternal and child health (MCH) linkages. "Pittsburgh's Alliance for Infants," by Virginia Bowman, describes a comprehensive in-home follow-up program serving very low birthweight babies and their families. "The Case of Orange County, California's 'Child Health Network,' A Public/Private Partnership," by Len Foster, Anthony R. Edmonds and David Ward, discusses the Child Health and Disability Prevention Program. It describes the treatment unit of the program and also includes comments by one of the health care providers participating in the program. The next two presentations focus on the role of urban health departments in Medicaid managed care. "Publicly Funded Managed Care and Children's Health, An Urban Perspective," by Magda G. Peck addresses some of the issues and concerns associated with managed care programs. "Lessons from Boston, Massachusetts," by Lillian Shirley relates experience with Medicaid managed care in Boston, Massachusetts. Conference closing remarks are by Kathy Carson. The second section of the report presents profiles of successful urban MCH programs. It includes profiles of urban health department initiatives from over 90 cities in the United States. This section also includes conference profiles in the following categories: (1) improving outcomes of pregnancy; (2) improving access to health care; (3) improving primary and preventive care for children; (4) improving primary and preventive care for adolescents; (5) reducing and treating substance abuse; and (6) improving urban public health systems. More specific conference information is covered in 4 appendices: the planning committee, the program, participating Urban MCH leaders, and participating co-sponsors, speakers and guests. (TJQ)

# Improving Urban Maternal & Child Health Linkages



## Conference Highlights

# Improving Urban MCH Linkages

## Highlights of the 1993 Urban Maternal and Child Health Leadership Conference

Magda G. Peck, Sc.D., P.A., Editor

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City**Mat**CH is a national organization of urban maternal and child health programs and leaders. City**Mat**CH was initiated in 1988 to address the need for increased communication and collaboration among urban and 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**Mat**CH, 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**Mat**CH 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**Mat**CH, contact Magda Peck, City**Mat**CH Executive Director, Department of Pediatrics, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-2170, Telephone (402) 559-8323.

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## Acknowledgements

By now the annual Urban Maternal and Child Health Leadership Conference has become an MCH tradition. Urban maternal and child health leaders from city and county health departments nationwide have come to see this unique conference as a cornerstone for professional development and networking. An essential dynamic of of this tradition is the seemless organization behind the scenes. After four years the team of conference organizers, coordinators, and administrators gets even better.

CityMatCH continues to maintain excellent staff in the Section on Child Health Policy, Department of Pediatrics at the University of Nebraska Medical Center in Omaha, Nebraska. Joan Rostermundt, CityMatCH Administrative Technician, provided stellar logistic leadership with the ample assistance of Staff Assistant Barbara Sims. Elice Hubbert, Coordinator of the Municipal MCH Partners Project and the driving force behind CityMatCH research, enabled the profiles, small workgroups, and SpotLights to hang together effortlessly. Additional staff assistance came ably from Harry Bullerdiek and Diana Fisaga. Another efficient and attractive set of conference materials were designed by Joe Edwards at the UNMC Department of BioMedical Communications with printing under the direction of Mark Watson at UNMC's Printing and Duplicating Services. Diane Ruskamp, Accountant for the Department of Pediatrics at UNMC, again assisted in our Conference fiscal management.

The collaboration between CityMatCH and the National Center for Education in Maternal and Child Health in organizing the Urban Maternal and Child Health Leadership Conference continues to be extraordinary. Paula Sheahan, Kate Ryder, and Susana Eloy were a wonderful team of conference organizers who handled on-site logistics without a flaw. Chris Rigaux and Marcos Ballestero again produced striking graphics as are visible on the cover of this publication.

Co-Chairperson, Carolyn Slack (Administrator of Family Health Services, Columbus (OH) Health Department), was a splendid leader of the CityMatCH family. A hard working and creative Conference Planning Committee (see Appendix A) shaped the program, helped secure effective speakers, and guided us through the planning process. District of Columbia MCH Chief, Patricia Tompkins and her terrific staff at the D.C. Office of Maternal and Child Health again arranged an excellent tour of the D.C. area MCH programs as well as an innovative panel of youth voices on urban violence. And we are indebted to our many funders and co-sponsors (see page vii) whose support is absolutely essential.

Finally, the success of each Urban Maternal and Child Health Leadership Conference relies on the active participation of maternal and child health program directors in major city and county health departments who take the time to renew their commitment to urban MCH and to their colleagues nationwide. This conference enabled, for the first time, health departments serving small U.S. cities to come to the

table with their stories, concerns, and innovations. CityMatCH's mission is to enhance the ability of maternal and child health programs at the local level to improve the health and well-being of children and families in urban areas. This conference goes a long way in allowing this mission to be fulfilled. I acknowledge with great appreciation and gratitude the hard work of every individual who makes these special connections happen.

Magda G. Peck, ScD, PA
CityMatCH Executive Director and
Co-Chairperson
1993 Urban Maternal and Child Health Leadership Conference

# 1993 Urban Maternal and Child Health Leadership Conference
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# Welcoming Remarks

Carolyn Slack, RN, MS
Co-Chair, 1993 Urban MCH Leadership Conference
Administrator, Family Health Services
Columbus Health Department
Columbus, Ohio

Good morning. On behalf of the Conference Planning Committee, I am pleased to welcome you to the fourth City**MatCH** Urban Maternal and Child Health Leadership Conference.

I have a series of welcomes. First, welcome and thank you to our conference funders. Second, welcome to our numerous conference co-sponsors. Third, welcome and thank you to our speakers and other guests. And, finally I want to extend a warm welcome to my City**MatCH** colleagues.

I have spent some time thinking about what this conference means to me and why I am so grateful to be here. I believe there are three reasons why I am here and perhaps these reasons may apply to you.

First, I am here for a reunion. I have been fortunate in that I have attended all four conferences. But whether this is your first or fourth conference, you will find that this is a reunion of professionals who share your passion for serving our cities' children and families. I have found that when I read the paper or watch television or attend a movie and cities are mentioned, I immediately think about that city's MCH leaders. My guess is this year, because of the hit movies, "Sleepless in Seattle," many people have been thinking about Kathy Carson. I am glad to be here and look forward to our reunion.

Second, I am here for a respite. Charles Dickens wrote in his work Great Expectations, "In the little world in which children live, .....there is nothing so finely perceived or so finely felt as injustice." So much of our work is confronting and counteracting injustices. In a truly just country, would any child go to sleep poor, homeless or hungry? Yet in our cities, in our clinics, under our bridges, or in our shelters or public housing projects, each day we see and serve children and families in these unjust situations. The injustices are manifested in our city's health status measures - infant mortality rates, children killing children, immunization rates, and so on. We know so well the outcomes of injustice. I am tired and I am here for a respite.

Finally, I am here for a revival. I am here to be restored and to restore others. I am here, not only to continue creating, but also, learning to sustain a vision of healthy families in healthy cities. And, how is this done? This is done at networking sessions while we eat, in panel presentations, during work group sessions or in the elevator. It is done each and every time we share and learn what works, what doesn't and why. I am ready for a revival.

So, to my CityMatCH colleagues - friends - welcome to our reunion, respite and revival. Welcome to our conference, that will send each of us home better prepared to pursue justice for the children and families in our nation's cities.

# Improving Urban MCH Linkages: Pittsburgh's Alliance for Infants

Virginia Bowman, R.N., M.P.H
Chief, Maternal & Child Health Programs
Allegheny County Health Department
Pittsburgh, PA

Thank you for the opportunity to describe the linkages developed to better serve very low birthweight infants and their families in Pittsburgh and Allegheny County.

First, a little about Pittsburgh, home of the Steelers, the Penguins, and the Pirates! Pittsburgh is located in the southwest corner of Pennsylvania, only a few miles from Ohio and West Virginia. Pittsburgh's central city population is about 370,000. The city is surrounded is by 61 other municipalities which make up Allegheny County, with a combined census of 1.3 million. The Allegheny and Monongahela Rivers merge near the downtown area to form the Ohio River. Strong ethnic communities persist, facilitated by the rivers and hills. It is not unusual to hear that families have never been in downtown Pittsburgh or ventured far from their home communities.

About the Alliance for Infants Program

The Alliance for Infants is a comprehensive in-home follow-up program serving infants born weighing less than 1500 grams, and their families across Allegheny County. The goal of the Alliance is to help provide every very low birthweight (VLBW) baby the opportunity for optimal development within the context of a satisfying family relationship. Families are assisted in achieving optimal outcomes through coordinating, linking, and expanding infant services. Program services encompass identification, assessment, monitoring, treatment intervention, referral, and family support.

The Alliance was established three years ago. Prior to that time, nursing follow-up was provided by Allegheny County Health Department for VLBW infants born to low income women, primarily those receiving Medical Assistance. Only about half of the VLBW infants were referred and services continued for one year. Their services were part of a Statewide follow-up system which was planned by State MCH leaders without sufficient participation at the local level. While selected families benefitted from the program, it had serious limitations and lacked strong support from local stakeholders.

Under PL99-457 Pennsylvania exercised the option to extend early intervention services to infants 0-3. The State's Department of Public Welfare, Office of Mental Health/Mental Retardation was named the lead agency for this age group. As local

planning for implementation began, the need to integrate infant follow-up services became apparent. The County Health Department's follow-up services became part of the Alliance services as we contributed the nursing component.

The Alliance is a unique professional collaboration of agencies involved in service to infants in Allegheny County. It links all five Level III nurseries in the County, the Allegheny County Health Department, and the child development units of the five hospitals (see page 8). The program is coordinated by the University of Pittsburgh's Office of Child Development. Linkages also include community infant intervention programs.

The Alliance is jointly funded by the Allegheny Department of Health and Public Welfare. Funding through our Department has included both County and Title V money. Department of Welfare funding is through Pennsylvania's Early Intervention Services System Act and Part H of the Individuals with Disabilities Education Act.

How does the Alliance work? Infants are referred as soon as it is likely they will survive. The service team consists of public health nurses, social workers, and child development specialists. There is strong collaboration across disciplines. Staff begin an in-home assessment of family needs prior to the infant's discharge. This enhances the opportunities to address the families' concerns in the hospital discharge planning process.

After discharge there are ongoing assessments of the baby's health status, development, behavior, parent-child interaction, and overall family functioning. Among the goals of assessment are the early identification of health concerns, developmental disabilities or dysfunctional patterns of family interaction. Staff then facilitate the families' use of appropriate health and community resources. Services continue until the child reaches 3 years of age.

A strong focus is placed on enhancing parent-child interaction, increasing parents' knowledge of expected "preemie behavior" and appreciating the unique personality and needs of their own infant. Parents are helped to understand their child's medical history and health needs and to coordinate medical care. The provision of concrete services plays a vital role in building family trust. For example, the program loans infant car seats and playpens when needed. It also provides small gifts periodically such as a small, developmentally-appropriate toy.

Accomplishments to Date

What has the Alliance accomplished? An average of 15 referrals are received each month or about 180 annually. We know that this is essentially all the VLBW infants who survive. About 80% of those referred actually receive service. Some are not served because they move out of the County, are not interested, cannot be contacted,

or the infant died. Two-thirds of the infants served had birthweights between 1000 and 1500 grams. 60% of the infants are receiving Medical Assistance. 62% of the infants were born to single mothers, and 17% to teenage mothers. More than half of the infants are African American. (Please see page 9 for program demographics.)

Once in-home services begin, very few families drop out of the program. We believe this is attributable in part to flexibility in meeting families' needs, to providing intensive services when necessary. The developmental follow-up clinics report higher return rates since Alliance support began, and we believe more infants are remaining in the health care system. One indication is the fact that, by age 2, more than 90% of the children served had received all recommended immunizations.

Lessons Learned on Linkages

Two parent surveys have been completed. Parents report a very high degree of satisfaction with Alliance services. 19% of the infants have been referred for early intervention services. Time does not permit detailing the other referrals which have been made. A substantial database has been developed which can now be used for a variety of purposes.

What does it take to set up and maintain linkages such as those developed with the Alliance? Many of you are also involved in collaborations and can probably add to the following list of critical components.

- Participating agencies and individuals must share a common mission and purpose. This is the glue that holds everything together. There can be no question as to the mission of the program or the purpose of each agency's participation. It is best to develop the mission as a group with complete participation. This involves discussions about the values of the group and the group's vision.

- The leaders must be skilled and powerful. This is what propels the linkages, so selecting specific individuals is critical. You are building a team with authority, control and influence, but understanding and caring are also needed attributes.

- An appropriate cross-section of participants is needed. One of the NICUs in our community was very reluctant at first to refer infants to the Alliance. It took considerable nurturing and patience to gain their support and cooperation. Parents of children who were very low birthweight are members of the Alliance Advisory Board. Their advice has been very important in planning Alliance services.

- All participants in the collaboration must have a complete and uniform understanding of the program goals and the issues of the at-risk population being served. This includes personnel involved at all levels and is achieved through orientation and inservice education.

- Without compatible personalities, mutual respect and trust there can be no collaboration. The players must have respect for each other and the organizations they represent. Team building takes time and patience.

- True reciprocity of program ownership gets members to share in the stakes. Each player recognizes his or her individual contribution to the collaboration and what his or her agency can gain or learn from this linkage. For example in the Alliance, the County Health Department nurses contributed knowledge and skills around common health problems of VLBW infants, and around feeding and sleeping issues. They gained knowledge and skills in developmental assessment through working with the child development specialists.

- Sincere commitment produces loyalty and lessens autonomy and turf issues. The members must really want to collaborate. The nurses volunteered for this assignment so their interest and commitment were high.

- Meaningful incentives are needed. These may be professional, such as future supports or endorsements, shared staff training or referrals. You can each think of others. For us, important incentives for participating in the Alliance included the potential for enhanced services for families, enhanced knowledge and skills for staff and increased staff satisfaction.

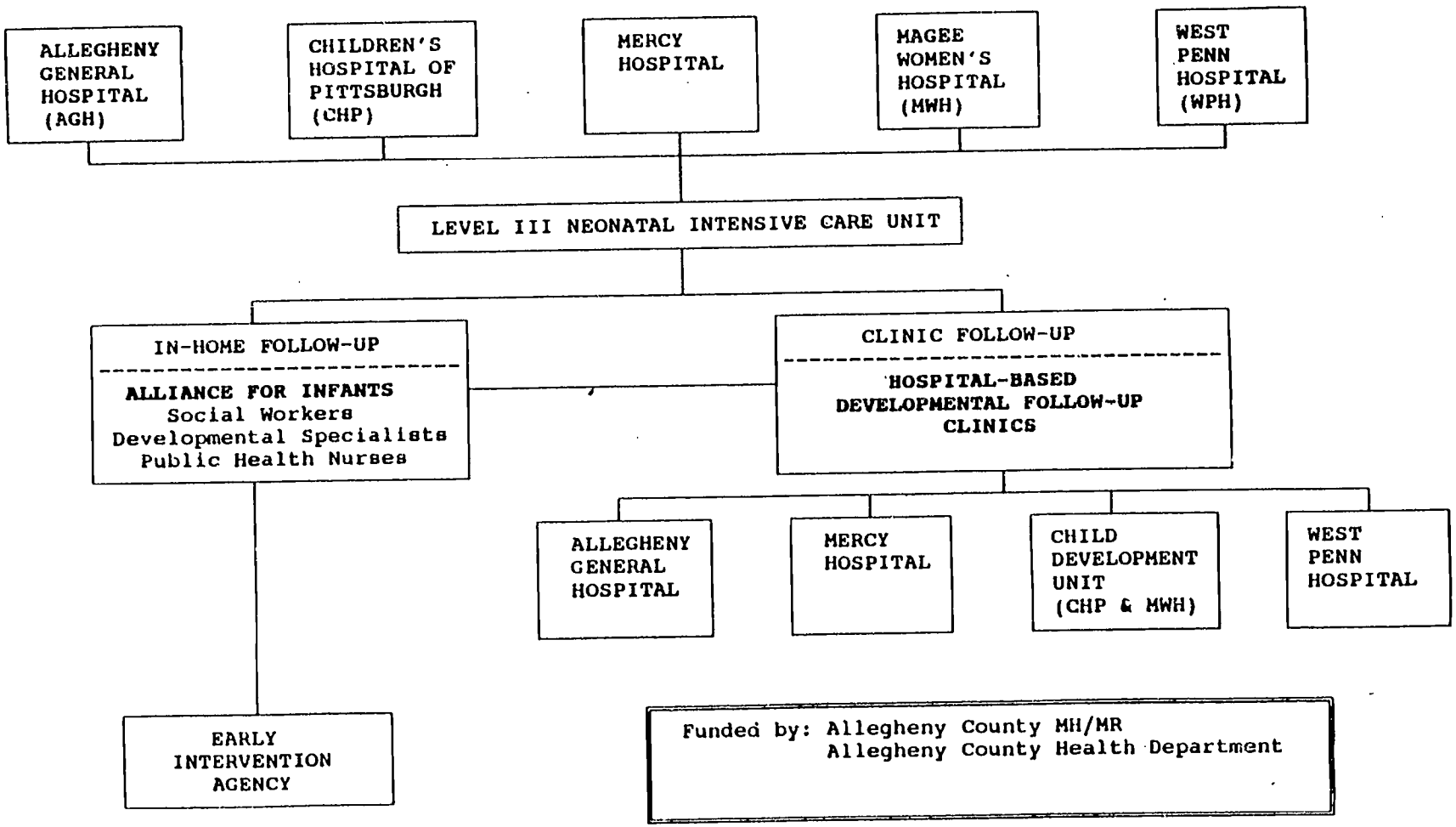
- Constant communication allows for flexibility and clarity of direction. A different vocabulary may be required as one learns to work with other agencies. There must be formal and informal communication links which include regularly scheduled meetings, telephone calls, meeting reports, memos and staff conferences. The communication process must give members the signal that it's OK to disagree and then use resolution of conflicts as a means of moving forward.

  Don't underestimate the time required for planning and meeting to develop successful linkages. We must continually review and revise. Here we step back and say - Where are we going? How are we doing? What needs to be changed? Are all the right players of the table? Are Program goals being met? Do we need different expertise? The flexibility to make needed changes is critical.

- Linkages require sufficient resources. This includes an adequate and consistent financial base to support program operations. It also includes the right attitudes, intelligence and staff time and commitment to the program.

In summary, developing linkages requires a lot of work, trouble and time if they are to be successful, but when successful, they are well worth the effort! The loss of control is well compensated by a less fragmented, enhanced system.

# PITTSBURGH'S ALLIANCE FOR INFANTS



## ALLIANCE FOR INFANTS
## ALLEGHENY COUNTY, PENNSYLVANIA

Program Demographics

| | | |
|---|---|---|
| Referrals annually | | 180 |
| Total caseload (infants/children receiving services at any given time) | | 300 |
| Infants served (% of those referred) | | 80% |
| Birthweights of infants served | | |
| < 800 gm | 15% | |
| 801 - 1000 gm | 21% | |
| 1001 - 1250 gm | 26% | |
| 1251 - 1500 gm | 38% | |
| Receiving Medical Assistance | | 60% |
| Single mothers | | 62% |
| Teenage mothers | | 17% |
| Racial distribution | | |
| African American | | 53% |
| White | | 46% |

# Improving Urban MCH Linkages: The Case of Orange County, California's "Child Health Network," A Public/Private Partnership

Overview

Orange County, California, is a rapidly urbanizing community of approximately 2.5 million people. It is located in the southern half of the state of California between Los Angeles and San Diego counties. Orange County, California - the home of Disneyland, and 2.5 million people - has the third largest child population of the State's 58 counties. Almost 24 percent is under 18 years of age with an estimated 241,000 of these children living below the poverty level, and "uninsured."

In 1973, the Child Health and Disability Prevention (CHDP) program became law in California. It provided the administrative mechanisms for the implementation of the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for Medi-Cal (California's Medicaid) recipients ages birth to 21 years. In addition, it offered components unique to California - "CHDP" health assessments for non-Med-Cal low income children ages birth to 6 years.

In 1989, with the passage of the Proposition 99 anti-smoking tax initiative, CHDP health assessment eligibility for non-Medi-Cal low income children was expanded to 19 years of age. In addition, legislation mandated the diagnosis and treatment of conditions uncovered by these CHDP health assessments. Counties could decide how to implement the treatment mandate e.g., absorb within County hospital setting or establish separate network of participating providers.

At the time of this program expansion there were 150 private sector physicians, community clinics and private hospitals as well as the County Health Department providing CHDP health assessments in Orange County. **The challenge to the County (with no County hospital) was to expand this existing public/private partnership, and build a network of support services to meet the needs of a population with limited or no access to medical care other than the emergency room of a private hospital.**

Orange County chose to fund the treatment mandate with cigarette tax dollars, and established the CHDP Treatment Unit within the Health Department to: develop program protocols; market the program to prospective providers; recruit, assist and monitor providers; facilitate patient access to services; and oversee processing and payment of provider claims. A County contract was established with a local billing company with a provision that claims be processed and paid within 10 days of receipt. Provider reimbursement would be at Medi-Cal rates for the Medi-Cal scope of service.

Attracted by minimal paperwork; a source of revenue for traditionally uncompensated care; 10-day payment turnaround; and immediate access to County professional staff activity involved in provider relations, most of the private sector CHDP medical practitioners agreed to participate along with the Health Department. They are supported by 300 private sector specialists, dentists, pharmacies, and hospitals. In just over three years 84,000 provider claims were paid with $3.7 million of cigarette tax revenue. Over 43,000 children have received diagnostic and treatment services.

This unique public/private partnership continues to provide a "medical home" to the "uninsured" children of Orange County bringing some relief to the hospital emergency system.

## Child Health and Disability Prevention (CHDP) Treatment Unit (CTU)

Len Foster, M.P.H.
Deputy Director of Public Health
Orange County Health Care Agency
Santa Ana, CA

California created a companion to the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Entitled the Child Health and Disability Prevention (CHDP) Program, it was the State's attempt to meet the basic health care needs of low income children who do not qualify for Medicaid, as well as to mandate the delivery of EPSDT services uniformly throughout California.

CHDP eligibility criteria (both age and income) have expanded over the years based on the strength of political will and the availability of financing. The Program has been widely viewed as successful in promoting access to preventive health services for low income children and in promoting a uniformity of care. The latter was accomplished by applying EPSDT standards to the scope of screening services made available to this vulnerable population. However, it has been consistently criticized for not providing a mechanism for the treatment of abnormalities. Without the availability of Medicaid coverage, most private providers have historically been reluctant to accept new CHDP eligible low income patients into their practice since they would feel the need to provide treatment without an identifiable source of reimbursement. The absence of a county hospital and primary care clinic system in Orange County posed substantial access problems for CHDP eligibles.

In 1989, the voters of California passed Proposition 99, a popular initiative which significantly increased taxes on tobacco products and allocated new revenue to improve health care services, particularly those that are provided to the medically indigents. As a means of implementing Proposition 99, the California legislature adopted Assembly Bill 75. This statute expanded the CHDP Program to include all children in California from birth to age 18 years whose family income was less than 200% of the federal poverty level. Moreover, the new state law **imposed upon counties** a mandate to provide definitive treatment for all new abnormalities detected during the course of the CHDP health assessment. Statutory language excluded from this mandate children eligible for diagnostic and treatment benefits from other governmental programs, i.e., CCS and Medicaid, or private insurance.

The size of the newly eligible population in Orange County was estimated to be over 310,000. Historical data related to the utilization of CHDP services among the traditionally eligible population, as well as the types of abnormalities detected during screening examinations was used by the County to determine its approach in implementing this new mandate. While significant information about the population was available, little was known about the future cost of services. In consultation with

MCH Program staff, a policy decision was made by the County's Health Care Agency that satisfying the CHDP mandate would be given funding priority in the allocation of the discretionary portion of Proposition 99 revenues. Based on initial cost estimates, a total of slightly over $2.4 million was budgeted. This total appropriation was to cover the cost of administration, medical services, dental services, pharmacy, laboratory, radiology and ambulatory surgery.

Without its own primary care infrastructure, the County was faced with the challenging task of formulating a strategy for ensuring that CHDP eligibles were provided access to diagnostic and follow-up treatment services. The approach taken by many other California counties was to instruct CHDP physicians to refer children with abnormalities to county clinics or the county hospital for diagnosis and treatment. This was a simplistic response, which was easy to implement, and one which took advantage of new revenue to provide some fiscal relief for these financially burdened county health care systems, but one which failed to address the need to establish a "medical home" for each child. The logic was that since many of these "indigent" patients were already being treated in the county health care system, the Proposition 99 revenue was merely paying them for services rendered. Looking to these counties provided Orange County with no viable models.

Although Orange County government had no primary care infrastructure, the county had long utilized contractual relationships with the private sector to accomplish important health care delivery missions. Since the State divested itself of the responsibility for providing care to the Medically Indigent Adult Medicaid patient, Orange County established contracts with nearly all local acute care hospitals, and by extension of their medical staffs, to render the level of care required to satisfy this mandate. The Medically Indigent Adult (MIA) Program placed a capped allocation from which providers drew reimbursement. All providers were at risk since only interim payments (about 40% of existing Medi-Cal rates) were paid upon delivery of services. The extent of further reimbursement was based upon a complex formula related to the volume of services rendered by the individual provider, to total volume of services provided through the network, and the balance in the payment account at the end of the fiscal year. While the private providers were not happy with this reimbursement method, the combination of political pressure, legal mandates placed on hospitals to provide emergency services irrespective of reimbursement, and the sheer volume of patients kept them involved in the MIA Program.

In developing a model for CHDP, it was recognized that long-term relationships had been established between the county and private providers involved with CHDP. The county clinics themselves were the largest single provider of CHDP Program services. The County's historical relationship with CHDP providers enabled the County to make an assessment regarding the extent to which private CHDP providers would be willing to serve as the mechanism by which the County would meet its treatment mandate. Ultimately, it was determined that private CHDP providers would be willing to provide

treatment services to eligibles if the billing process was not burdensome, the payment was prompt, and there was a readily available local resource to address problems related to provider relations. These issues were of much greater concern to the providers than was the level of reimbursement. Because of this finding, the County determined that existing Medicaid reimbursement rates would be utilized in making claim payments. Additionally, this approach would prevent the further expansion of a two-tiered system of health care delivery in the County.

Accordingly, the County decided to use the existing CHDP provider network as the nucleus of the new treatment program. It allocated $1.8 million to a trust fund for the reimbursement of claims. Also, rather than having the County take on the task of processing provider claims for payment, a fiscal intermediary was hired to ensure prompt and accurate payment. A key element of the original fiscal intermediary contract was a provision guaranteeing payment of all claims within 10 days of receipts.

Having acknowledged the mandate, developed its assumptions, appropriated the fiscal resources and determined how the CHDP Treatment Unit (CTU) would be organized, all that remained was to turn a somewhat vague model into a program to deliver high quality health care services to over 300,000 Orange County children in a cost effective manner, within the prescribed fiscal limitations. The challenge of accomplishing the Herculean task fell to Tony Edmonds. He will now describe the implementation and on-going operational phase of the CHDP Treatment Unit (CTU).

Anthony R. Edmonds
MCAH Program Operations Manager
Orange County Health Care Agency
Santa Ana, CA

## INTRODUCTION

CHDP Treatment Unit (CTU):

Late in 1989, California voted in Proposition 99 - the Tobacco Tax Initiative. Assembly Bill (AB) 75 made it law. Revenues raised would go to the counties conditional upon the counties providing diagnostic and treatment services for conditions identified at a CHDP health assessment.

CHDP, or Child Health and Disability Prevention, health assessments have been available to low income "uninsured" children since the 1970s. These comprehensive exams are provided by a network of public/private medical practitioners certified by local Health Departments and reimbursed by the State. AB 75 expanded eligibility for CHDP health assessments to include children 0 to 19 years of age.

My responsibility in April 1990, was to manage a small section of staff charged with administering the CHDP Diagnostic and Treatment Mandate. The section was called the CHDP Treatment Unit - abbreviated to "CTU." The Unit included three staff: myself as manager; a Nurse Consultant; and an Office Technician.

The CTU Nurse Consultant, in consultation with the Health Department Medical Director and the County Dentist, had already developed program guidelines to meet the anticipated needs of the patients, participating providers, and the intent of the legislation. The CTU Program Guidelines are available for your review. My telephone number is on the cover of the guidelines should you want copies.

The County Health Department Child Health Clinics had been providing CHDP services for many years, including diagnostic and treatment services. Clinic services expanded to accommodate the new adolescent eligibles. At that time, two private sector pharmacies agreed to fill CTU prescriptions and one private sector dentist - Dr. David Ward - chose to accept CTU dental referrals.

The County contracted with a local fiscal intermediary for the processing and payment of CTU claims. The contract covered the remaining few months of the fiscal year. Continuation of the contract would be decided by open bid process.

CTU was charged with:

- developing and implementing Program Guidelines
- expanding public sector participation to include private sector CHDP primary care providers
- building a support network of private sector dentists, medical specialists, pharmacies, and hospitals accepting CTU referrals from the primary care providers
- assisting the providers "all the way" in the CTU process
- monitoring the performance of the billing company.

Client/Provider Profile:

Orange County, California is the home of Disneyland. 2.5 million people live there, including the third largest child population of the State's 58 counties. Around 28 percent of the County population is under 18 years of age and approximately 240,000 of these children and teens live below the poverty level with no health insurance. Forty-six percent of these children are minority - primarily Hispanic and Southwest Asian.

In 1990, at the time of the CTU implementation, there were an estimated 222,000 CHDP program eligibles in Orange County i.e., children of low income families with no Medi-Cal (California's Medicaid), and no health insurance. There were 120 medical practitioners providing CHDP health assessments. The County hospital had been sold many years earlier to the University of California, Irvine and there were 32 other private sector hospitals. Approximately 30,000 (or 14 percent) of the eligible CHDP population at that time were given CHDP health assessments. However, it should be noted that the estimated eligible population included children 0 to 19 years of age. The children actually given health assessments were mostly 0 to 7 years of age as the legislation had only recently expanded eligibility to include teens.

The challenge to the County's CHDP program staff was to outreach the teen population and expand the CHDP provider pool. The challenge to the CTU program staff was to have these practitioners agree to participate in CTU and provide diagnostic and treatment services for new conditions identified by them at the time of the CHDP health assessment. These services would be billed to CTU.

## PLANNING

Provider Notification:

The County decided to build the CTU program on the foundation of the existing, primarily private sector, CHDP providership. Advance notice in the form of a CHDP Provider Information Letter was sent to all of the CHDP Providers within the County. The letter outlined the impact of the AB 75 legislation and addressed the role of the

County in implementing the CHDP Treatment Mandate. The concept of CTU was explained and the CHDP providers were invited to be a part of it. It was anticipated that most of these providers would be interested to learn more about CTU because CTU would be a new revenue opportunity for them. Most were already providing diagnostic and treatment services to this population for little to no compensation. The providers were told that the CTU manager would soon visit with each of them to discuss this opportunity further.

Program Guidelines:

The CHDP providers were already billing the State's Medicaid program (known as Medi-Cal) for diagnostic and treatment services to their Medi-Cal population. In order to provide a uniform standard of care to all CHDP eligibles i.e., Medi-Cal, and low income, the County chose to model the CTU program on the Medi-Cal Scope of Service. Providers would be reimbursed at the Medi-Cal Fee Schedule. Program Guidelines were developed to address:

- patient eligibility
- scope of service
- services requiring prior-authorization
- billing procedures
- program standards

Paperwork was to be minimal. To be eligible for CTU services, a patient must first be given a regularly scheduled CHDP health assessment. A copy of the CHDP health assessment report, called a PM 160 (which also serves as the CHDP billing report), and the Client Financial Declaration, called a DHS 4073, would be the patients key to accessing CTU. These documents would also serve as proof of eligibility to the billing company. The CHDP physician would simply attach a copy of the PM 160 and DHS 4073 to a universal billing form and bill for up to four primary care visits related to any one new condition identified at the time of the health assessment. The physician could refer the patient to a medical specialist or a dentist by attaching a copy of the PM 160 to a referral form. The specialist could diagnose the patient and develop a treatment plan, billing CTU by attaching a copy of the PM 160 to a universal billing form. The treatment plan required prior-authorization from CTU. The dentist could clean, examine, and treat, annually, to a ceiling of $350 without prior-authorization, billing the same process as the specialist. Related pharmacy was covered.

Fiscal Intermediary Contract:

Discussions with potential providers had indicated that the key to provider participation was:

- local coordination
- minimal paperwork
- quick processing and payment of provider claims

To this end, the County using the open bid process contracted with a local fiscal intermediary, already under County contract for the adult indigent medical program, to process and pay CTU claims. Under the terms of the contract the billing company was to reimburse providers within 10 working days of receipt of the claim. The billing company was to provide the County with specific weekly, monthly, quarterly and annual reports allowing the County to satisfy State reporting requirements, as well as monitoring and managing the program. A copy of the current CTU fiscal intermediary contract is available for your review.

Program Marketing/Provider Recruitment:

Initially the CTU "customers" were the CHDP practitioners. I understood that there were busy professionals - physicians who would need more than a letter and a copy of program guidelines to entice their participation. I knew that the only way to successfully market CTU to them would be by personal visit. For the first several months CTU grew slowly and I visited almost every CHDP provider in the County. I carried with me some powerful incentives. I told the physicians that:

- revenues would be maximized (they would be paid for traditionally uncompensated care)
- reimbursement for their services would be within 10 days of their claiming
- medical eligibility questions would be answered over the telephone while their patient was still with them, by an experienced Senior Public Health Nurse
- paperwork would be minimal
- suggestions would be encouraged and the program would be customized to meet their ongoing needs

I proposed that both they and their patients would benefit and that they had little to lose in "giving participation a go." There would be no contract, just a signed agreement to participate and abide by the program guidelines. They could withdraw from the program at any time by written notification.

At least 80 percent of the CHDP providers chose to participate, and a small number of medical specialists and dentists from the California Children Services program agreed to accept CTU referrals. Subsequently, this support network of medical specialists, dentists and pharmacists was also built by personal visit, driven largely by personal referral from the CHDP physician.

## PROVIDER NETWORK

Resource Directory:

A computer data base was developed enabling printing and distribution of a CTU Provider Resource Directory. The directory includes provider name, address, telephone, language capabilities, and relevant information such as patient age limitations, office hours, and nearest crossroads. The directory can be printed by city, by provider type, etc.

Currently, in the CTU program's fourth year, provider participation includes:

- 163 CHDP practitioners, including the County Health Department
- 127 private medical specialists, including 24 specialty areas
- 10 dentists, including the County Dentist
- 87 private pharmacies
- 28 private hospitals

## PROVIDER RELATIONS

On-Call Nurse Consultant:

I am a manager with no formal medical background. While I could, and do take the time to consult with the County's "in-house" medical and dental resources, I knew that the participating practitioners needed immediate answers to their questions of medical eligibility. To this end, a Senior Public Health Nurse was assigned to serve as the CTU Nurse Consultant. she had a background in utilization review, a good understanding of the CHDP program and many years of experience working in the California Children Services program (known elsewhere as the Crippled Children's Services program). Working closely with the Health Department Medical Director, and County Dentist this nurse acted as more than just a consultant to the providers. She monitored provider performance, coordinated the prior-authorization process, and case managed the patients through the process.

## PROGRAM ADMINISTRATION

CHDP Linkage:

The Orange County Health Care Agency CHDP program and CTU program are separate budget entities; however, both programs are linked organizationally. I act as the CTU Program Manager and as the CHDP Deputy Director. The CHDP program has assigned a CHDP Nurse Consultant to each of the CHDP practitioners to assist them to appropriately case manage their CHDP patients, to train and update providers and their office staff, and to assist the providers with CHDP billing issues. These nurses

make new CHDP providers aware of the CHDP Treatment Mandate paving the way for the CTU Nurse Consultant's visit. Each CHDP Nurse Consultant is provided with a monthly computer generated log of patients receiving CTU services by whom, for what, and the cost. The CHDP health assessment date is also included. This data assists them to determine that the CHDP patient has received appropriate treatment for any new abnormalities identified at the CHDP health assessment.

Management Reports:

The fiscal intermediary under contract to the County, provides me with a variety of management reports. These reports include:

- weekly individual provider utilization, by ICD 9 code
- monthly summary of individual provider utilization, including number of claims and total cost
- monthly percentage of claims processed and paid within 10 days and longer
- monthly log (cumulative) of patients served, including CHDP health assessment date, ICD 9 codes, provider name and costs
- quarterly reports showing provider summaries, and patients by age and by zip code
- annual reports of provider utilization

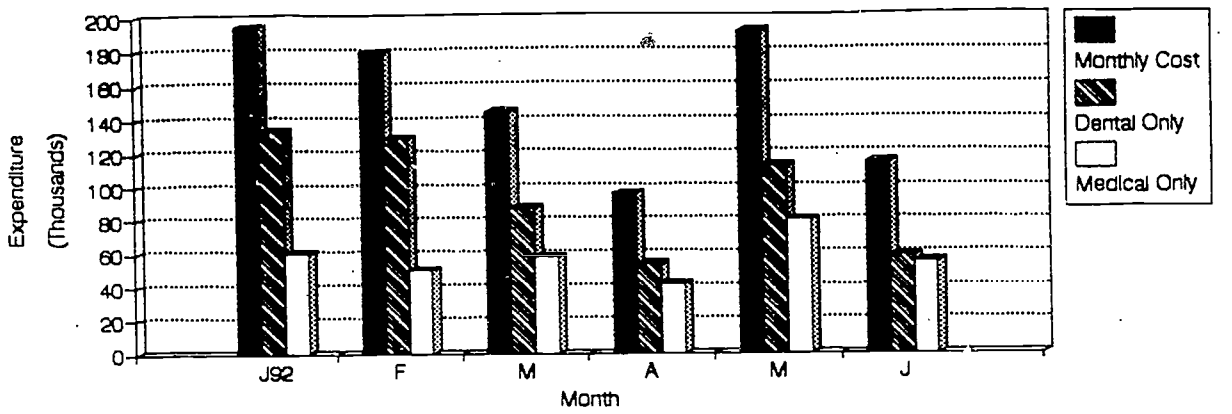
A variety of ad hoc reports are also available. Samples of reports are on display for your review. In addition, I developed a monthly management report, also on display, for use by management as a tool to monitor and plan future program strategies.

Program Integrity - Scope of Service Vs. Budget Constraints:

In the beginning, we knew how many of the CHDP Medi-Cal population were receiving Medi-Cal services and what those services were. However, while we could assume that at least a comparable number of CHDP non-Medi-cal eligibles would require similar services, the eligibility pool was considerably larger. What was the number in that pool and would they all seek these services? Health Care Agency management directed that the CTU program would be the primary recipient of the discretionary portion of the County's share of Cigarette Tax dollars. Initially, CTU was budgeted more than enough funds to meet the legislative mandate in Orange County. However, faced with a declining revenue source as more and more people ceased smoking cigarettes, and faced with a clientele that was growing monthly at an alarming rate, actions had to be taken. CTU in its present form had outgrown the budget as indicated by the following graph:

## CTU EXPENDITURE TRENDS

January - June 1992



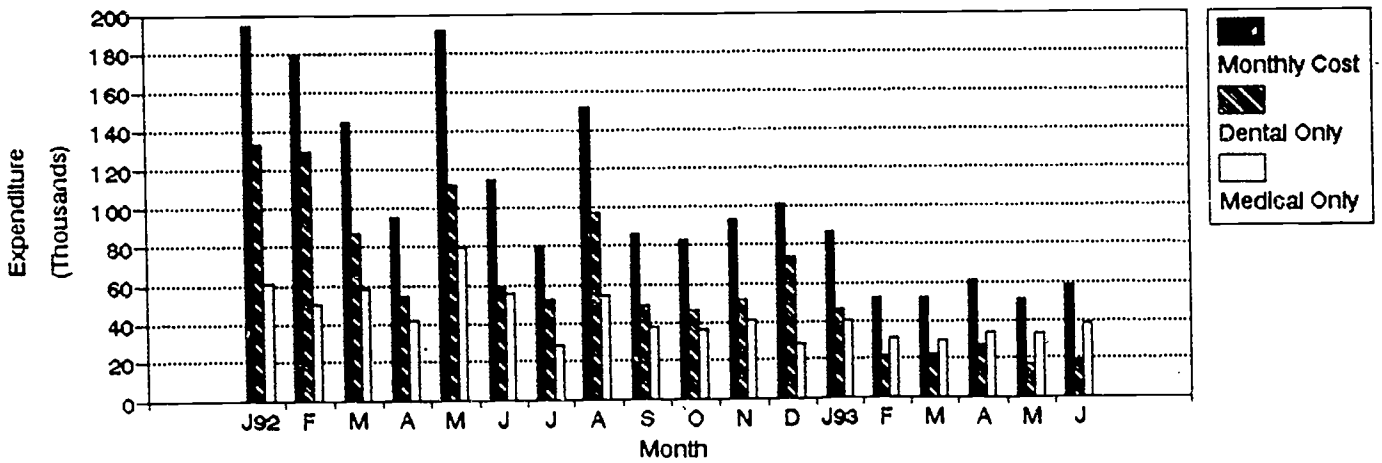

In order to continue to provide both medical and dental services with the limited funds available to the intent of the legislation several actions, all supported by utilization data, were taken. As a result, CTU patients are now eligible for the following services without prior-authorization:

- up to two primary care follow-up visits
- related pharmacy
- basic laboratory and radiology services
- specialist diagnostic services including treatment plan
- dental diagnostic and treatment services to a ceiling of $300 for patient 6 to 19 years

Additional services may be available pending prior-authorization, including urgent dental care for patients 0 to 6 years. Over time these actions have resulted in a scope of service that provides affordable diagnosis and treatment to medically necessary conditions. The financial impact can be seen on the following graph:

# CTU EXPENDITURE TRENDS

January 1992 - June 1993




Quality Assurance:

The CHDP Nurse Consultants randomly select CHDP provider offices for audit, including observation of health assessments, in an effort to assess the standard of medical practice. The CTU Nurse Consultant teams with the Health Department Medical Director to review and approve CTU medical services requiring prior-authorization. Regular audits of the billing company are made to determine that the medical providers are billing, and being paid for CTU approved services. The County Dentist and CTU Nurse Consultant determine that treatment was prior-approved, completed, billed accordingly and paid appropriately. Some medical and dental providers have been denied access to CTU patients due to improprieties found in the quality assurance process.

## IMPACT

Statistical Review:

CTU became operational in April 1990. AB 75, the enabling legislation for the implementation of the Proposition 99 Tobacco Tax sunseted in June 1992. AB 99, continues legislation through to June 1994. Use of Tobacco Tax dollars as a funding stream for the CHDP Treatment Mandate beyond June 1994, is unknown.

CTU continues to be a viable and productive public/private partnership in Orange County:

- 415 CTU participating providers
- 84,000 claims generated, totalling $3.7 million of Tobacco Tax revenue
- 43,000 children have received diagnostic and treatment services.

This unique public/private partnership continues to provide a "medical home" to the "uninsured" children of Orange County bringing some relief to the hospital emergency system.

David Ward, D.D.S.
Private Practice Dentist
Santa Ana, CA

Len Foster and Tony Edmonds and their staffs developed the model and subsequent program to deliver health care services to the many children in Orange County that qualified. Part of the implementation of the program was to recruit providers. I was asked to become one of the many dental care providers.

The letter I received and subsequent visit by the Program Manager inviting me to become a part of the program, included some background information about the program and the nuts and bolts of how the program would work. Everything about the program seemed desirable to me. It provided a relatively complete list of services for children reimbursed at Medi-Cal fees, it called for claims to be processed by an outside insurance administrator, quick processing and payment of claims, availability of program coordinators, and a network of primary care physicians that would make referrals.

## INITIAL REACTIONS FROM A PRIVATE PROVIDER'S PERSPECTIVE

Complete List of Services:

Having a complete list of services was an absolute must. We as providers have a difficult time trying to give treatment when we are limited as to the services we can provide. It makes for improper treatment and many times the patients are dissatisfied and feel as if they have not been treated properly.

Claims Processed by an Outside Insurance Administrator:

I think that government agencies have been unjustly criticized for red tape and paper work. I have had very little complaint about how government agencies have processed my paperwork whether it be taxes, sending me my drivers license, or processing my insurance claims, but we still have fears of claims and x-rays being lost and never found. Having an outside insurance administrator process the claims was therefore very appealing.

Quick Processing and Payment of Claims:

This feature is one that all of us would of course like to have. I'm not even sure it is necessary. We providers assume that when we are dealing with a government agency that it may take longer for us to get paid for what we do. We all expect it and try to adjust accordingly. I think we all feel that the inconvenience of waiting is offset by the fact that we know we will always get paid.

Availability of Program Coordinators:

All of us have had experiences where some piece of paperwork has been lost or handled incorrectly and it seems like it is impossible to get it resolved because there is nobody available to help us. The prospect of having a liaison between the provider and the program seemed very important.

Network of Primary Care Physicians that Would Make Referrals:

This, to me, was by far the most appealing part of the program. Statistics show that few dental practices are fully utilized. We are all hoping for more new patients. The prospect of getting referrals directly from physicians and from a county program can be a tremendous boost to any private dental practice. Also, the prospect of increasing your referral sources by word of mouth can be a beneficial off-shoot of such a program.

I became a dental services provider and have been one for about three years. I have been asked by Mr. Foster and Mr. Edmonds to evaluate how the program has performed from my perspective and why I have continued to be a provider. I have also been asked to give this conference a feeling for how the program functioned to keep the patients in the health care system even though they were not eligible for program benefits after their treatment was completed.

**HOW DID THE PROGRAM LIVE UP TO MY EXPECTATIONS?**

Complete List of Services:

Because of inadequate funding, the program had to cut back on services. For older children some nonessential services were eliminated but the essential scope of the program was kept in tact. For children under six years of age, all services except emergency and potential emergency services were eliminated. It has been somewhat difficult to deal with the treatment limitations of the under six group for the reasons I gave earlier when discussing the need for a complete list of services. The changes for the older children seem to have little or no detrimental effect.

Claims Processed by Outside Insurance Administrator:

This part of the program functioned as promised.

Quick Processing of Claims:

The program did not always live up to its promise on this facet. Mr. Edmonds has outlined how the Program outgrew the budget and what actions had to be taken. Until the actions had an impact, there were periods of time when payments were

delayed. As I mentioned before, this was not a problem because I expected this might happen and adjusted accordingly.

Availability of a Program Coordinator:

This part of the system greatly surpassed our expectations. Our nurse coordinator was always there and there never was a better one. She was always there to answer our questions, hear our complaints, check on a claim, bypass a piece of paperwork, or do whatever was necessary to make sure patients and providers were taken care of.

Network of Primary Care Physicians that Would Make Referrals:

All of my expectations were realized in this area.

**WHY HAVE I CONTINUED TO BE A PARTICIPATING PROVIDER?**

I have continued to be a provider in the program for several reasons. I continue to get referrals from physicians which are a valuable asset to my private practice. The program continues to function very well in its daily operation. I feel I owe the program much loyalty for making my private practice better and I have continued to develop outside referral sources as a direct off-shoot of the program.

**HOW HAS THE PROGRAM PERFORMED IN KEEPING THE PATIENTS IN THEIR HEALTH CARE SYSTEM?**

This has indeed been a very rewarding benefit. We try to make the patients feel that even though their treatment is complete and that their program benefits are over, we still think it is important to have regular check-ups and offer to do these at a reduced fee. We give them a card with the month they should be checked and tell them to call if they want a "check-up appointment." We get several calls weekly for these check-ups.

In conclusion, I feel the CHDP Treatment Unit (CTU) was a program that was well conceived, that has many facets desirable to the private practitioner, and that has benefitted greatly the low income children that it endeavored to provide services for.

# The Role of Urban Health Departments in Medicaid Managed Care: Publicly Funded Managed Care and Children's Health, An Urban Perspective

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Chief, Section on Child Health Policy
Department of Pediatrics, University of Nebraska Medical Center
CityMatCH Executive Director

Managed care seems to have taken the nation by storm. In a recent report issued in March 1993[1] on Medicaid Managed Care, the General Accounting Office (GAO) estimated that between 1987 and 1992, state enrollment of Medicaid beneficiaries in managed care plans has more than doubled; that two-thirds of states now have some managed care program; and by 1994, nearly all states are expected to have at least one managed care program in place. Since 1985, there has been an estimated 200% increase in the number of Medicaid recipients in managed care plans. States are motivated to adopt managed care in large part to control escalating costs of Medicaid, while also seeking to improve access to health services, particularly for low income women and children.

Managed care is not a single health care system, but a continuum of models of health services delivery which share a common approach. Managed health care plans manage the use and cost of services through such devices as second opinions, utilization review, physician gatekeepers, and financial incentives to reduce unnecessary services. There are many options under managed care. One set of options, including Health Maintenance Organizations (HMOs), Prepaid Health Plans (PHPs), and Health Insuring Organizations (HIOs), are based on capitated or risk-based contracting. Another set of options, including Primary Care Case Management (PCCM) and Specialty Care Case Management (SCCM), focus on gatekeeping or case management contracting. In short, managed care systems aim to encourage consumers to receive the highest quality care by the most appropriate provider in the most appropriate setting.

There have been several general concerns raised in tandem with the onslaught of managed care systems:

- **Are managed care plans financially solvent?**
- **Do managed care plans create incentives to underserved clients, such as Medicaid recipients?**
- **Are requirements in risk-based or capitated contracting adequate?**
- **Is enrollment sufficient to spread financial risk?**
- **Is effective quality assurance given sufficient emphasis in managed care programs?**

And as managed care programs have been implemented in many states, other questions have been raised based in part on hard lessons learned:

- **Has sufficient time been put into planning?** Some states have rushed into managed care arrangements without developing the operational structure necessary for a program that is far different from fee-for-service models.
- **Are there sufficient, expert staff to guide implementation?** In many states, the infrastructure of the current Medicaid and public health systems already is stretched thin.
- **Has enough effort been made to develop an adequate community base of support?** Building a strong constituency at the local level, physicians, and other key providers, is critical to the success of the program.
- **Have there been adequate efforts to educate consumers about how to use a managed care system and about what choices they have?** Assignment of a consumer to a primary care physician gatekeeper does not guarantee access to health care if that consumer is not informed and willing to comply with a new set of rules for obtaining care.

Of note in the rapid onset of managed care programs in Medicaid is the focus on the maternal and child health population. Most Medicaid managed care programs target pregnant women and children, not the elderly or disabled. Yet, its impact on women, infants, children and adolescents is not known. Impact on what?

- ACCESS TO CARE
- UTILIZATION OF CARE
- QUALITY OF CARE
- SATISFACTION
- PROVIDER PARTICIPATION
- ENROLLMENT AND DISENROLLMENT
- COST AND REIMBURSEMENT

In a recent briefing report on the impact of Medicaid managed care on children and adolescents, Fox and McManus[2] summarized findings from studies conducted in the past decade on various dimensions of the impact of managed care, as follows:

- On <u>access to care</u>, the literature shows that with the introduction of managed care, children's usual source of care shifts to physicians' offices and away from clinics and hospital outpatient departments. Overall availability of services is perceived as better in managed care plans than in fee-for-service plans.
- On <u>utilization</u>, emergency room and specialist physician services have been reduced, while inpatient hospital use results vary. Few differences have been found in primary and preventive care use among managed care and fee-for-service enrollees.

- On quality of care, no major differences have been reported with regard to the few health status outcomes studied -- perceived health status, immunization rates, low birthweight rates, and other screening results.
- On satisfaction, overall consumer satisfaction is lower among managed care enrollees, though in general satisfaction among families with Medicaid-insured children is quite high.
- On provider participation, the literature shows that adequacy of payment rates and desire to retain Medicaid market share are the major factors that influence whether or not providers participate in managed care.
- On enrollment and disenrollment, the literature reveals difficulties associated with relying primarily on eligibility workers to enroll and educate Medicaid families in managed care and with maintaining a stable enrollment base when children go on and off Medicaid so rapidly.
- On costs and reimbursements, studies show that compared to fee-for-service arrangements, managed care is either cost-neutral or results in savings ranging as high as 15 percent. Cost savings have been less than anticipated due to high administrative costs and capitation rates in managed care.

This year's Urban MCH Leadership Conference follows in the tradition set by City**Mat**CH four years ago: to offer a stimulus to the health and human services community in urban areas nationwide regarding current health policy concerns affecting urban children and their families. As we listen to our panelists today and as we embark on a conversation about managed care and children's health, let us keep in mind some final issues raised by the Association of Maternal and Child Health Programs in its recent discussion paper on managed care and maternal and child health[3], excerpts of which are as follows:

- "Women and children are being enrolled first, making specific attention to their needs imperative. Managed care is growing under Medicaid, and many health care reform initiatives would start by phasing in coverage of women and children. All women, children and adolescents have unique service needs. Families stressed by such problems as poverty, homelessness, or substance abuse require additional and more intensive services, as do children with chronic or complex medical conditions or disabilities. These basic and special needs of women, children and adolescents must be addressed in design of managed care."
- "Managed care must fit with initiatives developing comprehensive, family-centered, community-based systems of health, social and education services. Public policies and public-private partnerships are supporting new, better integrated approaches to child and family services. Services increasingly are being provided at easily accessible sites, including schools, day care and Head Start, and the home. Public and nonprofit providers, bound by missions and mandates and subsidized

to reach culturally diverse, high-risk and special needs groups, aim to provide coordinated community services that promote healthy growth and development of children and support families. Managed care must be a functional component of these existing and evolving systems."

- "Public health's responsibility for the entire population's health must be recognized in planning for managed care. Managed care plans cannot assume responsibility for population-based health promotion and disease prevention services such as eliminating sources of lead or analyzing health outcomes, such as infant mortality, for the entire population. Nor will managed care plans be responsible for availability of services outside their service area borders. These are public responsibilities carried out through core public health functions of assessment, policy development and assurance. Managed care can contribute to or undermine these public health responsibilities, with provisions for financing, data collection, and quality assurance particularly critical to public health's ability to promote the health of the entire population."

My current home state of Nebraska is one of a few states which is considering managed care, but has not decided upon which model(s). In Omaha we are struggling with Medicaid managed care in the wake of FY 94 legislation mandating a system in Omaha by at least 1994. The President's Health Care Task Force recommendations on health care reform are being released as we speak. Regardless of State and National action, there will be impact felt locally, especially in major urban communities nationwide.


1. MEDICAID: States turn to managed care to improve access and control costs. United States General Accounting Office, Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives. March 1993.

2. Fox HB and McManus MA: Medicaid managed care arrangements and their impact on children and adolescents: a briefing report. Fox Health Policy Consultants and McManus Health Policy, Inc., November 1992.

3. Managed care for women, children, adolescents & their families: a discussion paper with recommendations for assuring improved health outcomes and roles for state MCH programs. Association of Maternal and Child Health Programs, March 1993.

# The Role of Urban Health Departments in Medicaid Managed Care: Lessons from Boston, Massachusetts

Lillian Shirley, RN, MPH
Director of Family Health Services
Boston Department of Health & Hospitals
Boston, MA

## The Challenges

The dual goals of managed care have been to improve quality and contain costs. The challenges of this duality for local health departments are at least three-fold. The first is how to increase the percentage of the population receiving preventive services when the health department no longer pays directly for them. Second is how to create enhanced access when authorizing or utilizing a service across town or in school may result in lost revenue. Last is how to engage primary care providers and educators with recipients in the process of defining strategies for identifying what services are needed and how they will be implemented.

Medicaid managed care is provider driven, and as currently implemented, health care is **medical** care. The primary care gateway has all the dollars and makes all the decisions. Competition will follow for enrollment into managed care systems. Under a competitive model, there is no such thing as "enough" paying customers, resulting in excess capacity. These dynamics have consequences at the local level. Epidemiology and data will be used less and less to inform systems development. Medical care providers will do more and better of what they do. Local taxpayers will not allow "double dipping." As a result, the local public sector can be shut out of the game in two ways: First, as a provider. There may be no more need to sustain the missions of institutions of last resort, assuming that all will have access to and utilize the managed care providers assigned. Second, as a player. New managed care systems are set up to meet the medical needs of individuals; local health departments are organized to promote the health and well being of populations. And with most health care reform plans placing the onus of accountability at the state and national levels, the role for local health departments is even less clear.

## The Role of Local Health Departments

The local health department's role in Medicaid managed care should be one akin to a traffic cop for health care. In Boston, we have learned how important it is for the health department to assure standards and outcome measures and define the terminology of those standards for all parties within the health department's jurisdiction. Local public health leaders in managed care must understand what life is like for the client we are planning for and intending to serve. If we can develop this

role, with a strong community orientation, we can claim a place at the table for deciding how managed care is to be implemented in our jurisdictions. Moreover, the health department has to develop the political consensus for a health care agenda - and to get and keep health on the Mayor's agenda.

To date, the enrollment of Medicaid clients in managed care has not made the fundamental system cost less. HMO costs have increased along with the costs of other insurance in the last year. Under its managed care plan, the Massachusetts legislature mandated a higher rate per enrolled Medicaid recipient from high risk urban areas, assuming that urban clients will need more ancillary services like nutrition counseling and home visitation. However, providers of these ancillary services have to ask permission from the HMO to provide these kinds of services to clients; time and time again it is a battle.

Principles of Medicaid Managed Care

In Boston we have discussed and debated some basic principles to ensure a quality managed care system for the greatest number of citizens. These relate to primary care, comprehensive services, and community orientation. Boston has used its HRSA Healthy Start award to fund projects to promote this broader understanding of health care.

1. *Primary health care* should be ongoing and available to women regardless of reproductive or pregnancy status. To achieve this, policy-makers should ensure:

    - The provision of care by interdisciplinary teams with the patient advocate as the focal point of care;
    - The expansion of nurse practitioners and nurse-midwives as primary care providers;
    - The inclusion of postpartum risk assessment and coordination of all reproductive health services and well-child care;
    - Increased outreach and media campaigns to promote primary care for women/women's health issues;
    - Enhanced outreach and media campaigns to promote primary care for women/women's health issues;
    - Enhanced training of providers to value primary care; and
    - Strong linkages with primary prevention and health promotion programs which are provided by the public health sector.

2. *Comprehensive services* refers to the inclusion of a wide range of social services in a *standard benefit package*: health services, family planning counseling, domestic violence-related services, substance abuse treatment, and assistance with entitlements.

   - Reimbursement for these services must be comprehensive, disallowing "carve-outs" for ancillary services; and
   - A patient advocate/ombudsman or woman should form the core of the health provider team, responsible for coordinating services and assisting the woman with navigating and understanding information and services.

3. *Community-oriented services* are those for which the community served is both empowered to plan and accountable to monitor.

   In particular women in the community must be given a voice in creating the system of services. They can provide "technical assistance" to health professionals in planning and quality assurance.

Final Thoughts from Boston

Based on our experience, we suggest that managed care systems:

- Be designed as an integrated health care delivery system, not a hospital-based system;
- Be, and be perceived as, the highest quality provider of patient care and service;
- Be seamless from the perspective of users, buyers and payors; act in concert vis-a-vis payors;
- Incorporate physicians and non-hospital institutions;
- Be geographically well-designed to provide coverage;
- Be competitively superior in cost effective care delivery; and
- Facilitate the fulfillment of individual institutional missions and commitment to their local communities.

***Editor's note:*** *Lillian Shirley was asked to tell the story of managed care implementation in Boston, MA, where she is the Director of Family Health Services. Above are highlights of her presentation, capturing the key lessons learned from an urban MCH perspective. For more information about the Boston experience, contact Ms. Shirley directly at the Boston Department of Health and Hospitals (see Appendix A).*

## Closing Remarks

Kathy Carson, R.N.
Chair, 1992-1993 CityMatCH Board of Directors
Coordinator, Maternal and Child Health
Seattle-King County Department of Public Health
Seattle, Washington

Our topic for this meeting and a theme at all of our conferences has been linkages. We have talked about linking with our colleagues at the federal and state levels, with our co-sponsors, with other agencies in our communities, and with the community members that we serve.

But we have another opportunity for linkages that can be just as valuable as all of these, and that is the linkage to each other that is offered to us by CityMatCH.

This conference gives us the easiest way to make that linkage - we get to meet each other, hear our stories, share ideas, support each other in our frustrations - in other words, make new friends. The linkages I have made through CityMatCH have enriched my life. I am amazed by the energy and dedication of you, my colleagues. My problems seem somehow more manageable when I see how similar they are to problems you are also facing every day. Your interest and support buoys me up.

The benefits CityMatCH has brought me are not only personal. My Health Department and my community have benefitted from the ideas and inspiration I have gotten from you - at the conference, through your profiles, in *CityLights* articles, in our survey results and *What Works*, and in individual communications.

Especially this week with the historic events that have taken place in Washington, I am reminded of what Margaret Mead once said:

> *"Never doubt that a small group of committed citizens can change the world."*

We are a community of committed citizens that stretches across the country. Our ability to change the world that we care about - the women, children and families of America, is strengthened by the fact that we are linked in this CityMatCH community. I thank you for that and look forward to continuing to work with you to change the world.

# CITIES INCLUDED IN 1993 PROFILES:

# 1993

## Profiles of Urban Health Department Initiatives

### Reaching Out to Urban MCH Populations

| | Women's Health | | | Perinatal Health | | | | | | Child Health | | | | | | | | Adolescent Health | | | | Other | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Preconception health promotion | Family planning | Breast/cervical cancer | Prenatal care | Expanding maternity services | Home visiting | Low birthweight/infant mortality | Substance abuse prevention/treatment | Breastfeeding/nutrition/WIC | Immunization | Early intervention/zero to three | EPSDT/screenings | Expanded child health services | Injury (including child abuse) | Lead poisoning | Children with special health care needs | School-linked/school-based services | School-linked/school-based services | Violence prevention/youth-at-risk | Teen pregnancy | Teen parenting | Communicable diseases: STD, HIV/AIDS, TB, HepB | Other* |
| Akron, Ohio | | | | | | | | | | ♦ | | | | | | | | | | | | | |
| Albuquerque, New Mexico | | | | ♦ | | | | | ♦ | | | | | | | | | | | ♦ | | | |
| Anchorage, Alaska | | | | | | | | | | | | | | ♦ | | | | | | | | | |
| Aurora, Colorado | | | ♦ | | | | | | | | | | | | | | | | | | | | |
| Austin, Texas | | | | | | | | | | | | | | | | | ♦ | | | | | | |
| Bakersfield, California | ♦ | | | ♦ | | | ♦ | | | | | | | | | | | | | | | | |
| Baltimore, Maryland | | | ♦ | | | | | | | | | | | | | | | | | | | | |
| Boise, Idaho | | | | | | | | | | | ♦ | ♦ | | | | | | | | | | | |
| Boston, Massachusetts | | | | | | | | | | | | | | | | | | ♦ | | | | | |
| Charlotte, North Carolina | | | | | | | | | | | | | | | | | | | ♦ | | | | |
| Chattanooga, Tennessee | | | | | | | | | | ♦ | | | | | | | | | | | | | |
| Chicago, Illinois | | | | | | | | | | | | | | | ♦ | | | | | | | | |
| Cleveland, Ohio | | | | | | | ♦ | | | | | | | | | | | | | | | | |
| Colorado Springs, Colorado | ♦ | ♦ | | | | | | | | | | | | | | | | | | | | | |
| Columbus, Ohio | | | | | | | ♦ | | | | | | | | | | | | | ♦ | | | |
| Corpus Christi, Texas | | ♦ | | | | | | | | | | | | | | | | | | ♦ | | | |
| Dallas, Texas | | | | | | | | | | | | | | | | | | | | | | | |
| Dayton, Ohio | | | | | | | | | | | | | | | | | | | | | ♦ | | |
| Denver, Colorado | | | | | | | | ♦ | | | | | ♦ | | | | ♦ | ♦ | | | | | |
| Detroit, Michigan | | | | | | | | ♦ | | | | | | | | | | | | | | | |
| El Paso, Texas | | | | | | | | | | ♦ | | | ♦ | | | | | | | | | | |
| Erie, Pennsylvania | | | | | | | | | | ♦ | | | ♦ | | | | | | | | | | |
| Eugene, Oregon | | | | | | | ♦ | | | | ♦ | | | | | | | | | | | | |
| Flint, Michigan | | | | | | | ♦ | | | | | | | | | | | | | | | | |
| Fort Worth, Texas | | | | | | | | | | ♦ | | | ♦ | | | | ♦ | | | | | | |
| Gary, Indiana | | | | ♦ | | | | ♦ | | | | | | | | | | | | ♦ | | | |
| Grand Rapids, Michigan | | | | ♦ | | | ♦ | | | | | | | | | | | | | | | | |
| Hartford, Connecticut | | ♦ | | | | | | | | | | | | | | | | | | | ♦ | | |
| Honolulu, Hawaii | | | | ♦ | | | | | | | | | | | | | | | | | | | |
| Indianapolis, Indiana | | | | | | | ♦ | | | | | | | | | | | | | | | | |
| Jackson, Mississippi | | | | | | | | | | | | | ♦ | | | | | | | | | | |
| Jacksonville, Florida | | ♦ | | ♦ | | ♦ | ♦ | | | | | | | | | | | | | | | | |
| Jersey City, New Jersey | | | | | | | | | | ♦ | | | ♦ | | | | | | | | | | |
| Kansas City, Missouri | | | | | | | | | | | | | | | ♦ | | | | | | | | |
| Knoxville, Tennessee | | | | | | | | | | ♦ | | | | | | | | | | | | | |
| Laredo, Texas | | | | | | | | | ♦ | | | | | | | | ♦ | | | | | | 1 |
| Lexington, Kentucky | | | | | ♦ | | | | ♦ | | | | | | | | | | | | | | |
| Lincoln, Nebraska | | | | | | ♦ | | | | | | | | | | | | | | | | | |
| Little Rock, Arkansas | | | | | | | | | | ♦ | | | | | | | | | | | | | |
| Los Angeles, California | | | | | | | | | | | | ♦ | ♦ | | | | | | | | | | 2 |
| Louisville, Kentucky | | | | | | ♦ | | | | | | | ♦ | | | | | | | | | | |
| Lubbock, Texas | | | | ♦ | | | | | | ♦ | | | | | | | | | | | | | |
| Madison, Wisconsin | | ♦ | | | | | | | | | | | ♦ | | | | | | | | | | |
| Memphis, Tennessee | ♦ | ♦ | | | | | | | | | | | | | | | | | | | | ♦ | |
| Miami, Florida | | | | ♦ | | | | | | | | | | | | | | | | | | | |

*Key: 1=Neural tube defects 2=Foster care 3=Adult education 4=Job training

# 1993

## Profiles of Urban Health Department Initiatives

| | Improving Access to Care for Urban Children and Families | | | | | | | | | | | | Strengthening Urban Public Health Systems for MCH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Overcoming racial/ethnic/language/ cultural barriers | Reducing transportation barriers | Expanding private sector linkages | Clergy and health connections | Housing and health connections | Schools and health connections | One-stop shopping, co-location of services | Using mobile vans, clinics for outreach | Other outreach activities | Increasing social support systems | Case management/care coordination | Increasing access to Medicaid | Staff training | Strategic planning for urban MCH | Reshaping financing for urban MCH | Securing urban MCH technical assistance | Managed care initiatives | Building coalitions and partnerships | Building MCH data capacity | Immunization tracking, recall systems | Infant/child death review activities |
| Akron, Ohio | | | | | | | | | | | | | | | | | | ♦ | | ♦ | |
| Albuquerque, New Mexico | | | | | | | | | | | | | | | | | | | | | |
| Anchorage, Alaska | | | | | | | | | | | | | | | | | | | | | |
| Aurora, Colorado | | | | | | | | | | | | | | | | | | | | | |
| Austin, Texas | | | | | | ♦ | | | | | ♦ | | | | | | | | | | |
| Bakersfield California | ♦ | | | ♦ | | | | | | | | | | | | | | | | | |
| Baltimore, Maryland | | | | | | | | | | | | | | | | | | ♦ | | | |
| Boise Idaho | | | | | | | | | | | | | | | | | | | | | |
| Boston Massachusetts | | | | | | ♦ | | | | | | | | | | | | ♦ | | | |
| Charlotte North Carolina | | | | | | | | | | | | | | | | | | | | | |
| Chattanooga, Tennessee | | | ♦ | | | | | | | | | | | | | | | | | ♦ | |
| Chicago, Illinois | | | | | | | | | | | | | | | | | | ♦ | | | |
| Cleveland, Ohio | | | | | | | | | ♦ | | | | | | | | | ♦ | ♦ | | |
| Colorado Springs, Colorado | | | | | | | | | | | | | | | | | | | | | |
| Columbus, Ohio | ♦ | | | ♦ | | | | | | | | | | | | | | | | | |
| Corpus Christi Texas | | | | | | | | | | | | | | | | | | | | | |
| Dallas, Texas | | ♦ | | | | | | | | | ♦ | | | | | | | | | | |
| Dayton Ohio | | | | | | | | | | ♦ | ♦ | | | | | | | ♦ | | | |
| Denver Colorado | | | | | | ♦ | | | | | ♦ | | | | | | | ♦ | | | |
| Detroit, Michigan | | ♦ | | | | | | | | | ♦ | | | | | | | | | | |
| El Paso, Texas | | | | | | | | | | | | | | | | | | ♦ | | | |
| Erie, Pennsylvania | | | | | | | | | | | | | | | | | | ♦ | | | |
| Eugene, Oreon | | | | | | | | | | | ♦ | | | | | | | | | | |
| Flint, Michigan | | | | | | | | | | | | | | | | | | ♦ | ♦ | | |
| Fort Worth, Texas | | | | | | ♦ | | | | | | | | | | | | ♦ | | | |
| Gary Indiana | | | | | | | | | | | | | | | | | | | | | |
| Grand Rapids Michigan | | | | | | | | | | | | | | | | | | ♦ | | | |
| Hartford Connecticut | | | | | | | | | | ♦ | ♦ | | | | | | | | | | |
| Honolulu Hawaii | ♦ | | | | | | | | ♦ | ♦ | | | | | | | | ♦ | | | |
| Indianapolis Indiana | | | | | | | | | | | | | | | | ♦ | | | | | |
| Jackson, Mississippi | | | | | | | | | | | | ♦ | | | | | | | | | |
| Jacksonville, Florida | | | | | | | ♦ | ♦ | | | ♦ | | | | | | | | | | |
| Jersey City, New Jersey | | | | | | | | | | | | | | | | | | | | ♦ | |
| Kansas City, Missoun | | | | | | | | | | | | | | | | | | | ♦ | | |
| Knoxville, Tennessee | | | | | ♦ | | | | | | | | | | | | | ♦ | | | |
| Laredo Texas | | | | | | | | | | | | | | | | | | | ♦ | | |
| Lexington Kentucky | | | | | | | ♦ | | | | | | | | | | | | | | |
| Lincoln Nebraska | ♦ | ♦ | ♦ | | | | | | | | ♦ | ♦ | | | | | | | | | |
| Little Rock Arkansas | | | | | | | | | | | | | | | | | | | ♦ | ♦ | |
| Los Angeles California | | | | | | | | | | | | | | | | | | | | | |
| Louisville, Kentucky | | | | | | | | | ♦ | | ♦ | | | | | | | | | | |
| Lubbock, Texas | | | | | ♦ | | | | ♦ | | | | | | | | | | | | |
| Madison, Wisconsin | | | | | | | ♦ | | | ♦ | | | | | | | | | | | |
| Memphis, Tennessee | | | | | | | | | | | | | | | | | | | | | |
| Miami, Florida | | ♦ | | | | | | ♦ | | | | | | | | | | | | | |

# 1993

## Profiles of Urban Health Department Initiatives

### Reaching Out to Urban MCH Populations

| | Women's Health | | | Perinatal Health | | | | | | Child Health | | | | | | | | Adolescent Health | | | | Other | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Preconception health promotion | Family planning | Breast/cervical cancer | Prenatal care | Expanding maternity services | Home visiting | Low birthweight/infant mortality | Substance abuse prevention/treatment | Breastfeeding/nutrition/WIC | Immunization | Early intervention/zero to three | EPSDT/screenings | Expanded child health services | Injury (including child abuse) | Lead poisoning | Children with special health care needs | School-linked/school-based services | School-linked/school-based services | Violence prevention/youth-at-risk | Teen pregnancy | Teen parenting | Communicable diseases: STD, HIV/AIDS, TB, HepB | Other* |
| Milwaukee, Wisconsin | | | | | | | | ♦ | | | | | | ♦ | | | | | | | | ♦ | |
| Minneapolis, Minnesota | | | | | | | | | | | | | | | | | | | | | | | |
| Missoula, Montana | | | | | | | ♦ | | | | ♦ | | | | | | | | | | | | |
| Mobile, Alabama | | | | | ♦ | ♦ | | | | | ♦ | | | | | | | | | | | | |
| Modesto, California | | | | ♦ | | | | | | | | | | | | | | | | | | | |
| Nashville Tennessee | | | | | | ♦ | | | | | | | | | | | ♦ | | | | | | |
| Newark New Jersey | | | | ♦ | | ♦ | | | | | | | | | | | | | | | | | |
| New Haven Connecticut | | | | | | | ♦ | | | | | | | | | | | | | | | | |
| New York New York | | | | | | | | | | | | | | | | | | | | | | | |
| Norfolk Virginia | | | | | | | | | | | | | | | | | ♦ | | | | | | 3 |
| Oklahoma City Oklahoma | | | | | | | | | | ♦ | | | | | | | | | | | | | |
| Omaha, Nebraska | | | | | | | | | | ♦ | | | | | | | | | | | | | |
| Orlando, Florida | | | | | | | | ♦ | | | | | | | | | | | | | | | |
| Pasadena, California | | | | ♦ | | | | | | | | | | | | | | | | | | | |
| Peoria, Illinois | | | | ♦ | | | ♦ | | | | | ♦ | | | | | | | | | | | |
| Philadelphia Pennsylvania | | | | | | ♦ | | | | | | | | | | | | | | | | | |
| Phoenix Arizona | | ♦ | | ♦ | | | | | | ♦ | ♦ | | | | | | | | | ♦ | | | |
| Pittsburgh Pennsylvania | | | | | | | | ♦ | | | | | | | | | | | | | | | |
| Portland, Maine | | | | | | ♦ | | | | | | | | | | | | | | ♦ | ♦ | | 3 |
| Portland Oregon | | | | | | | | | | | | | | | | | | | | ♦ | ♦ | | |
| Providence, Rhode Island | | | | ♦ | | | | | ♦ | | | | | | | | | | | | | | |
| Raleigh, North Carolina | | | | ♦ | | | | ♦ | | | | | | | | | | | | | | | |
| Richmond, Virginia | | | | | | | | | | ♦ | | | | | | | | | | | | | |
| Rochester, New York | | | | ♦ | | ♦ | | | | | ♦ | | | | | | | | | | | | |
| Salem, Oregon | | | | | | | | ♦ | | | | | | | | | | | | | | | |
| Salt Lake City Utah | | | | | | | | ♦ | | | | | | | | | | | | | | | |
| San Antonio Texas | | | ♦ | | | | | | | | | | | | | | | | | | | | |
| San Diego, California | | | | | | | | | | | | | | | | | | | | | | | |
| San Juan Puerto Rico | | | | | | | | | | ♦ | | | ♦ | | | | | | | | | | |
| Santa Ana Anaheim CA | | | | | | | | | | | | | | | | | | | | | | | |
| Santa Rosa, California | | | | | | | | | | | | | | ♦ | | | | | | | | | |
| Seattle, Washington | | | | | | | | | ♦ | ♦ | | | ♦ | | | | | | | | | | |
| Spokane, Washington | | | | | | | | | ♦ | | | | | | | ♦ | | | | | | | |
| Springfield, Missouri | | | | | | | | | | | | | ♦ | | | | | | | | | | |
| St. Paul, Minnesota | | | | | | | | | | ♦ | | | | | | | | | | | | ♦ | |
| St Petersburg Florida | | | | | | ♦ | | | ♦ | ♦ | | ♦ | | | | | | | | | | | |
| Stockton California | | | | | | | ♦ | ♦ | | | | | | | | | | | | | | | |
| Tacoma Washington | | | | | | | | | | | | | | | | | | | ♦ | | | | 4 |
| Toledo Ohio | | | | | ♦ | | | | | | | | ♦ | | | | | | | | | | |
| Tucson Arizona | | ♦ | | ♦ | | | | | | | | | | | | | | | | | | | |
| Tulsa, Oklahoma | | | | | | | | | | ♦ | | | | | | | | | | | | | |
| Washington, D C | | | | | | | ♦ | | | | | | | | | | | | | | ♦ | | |
| Wichita, Kansas | | | | | | | | ♦ | | | | | | | | | | | | | | | |
| Wilmington, Delaware | | | | | | | | | | | | | | | ♦ | | | | | | | | |
| Yonkers New York | | | | ♦ | | | | | | | | | | | | | | | | | | | |

*Key 1=Neural tube defects 2=Foster care. 3=Adult education 4=Job training

# 1993

## Profiles of Urban Health Department Initiatives

| | Improving Access to Care for Urban Children and Families | | | | | | | | | | | | Strengthening Urban Public Health Systems for MCH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Overcoming racial/ethnic/language/ cultural barriers | Reducing transportation barriers | Expanding private sector linkages | Clergy and health connections | Housing and health connections | Schools and health connections | One-stop shopping, co-location of services | Using mobile vans, clinics for outreach | Other outreach activities | Increasing social support systems | Case management care coordination | Increasing access to Medicaid | Staff training | Strategic planning for urban MCH | Reshaping financing for urban MCH | Securing urban MCH technical assistance | Managed care initiatives | Building coalitions and partnerships | Building MCH data capacity | Immunization tracking, recall systems | Infant/child death review activities |
| Milwaukee, Wisconsin | ♦ | | | | | | | | | | ♦ | | | | | | | ♦ | ♦ | | |
| Minneapolis, Minnesota | | | | | | | | | | | ♦ | ♦ | | | | | | | | | |
| Missoula, Montana | | | ♦ | | | | | | | | | ♦ | | | | | | | | | |
| Mobile, Alabama | | | | | | | | | | | | | | | | | | | | | |
| Modesto, California | | | | | | | ♦ | | | | | ♦ | | | | | | | | | |
| Nashville, Tennessee | | | | | | ♦ | ♦ | | | | ♦ | | | | | | | | | | |
| Newark, New Jersey | | | | | | | | | | | ♦ | | | | | | | | ♦ | | |
| New Haven, Connecticut | ♦ | | | | | | | | ♦ | ♦ | | ♦ | | ♦ | ♦ | | | | | | |
| New York, New York | | | ♦ | | | | | | | | | | | | | | ♦ | | | | |
| Norfolk, Virginia | | ♦ | | | | ♦ | ♦ | | | ♦ | | | | | | | | ♦ | | ♦ | |
| Oklahoma City, Oklahoma | ♦ | | | | | ♦ | ♦ | | | | | | | | | | | ♦ | | ♦ | |
| Omaha, Nebraska | | | | | | | | | | | | | | | | | | | | | |
| Orlando, Florida | | | | | | | | | | ♦ | | | | | | | | | | | |
| Pasadena, California | ♦ | | | | | | | | | | | ♦ | | | | | | | | | |
| Peoria, Illinois | | | | | | | | | | | ♦ | | | | | | | | | | |
| Philadelphia, Pennsylvania | | | | | | | | | ♦ | | | | ♦ | | | | | ♦ | | | |
| Phoenix, Arizona | | | | | | | ♦ | | | | | | | | | | | ♦ | | | |
| Pittsburgh, Pennsylvania | | | | | | | | | ♦ | | | | | | | | | | | | |
| Portland, Maine | | | | | | ♦ | | | | | | | | | | | | | | | |
| Portland, Oregon | | | | | | | | | | | ♦ | | | | | | | | ♦ | | |
| Providence, Rhode Island | | | | | | | | | | | ♦ | | | | | | | | | | |
| Raleigh, North Carolina | | | | | | | | | | | ♦ | | | | | | | | | ♦ | |
| Richmond, Virginia | | | ♦ | | | | | | | | | | | | | | | | | | |
| Rochester, New York | | | | | | | | | | | | | | | ♦ | | | | | | |
| Salem, Oregon | | | | | ♦ | | | | | | ♦ | | | | | | | | | | |
| Salt Lake City, Utah | | | | | | | | | | | ♦ | | | | | | | | | | |
| San Antonio, Texas | ♦ | | | | | | | | | | | | | | | | | | | | |
| San Diego, California | | | | | | | | | | | | | | ♦ | | | | ♦ | | | |
| San Juan, Puerto Rico | | | | | | | | | | | | | | | | | | ♦ | | | |
| Santa Ana, Anaheim, CA | | | ♦ | | | | | | | | ♦ | ♦ | | | | | | ♦ | | | |
| Santa Rosa, California | | | | | | | | | | | | | | | | | | | ♦ | | ♦ |
| Seattle, Washington | | | ♦ | | | | | | | | | | | | | | | | ♦ | | |
| Spokane, Washington | | | | | | | | | | | ♦ | | | | | | | | | | |
| Springfield, Missouri | | | | | | | | | | | | | | | | | | ♦ | | | |
| St. Paul, Minnesota | | | | | | | | | | | | | | | | | | | | | |
| St. Petersburg, Florida | | ♦ | | | | | | | | | ♦ | ♦ | | | | | | | | | |
| Stockton, California | | | | | | | | ♦ | | | | | | | | | | | | | |
| Tacoma, Washington | ♦ | | | | | | | | | | | | | | | | | | | | |
| Toledo, Ohio | | | | | | | | | | | | | | | | | | | | | |
| Tucson, Arizona | ♦ | ♦ | | | | | | | | | | ♦ | | | | | | | | | |
| Tulsa, Oklahoma | | | | | | | | | | | | | | | | | | ♦ | | | |
| Washington, D.C. | | | | | | | | | | | ♦ | ♦ | | | | | | | | | |
| Wichita, Kansas | | | | | | | | | | | ♦ | ♦ | | | | | | | | | |
| Wilmington, Delaware | ♦ | | | | | | | | | | | | | | | | | | | | |
| Yonkers, New York | ♦ | ♦ | | | | | | | | | | ♦ | | | | | | | | | |

# 1993 URBAN MCH LEADERSHIP CONFERENCE PROFILES
## List of Categories *

| MAJOR FOCUS |
|---|
| **IMPROVING OUTCOMES OF PREGNANCY**<br>**Representative topics:**<br>- Prenatal care<br>- IMR reduction<br>- Family planning<br>- Women's health |
| **IMPROVING ACCESS TO HEALTH CARE**<br>**Representative topics:**<br>- Outreach<br>- Home visitation<br>- "One-stop shopping" models |
| **IMPROVING PRIMARY/PREVENTIVE CARE FOR CHILDREN**<br>**Representative topics:**<br>- Immunization<br>- Lead<br>- Breastfeeding<br>- Elementary school-based clinics |
| **IMPROVING PRIMARY/PREVENTIVE CARE FOR ADOLESCENTS**<br>**Representative topics:**<br>- Adolescent pregnancy reduction<br>- Building teen parenting skills<br>- Secondary school-based clinics<br>- Teen conflict resolution |
| **REDUCING AND TREATING SUBSTANCE ABUSE**<br>**Representative topics:**<br>- Intervention and prevention<br>- Comprehensive case management<br>- Self-empowerment groups |
| **IMPROVING URBAN PUBLIC HEALTH SYSTEMS**<br>**Representative topics:**<br>- Increasing data capabilities<br>- Coalition building<br>- Child death reviews |

* These categories were the focus areas for the "What Works" small group sessions held on September 13 and 14.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Akron Department of Health | City/State: | Akron, OH |
| Contact Person: | Christine Johnson RN<br>Child Health Supervisor | Telephone: | (216) 375-2430 |
| Small Group: | Improving Primary and Preventive Care for Children | | |

**1. Initiative Name:** Immunization Coalition of Summit County - "For Kid's Sake Vaccinate"

**2. Describe the initiative.**

In June 1991, at the initiative of Akron Junior League, a coalition was formed between 3 local health departments, ODH, local CFHS, and Akron Children's Hospital. Focus was on: 1) increasing public awareness in Summit County about importance of timely immunizations; 2) reducing missed opportunities by educating physicians about unnecessary caution; 3) reducing barriers within the health care system; and 4) implementing a computerized tracking system to maintain immunization records which can be entered and retrieved by Children's Hospital and the 3 local health departments, thus making each interaction with one of these providers an opportunity for immunization. This initiative extends over 3 years. A yearly Immunization Day will be held at three area malls; parent pamphlets and videos are distributed; physicians receive a laminated pocket-size card showing immunization schedules and true/false contradictions. Billboards, bus-signs as well as radio, TV and local papers are means of advertising and reminding parents.

Each year advertising will be done building on what was developed for the first year, thus keeping costs down. Any health care provider with computer capabilities may join the tracking system as desired.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Advertising was donated by the Akron Advertising Club. The Junior League took responsibility for fund-raising, donated money as well as volunteers. Public Health nurses planned the medical literature and staffed the Immunization Day together with nurses from Children's Hospital. Several local physicians gave their time to be present at the Malls during immunizations. The malls donated space and set up. Children's Hospital secured Rosalyn Carter and Betty Bumpers to kick off the campaign. Computer staff from the involved agencies planned the tracking system. McDonald's gave free meal coupons. ODH made sure, sufficient vaccine was available. We were an unbeatable combination!

**4. What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Resistance by some medical providers to give immunizations in shopping malls.

How overcome? We made sure a strong medical protocol was in place, volunteers were trained, experienced nurses were working, advertising stressed seriousness of that day. Coalition felt strongly immunizations need to be given where the people are.

Barrier 2: Devising tracking system which allows easy access and yet assures confidentiality, without being very expensive.

How overcome? Building on an existing system, computer staff at Children's and the health department were able to devise this without needing extensive/expensive additional equipment or staff.

**5. How is it funded?** Private source(s): Local foundations, Local businesses.

**What is the approximate annual budget for this initiative?** $110,000.00 for three-year effort.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The computer system is in place and being utilized by the three health departments and Children's Hospital. Approximately 800 children received over 1600 immunizations during the event at the malls. Physician pocket cards have been distributed. Parent flyers are handed out at every opportunity. Response by the public has been gratifying; we have had a lot of requests to return to the Malls.

Health care providers from an adjacent county are in the process of joining our computer tracking system.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, definitely. What is required is that the different sectors are able to put turf issues aside and really concentrate on getting the job done. Much time must be spent in preparation to ensure success; our planning process took monthly meetings, many phone calls, as well as research over almost two years. During the last few months prior to the Mall event we met more frequently. All felt that we were really a "working" group as opposed to a "talking" group. Everyone's special expertise was utilized to the fullest.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | New Mexico Public Health Division, District I | City/State: | Albuquerque, NM |
| Contact Person: | Maria Goldstein MD | Telephone: | (505) 841-4100 |
| Small Group: | Improving Primary and Preventive Care for Adolescents | | |

**1. Initiative Name:** TWIC (Teen - WIC)

**2. Describe the initiative.**

TWIC clinics provide comprehensive preventive services to pregnant adolescents and their children when they attend monthly WIC clinics. The goals of this project are to: Improve pregnancy outcome, postpone future pregnancies for at least 2 years, improve immunization status by 2 years age, increase the incidence of breastfeeding, improve parenting skills of teen moms, and increase number of teen moms who finish high school or get GED. TWIC clinics try to achieve these goals by providing: initial home visit to assess medical, psychosocial environment of teen mother and explain the program. When pregnant teen comes to WIC she talks with nutritionist as well as PHN to assess need for prenatal care. If pregnant teen is getting prenatal care we provide anticipatory health education including preparation for breastfeeding. If she is not receiving prenatal care we provide it for her, we help her access prenatal care and ensure she receives it.

After baby is born, both mother and child are encouraged to attend WIC services. If mother needs family planning services or child needs well child care or immunizations they are provided at the time of the WIC visit.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

TWIC is a collaboration between the State of NM WIC program and the NM Public Health Division's local health offices. They take place in several counties in NM. It has taken considerable flexibility on the part of the WIC staff and the health office staff to provide all services in the most appropriate way for their particular population. For instance, in one site, teens taking time off school for any reason are penalized. WIC services are then provided in the school and both a PHN and a physician staff the clinic to provide education and help clients access all services.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Logistics of providing all services in an efficient manner.<br><br>How overcome? Cooperation of the staff who have become very enthusiastic about the program. | Barrier 2: Sites where WIC clinics are not conducted in health offices are much more difficult to organize.<br><br>How overcome? We haven't expanded yet to other WIC sites. |

**5. How is it funded?** General state funds; Other Federal funds.

**What is the approximate annual budget for this initiative?** $12,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

We think this is a successful program because clients like it and attend faithfully. The clients develop close ties with the WIC nutritionist and public health nurse. Clients call when they need help even if they are getting medical services elsewhere. We are in the process of collecting the data from one of the TWIC sites to measure outcomes as they relate to the goals of the project and comparing them to outcomes in a WIC clinic.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

I think it could work, especially if WIC and other services like family planning and immunizations are provided in same site. Continuing to address the needs of pregnant teens and their children in a "one stop shopping" makes a lot of sense.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Dept Health & Human Services | City/State: | Anchorage, AK |
| Contact Person: | Joan Diamond<br>Health Education | Telephone: | (907) 343-6583 |
| Small Group: | Improving Primary and Preventive Care for Adolescents | | |

**1. Initiative Name:** Bike Helmet Policy

**2. Describe the initiative.**

The Health Education section of the Department of Health & Human Services entered into a collaborative relationship with the Anchorage School District and the municipal summer recreation program to write a bike helmet policy. It took two years for the policy to be written and fully implemented. It has been in place since 1991. The policy states that a helmet must be worn on all bike field trips sponsored by the school district. This same policy applies to all summer recreation programs.

Helmets were purchased, at cost, to be either sold at a low price or at no cost to families with low income.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were made with non-profit agencies, City Parks and Recreation, administration, risk management, and nursing services within the school district. These collaborative efforts were successful because a policy was written and to date continued enforcement of this policy is taking place. It was not necessary to involve any legal system because programs became the enforcement agency.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Break down social habit of riding bikes without a helmet.<br><br>How overcome? Education was a major factor in implementing the helmet policy. Issues such as what are the statistics for bike injury, what happens in a bike crash, what is a head injury, and what is the potential life time impact for both child and family were addressed in the education process. | Barrier 2: How to deal with children who could not afford a helmet.<br><br>How overcome? Funds were raised to buy helmets. Helmet manufacturers sold their products at cost. The school district has assumed responsibility for either selling or loaning helmets. |

5. **How is it funded?** General state funds; Private source(s) - Fund Raiser.

**What is the approximate annual budget for this initiative?** $5,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

This policy has been successful because the environment of riding bikes has been modified by the bike helmet policy. It has been well documented that helmets reduce head injury by 85%. The drawback of not enforcing the policy is litigation for personal injury. It is hoped that a ripple effect will take place as a result of this policy where children will wear a helmet when riding a bike regardless of where they are riding.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

This policy can work anywhere. Momentum from different segments of the community can support a bike helmet policy. It can be initiated in conjunction with other education efforts of the community. Timing of this type of policy is crucial and can lend itself to success or failure.

Bike helmet manufacturers were more than willing to support the efforts with discount programs.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Tri-County Health Department of Adams, Arapahoe & Douglas Co. | City/State: | Aurora, CO |
| Contact Person: | Director of Nursing | Telephone: | (303) 220-9200 |
| Small Group: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Women's Heath Colposcopy Service

**2. Describe the initiative.**

To provide follow-up care for women with abnormal PAP smears.

1. Evaluate PAP smear results and recommend treatment.
2. Manage on-going care, pre- and post-treatment.
3. Provide colposcopy evaluation, cryotherapy and leep treatment at minimal or no cost.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

1. County Medical Society - assisted in obtaining seed money.
2. Planned Parenthood - provided space in a training program for the staff.

Both interactions were positive, and the relationship has continued beyond this project, resulting in additional collaborative endeavors.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: Seed money. | Barrier 2: Finding the used colposcope. |
|---|---|
| How overcome? Enlisted the aid of physicians in the community, generally OB/GYN, who were aware of the significance of the problem. They took our request to the OB Society and then to the County Medical Society for assistance. The County Society agreed to provide the money to purchase a used colposcope. | How overcome? An equipment dealer put us on to the fact that the county hospital was wanting to buy a new colposcope if they could trade or sell the one they had. |

5. **How is it funded?** City/County/Local government funds; General state funds; Other Federal funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $120,000.00.

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Prior to the program's establishment, less than 20% of our clients with abnormal PAP smears were receiving the necessary follow-up care. Since the program has been operational, we have been able to provide this care to any client who had an abnormal PAP. This number would be 100% except for a few clients who chose to go elsewhere or have decided not to have any treatment.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. The seed money required was minimal and conceivably could be obtained from a variety of community service or cancer-related organizations. Used equipment is generally easily located, and physicians in the OB/GYN community are generally supportive of assisting in getting a treatment source for indigent clients.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Austin Health & Human Services Dept/ Travis Co Health Dept | City/State: | Austin, TX |
| Contact Person: | Ann Vetter MSN RN<br>Paula Anderson MPH | Telephone: | (512) 476-0020 |
| Small Group: | Improving Primary and Preventive Care for Children | | |

**1. Initiative Name:** SCHOOL SERVICES TEAM: Currently being piloted in two elementary schools.

**2. Describe the initiative.**

PROPOSAL: A full-time, school-based team in every high-risk elementary school consisting of a Registered Nurse, Mental Health Counselor, Social Worker, Community Outreach Worker.

OBJECTIVE: To maximize the learning readiness and learning potential of preschoolers and elementary grade children by improving and maintaining their physical, social, and emotional health.

ACTIVITIES:
-Individual assessments, screenings, counseling, referrals
-Identification of children needing help
-Case management for child/family, home visits
-Customized services based on the identified collective needs of the school
-Health promotion and education of students, parents, faculty

The team is based in or near the school campus and operates within the school's attendance area. It establishes collaborative working relationships/agreements with the school staff, community health and social service providers. The team enhances services to the school by using community experts and volunteers. There is coordination with "feeder" schools.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The proposal was planned and written jointly by Ann Vetter, Child Health Program Coordinator (HD), and Jan Ozias, Supervisor of the Austin Independent School District Health Services. It has been a smooth collaboration. An interlocal agreement between the agencies spelled out parameters, liability.

Many community organizations supported the project, rallying parents in proposed pilot school areas - Austin Interfaith, the Hogg Foundation, University of Texas Schools of Social Work and Nursing, and others.

**4. What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: The assumption by a group of citizens that this project was a devious plan to get a very "liberal" sex education curriculum into elementary schools.

How overcome? The community organizations identified in Question #3 took over the defense of the proposal, brought in parental support. The proposal also had support from the majority of city council persons and school board members.

Barrier 2: The establishment of smooth working relationships and team cohesion between the staffs of two large bureaucracies.

How overcome? Although the city was funding the team staff, the principals and counselors of the pilot schools were invited to be part of the interview team and hiring decision. We also held "team building" sessions for school and city staff to express concerns and define job descriptions and working relationships.

**5. How is it funded?** City/County/Local government funds; Private source(s) - Multi-funding of teams is planned; Other - Not at this time; EPSDT is planned.

**What is the approximate annual budget for this initiative?** $150,000.00 per school

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

A formal evaluation of this project is planned for May, 1994, after a full school year of the team's operation. Currently, measurable objectives are being written based on:

- baseline data routinely collected by the school
- data collected by the team
- problem areas identified by the school and team staffs
- assessment of intervention strategies

Informally, verbal feedback from the school staffs has been very positive.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. This concept suggests school as an excellent base for primary preventive services. It is holistic in approach. Although the student is the main target, many of his/her problems lie in the home, the family, and the community. The outreach capability, the multi-discipline availability appears to be the most effective ways to deal with these problems. Over time, the team also begins to identify the collective student problems (frequently unique to each school) and can begin to customize programs and services to students, parents, and faculty. Home visits and parenting classes draw parents into school involvement and they address chronic absenteeism, health problems, etc. Possible problem areas: central supervision of a multi-funded program; liability issues in multi-funded program.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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| Health Department: | Kern County Department of Public Health | City/State: | Bakersfield, CA |
| Contact Person: | Boyce B Dulan MD<br>MCAH Director | Telephone: | (805) 861-3010 |
| Category: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Black Infant Perinatal Improvement Project (BIPIP)

**2. Describe the initiative.**

The Black Infant Perinatal Improvement Project is centered in the heart of the African-American sector of Southeast Bakersfield which has had adversive perinatal outcomes for this sub-population for several decades. BIPIP, with funding from the State MCH Branch, sought to improve perinatal and infant outcomes by enhancing coordination of multiple services needed to improve pregnancy outcomes for African-American women and their infants and developing comprehensive services for these clients through linkages with other agencies and organizations; providing African-American pre-conceptual and/or pregnant women with the necessary knowledge, information, and skills to support a change in their behaviors to facilitate a reduction in adversive pregnancy and infant outcomes; developing a community-based network of African-American churches, social organizations and programs who will assume "ownership" of the task of community advocacy and empowerment to increase the number of women in the target population who seek early and continuing pregnancy care and who enter their infants into early and continuing health supervision during the first year of life. The Maternal, Child and Adolescent Health Program of the Health Department, two African-American community outreach organizations, three community-based clinics, and one African-American mid-level practitioner who rotated between the clinics formed the project coalition with the Health Department as the lead agency.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Health Department subcontracted with the community organizations previously mentioned. All six organizations collaborated to design the project and have continued working together throughout the project. Linkages between the clinics and the County Hospital for delivery services have been further strengthened through the MCAH's Prenatal Guidance Program, Comprehensive Perinatal Services Program, and the Perinatal Services Coordinator. The Epidemiology and Data Management of the Health Department along with the Project director and part-time clerk provide support for data and statistical support. The community Black Infant Coalition provides awareness in the community of the project.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: Forming Coalition. | Barrier 2: Behavioral Change. |
|---|---|
| How overcome? 1) Subcontracting services. 2) All organizations developed project as equals and developed policies and procedures. 3) Weekly, bi-weekly and monthly meetings for problem solving and training of outreach workers and on-site coordinators developed trusting relationship between coalition members who had never worked cooperatively together before. 4) Policy and procedures allowed sharing patient information and facilitated locating lost patients and getting/keeping them in the program. 5) MCAH neutrality arbitrated C.B.O. differences and provided a win-win resolution of differences. | How overcome? 1) Outreach workers training. 2) One-on-one worker with client case-management and informing. 3) Referral to other agencies for intensive counseling/therapy. 4) Culturally relevant community events to highlight positive values as models of behavior, e.g. fairs, baby showers, etc. 5) Personal touch, e.g. providing diapers, emergency food, transportation. 6) Developing a women's support group. 7) African-American mid-level practitioner gave reassurance directly to clients and reinforced value system. |

**5. How is it funded?** MCH block grant funds.

**What is the approximate annual budget for this initiative?** $100,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Project has been fully operative for less than two years. In spite of reductions in funding, the coalition has still continued to work strongly together to serve these women. The infant mortality rate for African-Americans in this county has dropped from 24.8 to 16.4 per 1,000 live births. This is the largest single year drop since 1985. It is not clear the extent to which this drop may be attributed to BIPIP alone since other improvements in state programs have occurred during the same time. Early entry into prenatal care has improved six percentage points for African-American women provisionally for the entire county in 1992. Data for BIPIP clients is still being analyzed at this time.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Success in a project similar to this one will depend upon a number of factors, such as: 1) the willingness of all organizations to work together for the benefit of the women and children, 2) the willingness of organizations to develop policies and procedures that allow transfer of client information for data collection, patient follow-up and tracking, etc., 3) a neutral organization such as the Health Department to be the lead agency and to assist in resolution of differences, 4) adequate and continuing funding, and 5) an organization such as the Health Department which can do the needed project data gathering and evaluation.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Baltimore City Health Department | City/State: | Baltimore, MD |
| Contact Person: | Nira R. Bonner MD MPH | Telephone: | (410) 396-1834 |
| Category: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Women's Cancer Screening Project

**2. Describe the initiative.**

Baltimore City took the opportunity presented by funding from the Centers for Disease Control to create a breast and cervical cancer screening program that utilizes Baltimore's existing primary care infrastructure; advancing the concept of holistic care by integrating cancer screening services into ongoing primary care. Baltimore's long tradition of service delivery of primary care to subpopulations of low income residents through public/private partnerships provides the model for this new initiative: appropriate, quality breast and cervical cancer screening services for all older women through a coordinated, citywide effort targeted at underserved communities through established primary care providers. Baltimore City Health Department, fulfilling its mission of the public health triad of needs assessment, planning and assurance of quality care, serves as the linchpin in this partnership.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Numerous coalitions with public agencies, grassroots-level community, religious and social organizations have offered a great deal of outreach support. The YWCA, the City's Commission on Aging and Retirement, Education and Easter Seals have organized outreach programs to recruit eligible women for screening services. It is too early to tell if grassroots efforts through neighborhood organizations will be successful.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Breast Cancer is the leading cause of cancer death for African-American women. Only 58% of African-American women 40 and older have ever had a mammogram, compared with 65% of white women in that age group.<br><br>How overcome? Baltimore City targets its outreach and public education messages to older, African-American women through trusted institutions in their communities; utilizes African-American community, outreach workers to recruit women for screening; relies heavily on existing clients to promote screening to others by "word of mouth." | Barrier 2: Access to services does present a problem. Especially to older women who live alone and on fixed incomes and have no transportation. Fear of traveling alone is also an issue.<br><br>How overcome? Some of Baltimore's five centers provide transportation (from churches, etc.); YWCA and Commission on Aging recruit women's groups and transport them together in agency vans for screening; some centers provide reimbursement for public transportation. |

**5. How is it funded?** Other Federal funds: CDC.

**What is the approximate annual budget for this initiative?** $194,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Since it was implemented in October of 1992, roughly 181 women have been screened; more or less than 10 have been referred for further diagnostic tests and two are in cancer treatment.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Maryland is the only CDC funded State that is administering this project exclusively through local health departments that have contracts with the private sector; Baltimore City, the only muncipality that has built the program on a primary care, community-based model. Both CDC and Johns Hopkins University are studying the process and outcome of the City's grant project with an eye to reproducing the project's design in newly funded states. This project could easily be replicated in any city that has an adequate primary care network.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Central District Health Dept City/State: Boise, ID

Contact Person: Kathy Holley Telephone: (208) 375-5211

Small Group: Improving Primary and Preventive Care for Children

**1. Initiative Name:** Child Health Improvement Program "CHIP"

**2. Describe the initiative.**

The Child Health Improvement Program provides child health screening services for children birth to age five, targeting children from low-income families or those with limited availability to health care. Structured in a "discovery" clinic format, the program seeks to identify health and developmental problems early in a child's life and direct that child to appropriate treatment.

Through early intervention, the program aims to reduce the incidence of preventable disease and handicapping conditions; increase the number of children appropriately immunized against disease; and increase the number of children receiving health assessments and referral to primary care.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were established with the Women, Infant, and Children Program; the Infant and Toddler Program; Idaho Medicaid, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program; Head Start; and the Idaho CareLine.

Collaboration has been most effective with these agencies and sectors because this program promotes the health of children by providing family-centered, community-based preventative and primary care services which is a common goal for all those involved in child health.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Limited funding of the program for the high demand of services. | Barrier 2: Limited professionals to provide services for the large number of children in need of screenings. |
| How overcome? With the addition of the Infant and Toddler Program and Early Periodic Screening, Diagnosis, and Treatment Program, we were able to obtain adequate funding in order to increase our services for clients. | How overcome? The Early Periodic, Screening, Diagnosis, and Treatment Program allowed RN screeners to be certified. This enabled more revenue to be generated in order to hire more professionals to screen these children. |

5. **How is it funded?** City/County/Local government funds; General State funds; Other Federal Funds-Infant/Toddler; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $120,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The central Infant and Toddler data base system is operated through our health department, and this data supports the accomplishments of our child health screening program as being a source of primary and secondary prevention. Identification of risk factors in an apparently well individual is primary prevention. Screening and detection of presymptomatic disease or delays is secondary prevention.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Child health screening is an integral component of preventive health care services and would be a welcome aspect of well child care which positively influences the child's health, growth, and development within any community.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Boston Health and Hospital | City/State: | Boston, MA |
| Contact Person: | Lillian Shirley | Telephone: | (617) 534-5395 |
| Small Group: | Improving Primary and Preventive Care for Adolescents | | |

**1. Initiative Name:** School Health Program

**2. Describe the initiative.**

1. The development of school/student Health Clinics in 9 high schools.
2. The technical support to school staff (student support) in developing a coding of comprehensive services that are within schools.
3. The coordination/technical support to Headmasters and Central Office staff in regards to medical and health needs of BPS students.
4. The development and coordination of program oversight, monitoring and evaluation within each site.
5. The establishment of service partnership with other health care and community health providers.
6. Provision of clinical staff to citywide community initiatives such as summer worker.
7. The presentation and preparation of Preventive/Health Education in areas of nutrition, reproductive health and acute care.
8. The preparation of public information.
9. The ongoing dialogue, communication, support of parents/students within BPS concerning health related issues.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

1. The development of communication linkages with state agencies (DMH, DPH, DSS, DPW).
2. The development of linkages with legislative bodies, Senate, House of Medical Subcommittee at state level.
3. Linkages with community groups, Healthy Boston Coalitions and with churches and service agencies.
4. Linkages with Federal/Philanthropic Initiative, Casey United, Healthy Start.
5. Linkages with city-wide provider agency officers, School committee, Boston Children's Services.
6. Linkages with community health centers.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: To overcome the apprehension of school nurses.<br><br>How overcome? 1) By meeting with nurses and working collaboratively with them. 2) By developing personal relationships. 3) By including them in the decision making process. 4) By assisting in clarifying their roles. 5) By maintaining our own professional standards as clinicians and professionals. | Barrier 2: Interagency collaboration clarity of roles relationship/interdependence.<br><br>How overcome? 1) By fostering the central role of the school staff. 2) By presenting ourselves as one provider, willing to work in a team. 3) By providing as much as possible Technical Support/Assistance. 4) By facilitating other providers into the collaborative process. |

**5. How is it funded?** City/County/Local government funds; Other - Medicaid Voluntary Payment.

**What is the approximate annual budget for this initiative?** $980,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

In less than 2 months we were beginning to see patients - 118 encounters. Developing an infrastructure for September 1993. Developing relationships with school personnel/school nurses, other providers.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. The need is present, the direct service and comprehensive vision will be able to address/provide for adolescent's in a very particular manner.

Decreases duplication of efforts by School Boards and Boards of Health in servicing their common population.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Mecklenburg County Health Dept | City/State: | Charlotte, NC |
| Contact Person: | Jill Shade-Fowler<br>Project Director | Telephone: | (704) 365-5445 |
| Small Group: | Improving Primary and Preventive Care of Adolescents | | |

**1. Initiative Name:** Youth Gang Drug Abuse Prevention Program

**2. Describe the initiative.**

The Deborah Prothrow-Stith Violence Prevention curriculum was used as a basis for much of the programming. The initiative is also based on the concept that providing positive alternatives for youth will effect their beliefs and thinking which will in turn result in positive behaviors. Two inner city communities from Charlotte, NC were targeted and the seventh graders and their families from those communities, were asked to participate in this project. The project had two components, the first was to work directly with the students. This included weekly after-school programs that concentrated on teaching skills such as conflict resolution and anger management, as well as life skills, i.e., check writing, employment seeking skills, etc. The youth were also given the opportunity to go to museums, movies, local parks, and other activities that enhanced their views of their community and exposed them to experiences they might not routinely have had access to. For the families there were biweekly evening meetings during which dinner was served and a program was presented. These programs covered issues that involved being parents of teenagers, community services they may not have been familiar with and time for socialization.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were made with local law enforcement personnel for initial data. Contacts were also made with human services providers, school employees, and community workers in the earlier stages of the project. During the project many of these contacts have continued and been strengthened. We have also worked with a tutoring/mentor program for African-American males, and students from a local college have provided tutoring for the females involved in the project. The collaboration has been effective as far as providing the project staff with additional resources. The tutoring/mentor program had limited success due in part to the inability of the mentors to be flexible with their schedules. This limited the contacts between the students and the mentors considerably and, in turn impacted upon the youth's enthusiasm and participation.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: Student and family participation | Barrier 2: |
|---|---|
| How overcome? We have asked for input from the participants as to activities and speakers that would be of interest to them. However, there have continued to be problems in this area and it has become obvious that all we can do is to provide the programs on a consistent basis. This situation has also led to discouragement on the part of the staff and that has had to be addressed in weekly team meetings. | How overcome? |

**5. How is it funded?** Other Federal funds.

**What is the approximate annual budget for this initiative?** $150,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Questionnaires and data have been utilized throughout the project and the results are not available at this time. However, we do believe that this initiative has been a positive influence in the participants' and their families' lives given the on-going involvement. A majority of the initial participants are still active after 2 1/2 years. We are also encouraged that the youth involved have had limited interactions with law enforcement and school personnel for behavior problems during this grant period. Continued major accomplishments of the initiative include developing a connection between city and county government in Mecklenburg County to lease a vehicle which was used to transport participants in the program. An agreement of this nature had never existed prior to this project. Cooperation was the key when working with two middle schools in allowing programming to be provided to the grant participants on the campuses.

We see the building of bonds of trust and understanding with the youth as a major accomplishment of this initiative. The youth who participated in this program have had limited exposure to on-going positive support, and this project has been able to provide that. The project also provided advocacy for the youth in the school setting as well as promoting empowerment.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Certainly. It would be important to have key staff who have had experience with conflict resolution, peer mediation skills, etc. and a program that provides an incentive component for appropriate school behavior and overall participation in the various aspects of the program. It also seems to be important for there to be a "Family Component" to the initiative so that the family will derive benefits from the program and to act in a supportive manner to encourage participation of their children.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Chattanooga-Hamilton County Health Department

City/State: Chattanooga, TN

Contact Person: Donna Needham RN

Telephone: (615) 757-2633

Category: Improving Primary/Preventive Care for Children

**1. Initiative Name:** Cooperative Immunization Project

**2. Describe the initiative.**

The goal of the Cooperative Immunization Project is to increase Chattanooga-Hamilton County's overall immunization percent of 24 month old children. A county-wide computerized immunization tracking system is to be installed in early 1994. All local pediatricians and public and private clinics providing immunizations are participating. The computer system will allow sharing of immunization records, tracking of children delinquent for vaccine, and generation of reports and statistics. The staff funded by the project will conduct additional tracking and outreach and education activities.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The success of this project has required cooperation and input between the local and state health departments, public and private clinic staffs, and pediatric groups. The collaboration has been effective to date due to communication of plans, procedures, and benefits to all participants (physicians, nurses, and office managers).

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Obtaining cooperative participation from all area immunization providers' staffs. | Barrier 2: |
| How overcome? A Health Department staff member visited each office, met the staff, explained all procedures and benefits, and allayed concerns regarding increased work demands. | How overcome? |

**5. How is it funded?** Other federal funds.

**What is the approximate annual budget for this initiative?** $180,000.00 first year, then $90,000.00 annually.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The project is still in the implementation phase. True documentation of success will not be until 1996 although trends can be observed through annual monitoring of the 24 month old survey.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, because computerized tracking and monitoring simplifies follow-up of immunization-delinquent children which should increase immunization levels.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Chicago Department of Health City/State: Chicago, IL

Contact Person: Dr. Alina M Fernandez Telephone: (312) 747-5360

Small Group: Improving Primary and Preventive Care for Children

1. **Initiative Name**: Public/Private Expansion of Lead Screening Activities

2. **Describe the initiative.** In order to meet the Chicago Dept of Health's (CDOH) Year 2000 Objectives, the Lead Poisoning Prevention Program designed a Public/Private community health initiative in 1990. This was done in order to promote universal lead screening among all children in the city of Chicago between the ages of 6 months and 6 years of age. Through an intensive outreach, education and screening effort, the program continues to identify those with significant exposure to lead, thus preventing further poisoning. Our intention was to involve private physicians, health care organizations, and child care institutions in our mission. Through collaborative partnerships, the following were agreed upon:

   By the Chicago Department of Health (CDOH):
   - free analysis of blood lead samples collected by partner institutions and health care providers;
   - twenty-four hour turn around time for results, from the time samples are submitted to our laboratory;
   - environmental inspection follow-up for all positive cases (≥ 20 mcg/dL);
   - referral for medical follow-up;
   - educational literature;
   - health educators to address clients, as well as provide professional in-services; and
   - support for all outreach efforts and health fairs.

   By Partner Institutions:
   - draw venous blood samples for lead screening on all children between the ages of 6 months to 6 years;
   - report all positive cases identified by private laboratories to the Chicago Department of Health;
   - encourage all staff members to screen children for lead poisoning through their private practice;
   - provide medical management or make appropriate referral for treatment of lead poisoning cases;
   - support the Lead Program's outreach efforts; and
   - support public relations activities.

   The CDOH has continued to discover thousands of children with increased blood lead levels each year. Free lead screening services are offered throughout the 16 neighborhood health centers and clinics, as well as through all the various outreach centers that have been set up through this initiative. In addition to lead screening services, the program offers medical, environmental, legal enforcement, case management and health education services. As a result of the expansion in lead screening, these other components of the program have faced dramatic increase in the quantity and quality of services provided.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?** Written agreements were drawn between the Chicago Department of Health and the following kind of institutions: Private clinics, private physicians, private hospitals, not-for-profit social service community agencies, Chicago Board of Education (Early Childhood Programs such as State Pre-kindergarten, Head-Start and Child Parent Centers), Day Care Centers, Department of Human Services Head-Start as well as private Head-Start programs. Collaboration between the private sector and Chicago Department of Health has been most successful. While 47,668 screening tests were performed in 1989, this represented only 17% of those who should have been screened in Chicago (Pre-school population 278,000). In 1992, the program exceeded its established goals by screening 109,330 children. This represented, approximately 40% of Chicago's pre-school population, therefore increasing our effectiveness in targeting the population at greatest risk.

4. **What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: To obtain private provider support to our initiative. | Barrier 2: To obtain man-power to support screening and blood analysis services within the laboratories. |
| How overcome? Through personal telephone calls or visits by either the Director of Child Health Programs, Director of Lead Screening and Health Educators to inform potential private partners of CDOH proposed plan and highlight advantages to the children served. | How overcome? Phlebotomists were hired on a contractual basis to work at an hourly rate as needed, in support of outreach activities. Two lab technicians were assigned to the division of laboratories to support blood analysis services. |

5. **How is it funded?** City/County/Local government funds.

   **What is the approximate annual budget for this initiative?** $886,306.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?** Between January and June 1989, a total of 22,035 venous blood samples were analyzed by CDOH laboratories. Of these 14,407 were drawn by CDOH clinics and 7,628 were drawn by private providers and CDOH outreach activities. Between January and June 1993, a total of 62,651 venous blood samples were analyzed by CDOH laboratories. Of these, 20,043 were drawn by CHOD clinics (a 40% increase over 1989), and 42,608 were drawn by private providers and CHOD outreach activities (an increase of 460% over 1989). This public/private partnership grew beyond our original expectations. CDOH program staff, as well as the private providers who responded to the plan, can be credited for initiating 62,651 battles against lead poisoning.

7. **Do you think that this initiative would work if implemented in another urban community? Why?** This initiative has the potential to be replicated in other major urban settings. It was accomplished in Chicago through a collaborative and mutually beneficial community health initiative. It is a good example of how private and public partnerships can be fostered for the protection of children's health and safety.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Cleveland Department of Public Health City/State: Cleveland, OH

Contact Person: Karen K Butler Telephone: (216) 664-2324

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Greater Cleveland Healthy Family/Healthy Start (HF/HS)

**2. Describe the initiative.**

With an infant mortality rate of 16.9 deaths per 1,000 live births in 1988, Cleveland has one of the most severe public health problems in the nation (ninth worst among U.S. cities). In response, the Cleveland Department of Public Health, in collaboration with a broad-based consortium of public and private organizations, received over $15 million to develop and implement a comprehensive five year plan to reduce infant mortality in the Greater Cleveland area by 50%.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Cleveland Healthy Family/Healthy Start is being accomplished through a public-private consortium consisting of community residents, church and business leaders, city, county, and state officials, social service agencies, and academic institutions. This has proven to be an effective means of addressing the wide variety of factors which impact upon infant mortality.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Difficulties in developing the Management Information System (MIS).<br><br>How overcome? A committee, including all participating HF/HS medical institutions, was formed to address all issues related to developing the MIS. | Barrier 2: Increasing consumer involvement in the neighborhood consortia.<br><br>How overcome? Outreach workers are now required to bring a client to each of the monthly neighborhood meetings. |

**5. How is it funded?** City/County/Local government funds; Other Federal funds.

**What is the approximate annual budget for this initiative?** $15,000,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The Cleveland Healthy Family/Healthy Start Program succeeded in implementing its community outreach/centralized training program, in addition to delivering comprehensive primary care services, expanding the consortium, initiating a public information campaign, and developing a comprehensive data collection process.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

The successful implementation of this initiative will be contingent upon the availability of sufficient funding and a strong commitment to overcoming the barriers to interagency collaboration. Some urban communities have been able to implement similar programs across the country.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: El Paso County Department of Health and Environment

City/State: Colorado Springs, CO

Contact Person: Diana Howell RN

Telephone: (719) 578-3257

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Preconception Health Promotion

**2. Describe the initiative.**

When pregnancy occurs, it is too late to change or modify risk factors that can affect the infant. This program encourages changes in behavior before pregnancy occurs, thus reducing prematurity and preventable birth defects. Clients in the Women's Clinic who come for family planning visits are assessed through use of a self-administered risk appraisal which identifies factors adversely affecting health such as use of alcohol and other drugs, smoking, poor nutrition, domestic violence, medical conditions and genetic pre-dispositions. Clients are counseled by a public health nurse about the nature and severity of their risks. Health education and referrals to community resources are made by the nurse.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Health Department offers services for potentially child bearing women in the areas of alcohol and drug counseling, treatment, and prevention; nutrition counseling and WIC; STD prevention and treatment; child abuse prevention; and skilled public health nursing. We also have close collaboration with the Expanded Food and Nutrition Program, the Center for Health and Nutrition at Penrose Hospital, the Center for Prevention of Domestic Violence, and the Genetics Clinic at Memorial Hospital.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Lack of understanding on clients' part about importance of good health and healthy life styles before pregnancy occurs.<br><br>How overcome? Increase community awareness of program and preconception/health promotion through outreach marketing activities. | Barrier 2: Lack of financial resources for referrals to community activities which normally have a fee attached to their services.<br><br>How overcome? 1) Develop relationships with community resources to make access available at low or not cost to clients. 2) Use of available health insurance including Medicaid. |

5. **How is it funded?** Private source(s): Colorado Trust Grant.

**What is the approximate annual budget for this initiative?** $39,223.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

This program was implemented in August, 1993 so its success has not yet been judged. The effectiveness will be evaluated by tracking changes in clients' behavior and utilization of resources. Data on number of clients, number and type of referrals, summary statistics for risk assessments, and number and type of marketing activities will be evaluated every 6 months. The ultimate goal will be reduction of low birth weight and decrease of infant mortality and morbidity.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. By the end of the 3-year project a detailed protocol will be available which can enhance replication in other communities. It is designed to be low cost to conserve valuable resources.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Columbus Health Department — City/State: Columbus, OH

Contact Person: Ron Ryles — Telephone: (614) 645-7649

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** KUUMBA

**2. Describe the initiative.**

KUUMBA is an infant mortality reduction project. It is a female clergy health outreach coalition. It is coordinated by the CHD. Members are African-American female clergy or wives of clergy. The goal is to reduce infant mortality through outreach, support and educational efforts. Activities include some of the following:

1. Insure timely visits to prenatal appointments;
2. Collect and distribute layettes;
3. "Adopt" a pregnant teen;
4. Participate in health fairs;
5. Expand membership and increase effectiveness through infrastructure of the church;
6. Identify and refer women for prenatal care; and
7. Inform congregation of MCH issues.

The KUUMBA mission in effect promotes prevention and positive life-styles related to healthier outcomes. The spin off potential for other health related activities is limitless.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Extensive linkages with religious community. Individual church visits, contacts with religious media. Worked closely with City Council members to convene the coalition initially.

4. **What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Lack of a sense of power to make a difference in a major community issue, especially by a non-male coalition.<br><br>How overcome? Created a sense of empowerment or women's reality through the uniqueness of the female role in the Maternal Child Health process. Offering the opportunity to make decisions for more positive health outcomes for young childbearing women and infants. | Barrier 2: Realizing and maintaining an adequate intensity level to get the program "On-stream."<br><br>How overcome? Education and motivation through statistics, assuring input by all members in all decision making processes. Continuous demonstration of supportive and administrative commitment from outreach staff and department administration. |

5. **How is it funded?** MCH block grant funds.

**What is the approximate annual budget for this initiative?** Staff time of people supported on grant.

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

KUUMBA members have adopted "24" pregnant teens.

Fifty (50) layettes were obtained by members.

Mother's Day bulletin inserts provided information about the importance of prenatal care for participating churches.

With the Columbus Health Department KUUMBA funded for a major health fair during April (Minority Health Month).

Bimonthly newsletter.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. We have already franchised this effort, successfully in another urban community. (Miami, Florida)

There is a rather comprehensive understanding of the issues and service base sites, (churches) to launch this program in many urban communities. Additionally, we have received some inquiries from other cities regarding KUUMBA chapters.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Corpus Christi-Neuces County Health Department

City/State: Corpus Christi, TX

Contact Person: Annette Sultemeier

Telephone: (512) 851-7260

Category: Improving Primary/Preventive Care for Adolescents

**1. Initiative Name:** Family Life Education for Teens

**2. Describe the initiative.**

High school students (grade 9-12) are bused to the Health Department (approximately 100-120 at each session). They arrive with parental consent. Presenters from Health Education, Family Planning, STD and AIDS Programs talk to the group. Cards (blank) are distributed so questions can be submitted anonymously. The prevention focus is sexual abstinence as a teen. However, dealing with reality, we also include birth control. There is emphasis on decision making, self esteem and responsibility.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Initiation of this project began with our participation in a "first ever" Health Fair at one high school. The very receptive and progressive school nurse instigated further work with teens in our program. Other schools and community groups learned of it by word of mouth and we are now in more demand and working cooperatively.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Conservative community with a very influential Catholic bishop and fear of repercussions if any initiative was taken. | Barrier 2: Lack of transportation for students. |
| How overcome? Getting parental consent. Emphasizing abstinence is the only way to avoid pregnancy and sexually transmitted disease. Having the sessions at the Health Department not the school. | How overcome? School district supplies some transportation but barrier is still there. |

5. **How is it funded?** City/County/Local government funds.

**What is the approximate annual budget for this initiative?** N/A

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

There has been a drop in teenage pregnancies in ages 17-19 years. Unfortunately, there is an increase for ages <17 years. We need to be able to reach middle school students.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, it would work. We learned what is needed and best received by trial and error. Every community is different and programs must be tailored to fit each one.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Dallas Health Department | City/State: Dallas, TX

Contact Person: Jessica Walker | Telephone: (214) 670-8376

Small Group: Improving Access to Health Care

**1. Initiative Name:** MISSION POSSIBLE: High Risk Case Management Program

**2. Describe the initiative.**

Comprehensive case management was initiated in October of 1991 to identify and assist high risk mothers and infants access to medical, nutritional, developmental, educational, social, and other services as needed. The program strives to empower clients as well as enabling them to access needed services. A system of coordinated care is key to avoiding duplication of services. With a staff of four case managers (2 RNs and 2 SWs) and twelve community service aides (CSAs), targeted clients are contacted on a monthly basis or more often as necessary. The patient and family are partners in all aspects of care; the client/parent must agree with and sign a contract outlining their service plan which includes the client's areas of responsibility towards meeting goals. In addition to monitoring and tracking clients, CSAs are able to provide practical one-on-one education, i.e., initially riding with a client on a bus to teach them how to use the transportation system or accompanying the intimidated client to resource agencies.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were established with area hospitals, health agencies, Maternal Health and Family Planning clinics, Texas Department of Health, Early Childhood Intervention programs, and other area agencies. The collaboration has been very helpful in providing a variety of ideas that result in successful intervention strategies for complex client needs and in helping cut through red tape.

4. **What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Duplication of services as a result of multiple agencies in the area providing case management to overlapping populations.<br><br>How overcome? 1) Established coalition of agencies providing case management. 2) Developed computer based clearinghouse of managed client. 3) Agreed on division of high risk population between agencies. 4) Mediated duplicated clients. 5) Educated clients. | Barrier 2: Client transportation to resource health services and other agencies.<br><br>How overcome? 1) Assist client to think through family and friend support. 2) Arrange appointments at times transportation may be available. 3) Access Medicaid transportation resources. 4) Provide limited number of donated bus and taxi vouchers. 5) Teach client how to ride the bus when necessary. |

5. **How is it funded?** City/County/Local government funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance); Other - Healthy Tomorrows.

**What is the approximate annual budget for this initiative?** $650,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Data on clients who have been case managed for a full year is in the process of entry and evaluation. Clients lost to follow-up in the Low Birth Weight Program are being found and re-entered into services. The immunization level of high risk infants is equal to that found in Well Child clinics. From October 1992 to June 1993, 1,220 home visits were completed and 2,500 additional client contacts made (telephone and office visits).

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Providing adequate health and social services to high risk mothers and infants is necessary to reduce high infant mortality and morbidity rates and high teen pregnancy rates. Utilizing a team approach with multiple agency linkages plus frequent one-to-one client contact can make a difference for patients who previously became lost in the system. Maximizing use of CSAs frees valuable time doctors, nurses, and social workers can provide direct patient care.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Combined Health District of Montgomery County | City/State: | Dayton, OH |
| Contact Person: | Frederick L Steed | Telephone: | (513) 225-4966 |
| Small Group: | Improving Primary and Preventive Care for Adolescents | | |

**1. Initiative Name:** Supportive Services for Teen Parents

**2. Describe the initiative.**

Parenting can be frequently stressful. New patients, especially teen parents, confront many stresses including changes in roles and relationships, new financial burdens, and changes in lifestyles and daily routines. Many teen parents are isolated and alienated from support systems, i.e. family and friends. They are often living in poverty. Some have a history of parental deprivation and abuse, and therefore would have a difficult time being good parents themselves.

Family Services Association (FSA) and the Combined Health District (CHD) formed a partnership that will bring together expertise from each agency in providing for the physical and psychosocial well being of all teen parents who use the child health services of the CHD. It is projected the program will serve 100 teen parents annually. Each teen parent will be offered intense home-based counseling and case management services by social workers. Services will be individualized to each teen parent with provision for both individual and group support activities. The goal of the program is to demonstrate that high-risk teen parents with appropriate intervention can become successful parents and can develop necessary life coping skills to become contributing members of society. Specifically, program objectives will measure changes in psychosocial determinants of the teen parents, and medical compliance issues for the child.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Family Services Association (FSA) is a community supported agency that has provided social services to various socio-economic groups in the community for over 100 years. The Combined Health District (CHD) has provided an array of health services to this community for over five decades. Both agencies have a track record and reputation for providing quality and effective services. Moreover, both agencies recognized the need for expanded services to teen parents and it was agreed that a collaborative program would be implemented to meet the teens' need. Teen parents are identified by their participation in the CFHS Program and referred to the FSA.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: | Barrier 2: |
|---|---|
| How overcome? | How overcome? |

**5. How is it funded?** City/County/Local government funds.

**What is the approximate annual budget for this initiative?** $25,000.00 per year

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The program is a pilot program with very limited data to evaluate at this point. However, the valuative criteria to measure program success will be the Family Intervention Scale. The scale measures client changes on five variables: 1) family role, 2) social support, 3) physical maintenance, 4) use of community resources, and 5) emotional well-being. In addition, the evaluation will measure the teen parents' behavior in obtaining health care for the child using such indicators as: 1) No-Show appointment rate; 2) percent compliance with Health Check and immunization levels; 3) completion rate of referrals to WIC, and other qualifying programs; and, 4) reported child abuse and neglect.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. This program offers encouragement and practical assistance in helping teen parents handle their situation.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Denver Dept of Health & Hospitals City/State: Denver, CO

Contact Person: Paul Melinkovich MD Telephone: (303) 436-7433

Small Group: Improving Primary and Preventive Care for Children
Improving Primary and Preventive Care for Adolescents

**1. Initiative Name:** Denver School Based Clinics - Montbello Expansion

**2. Describe the initiative.**

Through a collaborative multi-agency model, primary health services have been expanded from 3 original Robert Wood Johnson funded high school sites to 7 new public school sites in Denver. Services were implemented at one high school, one middle school, 5 elementary schools in a geographically underserved community.

Services provided include primary care medical services, school nurse assessment and triage and case management. mental health counseling, social services and substance treatment services.

This initiative is possible through the collaboration of a number of agencies and service providers in Denver. They include the Community Health Services of the Department of Health and Hospitals, Denver Public Schools, the Denver Mental Health Corporation, Arapahoe House Drug and Alcohol Treatment Program, the University of Colorado Schools of Medicine and Nursing, the Children's Hospital/Department of Pediatrics, and the Mayor's Office.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages are made with a number of community providers with the school serving as the hub of service. The important linkages include a community-based neighborhood health center, community-based private physicians, the public hospital, the private Children's Hospital, the community-based mental health association, and drug and alcohol treatment programs.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Financial.<br><br>How overcome? Encouraging participation of all parties in a significant manner (i.e. either definite funding or commitment of staff) through a coordinating council. | Barrier 2: Special interests of existing school staff.<br><br>How overcome? Utilization of school staff in the staffing and implementation of school-based clinic. |

**5. How is it funded?** City/County/Local government funds; MCH block grant funds; 330 funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $700,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Major accomplishments include establishment of services at each school and the delivery of basic primary care services to school students.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. This model is replicable in any community where school health nurses staff public school health offices and other health providers are willing to participate collaboratively.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Detroit Health Department City/State: Detroit, MI

Contact Person: Judith F Harper MPH Telephone: (313) 876-4228

Small Group: Reducing and Treating Substance Abuse

**1. Initiative Name:** Mother and Infant Substance Addiction Network (MISAN)

**2. Describe the initiative.**

MISAN is a continuum of care program designed to coordinate maternal and infant care with substance abuse treatment. This is accomplished through a case management system which includes public and private providers. The program focus has expanded to give clients a greater role in the design and delivery of services.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

A number of very effective linkages have been established. Most notable are those with Hutzel Hospital which provides substance abuse treatment and prenatal care for MISAN clients and the Detroit Housing Department which has facilitated on-site recruitment and assessment by MISAN.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Maintaining contact with clients over time.<br><br>How overcome? The increased number of "socialization" activities the program offers have helped increase client's self-esteem and maintain their interest so that they are anxious to keep appointments and attend group meetings. | Barrier 2: Transportation.<br><br>How overcome? Purchase of bus passes and taxi vouchers for clients. |

**5. How is it funded?** Other Federal funds.

**What is the approximate annual budget for this initiative?** $450,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Clients have begun to claim ownership of the program and expect to actively participate in the operation. Successful clients serve as mentors. Job training has also been incorporated as a strategy for permanent recovery.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. The problems experienced by MISAN clients are not unique to Detroit. Recovering women, like other adults, prefer to participate in decisions which affect them.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: El Paso City-County Health and Environmental District

City/State: El Paso, TX

Contact Person: Martha Quiroga

Telephone: (915) 543-3545

Small Group: Improving Primary and Preventive Care for Children

**1. Initiative Name:** Immunization Action Plan

**2. Describe the initiative.**

The IAP (Immunization Action Plan) was funded from January, 1993 to December, 1993 through the collaborative efforts of approximately ninety agencies from the El Paso County, to include the New Mexico Health Department, and the Juarez Health Department in Mexico. This IAP partnership involved the school districts, the medical society, the nursing school, the school of public health, head start centers, YWCA day care centers, the community health centers, the medical school, the hospitals in the county-private and public, and the Kiwanis, to name a few.

After the 1991 immunization survey indicated that only 40% of the children under two years of age were completely immunized with the four DTP's, three OPV's, and the one MMR, strategies were identified to improve this immunization level to 90% by the year 2000. The two main avenues for expansion of immunization services which were funded were hiring nurses to immunize at the DHS sites in the county and hiring nurses to immunize at the WIC sites through WIC funds.

Funds also provided for hiring 1 FTE nurse and 1/2 FTE nurse at two different CHC's specifically for the purpose of providing walk-in immunizations to the public. Monies were also available to provide a conference on immunizations for the community as an update and also to provide a course through the community college as an update each semester for other health care providers.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages with other agencies were established through working committees which addressed such issues as barriers to immunizations, survey of the validity of the birth certificate address for follow-up on immunization information for parents, establishing services at the WIC sites, and development of the logo.

4. What have been the greatest barriers faced in implementing this initiative?

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|---|---|
| Barrier 1: Severe personality clash between the grants writer and nurse coordinator for outreach activities.<br><br>How overcome? This resolved itself in that both ended up leaving the system one month from each other. Project ended up in the lap of the Chief Nursing Officer and the new Nursing Supervisor. | Barrier 2:<br><br>How overcome? |

5. How is it funded? Other: CDC monies through the State Dept. of Health

What is the approximate annual budget for this initiative? $148,085.00

6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?

To date this IAP Partnership has shown that several agencies given the same goal, which affects children, can work together. Some major accomplishments included providing off-hour services after 5 p.m. and on weekends and providing a media campaign which targets both the English and Spanish population with a catchy jingle.

7. Do you think that this initiative would work if implemented in another urban community? Why?

This initiative would work if the issue of turfism is not interfering with the main goal - Improving Children's Health Services.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Erie County Department of Health City/State: Erie, PA

Contact Person: Charlotte Berringer RN Telephone: (814) 451-6721

Small Group: Improving Primary and Preventive Care for Children

**1. Initiative Name:** Immunization Action Plan

**2. Describe the initiative.**

In early 1990, the backlog of immunization appointments in public health clinics in Erie County was typically 3 months. Public Health was in a position of no longer even being able to keep a child on schedule once they entered the immunization system for care.

ECDH approached hospitals and other medical agencies in the county regarding this backlog and the detrimental effects to children's health. Facilities were approached through various interdisciplinary and community meetings throughout the county, in addition to press releases which generated some responses.

Over the last 1.5 years, two hospitals, a primary health care agency and a skilled nursing agency have all volunteeed their staff to administer Health Department vaccines, working under Public Health Protocols. This additional community support has resulted in a 27% increase in the number of patient contacts for vaccine services and a 60% increase in the number of vaccines administered between the first half of 1990 and the first six months of 1993.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

ECDH has provided Health Department vaccines and costly medical supplies (syringes, medical waste disposal) to two hospitals, a primary health care agency and a skilled nursing agency. ECDH has trained those facilities' staff regarding administration and immunization protocols. The collaboration has been effective as described above and in educating acute care providers to other aspects of public health beyond immunizations.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Acute care facilities initial reluctance to address preventative health care concerns.<br><br>How overcome? Hard data presented to agency administrators regarding immunization backlog, cost effectiveness of vaccines, local disease incidence and impact on children and families. | Barrier 2: Keeping other than Public Health staff up-to-date regarding current protocols.<br><br>How overcome? Regular interaction with a key contact person in each agency regarding protocol changes and general immunization updates. |

**5. How is it funded?** City/County/Local government funds; Private source(s): Local hospitals and a skilled nursing agency paying their staff to administer Health Department vaccines.

**What is the approximate annual budget for this initiative?** In-kind services through ECDH.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

It has been successful because more children are receiving more vaccines at a time the local population has remained stable. Vaccine preventable illness on the decline also.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This initiative can work in any community where health care institutions and agencies are willing to look beyond their front door and where public health officials will continually advocate for preventative care services.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Lane County Health Department City/State: Eugene, OR

Contact Person: Jeannette Bobst Telephone: (503) 687-4013

Category: Improving Access to Health Care

**1. Initiative Name:** Develop a Hawaiian "Healthy Start" Model for Lane County

**2. Describe the initiative.**

Lane County Public MCH Staff along with local Birth to Three Staff wanted to explore the nationally known Hawaii "Healthy Start" model with one difference. That initial contact with client would be prenatally rather than after the birth of a child. In the beginning services will be limited to First Time pregnant women. Utilizing home visitors, MCH Nurse for Maternity Case Management and utilizing local agencies to meet client's needs. Plan to implement mid-1994.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were broadened to include urban and rural hospitals, State Children Services Division and Adult and Family Services Division; local agencies that provide a wide variety of basic needs; counseling, day care and respite care. We are in our fifth month of planning.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: To get the private prenatal care providers to refer clients for this service.<br><br>How overcome? Our plan is to educate all providers as to the value of this new community service by using local T.V., radio and news print ads/interviews, advocates to visit providers' offices and make community presentations. | Barrier 2: What developmental screening tool should be used to follow infants and who should do them.<br><br>How overcome? Presently a subcommittee of the larger planning group is evaluating this question. It is made up of MCH nurses and Early Developmental Intervention specialist. |

5. **How is it funded?** City/County/Local government funds.

**What is the approximate annual budget for this initiative?** N/A

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

This initiative is based on the Hawaii model which has had favorable outcomes. Our model will begin services prenatally which can only enhance future outcomes and the community providers are enthused and willing to participate in this initiative.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. Most communities provide a wide range of services to pregnant women and children. All it requires is a commitment to work collaboratively and build the system around what already exists, rather than build a "new system."

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Genesee County Public Health Dept City/State: Flint, MI

Contact Person: Jenifer Murray BSN MPH Telephone: (313) 785-5263

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Genesee County PRIDE (Programs for Reducing Infant Deaths Effectively) Coalition.

**2. Describe the initiative.**

The Genesee County Health Department (GCHD) initiated the PRIDE Coalition in early 1990. This group consists of representatives from over thirty service providers in Genesee County. The group meets on a regular basis to explore ways in which the problem of high infant mortality in Genesee County can be addressed cooperatively and systematically. Where new programs are necessary, the PRIDE Coalition is dedicated to securing funding for such activities. Existing programs housed at each of the member agencies are reported on with discussion as to how efforts can be combined in order to strengthen such programs. The two major benefits of the PRIDE Coalition are, therefore, a "united front" for pursuing new strategies to reduce infant mortality and create new relationships among existing service providers in order to ensure more comprehensive and better coordinated care for the people of Genesee County. The PRIDE Coalition's purpose is three-fold: to collect data on the incidence and causes of infant mortality in Genesee County; to share information about maternal and infant health programs and identify gaps and barriers in services related to infant mortality prevention; and to advocate, in collaboration with other related community coalitions, for more effective utilizaton of resources for maternal and infant health programs.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Coalition membership includes representatives from hospitals and neighborhood clinics, drug rehabilitation centers, mental health services, the school system, youth and adolescent programs, unaffiliated citizens, churches, the Native American community, political organizations, and local and state health departments. Collaborative relationships are established through the coalition meetings. The collaboration has been effective in several ways: area agencies have developed referral systems which allow services to meet client needs in a quicker and more organized fashion; agency programs have improved when members have shared about their agencies' prior experiences; coalition members have a greater awareness of the community perspectives of maternal and child health care, especially perspectives from cultures of which they are not members.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Members of the Coalition have jointly submitted several unsuccessful grant proposals for programs to address infant mortality and maternal and child health care. The Coalition lacked the expertise needed to secure grant funding in the highly competitive search for limited dollars.<br><br>How overcome? The PRIDE Coalition has begun to consult with GCHD's Grant Writing Specialist. We are also discussing ways to increase the involvement of the lay community and the medical community in this coalition. These expanded relationships will allow the Coalition to mobilize support from all areas of the community in applying for future grants and other funding. | Barrier 2: Turf issues are common when dealing with several agencies who are often vying for the same resources and client base. The PRIDE Coalition, in its beginnings, had experienced some of these issues which initially stifled the amount of sharing and communicating outside of meetings.<br><br>How overcome? Through better understanding and joint efforts to expand area resources and programming, personal and professional relationships among individuals from the various agencies have expanded and therefore this barrier is rapidly diminishing. |

**5. How is it funded?** Other: Fundraising-annual "Gospel Music Benefit."

**What is the approximate annual budget for this initiative?** N/A

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?** Aside from the collaboration fostered through the relationships among PRIDE members, and the annual Gospel Music Benefit, other major accomplishments to date have been the hiring of a Maternal and Child Health Consultant Team and the establishment of the community Outreach Sub-Committee. The Consultant team has been charged with the tasks of analyzing infant deaths in Genesee County in 1992, assessing the availability of prenatal and pediatric care, and analyzing services at GCHD that are committed to MCH. The outreach worker sub-committee consists of outreach supervisors from the coalition whose agencies use para-professional outreach workers to enhance the services they provide. This sub-committee has organized a network to enable outreach workers to share information about resources of which their clients are in need. In addition, this sub-committee is assessing the continuing education training of the workers.

**7. Do you think that this initiative would work if implemented in another urban community? Why?** This initiative would work in any urban community because it requires little to no funding and is not specific to the community in Genesee County. If there is an agency which is willing to take the lead in the effort by coordinating meetings, committing staff for the facilitation of meetings, recording and distributing meeting minutes, and encouraging the development of relationships outside of meeting time, a coalition of area agencies is possible. Though there may be barriers to communication in the beginning, time and continued joint efforts will eliminate them. Eventually, maternal and child health care providers, working together, will be able to address problems of maternal and child health in a comprehensive and efficient way.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Tarrant County Health Department City/State: Fort Worth, TX

Contact Person: Glenda Thompson RN MSN Telephone: (817) 871-7209

Small Group: Improving Primary and Preventive Care for Children

**1. Initiative Name:** S.S. Dillow Elementary School Based Clinic

**2. Describe the initiative.**

This is a collaborative initiative involving the Fort Worth Independent School District, The Tarrant County Hospital District, Cook Childrens Medical Center and the Ft. Worth/Tarrant County Health Department. The purpose of the program is to provide school based primary care to students attending a local elementary school, grades pre-kindergarten through fifth. The school is located in a low income, multi-ethnic area of town. The Ft. Worth Independent School District has set aside space at the school to establish the clinic; and the community has shown a great interest in this project. Services to be offered will include routine periodic pediatric screening; immunizations; dental, vision, and hearing screening; sports physical; health education; and mental health referrals.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Representatives from each of the above agencies met to form a collaboration designed to initiate a project dealing with children in our community. Interest in school-based health centers has grown considerably because they have proved to be effective and cost effective in providing school-age children with a range of health services including prevention. The collaborative established goals and objectives for the program, developed a budget and established an evaluation procedure.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: Multi-governance. | Barrier 2: Turf proprietorship. |
|---|---|
| How overcome? The collaborative decided the Health Department would be lead agency for the medical and social issues; the hospitals donated supplies and accepted referrals. The school provides space and follow-up, a health assistant, utilities and supplies. | How overcome? Continued collaboration and maintaining team focus on the goal. Emphasis on attaining the greater good for a greater number. |

5. **How is it funded?** City/County/Local government funds; Private sources - Ft. Worth Independent School District; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $306,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

A pilot program was initiated in 1992 and was very successful in terms of collaboration and child health screening. A permanent school based clinic is a reality this school year (93-94). The Health Department has two full-time pediatric nurse practitioners, the School District has one full-time RN and a health aide. Cook Medical Center donated a refrigerator and other supplies. During the 9 week pilot, 38 children received physicals. Problems identified and referred were: eight dental defects, one serious heart murmur, one rheumatoid arthritis, one asthmatic, one undescended testicle and one unequal leg length. All of these children were referred to various physicians and clinics in the community.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. It speaks for itself.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Gary Health Department City/State: Gary, IN

Contact Person: Sharon Mitchell Telephone: (219) 887-5147

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** PREC-INCT Prenatal Clinic

**2. Describe the initiative.**

April 1990, Prec-Inct started a prenatal clinic with a dental component. Educating expectant women and providing early, continuous comprehensive prenatal care to women and teenagers who are unable to purchase these services is our primary focus of this section of the Maternal Child Division. Staffed with Obstetricians, a family practitioner, and nurse practitioner, the following services are provided: physical exam, pregnancy profile, pregnancy testing, dental screening, nutritional counseling, social services, and complete prenatal care. The delivery component will be performed by the individual physicians.

Fall of 1990, the Prenatal Substance Abuse Prevention Program began. This program is designed to provide education and counseling about the effects of substance abuse on women and their babies. The counselor is available to counsel pregnant women and to educate the community and health care personnel in effective prevention strategies.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

WIC: Collaboration effective due to ability of Prec-Inct's nutritionist to certify clients into WIC for services.

Methodist Hospital Northlake: Provide laboratory services and specimen pickups.

OB Clinic: Source for referrals for high risk prenatals. Appointments given at time of call for referrals.

4. What have been the greatest barriers faced in implementing this initiative?

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|---|---|
| Barrier 1: Private physicians' resistance.<br><br>How overcome? Physicians were reassured of clinic's focus to provide services to clients with little or no insurance. Referred clients to doctors offices for prenatal care. | Barrier 2:<br><br>How overcome? |

5. How is it funded? City/County/Local government funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance).

   What is the approximate annual budget for this initiative? $536,609.00

6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?

   Success can be measured on the number of patients now entering the clinic within the first trimester of pregnancy. The clinic is in its fourth year of operation and averages approximately 80 patients yearly.

7. Do you think that this initiative would work if implemented in another urban community? Why?

   Yes, the high incidence of teen pregnancies and people with little or no insurance coverage warrants this type of program. Clients need a place where large down payments are not required for the first clinic visit and medical cards are accepted. They also need a place where the staff can instruct them on preventative health and infant care most taken for granted.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Kent County Health Department — City/State: Grand Rapids, MI

Contact Person: Nancy Peot, Planner — Telephone: (616) 774-3929

Category: Improving Access to Health Care

**1. Initiative Name:** Kent County Initiative to Reduce Infant Mortality

**2. Describe the initiative.**

The Kent County Initiative to Reduce Infant Mortality is the process for implementing the recommendations from the Forum on Prenatal and Infant Health. The recommendations propose a neighborhood-based center model for service delivery of a continuum of services, including clinical, social service, educational, mental health and ancillary services. The "center" will reflect the needs of the neighborhood in which it is located. Five neighborhood areas have been identified, based on criteria such as infant deaths, female head of household, and poverty levels. Neighborhood leaders were contacted and health care services prioritized. The neighborhood leaders then requested that Federally Qualified Health Center (FQHC) seek federal grant funds to establish a satellite center in the neighborhood. The FQHC committed to delivery of prenatal care services in conjunction with existing Health Department programs whether or not the federal grant is funded.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The initiative so far has been focused in one inner city neighborhood in the west side of the city. Linkages were established with the following organizations: Cherry Street Health Services, West Grand Neighborhood Association, South West Association of Neighbors, West Side Complex, Grand Rapids Public Schools, John Ball Park Neighborhood Association, Grand Rapids Inter-Tribal Council, 4 area hospitals, Grand Rapids Chamber of Commerce, March of Dimes, Steelcase Foundation, West Michigan Dental Society and citizens from the neighborhood. This collaboration has been extremely effective in terms of determining kinds of services and hours of service delivery needed in the neighborhood, and in delivery of prenatal services, which will begin October 1, 1993.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Making sure all the players were at the table, e.g., community organization.<br><br>How overcome? Continual interaction with community groups, agencies and providers. | Barrier 2: Funding.<br><br>How overcome? Steelcase Foundation and the 4 area hospitals were approached with a proposal for a half time planning position, and federal funding was requested for a satellite federally qualified health center. Funding of Federal staffing grant denied so this need remains unresolved. |

**5. How is it funded?** Private source(s): Steelcase Foundation - $74,000; 4 area hospitals - $1,125 each; KCHD in-kind; private sources e.g., church and community fund raisers and donations; Third party reimbursement is expected.

**What is the approximate annual budget for this initiative?** See above.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The first of several neighborhood centers is in the process of becoming a reality, 3 more are in the planning stages. It is too soon to evaluate if infant mortality has been affected.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, because the process used to garner support was a community effort.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Hartford Health Department City/State: Hartford, CT

Contact Person: Martha Stringer-Page Telephone: (203) 722-6978

Small Group: Improving Primary and Preventive Care for Adolescents

**1. Initiative Name:** Adolescent Parenting and Development Program (APDP)

**2. Describe the initiative.**

The program is targeted to teen mothers living in Hartford, from the ages of 12-19, with one child. The major goals of the program are to prevent a second pregnancy, improve maternal and child health, increase their knowledge of child development and child abuse, improve parenting skills and to encourage the girls to continue their education.

The program has four components:

Case Management - Each teen is assigned a case manager who does home visits, one-on-one counseling and case advocacy.

Training and Education - This component consists of a 14-week training known as "lifetones," which provides education on parenting, STD's, birth control, child development, child abuse prevention, etc.

Self-Help/Group Development - These groups are similar to support groups which the teens themselves form.

Self-Sufficiency - This component focuses on educational and employment development.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were made with all area hospitals and high schools which serve as referral sources; Teenage Parents Program (TAPP) which serves as an alternative education placement and many of the City of Hartford's other departments and programs. These linkages have been effective, due to the commitment of all involved to enhance and strengthen the lives of these teen parents.

4. What have been the greatest barriers faced in implementing this initiative?

| Barrier 1. Housing. | Barrier 2: Day-care. |
|---|---|
| How overcome? Housing continues to be a problem in this city for everyone, but more so for teens 18 and over. | How overcome? Throughout the years many licensed day-care homes have been established and have been available to our teens; the Department of Human Resources has developed day-care programs as well as the Department of Income Maintenance, who also will assist teens with day-care payments. |

5. How is it funded? City/County/Local government funds; Private source(s): HTFD, Foundation for Public giving.

What is the approximate annual budget for this initiative? $243,700.00

6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?

During the last five years only 5% of our teens have had a second pregnancy; the teens developed a stress video which is now being used as a training tool for other teen mothers, parents, schools and to prevent pregnancy in youth ages 9-12. Since the program's inception about 40% of the teens entered the program as school drop outs, and due to their involvement in the program, 30% have re-entered or completed their high school education, GED preparation or vocational training.

7. Do you think that this initiative would work if implemented in another urban community? Why?

Yes, if the commitment is there to reduce the number of births to teens and because the same resources exist basically in all urban communities. This is not an expensive or complicated program, and the major expense is employee salaries. The community benefits from successful programs such as this, and outweighs the minor cost of operation.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Hawaii State Dept of Health — City/State: Honolulu, HI

Contact Person: Dianne Okumura — Telephone: (808) 733-9033

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Perinatal Support Services

**2. Describe the initiative.**

With the intent of increasing accessibility, availability and quality of care for low income high risk pregnant women, Perinatal Support Services was developed. Support services encompass the creation of support teams, a hotline and incentives program and a coalition for networking and advocacy.

Through a private-public partnership administered by the Maternal and Child Health Branch, perinatal support teams were developed to provide comprehensive perinatal services for low-income high risk women. Service delivery is contracted out to 13 private community agencies. Services include community outreach and enrollment in health insurance, health assessment and medical assessment/intervention/follow-up, psychosocial assessment and care coordination. Utilizing the Regional Perinatal and national family planning guidelines as a base, program staff provide health education at appropriate intervals.

Due to the multi-cultural nature of Hawaii's population, bilingual aides are available at sites serving a larger immigrant clientele. The bilingual access line is utilized if no on-site interpreter is available.

The MothersCare Hotline and Incentives Program provides information and referrals as well as coordination of gifts/incentives distribution at the various support team sites and other community sites. TV and radio spots have been well received by the community and an awareness for the need to access prenatal care is being increased. Through the Healthy Mothers Healthy Babies Coalition private and public agencies network and look at creative ways to advocate for the health of women/infants of the state.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Effective collaboration has been accomplished with private hospitals, physicians, nurse midwives/practitioners, and various community organizations (e.g. Hawaii Academy of Obstetricians/Gynecologists, Hawaii Nurses Assoc., Hawaii Medical Assoc., American Academy of Pediatrics Hawaii Chapter, etc.) as well as state run agencies (e.g. Public Health Nursing, Children with Special Health Needs, School Health, etc.). Ongoing linkage is done through committee, board and council meetings. Continued collaboration can be attributed to the opportunity for all facets to share their concerns, brainstorm on issues and work together to develop resolutions or creative ways to resolve issues.

**4. What have been the greatest barriers faced in implementing this initiative?**

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| Barrier 1: Financial.<br><br>How overcome? 1) Advocacy through the State Department of Health; State Legislature; Community groups; etc. 2) Linkage with private agencies as well as Dept. of Human Services; and other Dept. of Health programs (e.g. PHN, CSHN, SH, etc.). 3) Writing grant proposals. | Barrier 2: Late entry into care.<br><br>How overcome? 1) Study done to review cultural barriers and utilization of this knowledge at provider sites. 2) Bilingual staff used to assist immigrant clients. 3) Presumptive eligibility for insurance determination. 4) Offering transportation. 5) Incentives/gifts to clients. |

**5. How is it funded?** General state funds; MCH block grant funds.

**What is the approximate annual budget for this initiative?** $1,400,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

91.4% of the women seen demonstrated good pregnancy outcomes. 3.8% reduction in low birthweight from 1990 clients (in 1991). 60% reduction in prematurity rate from 1990 clients (in 1991). 100% of the premature births were over 2500 grams in birthweight. 20% reduction in infant mortality for the island of Oahu and Maui. Of the total number seen in 1991, only 7% of the women still had no insurance coverage at the time of delivery; showing that of the women entering programs with no insurance, 93% were assisted in obtaining coverage.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Definitely. The concept is a generic model that can be implemented anywhere, with support from the State or County level, Health Departments, other departmental agencies and community groups.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Marion County Health Department City/State: Indianapolis, IN

Contact Person: Elvin Plank Telephone: (317) 251-4026

Small Group: Improving Public Health Systems in Urban Communities

**1. Initiative Name:** Technical Assistance Review

**2. Describe the initiative.**

After 5 years of many targeted initiatives that were somewhat unsuccessful in lowering the high Black infant mortality rate in Indianapolis, the Health Department leadership decided to request a technical review of our entire MCH program and services from the Region V Maternal and Child Health-Family Planning Department. While the Black infant mortality rate had decreased in the early years of these efforts, there had been no improvement in the last three years. From July 28-30, 1993, there were eleven professionals from outside Indiana and ten from the Indiana State Department of Health who did and in-depth review of the maternal/child health programs and services in Indianapolis. Of the eleven individuals from outside Indiana, seven were either urban MCH leaders in their home communities, or they were recognized experts in MCH. The remaining four were Region V employees. Included in this mix were physicians, dentists, social workers, nurses, nutritionists, and MPH prepared persons. Interviews were conducted with over forty organizations during these three days. A summation conference was held on the last day to share some preliminary findings and a final report will be issued in the near future.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Planning this review was a logistical nightmare because of the need to schedule interviews with so many organizations in such a short period of time. It was tremendously beneficial because communication linkages were established or renewed with so many organizations involved in MCH programs and/or services. We believe this will yield long term benefits.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Local MCH departments do not normally work with Regional MCH departments.<br><br>How overcome? The Indiana State Department of Health personnel were very eager to work outside historical communication channels. | Barrier 2: Getting a cross section of persons from across the country to participate as reviewers.<br><br>How overcome? The Marion County Health Department paid for two of the reviewers. |

**5. How is it funded?** City/County/Local government funds; Other Federal funds.

**What is the approximate annual budget for this initiative?** $40,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

This review occurred very recently, but it has paid immediate dividends. It bought many organizations together under a common cause. All of the major hospitals participated in the review as well as many community-based organizations and individuals. Extensive consumer input was arranged by the care coordination teams serving them. We believe that much of this short-term communication linkage can be massaged into long-term collaborative efforts.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

I think we must look at many ways of pooling our knowledge bases for the benefit of the urban family. I hope that this is just the beginning of many Local/State/Federal collaborative efforts at assisting MCH leaders.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Jackson Health Department City/State: Jackson, MS

Contact Person: Don Grillo MD FACOG Telephone: (601) 987-3977

Small Group: Improving Primary and Preventive Care for Children

**1. Initiative Name:** Consolidated Integrated Services

**2. Describe the initiative.**

The State of Mississippi is a rural state with one metropolitan area and one teaching center/medical school. The City of Jackson boasts the highest number of physicians but few take Medicaid. The emergency room at its large University teaching center is not the proper place for the worried mother - either from a prevention or triage point-of-view - and her child needing urgent care. The Jackson Health Department as part of the Hinds County Department of Health of the Mississippi State Department of Health currently operates six division clinics. Although the primary thrust of the health department is prevention - EPSDT, immunization and well-baby checks - it is apparent that these routine preventative health measures are frequently utilized by the parent as a way to get help for the sick child. In 1989, it was elected to put a full-time pediatrician and dedicated staff daily at a central site that would accept children without appointments or consideration of payment source. The other five sites freely use this consultation service. Two major problems quickly emerged: funding and 8:00 - 5:00 accessibility only. The 1993 Integrated Services Grant seeks to solve both of these difficulties.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Jointly working with the federally funded Jackson-Hinds Comprehensive Health Center, we are able to provide extended hours for the medically indigent child 0800 - 2200 hours. Care from 2200 - 0800 hours is provided by telephone consultation by a private community physician on a set retainer basis. The retainer fees, social work support and data sharing costs are supported by C.I.S.S. Medicaid reimburses at the 133% poverty level for children 0-6 years and provides for its vast majority of our clients. The cost of the remaining 10% are covered by the grant and/or absorbed by the federally funded clinics and Mississippi State Department of Health.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Lack of Fund<br><br>How overcome? Utilization of multiple funding sources. | Barrier 2: Physicians unwilling to accept Medicaid rates.<br><br>How overcome? This is still an obstacle. |

**5. How is it funded?** City/County/Local government funds; General state funds; MCH block grant funds; Other Federal funds; Third party reimbursement (Medicaid,insurance).

**What is the approximate annual budget for this initiative?** $159,512.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Availability of child health 16 hours a day has been the major accomplishment. Secondary success has been networking private practitioners and other health centers with health departments.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, because this initiative is basically a community effort.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Duval County Public Health Unit City/State: Jacksonville, FL

Contact Person: Donald Hagel MD Telephone: (904) 354-3907

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Jacksonville's Healthy Beginnings

**2. Describe the initiative.**

To reduce the infant mortality rate and the low birth weight, the Duval County/Jacksonville Public Health Unit concentrated on efforts to improve first trimester admits, patient compliance for care, prenatal education, and family planning visits. Two physicians and a team of ARNPs provide services in two Public Health Centers devoted entirely to Women's Health and in two multi-service clinics. Concurrently, a statewide "Healthy Start" initiative was implemented to screen all prenatal patients and newborns for factors that can affect the health and welfare of the infant. Each prenatal patient is screened at the first prenatal visit by the public or private health care provider and each newborn is screened at birth. A team of public health professionals are then available to coordinate a range of enhanced services that include: prenatal and parenting education, smoking cessation, immunizations, nutritional counseling, and assistance in linking with medical and social services. Home visits include a Home Safety Checklist and referrals are made to the health unit's Injury Prevention Program to obtain car safety seats and smoke alarms. Outreach efforts include a mobile van for prenatal and family planning education. Economic Service Workers are co-located at all four clinic sites to assist with entrance into Medicaid and AFDC.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Successful linkages have been established within the public health unit (WIC, Injury Prevention, Immunizations) and with other community services. A multi-county Healthy Start Coalition meets regularly to assess needs, establish resources, and provide community-wide outreach. The ChildBirth Education Association provides additional classes both in the public and private sector. Funds were obtained from the city to operate the mobile van. Prenatal and infant screening and referral depends upon the level of training and cooperation from the hospitals and private providers. Effectiveness can be increased with the building of a feedback system.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Case Management Services. The public health unit provides nurses and social workers to serve as case managers without additional funding.<br><br>How overcome? Examination of priorities were set after review of the budget and county health outcomes. More services are needed and barrier is not completely overcome. Further analysis may indicate use of para-professionals to expand services. | Barrier 2: Access and capabilities to gather and analyze data.<br><br>How overcome? Computer programming was a first step, but more linkages are needed. Data needs to be analyzed to determine further interventions and to provide feedback to all providers. |

**5. How is it funded?** City/County/Local government funds; General state funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $850,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

- First trimester admits in public health clinics have increased 6.7%.
- Patient compliance rate for routine prenatal visits averages 85%.
- Nearly 1100 Norplant systems were implanted during the past year in public health clinic.
- Cooperation of community, ie: local hardware store donated fire alarms, local grocery store chain supplies diapers. Breastfeeding Task Force was revitalized, local service. Clubs led by the Kiwannis are serving as caring mentors for immunizations.
- Over 75% of private providers cooperated in prenatal screens the first year.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, because efforts to reduce infant mortality call for a broad-based approach to address all contributing factors. Collaborative efforts build ownership and team spirit and also are economical. Duplication of resources are avoided and each program can concentrate on area of expertise and strengths.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Jersey City Department of Health and Human Services, Division of Health

City/State: Jersey City, NJ

Contact Person: Marna Miller Pal RN MA

Telephone: (201) 547-5928

Small Group: Improving Primary and Preventive Care for Children

**1. Initiative Name:** Preschool Preventative Health Services: Immunization and Coordination of Health Services at the CHC.

**2. Describe the initiative.**

The goals of this initiative address appropriate preschool immunization, with attention to age appropriate immunizations by age two, prevention of a measles outbreak in the preschool population and the provision of comprehensive preventative health services at one location for the preschool population. At the CHC the following is provided: immunizations, physical examinations, hearing and vision testing, lead and hemoglobin screening, WIC, social work services for referrals and follow-up and a linkage with on-call physician services for immunization related problems occuring after clinic hours. Laboratory screening will be expanded in early 1994. In addition to CHC clinics, additional immunization clinics are scheduled to coordinate with WIC sessions to screen and provide immunizations, and channel the children into the CHC. CHC personnel audit all 61 day care, preschool and Head Start programs in the City for immunization compliance, with attention to age appropriate immunization by age two. Special arrangements were made to immunize Head Start children in immunization clinics. A computer program recently installed will track registrants not age appropriately immunized, and will identify delinquent children and the immunizations they require; this information will be generated on appointment letters and reminder notices.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The local Medical Center provides the CHC social worker, CHC client access to the hospital's on call physician service and acute care services. The Medical Center is located adjacent to the CHC site. The WIC and Lead Screening Program Directors/Coordinators are directly involved with planning immunization services. The Lead Screening program provides lead and hemoglobin screening on CHC site and reports treating results to the CHC. WIC program staff is on site at the CHC, and CHC staff screen clients in WIC waiting rooms and escort them to nearby immunization clinics; there are plans to directly immunize on the WIC floor.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: WIC clients are not required to produce immunization records for WIC certification and recertification.<br><br>How overcome? WIC appointment letters now request immunization records be brought with other required documents; request is highlighted with a marker; the compliance rate increased form 54% to 97%. | Barrier 2: Due to volume, WIC processing must adhere to appointment schedules; WIC clients are reluctant to extend WIC appointment time to receive immunizations.<br><br>How overcome? A collaborative effort between WIC and CHC personnel produced a client group batching system for WIC registration and immunization screening and administration, tagging the switching groups between service; WIC appointments are maintained, and clients are prescreened while waiting for WIC appointments and immunized while waiting for or immediately after WIC registration. |

**5. How is it funded?** City/County/Local government funds; General state funds.

**What is the approximate annual budget for this initiative?** $120,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Audits of preschool programs and WIC client immunization records have shown marked improvement in overall immunization compliance and age appropriate compliance by age two. Few measles cases were reported this year. There is a high percentage of follow through on CHC referrals for acute care and anomalies, reflected by the number of written referral responses. Social work, lead screening, WIC, hearing and vision screening, physical exams, and blood work are provided at the CHC site.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

The clients "sought" for many preventive and acute care programs are drawn from the same population, and the services provided are often both supplementary and complementary to each other. It is possible to develop feedback mechanisms and coordinate staffing patterns and program sessions to "repeat" services at different sites for the same pool of clients. The CHC can serve as a magnet for the other services as immunizations are state required, and draw the numbers other programs may find beneficial to their program goal.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Kansas City, MO Health Department City/State: Kansas City, MO

Contact Person: Sid Bates
Chief, MCH Services
Telephone: (816) 923-2600

Small Group: Improving Primary and Preventive Care for Children

**1. Initiative Name:** Childhood Blood Lead Pilot Screening

**2. Descri .e the initiative.**

Kansas City had no available data on childhood blood lead levels <25 ug/dl. Based on the CDC guidelines of 10/91, the City did not know the extent or nature of the problem. The City health department did not have atomic absorption spectrophotometer capability in its laboratory. Working with the Missouri Department of Health and the Children's Mercy Hospital, AAS screening and confirmatory tests were obtained for a pilot study of children 6 months to 6 years of age. A State developed risk questionnaire was employed and demographic data was retained at the local level as well as state-wide so detailed analysis at the city level could be performed. The results allowed the City to plan an appropriate response to childhood blood lead poisoning unique to Kansas City, while the data collected helped the State in preparing its grant request to CDC.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages with the State were crucial in obtaining AAS services. The State in turn formed a partnership with the Saint Louis Public Health Laboratory to perform AAS analysis on finger stick samples. The State laboratory conducted testing on venous confirmatory samples. The Children's Mercy Hospital performed the venipunctures and the City health department collected finger stick samples and conducted patient interviews.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Availability of AAS analysis on finger stick samples.<br><br>How overcome? Because of the need for state-wide data, State first found lab availability for analysis of finger-stick samples, later began conducting the tests in State lab. | Barrier 2: Funding for AAS analysis.<br><br>How overcome? Utilizing capability of State lab, in lieu of local capability. |

5. **How is it funded?** City/County/Local government funds; General state funds; MCH block grant funds; Private sources.

**What is the approximate annual budget for this initiative?** N/A (All in-kind contribution)

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Accurate data was obtained on a statistically significant sample that provided Kansas City with an accurate picture of its childhood blood lead levels. This was particularly useful several months later when an industrial accident created the potential for lead poisoni .g in a neighborhood already at risk for elevated lead levels.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. AAS analysis is expensive and many local health departments lack the laboratory capability. However, the capability is usually available somewhere in the state. A collaborative partnership to conduct pilot studies or on-going services help maximize use of available resources.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Knox County Health Department City/State: Knoxville, TN

Contact Person: Bea Emory
Karen Bateman
Elaine Wallace

Telephone: (615) 544-4214

Small Group: Improving Primary and Preventive Care for Children

**1. Initiative Name:** Neighborhood Immunization Clinic

**2. Describe the initiative.**

Due to declining immunization rates in children less than two years of age, the department implemented a series of immunization clinics. These were located in areas with large numbers of vaccine delinquent children. Clinics were scheduled in five neighborhoods for two days each. Two nurses were assigned to each clinic.

Vaccines were offered without charge on a walk-in basis.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were established with the Housing Authority Recreation Centers, Community Action Centers, Urban League, and area businesses. The centers assisted by providing space and advertising the clinics. The Urban League provided manpower to go door to door with door hangers on the Friday immediately preceding the clinic for targeted neighborhood.

Local businesses provided funds to purchase juice and cookies for people coming to clinic, books to give to children completing needed immunizations by 15 months of age, and immunization schedule reminder magnets to be given to mothers.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: Lack of knowledge by parents in community of required immunizations. | Barrier 2: Lack of knowledge by neighborhood residents of clinic availability. |
|---|---|
| How overcome? 1) Posters in neighborhood stores with schedule of immunizations. 2) Flyers distributed by food commodity centers. 3) Flyers distributed in every grocery sack by major chain over a holiday weekend. | How overcome? 1) Door hangers placed on every residence in neighborhood on Friday preceding the scheduled clinic. 2) Posters in community centers where clinic held. 3) Media coverage by radio, television, and newspaper. |

**5. How is it funded?** City/County/Local government funds.

**What is the approximate annual budget for this initiative?** No additional dollars were required.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Success is difficult to measure at this point, but we have had an overall increase in doses of vaccine administered in the month of July, 1993 over July, 1992. In all our neighborhood clinics, we had a small number of children 2 - 3 years of age receive immunizations for the first time.

Heightened awareness in the community as a whole appears to be the major accomplishment. The overall success of this initiative will be determined when we do our survey of 24 month old children next spring (1994).

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Location of the clinics is critical. A computer program was used to map vaccine delinquent children and by concentrating on areas where a larger number of children lived, clinic site was selected.

From our experience, sites should be located outside housing projects but in an accessible area. (Our most successful clinic was located in a YMCA and drew from a larger area than the clinics located in housing project recreation centers.)

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.


Health Department: Laredo Health Department — City/State: Laredo, TX

Contact Person: Lisa Sanford RN MPH, Chief, Preventive Health Services — Telephone: (210) 723-2051 Ext. 232


Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Neural Tube Defect Project

**2. Describe the initiative.**

After identification of a "cluster" of anencephalic births in the lower Rio Grande in 1992, the Texas Department of Health applied to the Centers for Disease Control for funding to establish a neural tube defects (NTD) surveillance/prevention project along the fourteen county Mexico-Texas border region. Teams have been placed in El Paso and the Brownsville area, housed by the Texas Department of Health regional offices. The City of Laredo Health Department was selected as the third site and a team composed of a public health technician and a registered nurse has been hired.

The Laredo team is responsible for data collection in a seven-county area covering over 22,000 square miles. Surveillance activities entail the establishment of personal networks with multiple agencies and lay midwives in each county. Due to the sensitive nature of this project and the local attitudes, creating open lines of communication between team members and community contacts has been challenging as well as exciting. As the project matures, a prevention component will be added as well. This component will focus on approaching all women who have experienced a neural tube affected pregnancy and interviewing them in an attempt to identify possible exposure risks. These women will also be offered folic acid supplementation as a possible prevention method for subsequent pregnancies.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Formal linkages established involve the State Health Department, local hospitals, radiology centers, private physicians offices, genetic counseling centers, ECI programs, public health clinics, and lay midwives. Informal linkages have been established with local school districts with teen parenting programs, the local junior college, the Pregnancy Hotline, and other interested parties who have encounters with pregnant women.

To date, the cooperative and collaboration with the various agencies involved has been excellent. The informal system is often "more efficient" than the formal and provides excellent leads. A key factor in this effectiveness has been the staff itself with their excellent interpersonal skills and cultural sensitivity.

**4. What have been the greatest barriers faced in implementing this initiative?**

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| Barrier 1: Reluctance to disclose information.<br><br>How overcome? Personal contact between team members and key individuals in the various agencies has proven to be highly effective. (Recent Texas legislation will make reporting of neural tube affected pregnancies mandatory, though it is preferred to maintain the personal contact.) | Barrier 2: Tremendous distances make "personal contact" and networking difficult for team members.<br><br>How overcome? Aggressive telephone networking, coupled with mailed newsletters from the Health Department are methods used to maintain contact. Also, at least monthly field visits help maintain relationships with key individuals. |

**5. How is it funded?** City/County/Local government funds; Other Federal funds.

**What is the approximate annual budget for this initiative?** $88,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The actual success and/or impact of this project cannot be measured yet, though the potential significance is quite great. A valid study of neural tube defect incidence along the Texas-Mexico border could result in additional health care resource allocation in an area already identified as highly impacted. The greatest accomplishment to date has been the effective networking and increased level of awareness of neural tube defects among both the professional and non-professional communities.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This initiative would definitely be applicable to other metropolitan areas either as is, or in an expanded format to track all congenital birth defects. The challenge of long distance networking would probably be avoided, thereby facilitating program activities.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Lexington-Fayette County Health Dept City/State: Lexington, KY

Contact Person: Carla G. Cordier RN, Director Telephone: (606) 288-2425

Category: Improving Access to Health Care

**1. Initiative Name:** Nursing/Nutrition Education Expansion

**2. Describe the initiative.**

Maternity services were expanded significantly by the provision of screening and individualized counseling and education for Medicaid and low-income women who are seen at the University of Kentucky Obstetrics and Gynecology clinic, by the provision of same-day nurse education and individualized counseling for postpartum women receiving WIC and MCH Nutrition services and by same-day follow-up and counseling of women with positive pregnancy tests.

In addition to the expansion of services at the University of Kentucky Medical Center, the Health Department clinic site services were expanded. Services of the Health Department clinic and WIC were integrated during the past year which allowed for more efficiency of staff and easier access to services for patients. Patients now can receive WIC, prenatal, postpartum, and child health services at the same time at the Health Department site.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were already in place, they were just enhanced with the expansion of services. Several planning meetings were held with all staff involved.

**4. What have been the greatest barriers faced in implementing this initiative?**

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| Barrier 1: Space for staff to provide counseling was a problem.<br><br>How overcome? The University of Kentucky Obstetrics and Gynecology clinic was in the process of expanding and renovating their clinic. Space was assigned for our staff to use. Counseling rooms were available at the Health Department site on the second floor and in our Annex building. Space continues to be a problem at the Health Department. Clients must move to several different areas for one complete visit. | Barrier 2:<br><br>How overcome? |

**5. How is it funded?** City/County/Local government funds, General state funds, MCH block grant funds, 330 funds, Third part reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** Maternity Program Budget: $486,772.00. It would be difficult to separate this initiative.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

619 women have received nursing and nutrition counseling and education from July 1, 1992 to June 30, 1993.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This initiative could be successful in any area. Many women could receive counseling services.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Lincoln-Lancaster County Health Department

City/State: Lincoln, NE

Contact Person: Carole Douglas RN MPH

Telephone: (402) 441-8051

Small Group: Improving Access to Health Care

**1. Initiative Name:** Medicaid Access Coordination (MAC) Programs

**2. Describe the initiative.**

Early in 1990, our community experienced a crisis with no physicians willing to take new Medicaid or low income patients and no alternatives for care except costly, fragmented emergency room care. In response, the MAC Program was implemented as a public/private partnership solution to accessing health care for eligible clients. Using a single telephone access point, clients work with a Public Health Nurse (PHN) to access barriers to care and urgency of health needs. An appointment is then made and transportation, preventive health care and case management is arranged as needed. The program integrates existing programs to simplify care for recipients including PHN home visitation (case management for pregnancy, parenting and health care compliance), WIC, presumptive eligibility, immunizations and recently, an outreach project - "Healthy Homes," utilizing trained lay visitors targeting our minority communities. A simple rotation system and computerized central registry assures equitable distribution of clients among all participating primary care physicians.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Achieving a creative solution required establishing a close partnership with the Nebraska Department of Social Services, the Lancaster County Medical Society and the Lincoln-Lancaster County Health Department. The group first did a thorough assessment of the problem and worked closely to come up with a solution that would work for our community. A complex, highly coordinated project such as this requires frequent communication to resolve problems before they become overwhelming. We are proud to say it is working!

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Physicians were reluctant to agree to take Medicaid clients for fear of being the sole provider and being overwhelmed with clients needing care.<br><br>How overcome? A simple rotational system was established that assigns new clients to the next physician in line. In seeking participation, physicians were also told what to expect per month and year for each physician if everyone did their fair share. Over 90% of all primary care physicians participate. | Barrier 2: In an era of constrained resources, how can we meet the increased demand that the program would make for Public Health Nursing?<br><br>How overcome? Funding for the increased demand was worked out with NDSS and the Health Department under Medicaid administrative monies which provides 75% federal reimbursement. This allowed the Health Department to leverage one current position into two PHN's on the phone and field visits for case coordination. The Medical Society also provided staff, materials and training expenses from membership fees. |

**5. How is it funded?** City/County/Local government funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $75,532.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

To date, the Health Department has handled over 15,388 calls resulting in 7,192 clients being assigned to a primary care physician. The effectiveness of assessment and case management components has resulted in only 40 individuals presenting serious non-compliance problems which threaten use of the program. Over 700 pregnant women and infants are currently enrolled in home-based visitation. Since the 1988 high of 12.4/1000, our infant mortality rate has fallen to below 8/1,000 for the past three years.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. This type of program leverages a modest investment of local dollars into an effective cost saving program. We strongly believe that the only way such a program can be successful is when the community carefully does an assessment engaging all parties in discussion and keeps the system as simple as possible at all points.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Pulaski County Health Department City/State: Little Rock, AR

Contact Person: Zenobia Harris Telephone: (501) 663-6080

Small Group: Improving Public Health Systems in Urban Communities

**1. Initiative Name:** Arkansas Immunization Reporting System (AIRS)

**2. Describe the initiative.**

The Arkansas Department of Health has developed a centralized statewide data processing tracking and communications network. The capabilities include a 24-hour, on-line, real-time network with 96 ADH clinics, 10 Area Management Offices and the Central Administrative Office linked via dedicated lease lines. Because all full-time clinics which provide integrated health services to children in all Arkansas counties are on the system; ADH has been able to develop computer software which reduces agency costs and expedites services to clients.

In recent months, the Immunization and WIC (Special Supplemental Food Program for Women, Infants, and Children) databases were merged so that each patient has one patient identification number. The Immunization database, called Arkansas Immunization Reporting System (AIRS), currently includes 847,500 immunization patients and over 200,000 patients with WIC records. All immunization patients served by the public sector (ADH local health units, Community Health Centers, and 3 of the largest hospitals in the state) have records in this system; this includes approximately 85-90% of all children in Arkansas. All WIC patients in Arkansas are served by ADH local health units and records on all WIC patients for the past three years are in the system (1990-1993)

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Department of Health met with community health center staff members and large hospital staff members to provide training, technical assistance, vaccine and access to the AIRS.

This collaboration enabled the Department of Health to more effectively and comprehensively promote immunization efforts among major providers of these services in the state.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Limited computer use experience of local health unit staff<br><br>How overcome? Provided in-services to local unit staff on computer use, accessing WIC and immunization data on clients, etc. | Barrier 2:<br><br>How overcome? |

**5. How is it funded?**

**What is the approximate annual budget for this initiative?**

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

1. Has encouraged local health unit staff to coordinate Immunization and WIC clients, regardless of reason for clinic visits.
2. Reduces staff time spent searching for funds.
3. Reduces client time spent waiting for services.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, particularly those units with large client caseloads. It affords for local data entry and allows local units the ability to transfer patient computer records from one site to another, update patient information, and help to eliminate duplication of immunization doses.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Los Angeles County Department of Health Services

City/State: Los Angeles, CA

Contact Person: Arthur D Lisbin MD

Telephone: (213) 240-8090

Category: Improving Primary and Preventive Care for Children

**1. Initiative Name:** Protective Services Child Health System

**2. Describe the initiative.**

Los Angeles County has about 50,000 children in foster care at any one time. Most of these children have health or mental health problems which interfere with them achieving their full potential. Through the EPSDT Program, 20 public health nurses have been hired to act as consultants to children service workers (CSW) in our Department of Children Services (foster Care). The nurses will be available for the CSWs when they or the children's families have health related questions. The public health nurses will assist the CSW in obtaining proper medical and mental health services for the child. A pediatrician is available if the nurse needs further medical advice.

Within the next 4-5 years, 7 hubs will be established in the County. These hubs will provide complete physical, mental and psychosocial evaluation of the children and their families prior to placement. This will be in addition to the public health nurses activities as described above.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were established between the Los Angeles County Board of Supervisors, the Department of Children Services, the Department of Social Services, Probation, the Department of Mental Health and the Department of Health Services. This collaboration was effective because all participants are concerned about the medical and mental health needs of foster children which are much more than the needs of the average population. The participants want to ensure that these children receive the services they need. Turf was not a problem.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Money.<br><br>How overcome? The Directors of DCS convinced the Board of Supervisors the county money was needed to match the federal EPSDT money which is a 75/25 match (Federal/County). | Barrier 2: Explaining to staff that nurses hired with EPSDT money could not deliver direct services to the patient or the family.<br><br>How overcome? Cross-training was very important. Frequent meetings were held with all participants to fully explain the nurse's role in the program. |

**5. How is it funded?** City/County/Local government funds; Other Federal funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $2,082,058.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The program has just started, but the enthusiasm of all participants will ensure its success. Its major accomplishment to date is bringing together all of the players necessary to providing adequate and quality health care to foster children.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, This would work in other communities provided you had the enthusiasm and determination of the various agencies to make it work. The issue of turf must be resolved as soon as possible for the good of the children.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Jefferson County Health Department City/State: Louisville, KY

Contact Person: Flora Ponder RN Coordinator Telephone: (502) 574-5714

Category: Improving Access to Health Care

**1. Initiative Name:** Pediatric Outreach/Follow-Up

**2. Describe the initiative.**

A developed program of 1 year that recognizes there is a population of infants and children that have a higher risk of health problems due to medical, environmental or social risk factors. This program attempts to: assure that infants and children enter into health care as early as possible; locate lost-to-care infants; assist patients in gaining access to needed medical, psycho-social, educational or other services; and that children from birth to 21 years of age are served regardless of income.

The Pediatric Outreach team is composed of one Nurse Coordinator, one Community Health Nurse, one Social Worker, one Health Educator, and one Medical Assistant. Specific activities of the team include: home visits to assess family's need for health care and arrange appointments for family members; follow-up on missed appointments; follow-up on referrals from Health Department clinics; contacting physicians and community service providers to encourage referral to program; and counseling of Sudden Infant Death Syndrome parents.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Jefferson County Public Schools - effective collaboration, referrals received from Family Resource Centers located in the schools. University Child Health Specialists (University of Louisville Pediatric Clinic) - effective collaboration, referrals received on a regular basis. Kosair Children's Hospital - somewhat effective collaboration, large institution, need a more specific area to approach for contact. Kentucky Commission for Handicapped Children - effective collaboration, large institution, need a more specific area to approach contact (few patients received). SIDS Section - Frankfort, Kentucky - effective collaboration, referrals received on a regular basis. University of Louisville Hematology & Oncology Clinics - effective collaboration, referrals received on a regular basis. Jefferson County Child Fatality Review Team - a new initiative.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Hiring a new staff with limited experience.<br><br>How overcome? 1) Establish standards, procedures and outlines relating to expected initiative performance. 2) Intensive orientation on multiple topics, ie. home visits, other service agencies, etc. 3) Entertained and proceeded to attend outside seminars, workshops, symposiums, etc. that were available and appropriate. | Barrier 2: Establishing awareness of program.<br><br>How overcome? 1) Inservice with other Health Department staff as to program. 2) Letter to colleagues in Jefferson County. 3) Meeting with agency directors. 4) Presentations to groups when permitted with lectures, slide presentations and pamphlets. 5) Visible at Community Health Fairs, Expos, etc. 6) Word-of-mouth; communications of satisfied customers. |

**5. How is it funded?** MCH Bloack grant funds.

**What is the approximate annual budget for this initiative?** $142,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The program has been successful in contacting many families in need of health care. During the first twelve months of the program 3,728 families have been contacted by mail and 1,960 home visits have been made. These numbers do not include telephone calls, office and hospital visits. As an example - in a two month period one agency referred twenty five children in need of medical care but have missed multiple appointments. After being contacted by the Pediatric Outreach and Follow-up Team, twenty three children kept their appointments.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This program would be helpful in other urban communities as many families do not know how to access health care and are unaware of the importance of preventive care. Since many communities have decreased or eliminated the practice of home visits an outreach and follow-up team could perform this essential service.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Lubbock Health Dept

City/State: Lubbock, TX

Contact Person: Mary M Strange RN CNA
Program Coordinator

Telephone: (806) 767-2899

Small Group: Improving Access to Health Care

**1. Initiative Name:** Greenfair Clinic

**2. Describe the initiative.**

Greenfair is a housing project, located in the eastern sector of Lubbock, Texas (population 189,000). The Health Department identified the need for easily accessible health care to the residents after seeing individuals with high blood pressure, in their last trimester of pregnancy, and with no family planning services. In cooperation with the Housing Authority Director, the Health Department staff obtained a room from which to offer blood pressure, glucose and pregnancy screening; immunizations; health assessment and referrals. Located downstairs, the first room was not conducive to attracting the residents, nor did it meet ADA standards. Therefore, on February 19, 1993, a ribbon-cutting ceremony was held to open the "new" Greenfair Clinic. Adequate space was available for the Health Department to provide services. The staff consists of an OB-GYN Nurse Practitioner, a Registered Nurse, and 2 Community Service Aides. HIV/AIDS counseling and testing was also added to the list of services.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Lubbock Housing Authority and the City of Lubbock Health Department provided the primary linkages. The clinic is a Win-Win-Win situation for all involved. The Housing Authority staff is relieved of making health related decisions - ones they were not prepared nor expected to make. The Health Department provides badly-needed services to individuals who would not go elsewhere for care. Many children would be starting their immunizations at age four, instead of completing them. The Greenfair residents win in having health care services and advice only a short walk from their apartments.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Health care screening and services not easily accessible.<br><br>How overcome? Greenfair Clinic was established, located within the housing complex. | Barrier 2: Initial location not adequate.<br><br>How overcome? New location was provided that was ADA accessible and more obvious to clientele. |

**5. How is it funded?** City/County/Local government funds.

**What is the approximate annual budget for this initiative?** N/A -- Part of current budget for Personal Health Services.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

During the 4 months of operation, the Greenfair Clinic has taken 242 blood pressures, conducted 74 blood sugar screenings, given 70 children immunizations, provided 21 child health screenings, and referred 61 adults to other health care providers. Of these, 34 were referred to the City of Lubbock Health Department for prenatal care or family planning services.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This project needs minimal space - the Health Department operates out of two 10' x 10' rooms. Rooms are furnished with excess equipment from both Health Department and Housing Authority. No new staff, nor funds were added to the annual budget. The Housing Authority is providing space 1 day/week, that they are not using. Similar projects just take initiative and the willingness to cooperate, and allowing personnel time to staff the clinic. This clinic is another example of how, through cooperation, health services can be taken to the people who need them most.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Madison Department of Public Health City/State: Madison, WI

Contact Person: Gay Gross, Health Planner Telephone: (608) 266-4821

Small Group: Improving Access to Health Care

**1. Initiative Name:** South Madison Health and Family Center (SMHFC)

**2. Describe the initiative.**

The SMHFC is currently the co-location of five health and family support agencies: Madison Department of Public Health, Madison Community Health Center, Planned Parenthood, Family Enhancement Early Childhood Center and University of Wisconsin medical staff, medical and nursing students. The center services, which have been offered since 1991, are designed to meet the preventive and primary health care needs as well as the family and parent support needs of this under-served South Madison community.

Health services include: WIC Nutritional Program, immunizations, health check (EPSDT), well child clinics, HIV counseling and testing, primary health care services, family planning, pregnancy testing, childbirth classes, reproductive health services, STD testing and treatment, and a Saturday morning No-fee Clinic providing routine health care, screening and medical care.

Child and family support services include: Resource Center, Parenting Classes, Toy Lending Library, GED Classes, and a Drop-In Center.

Enlargement of the facility would allow for the expansion and better integration of existing services, as well as inclusion of the Head Start and a branch of the Madison Public Library.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were established with Madison Community Health Center, Planned Parenthood, Family Enhancement, and the UW Department of Family Medicine, as well as residents and community organizations in South Madison. Collaboration has been effective because all agencies serve many of the same families and share the same goals in focusing on health and families. Also, the staffs of the separate agencies know each other, meet regularly on both a formal and informal basis, and have increased their familiarity with each other's programs.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Inadequate space.<br><br>How overcome? We hope to overcome the barrier by building a new center. Representatives of the collaborating agencies have begun planning for a new facility, working with a consultant architect funded by the City. Funds for construction of the building are being sought. | Barrier 2: Separate programs, different eligibility criteria and intake procedures and decentralized appointment scheduling of the collaborating agencies.<br><br>How overcome? Future plans to overcome this barrier include planning and designing common intake procedures and a staff person on site at all times to centralize the appointment scheduling for all the agencies. A larger facility will allow more agencies to function there simultaneously. |

**5. How is it funded?** City/County/Local government funds; MCH block grant funds; Private source(s): Planned Parenthood, United Way; Third Party reimbursement (Medicaid, insurance); Other: WI Children's Trust Fund.

**What is the approximate annual budget for this initiative?** Total funds unavailable (three different funding sources).

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The SMHFC's success has been reflected in the referral relationships between the collaborating agencies, including frequent referrals among agencies, explaining services of other agencies to clients, and often walking clients to another agency within the building. Success has also been reflected in the City's commitment to fund a consultant to research one-stop shopping models of care and an architectural consultant. The inclusion of all area private health care organizations (HMO's, clinics, hospitals, the University, etc.) on the planning team exemplified linkages to the private health care sector. The commitment to jointly build and fund the $3.2 million facility is a major accomplishment.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This iniative is workable in any urban community that is committed to developing public-private collaboration on a one-stop shopping model of health and family services, with the goals of decreasing fragmentation of services and improving access for children and families to comprehensive services designed to help them build on their strengths.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Memphis and Shelby Co Health Dept  City/State: Memphis, TN

Contact Person: Brenda Coulehan RN  Telephone: (901) 576-7910

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Title X Special Initiative: Family Planning in the Packer STD Clinic

**2. Describe the initiative.**

Although Family Planning patients who test positive for GC are treated by practitioners in the Primary Care Clinic over 3000 women between 10-35 years were treated for GC in the STD clinic in 1992. A needs assessment conducted in the STD clinic indicated that 47% of females surveyed did not receive F.P. counseling from their M.D., neighborhood clinic, or Planned Parenthood. STD examinations and counseling focus on STD's and do not provide the screening and counseling services provided in a routine F.P. intake examination. A F.P. practitioner and a health aide are now located in the STD clinic and offer a complete family planning work-up and counseling, with Rx of method of choice and referral to provider of choice for follow-up.

Addresses pre-conceptual health enhancement and prevention of STD's (including AIDS).

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The linkages have been through different sectors of our agency i.e., Family Planning and the STD Clinic. The collaboration is proving effective. The F.P. practitioner reports to the STD Supervisor and attends STD meetings. The STD nurses are very interested in the services being offered and are referring clients to F.P.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Space - The project had been conceptualized for some time but lack of space was prohibitive.<br><br>How overcome? Fortuitously, reconstruction of the Packer STD Clinic to provide more office space related to STD investigation and follow-up, resulted in enough added space to accommodate one examining room and space for history taking etc., for F.P. | Barrier 2: Funding - This project required the addition of 2 FTEs: a F.P. practitioner and a health aide.<br><br>How overcome? Once space became available a grant was submitted to Region IV Family Planning Program for a special initiative grant, based on a needs assessment completed in December of 1992 (had this not been funded it would have been submitted to STD). |

**5. How is it funded?** Other Federal funds.

**What is the approximate annual budget for this initiative?** $59,040.00/yr (Grant) Salaries + cost of F.P. supplies for 1 yr. (F.P. Budget)

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

93% of the patients seen did not have a F.P provider and have been referred to their neighborhood clinic following initial F.P. work-up and Rx of birth control method of choice. 7% of patients seen have been referred for mammogram and surgical clinic follow-up in addition to F.P. work-up. 16% of patients seen chose Depo Provera as method of choice 77% of patients chose B.C.P's. (It is too soon to evaluate numbers but they are increasing daily).

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, it would work if the need were demonstrated. Our needs assessment showed that many women attending the STD clinic did not have a medical home or a F.P. provider. They were missing out on many aspects of women's health care which are not provided in a STD workup but are provided in a F.P. workup e.g., breast exams and SBE instruction, thyroid and abdominal exams, Pap smears.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: HRS - Dade County Public Health Unit City/State: Miami, FL

Contact Person: Richard W Strait MBA Telephone: (305) 324-2481

Small Group: Improving Access to Health Care

**1. Initiative Name:** MOMmobile

**2. Describe the initiative.**

The MOMmobile is a 37 foot vehicle that is a mobile prenatal care clinic. The unit is equipped with two exam rooms, lab, waiting room, and interview area. The vehicle's lab is fully equipped for field work, has a portable ultrasound machine, cellular communications and computer capabilities, and radio.

Planning began over two years ago as a joint effort of the public health unit, The March of Dimes, and the Metro-Dade Children's Services Council. The needs for care following Hurricane Andrew accelerated implementation of this project.

The unit has now been in operation since February 22, 1993 serving prenatal clients who are unable to access care at a permanent site due to transportation, distance, social-economic conditions and other reasons.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

March of Dimes paid for the vehicle and all costs associated with converting it. University of Miami, the Primary Care Consortium, The Children's Services Council and various private providers assisted with planning. As a result the March of Dimes and the Dade County Public Health Unit have formed a very effective partnership to operate the vehicle (DCPHU staffs and provides services, March of Dimes fuels, maintains, and publicizes). The relationship has led to other joint programs between DCPHU and March of Dimes to provide services.

The University of Miami School of Medicine uses the vehicle and staff as a training resource for A.R.N.P. students.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Cost of purchasing and converting the vehicle and cost of staffing and operation.<br><br>How overcome? The South Florida Chapter of March of Dimes committed as their major fund raising efforts to purchase the vehicle.<br><br>F.E.M.A. funds following Hurricane Andrew gave the Public Health Unit the ability to hire and staff the vehicle for start up operations. | Barrier 2: Poor response by the public due to lack of understanding of what the vehicle was and its capabilities.<br><br>How overcome? Extensive print and T.V. publicity of the vehicle, its purposes and capabilities. Training of Health Department staff to encourage those seeking services to use the vehicle.<br><br>Stressing the on-site capabilities of the vehicle, i.e. ultrasound. |

**5. How is it funded?** City/County/Local government funds; Other Federal funds; Private Sources: March of Dimes.

**What is the approximate annual budget for this initiative?** $325,000.00 (An additional $476,000 was spent as a one-time expense).

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The number of clients using the unit has grown at an increasingly high rate. Several communities have called regarding service by the vehicle and the unit has gained political support by local leaders.

As of June 15, 1993, over 100 new maternity clients have entered care at the vehicle.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, if the community has areas of underserved populations and access to care issues which can be assisted by having a vehicle able to bring full services to the populations on a scheduled basis.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.


Health Department: Milwaukee Health Department

City/State: Milwaukee, WI

Contact Person: Jill Ritterbusch
Supervising Public Health Nurse
Elizabeth Zelazek
Public Health Nursing Manager

Telephone: (414) 286-8840
(414) 286-3606


Small Group: Reducing and Treating Substance Abuse

**1. Initiative Name:** Milwaukee Target Cities Project

**2. Describe the initiative.**

The Milwaukee Target Cities Project provides an opportunity for the Milwaukee Health Department to collaborate with Milwaukee County to provide public health nursing and case management to substance abusing women and minorities. The Target Cities Project is based at two outreach sites serving six zip codes in Milwaukee. The PHNs serve as an integral part of a team of case managers and housing and vocational education specialists to provide comprehensive health and social services to clients. In addition, the PHNs work with AODA treatment providers to insure management of overall health needs along with the substance abuse treatment needs of clients. Public health nursing services are both home and site based. They are targeted to substance abusers with suspected health problems with an emphasis on women and children affected by substance abuse. Services provided include assessment, counseling and referral for health needs such as high risk pregnancy, low birth weight infants, lead poisoning and immunizations. Child abuse and neglect prevention and intervention are a major focus of the public health nursing services. In addition, the detection and prevention of communicable diseases such as HIV infection, TB, and STDs is emphasized.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The project involves working with the State of Wisconsin Division of Community Services, Milwaukee County Adult Services and with various AODA treatment providers in the community. The collaboration has been challenging and sometimes difficult, but ultimately effective for the client who has access to a more comprehensive range of services.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Lack of understanding of the needs of women, including pregnant women, among AODA treatment providers.<br><br>How overcome? Advocacy by PHNs on women's issues in treatment. Education of AODA treatment providers about specific health and psychosocial needs of women. Working with case managers to identify and help women access gender specific AODA treatment. | Barrier 2: Lack of understanding of PHN role in the project by case managers.<br><br>How overcome? On-going role clarification by PHNs. On-going communication and team building with case managers through regular case discussions, formal case staffings and joint home visits. Positive evaluation of public health services by federal project officers and by independent evaluation contracted by project. |

**5. How is it funded?** Other Federal funds.

**What is the approximate annual budget for this initiative?** $350,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

- Comprehensive health, social and AODA services provided to substance abusing women and their children.
- Increased awareness by AODA treatment providers of health needs and of women's issues in treatment.
- Positive birth outcomes for pregnant clients through public health intervention.
- Implementation of HIV, TB, and STD risk assessment for all clients.
- Development of expertise by program PHNs in the area of substance abuse - an expertise now being shared with remainder of PHN staff.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. This project promotes the goals and assists in implementation of the strategic plan of the Milwaukee Health Department as it relates to improving the health status of women and children in the community. In addition, the collaboration of agencies, especially government agencies, and the teaming of professionals from different disciplines is an important and challenging step in the discovery of new, more effective ways to deliver service. Other communities could benefit from similar initiatives.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Minneapolis Department of Health and Family Support

City/State: Minneapolis, MN

Contact Person: Edward P Ehlinger MD

Telephone: (612) 673-2780

Small Group: Improving Public Health Systems in Urban Communities

**1. Initiative Name:** KIDSTAT - Child Health Status Monitoring Program

**2. Describe the initiative.**

KIDSTAT was established to monitor and track the health and well-being of all Minneapolis children under six years of age by collecting, describing, analyzing, and disseminating a broad array of social, economic, educational, psychological, health indicators for use by program planners, program evaluators, policy makers, researchers, and advocates. KIDSTAT uses existing data sets whenever possible to describe the health status of Minneapolis children at the city, community, and neighborhood level. Special studies and primary data collection are undertaken when data are not available to answer specific questions. KIDSTAT also provides information and education on data parameters to facilitate accurate interpretation among users of the data. KIDSTAT is an ongoing data monitoring program that issues reports periodically. Its dynamic nature allows for changes in data collection efforts and development of reports in response to community needs and interests.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

In developing KIDSTAT, an extensive literature search was done on monitoring the health of children. A survey of sixty representatives of local and state health departments, private and voluntary health and advocacy groups, and universities in Minnesota and throughout the country. Personal interviews were done with 14 of these individuals. Linkages with local agencies included review of indicators and developing access to existing data sets. Other agencies have been able to see the benefits that KIDSTAT would have on their activities so collaboration has been relatively easy.

4. What have been the greatest barriers faced in implementing this initiative?

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|---|---|
| Barrier 1: Lack of consensus on indicators to use in KIDSTAT reports.<br><br>How overcome? KIDSTAT started with a dream list of indicators and criteria for indicators that was slowly pared down with ongoing input from community agencies and data and monitoring works. The program has continued to solicit input from members of the community and has broadly disseminated reports that have been completed. | Barrier 2: Access to existing data sets.<br><br>How overcome? Gaining timely access to existing data sets is an ongoing problem. Best results are achieved when requests for data are specific and the agencies with the data know how the data will be used. Quality of the data improves when agencies know that the data will be published in a KIDSTAT report because they are cited as the source of the data. As the status of KIDSTAT reports increases, we are hoping for easier access to data. |

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative? $60,000.00

6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?

As a policy development vehicle, KIDSTAT has been remarkably successful. The mayor used the KIDSTAT report as the basis for his 1993 State of the City address. The news media have used the data from KIDSTAT in many of their reports and have discussed the implications of the data. Data from KIDSTAT have been frequently quoted by policy makers at the local and state level. At least one child health clinic has been relocated into a high need area because of the data generated by KIDSTAT.

7. Do you think that this initiative would work if implemented in another urban community? Why?

Yes. This type of activity must be duplicated in other urban communities. This type of program embodies all of the core functions of local health agencies - assessment, assurance, and policy development. If activities like this are not done by the local public health agency, they will be done by some other group that may not have a public health perspective.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.


Health Department: Missoula City-County Health Dept City/State: Missoula, MT

Contact Person: Yvonne Bradford
Director of Health Services
Telephone: (406) 523-4750


Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Access Links and Follow Me Programs

**2. Describe the initiative.**

Access Links, a Low Birthweight Prevention Program, was developed in partnership with the local medical community as an initiative to impact the 12.9% low birthweight (LBW) rate among low income women in Missoula. The Program provides case management through home visiting by nurses and social workers, prenatal education, initial prenatal clinical care with referral to participating physicians for ongoing care and delivery. WIC and Medicaid enrollment are expedited for women enrolled in the Program, as well as referrals to other community health and social service providers.

Recent implementation of Follow Me has formalized public health nursing services for infants and children at risk for developmental delay. A large percentage of Follow Me families have been Access Links clients, thus a continuum of care can be provided by the same public health professional prenatally and throughout early childhood. Planning and development of Follow Me was conducted by the state interagency Early Intervention Steering Committee. Missoula serves as a pilot project for early identification, intervention and tracking of high risk children to age 5.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

In order to assure access to care and cultural acceptability, Access Links and Follow Me Programs include coordination with Native American and refugee support agencies, including services of interpreters from the Russian and Asian communities and a Native American MCH Advocate. Other primary linkages for program development and/or comprehensive perinatal and early childhood service include health care providers, Medicaid/economic and human service support agencies, WIC, drug and alcohol treatment programs, family planning, child care and schools.

Interagency coordination has been facilitated through the Healthy Mothers, Healthy Babies Coalition and the recently formed Early Childhood Interagency Council.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Access links: Funding to maintain adequate staffing.<br><br>How overcome? A continuing challenge, program support enhanced by Medicaid Targeted Case Management; grant funds through community coalition for prevention of homelessness. | Barrier 2: Follow Me: Acceptance of change within existing newborn home visiting program.<br><br>How overcome? Communication and adopting changes gradually in coordination with hospital and other agencies. |

**5. How is it funded?** City/County/Local government funds; General state funds; MCH block grant funds; Other Federal funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $415,744.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

With low birthweight prevention as a goal and measurable outcome, the Access Links Program was successful in improving the LBW rate of the target population from 12.9% in 1985 to 5.5% by 1989. Having demonstrated these results, the Program served as a model for state legislative support through Montana's Initiative for the Abatement of Mortality in Infants (MIAMI). MIAMI has funded 9 other LBW prevention programs, a multimedia public education campaign and Infant Mortality Review at project sites. Medicaid changes resulting from state level effort include Targeted Case Management for High Risk Pregnant Women and increased physician reimbursement.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. With the current trends toward public and private health care partnerships, case management and interagency coordination, both of these programs would lend themselves to success in other communities.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Mobile County Health Department City/State: Mobile, AL

Contact Person: Joe Dawsey Telephone: (205) 690-8133

Small Group: Improving Access to Health Care

1. **Initiative Name:** Maternity Home Visiting Program

2. **Describe the initiative.**

The Mobile County Health Department Women's Center expanded services to include a home visiting program for new mothers who were discharged from the hospital in 36 hours or less. It includes a physical assessment of the mother and the baby by the visiting nurse, family planning counseling, teaching regarding individual needs such as breastfeeding, and ensuring newborn and post-partum appointments are made. The nurse receives a printout from the hospital daily on the deliveries which have occurred, the length of stay, any problems and the demographic information. The nurse attempts to reach the Mom by phone to schedule the home visit, but if unsuccessful she attempts a visit regardless within seven days.

According to the birth certificate if a new mother received no prenatal care a home visit is also made to assess the mother and child and to link them with the health care system.

Home visiting has become a valuable component of maternity care in Mobile.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

This program would not be possible without the collaboration of all providers of maternity care affiliated with the University Hospital. Initially all the physicians delivering at USA, public and private, were included in the planning for home visiting services, and consensus was reached on how it should be provided and the protocols which should serve as guidance. Medicaid and the University were important to the success of the program as well. Also the various clinics such as Family Planning had to coordinate appointments, health education, etc. All agencies have cooperated and they have each benefited from this collaboration.

4. What have been the greatest barriers faced in implementing this initiative?

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| Barrier 1: Diverse languages.<br><br>How overcome? We developed audio tapes in Cambodian and Vietnamese for the nurse to use with multiple choice answers to provide her with information on mother's health as well as the health of the baby. | Barrier 2: Unsuccessful telephone contact.<br><br>How overcome? Rather than waiting to contact the mothers by telephone, we began attempting visits which usually were completed. |

5. How is it funded? MCH block grant funds; Third party reimbursement (Medicaid, insurance).

What is the approximate annual budget for this initiative? $50,000.00

6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?

The opportunity for one-on-one health education and coordination and simplification of information for the patient who has just experienced a birth, but on average spent only 24 hours in the hospital, is an important benefit of the program. Problems are found early on which when left would otherwise be much worse. Patients who are lost in the system are brought back in, and the newborn and family planning appointment show rate has improved.

7. Do you think that this initiative would work if implemented in another urban community? Why?

Yes, when interested providers cooperate and combine resources with a common goal, mothers and babies will benefit even with limited expenditure of funds. As hospitals across the country discharge maternity patients earlier, new mothers have less time to absorb the information concerning their new baby and their own health status. Therefore the need for home visiting is greater in other communities as well. Providers will reduce the demand on their time by post-partum patients through home visiting and health education. So agencies in other cities should have motivation to implement this program.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Stanislaus County Public Health Dept City/State: Modesto, CA

Contact Person: Cleopathia Moore Telephone: (209) 558-7400

Small Group: Improving Access to Health Care

**1. Initiative Name:** Prenatal Care Access Initiative

**2. Describe the initiative.**

The goal of Stanislaus County Public Health Department, was to address the specific problem relating to prenatal care access for low income women. There was a significant lack of providers for women on Medi-Cal or for those without insurance. The ratio of physicians accepting Medi-Cal to women in the childbearing years who were Medi-Cal eligible, was 1:933. To address the prenatal access problem, Stanislaus County Department of Public Health established a network of decentralized clinics. We initiated satellite clinics offering "one-stop" shopping for prenatal services, WIC, counseling and support. This network provided the first widely accessible Comprehensive Perinatal Services (CPSP) in the County. The decentralized network of CPSP clinics was felt to be the most effective approach for meeting the needs of low income pregnant women in Stanislaus County.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Specific linkages in planning and implementing this initiative included: Department of Social Services for on-site Medi-Cal; Stanislaus Medical Faculty Group - for deliveries; WIC - on-site nutrition education classes and enrollment to the WIC program; Memorial Hospital Foundation - equipment; Sierra Foundation - "start-up funds;" Post-Newsweek Cable TV - public service announcements; King Kennedy Community Center - referral services and outreach to the Afro-American community.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Start-up funds: There was no money to provide staffing, equipment or rent for a service site.<br><br>How overcome? A grant was written to and awarded by the Sierra Foundation. This provided "seed money" which was matched by County funds and then supplemented through Medi-Cal and donations. | Barrier 2: Recruiting providers: Clinics were manned by mid-level practitioners; therefore, physicians were needed for consultation and deliveries.<br><br>How overcome? The Comprehensive Perinatal Services Program administrative staff provided public relations and recruitment of private physicians to the project. |

**5. How is it funded?** City/County/Local government funds; Private source(s): Sierra Foundation; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $834,760.00 (4 clinic sites)

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The evidence of the success of this initiative is: (1) there is no waiting time for women to access prenatal care services; (2) the number of women entering care in the first trimester was increased by 21% in the first year and a half; (3) the advent of these prenatal clinics has led to WIC, CHDP, FP, Immunizations and CPSP all being provided in a single satellite.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. This initiative can work in any urban community. The barriers experienced in Stanislaus County are universal and were overcome here because of a "push" for private and public collaboration. The services were taken to the patient through decentralization, thus providing accessible and quality care services to those women in need.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Metropolitan Health Department of Nashville/Davidson County | City/State: | Nashville, TN |
| Contact Person: | Joan Clayton | Telephone: | (615) 291-6021 |
| Small Group: | Improving Access to Health Care | | |

1. **Initiative Name:** "One Stop Shopping in a Northeast Nashville Community"

2. **Describe the initiative.**

The "One Stop Shopping in a Northeast Nashville Community" project is a public/private partnership that operates a family resource center and clinic on-site at Caldwell Early Childhood Center, a school serving more than 230 pre-kindergarten and kindergarten children from an inner-city low income community. Unmet needs identified by community representatives are addressed through one-stop shopping, home visiting, case management, developmental screening, and training of health professionals. Program services target pregnant women and families with children under age six. The major objectives are to see that children are born healthy; grow up healthy; nurtured by informed parents or care-givers; and have access to quality preschool services.

Regular services include: Certification for AFDC, food stamps, Medicaid, WIC, local social services, a family literacy program, GED classes, pediatric and prenatal clinics, school nurse year-round, parent club activities twice each week, preschool counseling service, rape and sexual abuse counseling, career counseling, job training, information and referral.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Metropolitan Health Department, Meharry Medical College, Vanderbilt Pediatric Department, in conjunction with United Way of Middle Tennessee Success by Six Initiative developed the "One Stop Shopping in a Northeast Nashville Community." The partnership for this project is extensive. They include Metropolitan Department of Education, Metro Health Department, Metro Social Services, Maternal and Infant Care Program, Vanderbilt Mental Health Center, Nashville READ, Metropolitan Developmental and Housing Agency, United Way of Middle Tennessee, St. Thomas Hospital. The unique nature and effectiveness of the project is evidenced by the cooperative relationship of the following providers in one location: state and local social services, health, literacy, housing and transportation, job training, and public education.

**4. What have been the greatest barriers faced in implementing this initiative?**

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| Barrier 1: Lack of centralized State and local Social Services (AFDC, Food Stamps, Medicaid) in the target community for pregnant women or families with young children.<br><br>How overcome? Agreement was signed between State Commissioner of Human Services (State Gov't) and Mayor of Metro Nashville (local Gov't) to train and authorize local Family Resource Center staff to complete application and reapplication for AFDC, Food Stamps, and Medicaid through the ACCENT system. | Barrier 2: Maintaining active parent and community resident involvement in all phases of the project and collaborative efforts.<br><br>How overcome? Recruited parents and community residents to serve on Success by Six Services Committee that developed the Model Family Resource Center, 51% parents on the projects Advisory Council and community/parents matched with 5 local and state government department heads to serve on Steering Committee, active involvement of Parents Club at Caldwell Early Childhood Center. |

**5. How is it funded?** City/County/Local government funds; General state funds; SPRANS funds; Private source: United Way of Middle Tennessee $250,000.00 for 3 years.

**What is the approximate annual budget for this initiative?** $675,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Easier access to prenatal care, pediatric services, and school health, state and local social services has been accomplished. Immunization rate for 230 four and five year olds enrolled at Caldwell Early Childhood was 98% of 230 at end of the 1992/1993 school year. 150 families are enrolled in the Family Resource Center for intensive case management. WIC certification has expanded from one day per week to 5 days per week. Parent education activities during the summer of 1993 to focus on teen mother. Literacy and job training activities have expanded.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This initiative would work in other urban communities because it enhances and improves public/private collaborative efforts, reduces barriers to health and social services, increases community involvement in self-determination, and establishes a framework to aid low income families to reduce welfare dependency, improve maternal and child health, and improve the educational status of children and adults.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Newark Health Department | City/State: Newark, NJ

Contact Person: Claude Wallace | Telephone: (201) 733-7590

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Prenatal Registry Initiative (Pilot Project)

**2. Describe the initiative.**

The City of Newark is developing a prenatal registry. The program is targeted to begin sometime during November, 1993. Initially, the registry will enroll 100 pregnant females who reside in a defined geographic location within the city. This sector of the city was chosen because of the concentration of infant morbidity and mortality.

The demographics of the primary population to be served include foreign born women in the childbearing age group with little or no health care coverage. This community also happens to be the only section of the city without benefit of a medical facility located in its borders or public health clinic.

The participants in the program will be case managed throughout the pregnancy. Health care will be coordinated to ensure access to all available benefits. Home visits and social services will assist the family in making the necessary connections required to meet their needs.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Newark Division of Community Health has established linkages with two agencies which are present in the community and provide some services to the particular population: Catholic Community Services and CAHACO (Caribbean Haitian Community Organization).

The meetings are still in the (planning) plenary phase. However, all agencies agree the need is great. No task seem insurmountable.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: | Barrier 2: |
|---|---|
| How overcome? | How overcome? |

5. **How is it funded?** City/County/Local government funds.

**What is the approximate annual budget for this initiative?** $26,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: New Haven Health Department City/State: New Haven, CT

Contact Person: Catherine S Jackson Telephone: (203) 787-8187

Small Group: Improving Access to Health Care

1. **Initiative Name:** FIRST STEPS IN NEW HAVEN

2. **Describe the initiative.** New Haven is a small (pop. 130,000), resource-rich city that was notorious in 1986 for having the highest IMR (20.2) in the USA for a city of its size. Working with Mayor John C. Daniels' new administration in 1989, the New Haven Foundation-sponsored Special Commission on Infant Health drafted a proposal for structural change with the foundation of five steps over five years, as follows: Step 1: Re-create a Maternal/Child Health Division in the City health department (the MCH Division had been allowed to atrophy in the 1970's after Medicaid and FQHC's seemed to promise health care for the poor); established 12/91, director hired 12/92. Step 2: Obtain state bonding funds to invest in 7 community-based agencies that provide some services to families in the target areas, to develop MCH offices where city workers would meet with clients in their own neighborhoods without transportation and child care concerns; Step 3: Expand the city's 1.5-person outreach effort into a team of 7 indigenous perinatal outreach and family support workers, with a field supervisor and the capacity for case finding as well as networking, public education and role-modeling to change client behavior. Step 4: Develop a "Healthy Start/Medicaid" program in the City health department (FY93) and pair Medicaid liaisons with outreach workers in each neighborhood. Step 5: Working with community residents, bring programs that strengthen families to the neighborhood centers, such as workshops, male and female support groups, and parenting classes.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?** The entire First Steps in New Haven initiative is predicted on establishing linkages with other agencies. The purpose of establishing the MCH Division was to coordinate independent programs that had sprouted haphazardly in various parts of the city. The most important linkages are: with community agencies who initially did not trust the municipal government; schools and churches, which are both rather turf-oriented; police, with community-based policing begun at about the same time and in the same neighborhoods; hospitals and care providers; and with INFOLINE, a telephone information/referral service that can schedule clinic prenatal care appointments; Department of Child and Family Services, the court system, and a collaborative relationship with the only two perinatal substance abuse treatment facilities accepting women with children.

4. **What have been the greatest barriers faced in implementing this initiative?**

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| Barrier 1: Developing a cohesive team of paraprofessionals drawn from the communit-ies they serve but required to blend nurturing attitudes and role model capabilities with social work expertise such as goal-setting, case management, detailed charting, and professional compartment.<br><br>How overcome? 1) contracting with Yale Child Study Center for social worker consultant who led case conferences and provided sounding board for program coordinator; 2) developing an intensive, "mandatory" in-house training and staff development program; and 3) involving staff in decision-making. TQM style, recognizing that the workers are more likely than management to know what will work, provided their thoughts are guided, which requires considerable patience and a lot of meeting time. | Barrier 2: Lack of trust in the community and lack of confidence among community-based agencies in the commitment and staying power of municipal government initiatives.<br><br>How overcome? Again by 3 key approaches: 1) Keeping the Mayor and his department leaders informed of problems so they could suggest or provide solutions; 2) developing coalitions of residents by neighborhoods, listening to their concerns and involving them in grant proposal-writing; and 3) hiring staff from the neighborhoods they serve and supporting them. NOTE: It would be preferable to begin program with a social worker/training coordinator on staff. |

5. **How is it funded?** City/County/Local government funds; General state funds; MCH block grant funds; Private sources: Seeking private; Other: Planning reimbursement.

   **What is the approximate annual budget for this initiative?** $650,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?** In 1987, New Haven's IMR was 20.2 deaths/1000 births. In 1989, this rate decreased to 18.5, and in 1990, the IMR was 10.9 deaths/1000 births-half the high of 1987! This dramatic improvement appears confirmed with provisional IMR data from 1991 and 1992, and the rate of LBW infants is also decreasing.

   Major accomplishments are that we have: organized a Division of Maternal/Child Health; funded, trained and are supervising a team of 8 outreach workers; completed renovations in three community-based agencies and begun the 4th and 5th office plans; secured a state-funded Healthy Start contract; begun office hours for outreach and Medicaid liaison workers, with support groups in two sites and a Summer G.E.D. course in one; provided 3766 home visits to 134 clients in FY92, conducted a total of 33 in-service and other staff training in FY93; distributed client satisfaction surveys to all discharged clients; conducted over 100 community presentations/year; established a case conference schedule with both hospitals, all of which indicate that the MCH Division is earning the confidence both of medical providers and of the community we serve. Also we have included schools, hospitals and community coalitions in our grant applications and been included in theirs; have designed data management and program evaluation components in consultation with Yale School of Public Health, and have refined program goals and objectives to measure directly FY93 program activities.

7. **Do you think that this initiative would work if implemented in another urban community? Why?** We are convinced that the neighborhood approach is the most promising initiative for urban areas because the needs of families differ from neighborhood to neighborhood and because the large (usually teaching) hospital institutions that serve low-income and minorities (the target population) typically do not organize their services in a culturally-sensitive or convenient manner; they alienate rather than accommodate the clients most at-risk of poor birth outcomes. However, providing role models to change behavior is very staff-intensive; to work requires low caseloads (12-15 families per worker). We would welcome questions.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | New York City Department of Health | City/State: | New York, NY |
| Contact Person: | Gary C Butts MD | Telephone: | (212) 788-5331 |
| Small Group: | Improving Public Health Systems in Urban Communities | | |

**1. Initiative Name:** Communicare

**2. Describe the initiative.**

Utilizing private practice as the model for publicly funded primary care. Communicare provides both preventive and acute care for the children it serves. The New York City Department of Health has renovated seven aging facilities to convert them into primary care facilities in medically underserved communities. Communicare health centers provide ongoing continuity of care by linking a child and his or her family to a primary care provider who follows the child throughout his or her development. Serving as the gatekeeper, the provider coordinates all the care rendered to the child, including admitting the patient to a hospital when required, following that patient during the entire hospital stay, and coordinating all referrals for specialty services when they are indicated. Communicare clients have 24-hour, seven-day a week access to a provider. Systems have been implemented to obtain reimbursement from all third party payers and to utilize a sliding fee scale to obtain complete or partial payment from clients who are uninsured or ineligible for Medicaid. Communicare offers a treatment setting for each child that allows him or her to be viewed in the context of the family, the school, the neighborhood, and the community.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were established with community-based organizations and elected officials to obtain the community's input regarding the needs and requirements of the surrounding population that the Communicare facility should address. Relationships were also established with voluntary and public hospitals to ensure that all Communicare physicians were granted admitting privileges and to ensure that clients would have access to specialty referrals and hospitalization when indicated.

**4. What have been the greatest barriers faced in implementing this initiative?**

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| Barrier 1: Obtaining admitting privileges for physicians at public and voluntary backup hospitals.<br><br>How overcome? Both the program's hiring practices for physicians and the relationships established with public and voluntary backup hospitals combined to ensure that Communicare physicians would have admitting privileges enabling them to monitor clients during their hospitalization as well as the care provided by specialty referrals. | Barrier 2: Ensuring that medically indigent Communicare clients are admitted to voluntary backup hospitals.<br><br>How overcome? Affiliate agreements were negotiated that met the requirements of the backup hospitals involved and the Department of Health's stipulation that all Communicare clients be admitted regardless of their ability to pay. |

**5. How is it funded?** City/County/Local government funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $10,000,000.00.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

As soon as the first Communicare site opened its doors, members of the surrounding community registered in numbers greater than expected during the first week of operation.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Communicare is a replicable model for delivering preventive and acute care service that is both revenue generated and responsive to the needs of the underinsured and medically indigent.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Norfolk Department of Public Health | City/State: | Norfolk, VA |
| Contact Person: | Joyce Boliard RN<br>Nurse Manager | Telephone: | (804) 683-2785 |
| Small Group: | Improving Access to Health Care | | |

**1. Initiative Name:** Berkley/Campostella Early Childhood Education School-Based Community Clinic

**2. Describe the initiative.** The purpose of the center is to enhance the learning process of students by offering parents a total enrichment program within the community. The full-service education center is designed to impact the total family. In addition to serving the basic education needs of 180, 3 and 4 year olds, the center also provides adult education classes, parental involvement activities and outreach services. The center provides before and after school care for its participants. In addition, free transportation is provided for children and adults. Parents can become involved in helping the children at school by serving as volunteers and helpers. Also, parents can attend a planned program of parent activities, including study groups, workshops, conferences, etc. Developing partnerships with parents is crucial. A variety of services to assist and support the family are available through the cooperation of many city support agencies. The Norfolk Community Services Board, Norfolk Department of Public Health, Norfolk Police Department and the Department of Human Resources all have offices within the center. Adult education classes, another major component of the center, are provided for parents and members of the Berkley/Campostella community. There are 55 adults enrolled in the basic education classes. But all of the adult participants do not have children enrolled in the center. Adult students range in age from 17 to 77. Classes are available in literacy, basic skills, GED preparation. An adult literacy computer lab is provided on site to assist parents in enhancing basic skills. In addition, child care is available for younger siblings whose families are participating in classes or activities at the center.

The school clinic is staffed full time by a public health nursing assistant and with a public health nurse (PHN) 2-3 days per week, as well as a nurse practitioner one day per week who does physical examinations (including basic lab work) for the children who attend the center and their siblings. Immunizations are given to these children on one day per week; also the clinic provides immunizations to other children in the community. Physical examinations and tuberculin skin tests required by parents who are seeking jobs, education or additional training are also provided. The public health nurse and assistant are responsible for the regular school health program as well as staffing for their initiative. The public health nurse also serves this community as case manager for all high-risk infants and pregnant women. Many of the parents are in her field case load. As a result of this, the public health nurse has been able to refer new infants who need well-baby check-ups into this clinic to get checked and their risk screens done by the nurse practitioner so that the PHN can become the Maternal Infant Care Coordinator through Medicaid. In addition, the public health nurse follows-up any identified problems and helps the client access continued medical services through other health department clinics, private providers or other hospital clinics. The public health nurse offers a 12 week class on Women's Health Issues at least 2 times per year and is involved in the Parent Support Program at the Center.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages have been with the Norfolk Public Schools, Norfolk Community Services Board, Norfolk Police Department, Department of Human Resources (Social Services), Tidewater Community College, Adult Basic Education and GED Program, and Police Assisted Community Enforcement (PACE).

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Finding space to enlarge small clinic area.<br><br>How overcome? Worked with principal and other Norfolk Public School administrators who were extremely cooperative. Finally used book storage room next door to clinic and NPS paid to do renovation and set up a small but entirely adequate clinic and exam room. | Barrier 2: Staffing by nurse practitioner (NP).<br><br>How overcome? It has been difficult due to clinician turnover to give one full day per week of Nurse Practitioner's time. Have had to cancel some clinic days, but departmental commitment is determined to make this work. |

**5. How is it funded?** City/County/Local government funds; General state funds; Other Federal funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $3,200.00/month (four clinic days)

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

In the past four months 251 physical examinations have been done; 107 children immunized; 20 screened, counseled and followed for hypertension.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, because it meets the community needs and is placed in the community. It is family focused and the staff are well known and respected in the community with well established rapport. The Center principal and all school staff are positive and supportive to the families.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | City/County Health Department of Oklahoma County | City/State: | Oklahoma City, OK |
| Contact Person: | Loydene Cain RN | Telephone: | (405) 425-4406 |
| Category: | Improving Primary/Preventive Care for Children | | |

1. **Initiative Name:** Lack of immunization compliance by 2 years of age (58% are not appropriately immunized). Oklahoma County encompasses approximately 730 square miles.

2. **Describe the initiative.**

   a. Ensure standards for pediatric immunization practices are implemented by all providers that use state or federally purchased vaccine.
   b. Revised Oklahoma immunization record card and implemented in September of 1993.
   c. "Fast lane" immunization concept implemented in June of 1993.
   d. Increased the number of "off site" implementation clinics and hours of operation (once weekly PM clinic, added eight community sites, added all-day walk-in immunizations). In the planning stages are immunization delivery at licensed day-cares, homeless shelters, 15 subsidized housing projects, schools, neighborhood community clinics.
   e. Coordinate immunization services with existing WIC and Well Child services in Health Department by October of 1992.
   f. Hire Community Health Worker to assist with Spanish and Vietnamese interpretation and network with Hispanic and Southeast Asia communities by December of 1992.
   g. Hire 2 full-time nurses and 2 part-time clerks necessary for providing "express lane" services by December of 1992 and mobile "off-site" immunization team.
   h. Implement a coordinated and uniform automated recall and reminder notification system for collection and maintenance of immunization records (in process).
   i. Community Coalition in planning stages.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

**4. What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Fees and cost involved in immunization.

How overcome? In April of 1992, Oklahoma State Department of Health removed the administration fee for vaccines provided through public clinics in OSDH vaccine distribution system.

Barrier 2: Lack of convenient clinic hours and long clinic waiting times.

How overcome? Improved access to immunization services. Expanded clinic hours at times working parents can bring their children for services (evenings, during lunch hours, some weekends).

Barrier 3: Forgot or didn't know their needed vaccines.

How overcome? Extended health and education campaign: "Due by Two" multi-media campaign in early 1992; toll free statewide telephone number for public use to identify locations and hours of clinics; media campaign by using television, radio, newspapers, billboards and posters.

**5. How is it funded?** Other Federal funds.

**What is the approximate annual budget for this initiative?** $120,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

We will compare immunization levels prior to initiative with those after the initiative is completed and in place for one year.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

May be easily implemented anywhere. Key to success is education of parents and easy access to clinics.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Douglas County Health Dept | City/State: | Omaha, NE |
| Contact Person: | John Weston<br>Chief Clinical Services Div | Telephone: | (402) 444-7213 |
| Small Group: | Improving Primary and Preventive Care for Young Children | | |

**1. Initiative Name:** "Give Your Kid A Shot for Life"

**2. Describe the initiative.**

The Childhood Immunization Task Force-Metro Omaha is committed to increasing the number of preschool children in Douglas County who are age-appropriately immunized. Representatives on the Task Force include: hospitals, professional physician and nurse associations, public health, medical education institutions, and civic organizations.

Components of the comprehensive immunization program, "Give Your Kid A Shot for Life," address public awareness, tracking and surveillance, and increasing opportunities for immunization. Initial public awareness activities have incorporated professionally developed media efforts such as brochures, posters, billboards, PSA'S, and television/radio interviews. The DCHD has expanded immunization clinic hours including evening and Saturday clinics and locations to encourage utilization of public sector immunization services. In addition, the Health Department established satellite clinics in a collaborative agreement with targeted community-based organizations.

A key component of the initiative is to develop a central computerized immunization record keeping system for all public and private immunization tracking. Currently, the pilot project will computerize the Department's immunization program.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Childhood Immunization Task Force is a diverse representation of physician and nursing groups, public sector agencies, hospitals, and civic organizations. Each representative contributes information, commitment and access to other resources in the community. Task Force members obtain contributions for technical support and production as well as corporate in-kind support.

Individually, members are limited to the time and direct support available from their organizations. However, their suggestions and participation in planning are valuable.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Adequate funding to support proposed immunization promotion, education, and tracking activities. | Barrier 2: Information documenting effective public education efforts that increase the demand for immunization services. |
| How overcome? IAP funds from state, contributed technical assistance by computer firm, donations, in-kind contributions by member organizations. | How overcome? Collected information from the state, CDC, City**MatCH**, and professional organizations. |

**5. How is it funded?** City/County/Local government fund; Other Federal funds; Private source(s): in-kind donations by hospitals and businesses; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $75,000 (Primarily IAP and County funds to increase immunization clinic services and initiate tracking.)

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

A pilot project to establish a county-wide computerized record keeping system has been initiated at the Douglas County Health Department.

The coalition actively planned the "Give Your Kid A Shot For Life" campaign in the fall of 1992. Implementation of activities started in early spring of 1993. Therefore, impact on immunization status in the County has not been evaluated to date. However, community support through private technical assistance and donations has been very positive. The number of children served in public immunization clinics continues to rise.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

A broad base community-coordinated immunization initiative is critical to understand and address the unique issues in the private and public sector immunization system. Community links provide access to resources in the community and shared commitment to increasing the immunization status of our children.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | HRS/Orange County Public Health Unit | City/State: | Orlando, FL |
| Contact Person: | Victor A Harris PhD | Telephone: | (407) 836-2656 |
| Small Group: | Reducing and Treating Substance Abuse | | |

**1. Initiative Name:** Resource Sisters/Companeras Program

**2. Describe the initiative.**

This is helping to develop self-help groups for pregnant women who receive public health maternity services in Orange County, Florida. The overall goal is to reduce substance abuse among pregnant women, to improve birth outcomes, and to reduce child abuse and neglect by strengthening social supports among women in high risk neighborhoods. Because the groups are open to all pregnant and postpartum women using public services, women do not need to identify their drug use prior to participation. Through the program, women are able to discuss health, social, and personal problems, including substance abuse, in groups facilitated by a peer or a paraprofessional. These peer counselors also identify other at-risk women in the neighborhood and encourage their participation. The program also facilitates women's involvement in early intervention and treatment services in drug treatment programs. Women participate in the peer support groups through their child's first year of life.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

This project is being conducted by the local March of Dimes with funding from the Health Unit, Alcohol, Drug Abuse & Mental Health Program Office, and the Robert Wood Johnson Foundation. In addition to facilitating application to RWJ, the Health Unit negotiated the additional State funding, solicited the MOD to be the lead agency, worked with local groups to support the centralization of medical services and developed an ongoing patient sharing partnership with the local migrant health center. These relationships have been effective in achieving programmatic goals.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Obtaining the agreements among the various organizations which needed to cooperate to bring the project to fruition.<br><br>How overcome? The Health Unit had been working to develop local community coalition support for perinatal concerns--Healthy Start Coalitions; this coalition in turn provided support for the project and enabled the cooperation among agencies. | Barrier 2: Identifying and hiring appropriate staff.<br><br>How overcome? This has been a long term learning process. Over the first full year of the project, detailed training manuals were developed and role play and real world settings were used to help in the selection process. |

**5. How is it funded?** General state funds; MCH block grant funds; Other Federal funds; Private source - Robert Wood Johnson Foundation.

**What is the approximate annual budget for this initiative?** $500,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Approximately $45,000.00 of RWJ funds have been committed to an in-depth external program evaluation. The project, which started in one portion of the county, has now expanded to provide support services to three of the six catchment areas served by the Health Unit. To date, hundreds of women have participated in the peer support groups but the outcome analysis is in its initial phase. One anecdotal success is that some group participants have gone on to become paid facilitators thus validating the empowerment model.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This initiative could well work in another urban community. The factor which distinguishes this project from other paraprofessional support projects is that the goal is to have the participants help themselves and therefore the "peer" must really act like peers and not as "experts."

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Pasadena Health Department | City/State: | Pasadena, CA |
| Contact Person: | Mary Margaret Rowe PHN MSN | Telephone: | (818) 405-4384 |
| Category: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Black Infant Health Project

**2. Describe the initiative.**

African-American children in California are nearly twice as likely to die during infancy as white children. Pasadena has been identified as one of sixteen health jurisdictions in California with a high Black Infant Mortality rate. In response to this problem, the health department has convened a Black Infant Health (BIH) Advisory Committee made up of primarily African-American community leaders, both professional and grassroots, to deal with this trend. The main object is to implement community networks to empower African-American women in need of prenatal and perinatal services to seek them and to access the Medi-Cal (Medicaid) Program where appropriate for health care for pregnancy services. The committee will evaluate the feasibility of implementing a mentor program with African-American service organizations to empower the target population to seek early and continuous care for themselves and their infants. Funding for this project is through the State of California, Maternal Child Health Branch.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Initially, this BIH Advisory Committee was a subcommittee of the MCAH Advisory Council. We found that this was not broad-based enough to address the issue of Black Infant Health. Therefore, we subcontracted with a community consultant with strong MCAH background to convene a new BIH Advisory Council, with a more culturally and ethnic appropriate broad-based membership. The response for membership on this committee and the commitment to serve is overwhelming after only two meetings!

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: Community participation. | Barrier 2: Empowering target program. |
|---|---|
| How overcome? Subcontract services to convene broader-based committee to address problem of BIH in community. | How overcome? Establish mentor program (in progress). |

5. **How is it funded?** MCH block grant funds.

**What is the approximate annual budget for this initiative?** $125,000

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Increase percentage of target population seeking care in first trimester.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. Has met with success in 16 counties in California.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Peoria City/County Health Department | City/State: | Peoria, IL |
| Contact Person: | Lise Jankowski MS RN | Telephone: | (309) 679-6011 |
| Small Group: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Healthy Moms, Healthy Kids (Previously known as Families with a Future)

**2. Describe the initiative.**

This is a perinatal mortality reduction initiative targeting the Medicaid and medically indigent population. It is a joint collaborative effort between the Illinois Department of Public Health and the Illinois Department of Public Aid to assist pregnant women and women with children up to age 36 months access to perinatal care, EPSDT services and other community services to meet individual and family health care, environmental and psychosocial needs in a timely manner based upon case management and wholistic health care concepts and client empowerment.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Formal and informal linkages have been established with the Illinois Department of Public Aid, Department of Children and Family Services, 0-3 Early Intervention Programs, Chapter I Preschool and numerous community social service agencies and health care providers. Collaboration has been effective in addressing the multifaceted problems of families enrolled in the program because it addresses access to care and transportation barriers, provider reimbursement issues, substance abuse, family education needs, parenting skills, genetics, family planning, housing, domestic violence and other psychosocial needs/issues in a coordinated effort.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Adequate long-term staffing to case manage a projected caseload of up to 1800-2000 families.<br><br>How overcome? Increase number of social workers hired to do case management. Use RN's as case managers for medically high risk clients. | Barrier 2: Cooperation and networking between/among medical and community social service agencies i.e., "turf" issues.<br><br>How overcome? Through establishing referral patterns. Monthly networking meetings to update participating service providers, share, concerns and problem solve. Utilize Advisory Council comprised of various community-based organizations to problem solve and assist in planning/direction. |

5. **How is it funded?** City/County/Local government funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $900,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Clients on caseload have: 1) Improved infant birth weights. 2) Improved prenatal weight gains. More than 75% achieve weight gain of 22 lbs. or more. 3) More are receiving recommended prenatal medical care according to Kessner Index. 4) 84.2% of children under 2 years have received recommended immunizations for age. Transportation budget has been exceeded which indicates that clients need and utilize transportation for medical and social service agency appointments and removes a major barrier to receiving care. The substance abusing client continues to be a challenge. The state has expanded this program from 7 sites throughout Illinois to a statewide program.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. Based upon sound public health and community health principles. Positive outcomes cannot be achieved unless the client is assessed and all needs addressed in a wholistic empowering manner. Requires integration of and collaboration among/with all service providers.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Philadelphia Health Department | City/State: | Philadelphia, PA |
| Contact Person: | Rackell Arum MPH | Telephone: | (215) 875-5937 |
| Small Group: | Improving Public Health Systems in Urban Communities | | |

1. **Initiative Name:** Empowering Community Outreach Workers and Visitors in Maternal and Child Health

2. **Describe the initiative.**

In the Spring of 1992, the Philadelphia Department of Public Health (PDPH), Office of Maternal and Child Health (MCH) realized that funds had shifted from support of clinical maternal and infant services into community-based services with neighborhood workers conducting outreach and home visiting, and that further support from MCH was necessary. Providing supplemental support posed a challenge because community-based public health services are provided by a network of independent non-profits, whose services are delivered through contracts.

MCH responded by initiating two related activities. First, we organized a committee for in-service and support group meetings exclusively for front-line home visiting and outreach staff serving mothers and infants. Supervisors cannot attend in order to maximize openness and candor among participants. The group is facilitated by an experienced health educator from the PDPH/MCH office. The members of the group are the voice of the committee. At their request, meetings are held once a month. Meeting presentations are varied and topics are selected by the group. The success of the group has prompted some home visiting and outreach agencies that do not receive funding from PDPH/MCH have asked if their front-line staff can participate in these monthly meetings.

Highlights from the first year include: creating a haven where workers from different organizations can network and learn from one another; development of outreach workers and home visitors directory; sessions on stress, focusing on its personal and professional impact; emphasis on upgrading family planning knowledge and counseling among outreach and home visiting organizations.

The group also held a full-day conference in the Fall of 1992. This conference, entitled, "Impact-Action: Reaching Out to the Community," was fully planned and implemented by the group to meet their specific training needs and interests. A small grant was obtained from the March of Dimes to help cover the costs of the conference. This conference gave the participants a strong sense of their impact and importance in the maternal and child health system. It also encouraged them to assume responsibilities typically assigned to their supervisory staff.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

This purpose of the outreach and home visitor provider network is to ensure that all organizations providing community-based outreach and home visiting are working together. Our collaboration has been highly effective. We work with all of the agencies who receive funding from our office as well as several others who are supported by direct federal grants or independent foundation funding.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: The supervisory staff of the agencies were somewhat anxious about this committee because it was an atypical forum, i.e. only for front-line staff.<br><br>How overcome? Careful work with the supervisors and participating staff helped to alleviate agency concerns. MCH initiated quarterly meetings for the directors and/supervisors of the groups represented on the committee. Also, the greater focus of the workers' meetings gradually shifted to become a forum for participants to keep abreast of city-wide outreach and home visiting efforts, to express concerns and challenges and respond to them, when possible, to share effective strategies, and to collectively give each other support for the important work they do. | Barrier 2: We also suspect that some feared the group would undermine on-going education and in-service at the individual agency level.<br><br>How overcome? |

**5. How is it funded?** City/County/Local government funds; MCH block grant funds.

**What is the approximate annual budget for this initiative?**

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?** Please see answer #2 above.

**7. Do you think that this initiative would work if implemented in another urban community? Why?** We highly recommend other urban communities that use a decentralized model for the provision of core community outreach and home visiting services to adopt our model. In communities where the Public Health Department provides these services directly, the model may not be as useful.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Maricopa County Department of Public Health | City/State: | Phoenix, AZ |
| Contact Person: | Melissa Selbst MPH CHES | Telephone: | (602) 506-6066 |
| Small Group: | Improving Access to Health Care | | |

**1. Initiative Name:** Family Health Services and Centers

**2. Describe the initiative.**

The Family Health Centers are designed to provide a "one-stop shopping" approach to perinatal, family planning and early childhood services for individuals who are not enrolled in the AHCCCS system or who otherwise do not have medical insurance. Services include pregnancy verification, identification of high risk/low risk pregnancy, AHCCCS eligibility, WIC referral, clinical services and follow-up, transportation, education, counseling, and referrals to other appropriate services. Services are provided by multi-disciplinary team (MD, CNM, RN, Health Educator, Social Workers, Nutritionists, Patient Advocates). Team staff are provided from Maricopa County Departments of Public Health, Health Care Agency and Support Services. To best serve clients county-wide, the centers are strategically located in the east, central and west regions of the county. Service components include: Teen Prenatal Express-case management of women under age of 17; Newborn intensive care follow-up and Early Intervention Project providing home visits, screens, immunizations, and other assessments and intervention to reduce the mortality and morbidity of infants who are critically ill at birth through age three; Perinatal Hepatitis-B intervention program and follow-ups for positive serology to prevent congenital syphilis; Family planning, pre-discharge from the hospital and follow-up home visits; and Home visits and follow-ups on SIDS referrals received from the medical examiners office. Pregnancy Outreach performs home visits on clients who fail to show up for clinic appointments, or do not respond to mailed requests or are not reachable by phone. Patient advocates at the centers, shelters, and jails act as liaison between patient and system, and educate them using a twelve week prenatal education module and other teaching tools. Immunizations are also offered at the centers.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Family Health Center coordinates activities among 3 major county agencies and uses other county and city agencies for housing, social services, job training, AFDC, and SOBRA applications. The centers receive many clients from community based organizations, schools and churches who do not offer direct health resources. Referrals are generated between the agencies to coordinate care for clients. Grant and county funding is pooled to be able to offer a more comprehensive range of services.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Coordinating many departments, staff, facilities, staffing patterns and funding.<br><br>How overcome? A planning committee was organized comprising of key individuals from all the departments. The committee met bi-weekly and then monthly for 9 months until the plan had been set and in place. Monthly meetings for the staff involved still continue. | Barrier 2: Coordinate all the various data sets generated at the hospital, Public Health, and AHCCCS.<br><br>How overcome? Prepare monthly reports on all the services offered. Plans to computerize and network the various departments' data sets to obtain more accurate information and provide an effective and efficient manner to track clients. Plans to redesign Public Health Client records. |

**5. How is it funded?**

**What is the approximate annual budget for this initiative?** $500,000.00 Prenatal (Reallocation of staff & supplies for other program components)

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

- Maintain a NPC rate at Maricopa Medical Center between 6-11%, which is down from program level 15-19%.
- Women being screened for prenatal care and referred more effectively and efficiently in terms of medical and financial need.
- Pool resources and staff offering daily coordinated services.
- Served approximately 8,000 pregnant women per year, per facility.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, given similar resources and support. It has made services more convenient for clients and more organized within our system.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Allegheny County Health Department | City/State: | Pittsburgh, PA |
| Contact Person: | Virginia Bowman | Telephone: | (412) 355-5949 |
| Small Group: | Reducing and Treating Substance Abuse | | |

**1. Initiative Name:** Maternal Infant Recovery Consortium (MIRC)

**2. Describe the initiative.**

MIRC was a coordinated maternal/child health demonstration project for women in Allegheny County who use alcohol and other drugs during pregnancy and their babies. The Project goal was to provide coordinated health care and substance abuse treatment services to pregnant and postpartum women. This was accomplished through the integration of services provided at local institutions and intensive case management and home-based intervention. Provision of comprehensive care for these women results in better medical and developmental outcomes for their babies. Outreach staff included neighborhood outreach workers, public health nurses and child development specialists. Educational services were available to collaborating and community agencies. Training included the identification and clinical management of pregnant addicted women and their infants. Enrollees remained in the Project until the baby reached 30 months of age. The Department was not the grantee agency, but was contracted for public health nursing services.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were established between the Department, the only area drug and alcohol treatment facility providing care for pregnant women, the University of Pittsburgh, and several area hospitals, primarily those with prenatal clinics. The collaboration has been difficult because of the number of collaborators, because Project staff were not "housed" together and because of the very difficult issues which were addressed.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Public health and drug and alcohol professionals had differing perceptions of issues and ways to address them.<br><br>How overcome? By patience and honesty in relationships. Numerous meetings were required for planning, role definition and team development. | Barrier 2: The Project was managed by a steering committee rather than a single director.<br><br>How overcome? Members selected a weekly meeting time and were committed to the Project. |

5. **How is it funded?** General state funds; Other Federal funds.

**What is the approximate annual budget for this initiative?** $300,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The Project enrollment capacity filled quickly. Staff were successful in engaging women, slowly gaining their trust and supporting them in accessing needed services. Many women remained active throughout the Project and reduced their substance abuse. The formal evaluation will be available soon.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, provided agencies were willing to collaborate and understand that there are gains and losses in collaboration. The initiative effectively utilized the skills and knowledge of collaborators to the benefit of enrolled families.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Portland Health Department | City/State: | Portland, ME |
| Contact Person: | Meredith Lentz Tipton | Telephone: | (207) 874-8784 |
| Small Group: | Improving Primary and Preventive Care for Adolescents | | |

**1. Initiative Name:** Educational Incentives for Good Parenting

**2. Describe the initiative.**

- MCH nurses felt that an incentive was needed for young mothers to participate with more commitment in the education conducted during homevisiting sessions.
- MCH nurses wanted to "give" something tangible to the young mothers to acknowledge the hard work they were doing being good parents.
- Initiative is a credit program acknowledged by the Portland School System to young mothers who are not attending school because they are at home parenting. The educational modules have goals and objectives and pre- and post-tests. One Credit Hour is granted for the successful completion of each module. The MCH nurses were "deemed" qualified educators by the school system. Young mothers stay connected with educational system, so that it's presence is not lost in future goal setting.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Portland Public School Department: Office of Alternative Education and Superintendents Office.
Young Parent Program: YWCA.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Public school perception of skill abilities and qualifications of MCH nurses.<br><br>How overcome? Education, communication, had school officials join staff on home visits. | Barrier 2: Bureaucracy of public school system.<br><br>How overcome? Patience, negotiate, wait, focus on the needs of the young mothers, make the schools partners in the initiative. |

5. **How is it funded?** City/County/Local government funds.

**What is the approximate annual budget for this initiative?** $30,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Young mothers keep their appointments for the MCH home visit. Mother is much more engaged in the visit. Mother does well on the post-test. Baby is doing well.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. Young mothers need to feel that they were accomplishing something. They need affirmation from a respected authority. It connected them back with the educational system in an alternative fashion, that acknowledged that they were learning something that was valued.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Multnomah County Health Department | City/State: | Portland, OR |
| Contact Person: | Karen Lamica<br>Mary Lou Hennrich | Telephone: | (503) 248-3674 |
| Small Group: | Improving Primary and Preventive Care for Adolescents | | |

**1. Initiative Name:** Multnomah County Network on Teen Pregnancy and Young Parenting

**2. Describe the initiative.** The Health Department took the lead in a community development process aimed at increasing the effectiveness of a public/private partnership which had existed in Multnomah County for over six years, with private agencies, schools and the Health Department serving Teen Parents in a noncoordinated way. The process involved other funders of Teen Parent Programs (public and private), service providers, school personnel, business community representatives, young parents and former clients. A strong coalition was formed: The MC Network on Teen Pregnancy and Young Parenting.

The Network utilized an outside facilitator to bring the divergent groups together to agree on a common goal of a coordinated, community focused system of care utilizing the strengths of both public and private partners, irrespective of the source of program funding.

The service delivery model which includes hospital visits to all teen mothers by a Health Department nurse for comprehensive health and social assessment, referral via computer modem linkage with Teen Parent agencies, ongoing service delivery tracking via health department computer system, and an individualized service plan which may include home visits by CHN's and/or private agency case managers, support groups and interactive parent education.

The Health Department will be the central point of overall system coordination and will assign a nurse to facilitate this coordination at the Health Department and between private agencies. The Network will operate in an advisory role for implementation and maintenance of the new system.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Although many public and private agencies have been involved in serving Teen Parents, some actually receiving funds from the County, passed through both the Health and Social Services Department, there had been little formal coordination and systemwide planning prior to establishment of the network.

Major program funders including the county, Portland Public Schools, United Way, and state welfare came together with service providers such as YWCA, County CHN's, Youth Service Centers, Catholic and Lutheran Family Services, African American and Hispanic Service Organizations, etc.

It has taken nearly two years, a skilled facilitator and tenacity on everyone's part to make it.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Lack of trust between all players.<br><br>How overcome? 1) Started with small core group to conceptualize desired outcome and process. 2) Broad-based invitation to all interested parties to become involved in planning process. 3) Grit, determination and persistence by Health Department Leadership to keep the process nurtured and alive during many rocky moments. | Barrier 2: Funding issues were involved.<br><br>How overcome? 1) Brought all public and private funders together to see how current funding "fit" and left gaps in programs. 2) Reached agreement through the group process on overall goals and linked them to funding. 3) Identified each funder's "mandates" and "flexibility." 4) Followed process through to conclusion, even though it was very difficult at times. 5) Communicated openly and frequently. |

**5. How is it funded?** City/County/Local government funds; Private source(s): United Way, Education and Welfare Reform Funds.

**What is the approximate annual budget for this initiative?** $550,000.00.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Although the process has been a difficult one at times for all parties involved, the Health Department was able to issue a much better, more comprehensive and specific Request for Proposal to find case management, parent support groups and interactive parent education from community-based organizations. The RFP solicited services which are part of a continuum of care from hospital assessment by Health Department nurses to appropriate follow-up services in their home and community, linkage with school and job training programs. All agencies, no matter the source of funding, are involved in designing the service continuum and modifying it as it develops to better serve teen parents and their children.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. If done in a larger community (over 500,000 population) would probably have to be done by districts or subdivisions because of the number of "players." Even in our sized jurisdiction (450,000), the size of the group was difficult to "handle" at times. A skilled outside facilitator was essential.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Rhode Island Department of Health | City/State: | Providence, RI |
| Contact Person: | Helen Drew<br>Acting Administrator, RIte Start Program | Telephone: | (401) 277-1185<br>Ext. 134 |
| Category: | Improving Urban Public Health Systems | | |

**1. Initiative Name:** Comprehensive Prenatal Services Program (CPSP) and Care Coordination

**2. Describe the initiative.**

The CPSP and Care Coordination Programs have been in place at the 12 Community Health Centers and 3 hospital clinics who contract with the Rhode Island Department of Health to provide prenatal services. We had standardized risk criteria for the three risk assessments and program as well as agency protocols. In April 1993, the agencies were trained on new forms to report additional per client information to DOH: risk assessment data for medical, psychosocial, and nutritional assessments, indicators of risk for each area, and assignment to care coordination. This reporting provides a database to assess the risk variables of prenatal intakes across the community, by delivery site and other important variables.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The linkages were around the development of the standard risk criteria and the training. The collaboration to date has been successful. The next step will be to develop standard criteria for entry into care coordination. A process that will require significant collaboration and a level of agency sharing that will challenge their individual programs. Many agencies are sure they are providing care to the most difficult intakes - a standard measure will provide a basis for actual comparison which may drive a reassessment of some aspects of funding.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: | How overcome? | Barrier 2: | How overcome? |
|---|---|---|---|
| Training was not done simultaneously. | Accepted start date for reporting according to training schedule which helped the agencies but lost time for the overall effort. | Identification that some risk assessments are not provided. | Plan to work with individual agencies to review their policies and scheduling to help them identify the problem areas. The most consistent problem area is the nutrition risk assessment, especially where WIC provides the service and they are off site. |

5. **How is it funded?** MCH block grant funds.

**What is the approximate annual budget for this initiative?** Approximate annual budget: $800,000.00 for CPSP and Care Coordination.

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

We will know this additional reporting requirement has been a success when prenatal intakes get to needed services more expeditiously, and healthier outcomes result. This information collected tells us about the collective risk which directs our education to caregivers about the resources in the community responsive to those risks. Previously individual data was the defining element, now we can aggregate issues and help guide the development of resources.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. There are sufficient clients and client problems with insufficient resources to support all referral needs that this system could help set priorities for development and supportive, needed programs and use of current resources and programs.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Wake County Dept of Health | City/State: | Raleigh, NC |
| Contact Person: | Dorothy Cilanti MSW MPH | Telephone: | (919) 250-4635 |
| Small Group: | Reducing and Treating Substance Abuse | | |

1. **Initiative Name:** Step by Step (Comprehensive Health and Treatment Services for Substance Abusing Women and Children)

2. **Describe the initiative.**

   After failing to win a Federal OSAP grant, the WCDOH applied as lead agency for a 3 county consortium and won planning monies from the State to design a comprehensive treatment service for substance abusing women and their children. Dozens of representatives from several county's agencies, private providers, non-profit, community and civic organizations and advocates met for 9 months performing a needs assessment and developing the plan.

   Step by Step - the project name - won one of two State $400,000.00 grants which, supplemented by nearly $200,000.00 in Medicaid revenues, funds the program. The 2200 women receiving prenatal care at the WCDOH, 200 women in Johnston County to the south, and 300 migrant women at Tri County Community Health Center are screened for substance use and associated risk behaviors. Those screening positive are offered case management services, which may lead to high risk prenatal care, outpatient or intensive outpatient counseling, residential or even inpatient treatment for substance use. Children too are case managed and provided intensive developmental follow-up.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

   Collaboration was a requirement of funding, and is successful on a day to day, working basis. Contracts were made with UNC for evaluation; to Drug Action for outpatient treatment; Day by Day for residential treatment; Interact for domestic violence training and services; Motheread for maternal child education; Project Enlightenment for developmental counseling, etc. Each agency got something; all agencies depend on success of project for continued funding.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Getting together.<br><br>How overcome? By a consensus style, helped by the luxury of 9 months funded planning. We now frequently ask private/public foundations for planning monies prior to a large grant request. | Barrier 2: State bureaucracy.<br><br>How overcome? State monies were managed by Mental Health, not Health, and only tenacity, and requesting multiple waivers for various mental health rules and regulations, allowed the money to flow to all contract agencies, including non-traditional agencies. |

**5. How is it funded?** General state funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $600,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Evaluation is proceeding under contract with UNC; but after one year, over 1/2 of women screen positive for at least one risk behavior (domestic violence), and those with positive answers to substance use questions generally accept the layered case management, which meets them where they are. All are asked to contract not to continue in pregnancy; over (60) have accepted aggressive treatment.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Certainly, it will (and does) work elsewhere. Requires commitment to recognizing and respecting other's expertise, sharing monies, contracting for results, etc. Project could not be as comprehensive in reach without State monies. Medicaid revenues cover specific services, but not the outreach, evaluation. etc.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Richmond City Health Department | City/State: | Richmond, VA |
| Contact Person: | CMG Buttery MD MPH<br>ME Baron MD | Telephone: | (804) 780-4147 |
| Category: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** RICHMOND ALL KIDS COUNT

**2. Describe the initiative.**

RWJF awarded a 1 year planning grant to MCV 7 RCHD in Nov. 1992. In Nov. 1993 we will be notified if we have been awarded the 4 year implementation grant. The major focus of this grant is to insure appropriate immunization of children by the age of 2 years. This will be accomplished by the development of linkages between the six birth hospitals in the region, area health departments, and private health care providers. All live births will be enrolled into a computerized database that will be housed at Richmond City Health Department, and the Electronic Birth Certificate will facilitate this process. A data interface will be established by linking computers in physicians' offices, local hospitals and health departments to the regional database. Access to immunization records by multiple providers will remove one of the major barriers to immunizations. Number of persons potentially served includes all newborns in the Richmond Metropolitan area starting in January 1994. District 15 (Charles City Co., Chesterfield, Goochland, Hanover, Henrico, New Kent, Powhatan, & Richmond City) recorded 14,128 births in 1990.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

1) Office of Minority Health - yes - improved ability to focus on high risk population and perceived barriers to care.
2) Local business/industry - yes - commitment for support during implementation phase (financial awards or in-kind support).
3) VDH - yes - State views Richmond AKC as model for VA's tracking system. Plans are in place for replication.
4) Local/State government - yes - government views immunization project goals as priority and recognizes need to improve immunization rates.
5) Community Service Organizations - yes - agreed to assist project by providing volunteers and financial contributions.
6) Greater Richmond Transit Company - yes - agreed to serve on AKC Advisory Board to develop strategy to reduce transportation barriers.
7) Richmond Housing Authority - yes - provided household data regarding children in public housing.
8) Local hospitals - yes - agreed to participate as birth hospitals during implementation.
9) Private physicians - partially - have support letters from some physicians.

**4. What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Difficulty in changing immunization behavior/practices of parents.

How overcome?

1) Focused intervention on areas at risk.
2) Developed linkages within the community.
3) Utilized existing data related to access to care (urban primary care grant) and immunizations (VDH Bureau of Immunizations).
4) Collaborated with other immunization initiatives and studied their successes.
5) Health Fairs, patient education pamphlet.
6) Reminder and past due letters sent in timely fashion.

Barrier 2: Private physicians participation.

How overcome?

1) Persistance.
2) Message from their peers (other pediatricians).
3) Attended professional organization meetings to make presentations.
4) Accepted fact that more physicians will be willing to participate once implementation funds have been awarded.
5) Incorporated suggestions from MD's to encourage their ownership of project.

**5. How is it funded?** Private Source(s): Robert Wood Johnson Foundation

**What is the approximate annual budget for this initiative?** $125,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The objective for the pilot phase were met (i.e., enrolled 95% of live births into a computerized data base, registered 75% of children with a primary care provider.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. The design is complex in theory yet simple in practice. The electronic Birth Certificate is being implemented statewide as well as in approximately one half of the other states. The VDH PCMS has been implemented statewide. 33 of 35 local health departments are either PCMS oracle or PCMS prime, and we have a working model of the interface. The tracking system is user friendly and outreach to clients can be performed by other PHN's or trained lay workers from the community. Major accomplishments: a) Computer development of a PC version of tracking system (a working model and the interface of the oracle and prime versions of PCMS. b) Enthusiasm for project on part of private and public organizations. c) Beginning to receive actual data on enrollees.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.


Health Department: Monroe County Dept of Health

City/State: Rochester, NY

Contact Person: Karin Duncan
Director, Maternal-Child Health

Telephone: (716) 274-6192


Small Group: Improving Access to Health Care

1. **Initiative Name:** Financing Public Health Nurse Home Visits For Preventive Services For Women, Infants, Children And Their Families

2. **Describe the initiative.**

In the Monroe County Department of Health (MCDOH), public health nurse field activities are carried out under the auspices of the Department's Certified Home Health Agency. The CHHA regulations allow for billing of third party payors, including Medicaid, for eligible visits. While the major payor for the MCH visits is Medicaid, some revenues are generated from other third party insurances, particularly commercial HMO's for limited number of visits. Over 47% of the referrals to the CHHA in 1992 were for pediatric and maternal-child health services. Specific programs with field activities in the CHHA that are MCH focused include the high risk infant tracking program, the early intervention program, the maternity obstetrical medicaid services, and preventive visits for high risk prenatal families. There are two "teams" of PHNs in the CHHA who are skilled and experienced in working with high risk families. They are supervised by two experienced MCH supervisors. Critical to the success of this delivery model is the coordination that is necessary between two major divisions in the Department. Assuring this coordination takes place is the responsibility of an administrative supervisor in the CHHA. Regularly scheduled meetings between administrators are held. The CHHA maintains the billing system, the quality assurance and other necessary regulatory procedures. Securing funding for MCH home visits by PHNs requires resourcefulness and creativity. This is one model that works in Monroe County, where a public health department also has a CHHA division.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

This particular model of delivering services to MCH families through the CHHA has been in practice from the beginning of the official CHHA formation. Historical PHNs always made home visits for preventive care, health education and health promotion. When "reimbursable" visits became a reality and necessity, the preventive visits were continued under the CHHA. As stated above the major linkage to the success of this model is between the Department's CHHA division and the MCH division. It is critical that on-going dialogue take place between administration in both divisions for planning, monitoring, prioritizing of activities for both preventive visits and morbidity visits.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Prioritizing staff workloads.<br><br>How overcome? Because the CHHA activities are mainly morbidity focused, and morbidity referrals are often of a more immediate nature, staff are often reprioritizing their visit schedules and the MCH visits may be delayed to another time. When this occurs often, it is difficult for the PHN to establish a therapeutic relationship with the family and the expected outcomes may be compromised. There is continuous monitoring of referrals, staff caseloads to correct this. | Barrier 2: Recruitment of staff skilled in public health principles and maternal child health morbidity.<br><br>How overcome? Recruitment of staff with the necessary skill and experience in MCH has been ongoing. The Department has advertised in local newspapers, etc, but most staff learn of opportunities with the Department by word of mouth. In general, nurses looking for employment in a CHHA are much more experienced in morbidity care than preventive, health promotion activities. |

**5. How is it funded?** City/County/Local government funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?**

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

We believe this is a viable way to maintain PHN visits to high risk families in Monroe County. The CHHA totally supports its activities by revenue generated through home visits. Maternal child health visits are different from morbidity visits: more ineffective visits, more time consuming, more psychosocial interventions needed, increased time to establish "therapeutic" relationship, less tangible outcomes. Productivity standards, record requirements are not always appropriate for preventive visits. Administrative supervisors in both Divisions are continuously reinforcing to other supervisors and staff in the CHHA the value of the preventive visits and the unique skill needed by staff for such visits.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Public Health Departments would need to have their own CHHA which in some communities may be viewed as a function of the private sector. However, it has worked in Monroe County. It requires clear goals and expectations and on-going dialogue among everyone involved.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Marion County Health Department | City/State: | Salem, OR |
| Contact Person: | Donalda Dodson | Telephone: | (503) 588-5357 |
| Small Group: | Reducing and Treating Substance Abuse | | |

1. **Initiative Name:** Public Health Nurse targeted case management for pregnant and parenting substance abusers.

2. **Describe the initiative.**

   Comprehensive service for women who are either referred from the criminal justice system, whose children have been placed in the custody of juvenile court, or who are residents of a public housing project. These women present for treatment have many problems in addition to alcohol or other drugs. They require more intensive services than are ordinarily available from alcohol and drug treatment providers. Case management services are provided to women for a one-year period, during a residence in the transition house and for one year of after-care. The population served is pregnant women (and women) and children under five years of age who are in need of alcohol and drug abuse treatment. Specific services include intake and assessment, case plan development, referral to services as needed, and individual client support. The assessments are comprehensive, addressing major areas of the client's life, such as employment, education, mental health, housing, child care, and medical needs, as well as alcohol and drug use and history. The case plan outlines a strategy for ameliorating deficits in all these major areas. Services are planned with the participation and cooperation of others significant to the client's life, such as the alcohol and drug treatment provider, probation/parole representative, prenatal care provider, public housing agency representative, and CSD case manager.

3. **In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

   This program works with a private non-profit alcohol and drug provider who does residential and alcohol and drug treatment. In addition, children protective services, housing, other mental and physical health providers, both private and public, as well as various other social service providers. Also correction facilities are involved.

   The collaboration has been effective in that women are staying in treatment longer, completing their treatment plans and some have graduated to independent, clean and sober, community living.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Financial<br><br>How overcome? Developed targeted case management model. Have Medicaid funding. Justice system has assisted with funding for residential treatment. | Barrier 2: Turf<br><br>How overcome? Extensive collaboration efforts and frequent on-going communication. Joint sharing and case planning with demonstrating scope and content of what public health nursing case management can provide. |

**5. How is it funded?**

**What is the approximate annual budget for this initiative?** $66,465.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

- Women are staying in treatment longer - up to 100 days versus a few weeks.
- Women who stop treatment, re-engage treatment sooner.
- Women who begin to relapse receive intervention earlier and return to treatment.
- Does not matter when intervention occurs, we still see positive benefits to the child in the health, development and parenting for the family.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. 1) There is a basis for the program with the presence of public health nursing and the skills this profession brings to the service. 2) The opportunity to obtain targeted case management.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Salt Lake City-County Health Dept | City/State: | Salt Lake City, UT |
| Contact Person: | Jillian Jacobellis | Telephone: | (801) 468-2720 |
| Small Group: | Reducing and Treating Substance Abuse | | |

**1. Initiative Name:** Prevention and Intervention Program for Prenatal Drug Use and Abuse

**2. Describe the initiative.**

The program is designed to provide identification of substance abuse in a high risk, low income population of pregnant women who are applying for WIC services at two of the Health Department's service centers. The Health Department will hire two full-time case managers, two full-time case aides, one half-time public nurse, and one quarter-time secretary for the Kearns and Magna WIC/Family Health Centers. The case managers will participate on-site by training WIC staff to screen for and assess the presence of alcohol, tobacco and other drugs in all pregnant WIC applicants. Once a participant is identified, as a user of ATOD, she will be placed on a specialized caseload. These women will be scheduled monthly (rather than bimonthly) to receive their food vouchers all at the same time. At the time of the distribution of vouchers, the case manager will conduct specialized groups known as "Getting Ready for Baby." Topics for discussion will include but not be limited to: prenatal health needs, nutrition education, effects of ATOD during pregnancy, smoking cessation techniques, employment and economic needs and resources, housing needs and resources, legal resources, basic infant care, sibling rivalry, child care, post-partum issues, family planning and community resources including substance abuse treatment. Child supervision will be provided on-site during these sessions.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

A grant was submitted in partnership by the Health Department and County Division of Substance Abuse. To identify the target population and develop a service plan a community advisory group was formed with representatives from the following agencies: University of Utah Department of Pediatrics and Department of Perinatology, Utah State Department of Health, Community Health Centers, WIC, Salt Lake County Division of Substance Abuse and the Salt Lake City-County Health Department.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Finding monies to adequately support such a program. | Barrier 2: Hiring and training of staff to meet timeline. |
| How overcome? 1. Collaborating with Division of Substance Abuse. 2. Obtaining community support through the Apex process. | How overcome? Again, using the "group-resource" of Advisory Committee. |

5. **How is it funded?** General state funds.

   **What is the approximate annual budget for this initiative?** $175.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

   A community plan to address the issues of prenatal substance abuse was developed prior to implementation of the grant. Because identification of clients is through the WIC program and not the prenatal clinic, the community of prenatal providers are involved.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

   Yes.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | San Antonio Metropolitan Health District | City/State: | San Antonio, TX |
| Contact Person: | Mary Lou Quijano | Telephone: | (210) 434-7233 |
| Category: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Breast and Cervical Cancer Control Program

**2. Describe the initiative.**

The San Antonio Metropolitan Health District provides community breast cancer screening for women over age 40 and cervical cancer screening to women over age 18 - both groups must be under 200% of poverty.

**1) Breast Screening**

a) Women must be age 40 or over for mammography screening.
b) Women must be sexually active or age 18 or over for cervical screening.
c) Applicants must be below 200% poverty.
d) Applicants must have no third party payment for screening or diagnostic services.
e) Applicants must sign a written consent before services can be rendered. Eligible applicants ages 40-49 will receive annual clinical breast examinations, mammograms every two years. Eligible applicants age 50 and over will receive annual clinical breast examinations and annual mammograms.

**2) Cervical Screening**

a) Eligible applicants (sexually active or age 18 or over will receive pelvic examinations, paps test).

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

1) Surgical Oncology, University of Texas Health Science Center.
2) Community Health Promotion, University of Texas Health Center.
3) American Cancer Society.
4) Community Mammography Services.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Outreach, health education.<br><br>How overcome? "A Su Salud," a local community outreach program, collaborated with us in establishing community volunteers who educated and recruited women over age 40 into the mammography screening program. | Barrier 2: Low compliance with mammography clinics.<br><br>How overcome? Community education and outreach and conveniently located mammography clinics were scheduled throughout the city. |

**5. How is it funded?** Other Federal funds; Other = Chronic diseases program funds.

**What is the approximate annual budget for this initiative?** $107,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

We are identifying early lesions in patients.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. Appears to be beneficial and cost effective.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | San Diego County Health Department | City/State: | San Diego, CA |
| Contact Person: | Nancy Bowen MD<br>Chief of Maternal and Child Health | Telephone: | (619) 692-8808 |
| Category: | Improving Urban Public Health Systems | | |

**1. Initiative Name:** Strategic Plan for the Health of San Diego County's Children, Youth and Families

**2. Describe the initiative.**

The major public and private institutions concerned with the health of children, youth and families launched a strategic planning process in April of 1993. The Plan is a blueprint to identify priorities and actions to enable San Diego County to move towards its Vision and Goals by the Year 2000. The steps undertaken thus far are: obtaining funding and the staff; forming the Sponsors Group, Working Group and Executive Stakeholders; carrying out the "Parallel Process" to get broad, community-wide input through the planning process; doing a "Current State Assessment;" and finalizing the Vision, Values, Goals, and Indicators. Next steps are to getting commitment to actions; involve the media; "kick-off" event; implementation phase; and monitoring. The cycle will be repeated to revise actions annually. (This is not just a plan for County government operations, but for the entire community.)

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The major maternal and child health coalitions interested in planning were identified and agreed to be cosponsors responsible for directing the planning process. The key providers, funders, advocates and experts were identified (ensuring cultural diversity) and asked to commit to the "Working Group" (an extensive time commitment) or to the "Executive Stakeholders." During our "Parallel Process" regular presentations at key organizational meetings and public meetings were made.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: The County is huge (2½ million people and diverse).<br><br>How overcome? 1) Parallel process - take draft of each document "out" to the community for input and significantly revise documents. 2) Identify existing programs and community key leaders to work on identifying priority actions, coordinating efforts, and committing to actions. (Still in process). | Barrier 2: Overwhelming number of problems and limited resources.<br><br>How overcome? Ensure priorities for action are set and the actions are realistic. Also priorities are set for a few areas that require longer term planning efforts that will be ongoing and supported during the "implementation" phase. |

**5. How is it funded?** City/County/Local government funds; General state funds; MCH block grant funds; Other Federal funds.

**What is the approximate annual budget for this initiative?** $32,000.00 (1992-93), $87,800.00 (1993-94) (plus limited County staff and participant's time)

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

It has been successful in that many people are committed to drafting the Plan and implementing it. The vision, values statement, goals, and indicators are finalized and are excellent and represent input from hundreds of people.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: San Juan City Health Department City/State: San Juan, PR

Contact Person: Magda Torres Jusino MD Telephone: (809) 751-6975

Small Group: Improving Primary and Preventive Care for Young Children

**1. Initiative Name:** Infant Immunization Initiative - San Juan 2000

**2. Describe the initiative.**

In July 1992, the Maternal and Child Division submitted a coordinated proposal to reach children that were not immunized adequately according to age group. In March 1993, we were able to diminish administrative barriers that were denying access to an adequate vaccination process. The schedule was augmented 5:00pm - 8:00pm on a daily basis and Saturdays 8:00 am - 12:00 noon in seven different Diagnostic and Treatment Centers in San Juan. We also established vaccination services in San Juan clinics located in high risk area high delinquency in the vaccination process.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

About forty agencies were involved in the process of a Needs Assessment and development of an immunization action of the plan submitted to CDC. Actually five community-based organizations serve as satellite clinics where immunization services are offered. This service functions once a week during the morning in the San Juan area.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Personnel resistance to decrease administrative barriers that limit accessibility to the public. | Barrier 2: Referral from private pediatricians and private agencies. |
| How overcome? Reinforcement to personnel about patient needs. Close follow-up observation to make sure directives are being implanted. | How overcome? By giving publicity through massive communication media (TV - radio) written information: flyers, letters, posters, street banners, are being used successfully to sensitize persons on the immunization problems. |

5. **How is it funded?** City/County/Local government funds; Other Federal funds.

   **What is the approximate annual budget for this initiative?**

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

   We have accomplished our goal in terms of the administration of the DTP. Also public satisfaction with evening and Saturday services has been significant.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

   Yes, because it allows for administrative immunization services with no barriers. However, a serious compromise from clinic personnel as well as adequate public diffusion about services offered is needed.

   We reached the goal established at the beginning of the proposal of administering the DTP to the four years old (39% of the target). The special immunization services offered with a different schedule were highly approved by the group.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Orange County Health Care Agency City/State: Santa Ana/Anaheim, CA

Contact Person: Len Foster Telephone: (714) 834-3882

Small Group: Improving Outcomes of Pregnancy

**1. Initiative Name:** Maternal Outreach Management System (MOMS)

**2. Describe the initiative.**

The Maternal Outreach Management System (MOMS) is a public-private partnership between the County of Orange (Health Care Agency and Social Services Agency) and the private health care community designed to link Medicaid eligible pregnant women with perinatal care providers. Further, MOMS provides comprehensive case management services to its pregnant clients in order to ensure that they successfully negotiate the Medicaid application process, and that any barrier to their successful completion of their perinatal course is adequately addressed.

The genesis of this initiative was a Perinatal Task Force established by the County Board of Supervisors to review the County's perinatal care crisis. Among the findings made by the Task force was the reluctance of private physicians to accept Medicaid eligible patients for a variety of reasons including billing problems, language and cultural barriers, poor patient compliance, etc. MOMS was designed to provide the mechanism to address these barriers.

MOMS has been established as a 501 (c) (3) non-profit corporation. Its board of directors includes representatives of the Health Care Agency, private providers and corporate/foundation funding sources. Patients attending County pregnancy testing clinics are referred to MOMS for care. Public Health Nurses from the County's Health Care Agency are assigned to MOMS to provide case management services. Social Services Agency eligibility technicians provide expedited Medicaid eligibility processing.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Planning and implementation of this initiative required not only linkages, but ongoing participation by the local medical society, OB/GYN society, Social Services Agency, hospital council, Health Care Agency and other organizations. The collaboration has been effective when gauged by the number of Medicaid women who have been successfully linked with private physicians for care, the number of physicians recruited to participate in the Program, and the high rate of satisfaction expressed by both physicians and patients since the program was initiated in January 1993.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Initial lack of adequate resources within MOMS organization to support cost of case management services required.<br><br>How overcome? Since the patients targeted by MOMS were low income, the Health Care Agency determined that it was in the mutual interest of both the County and MOMS for county public health nurse personnel to be assigned to the project to support case management activities. This will continue until sufficient financial support can be generated by MOMS from private sources. | Barrier 2: As a new project, the problem of initiating and controlling a flow of patients to MOMS had to be addressed.<br><br>How overcome? In conjunction with the County's pregnancy testing clinics, target zip code locations were identified as representing areas of greatest need. These locations were matched with zip codes of participating physicians. Patients from these zip codes were given priority referral to MOMS. MOMS determined the maximum number who could be referred in any month. This number was determined by the availability of both case management resources and patients being accepted by physicians. |

**5. How is it funded?** Local/County/Local government funds; MCH block grant funds; Private source(s): Irvine Health Foundation, S. Joseph's Health System, St. Jude's Hospital, James Irvine Foundation, PacifiCare Foundation, TOKOS Medical Corporation, Western Medical Center-Santa Ana, and Chapman Medical Center.

**What is the approximate annual budget for this initiative?** $275,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Success of MOMS is measured by a number of objective measurements including: participation of nearly 50 private perinatal practitioners and eight (8) delivery sites; 90% of Medicaid applications processed within 28 days of application; over 300 Medicaid eligible pregnant women successfully connected to private medical care; and the commitment of nearly $300,000.00 in private funds to support MOMS. Additionally, a review of individual patients success stories provides a more subjective measurement of the Program's achievement.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

The concept of the MOMS project is not unique. A similar project was established in San Diego County some years ago. Similar, but quite different. Obviously the success of projects like MOMS is possible because of the unique problems and dynamics of the individual community in which it is located. MOMS-like initiatives can work in other jurisdictions if they can demonstrate success in overcoming the barriers which preclude private physician participation in the Medicaid program, thereby improving access to care for low income pregnant women.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Sonoma County Health Department | City/State: | Santa Rosa, CA |
| Contact Person: | Norma Ellis | Telephone: | (707) 576-4731 |
| Small Group: | Improving Public Health Systems in Urban Communities | | |

**1. Initiative Name:** Sonoma County Child Death Review Team (CDRT)

**2. Describe the initiative.**

In February 1993, Sonoma County Health Department implemented a local CDRT. This team was the thirty-first to be organized in California. While the original intention of teams, organized as early as 1978, was to improve investigations on child deaths, this team had a broader and more preventive focus. The mission included: a) identifying non-accidental child deaths, b) enhancing the investigation of child deaths, c) developing a data base on child deaths and d) developing recommendations on preventing and responding to child deaths. In addition to providing literature and background on the process, a speaker experience in CDRT was initially used to help motivate and organize potential participants. Using the publication Child Death Review Teams: A Manual for Design and Implementation by the Child Maltreatment Fatalities Project, team members clarified their purpose (as listed above), target groups for review (all child deaths up to age 18), frequency of meetings (monthly), process of review and agency and participant roles. The Health Department assigned staff funded through the MCH block grant to: a) review death certificates and coroner reports, b) notify participants and call the meetings, c) document specific data per case, d) act on recommendations by the team, and e) produce an annual report on findings.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages with agencies such as police, coroner, social services, district attorney, private and public hospitals, and mental health have been made by providing a written Memorandum of Understanding containing language to explain confidentiality and the legality of the process. Using the publication noted above, agency roles were defined and each participant reviews any existing record and openly shares the contents within the meeting. This collaboration effort has been very effective in gaining clarity about agency roles and improved relationships and expectations about future interagency teamwork when working with children and their families. The actual fact that a child had died allows agency staff to set aside any potential protectiveness of agency policy and help provide a systematic review of agency involvement to seek future improvements.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: The most difficult task was in choosing members who were most appropriate and in soliciting their participation within funding and time constraints.<br><br>How overcome? This was partially overcome by inviting Department Heads to the initial meeting, explaining the CDRT concept and the positive outcomes and clarifying participant expectations, whereby administrative backup was assured. Sharing the same information with actual team members was important because they in turn, designated potential future members who should be informed of the process and invited to participate based on a case-by-case basis. | Barrier 2: Another difficulty was in addressing concerns about confidentiality for potential participants.<br><br>How overcome? This was overcome by investigating mandates that applied to the process and providing these in writing to potential members. These were included in the Memorandum of Understanding and were reviewed by the County Counsel. The acknowledgement and attention of this as a concern helped gain acceptance by members that the issue had been well-addressed. |

**5. How is it funded?** MCH block grant funds.

**What is the approximate annual budget for this initiative?** $6,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Success has been measured in two ways. First, with five case review meetings completed, team members are strong in attendance and enthusiasm and have not waned in sharing their records. Secondly, the focus of prevention has become tangible through the process of the team members making six specific types of recommendations on preventive actions to a myriad of community providers and/or groups. This is especially important given the fact that the MCH staff in the Health Department is doing initial planning on a child injury prevention project for 93/94 and will benefit by the information gained by the CDRT and the focus on prevention.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. This would be most successful where there is a specific geographic structure that defines the boundaries of agency responsibility so that there is no controversy about case jurisdictions especially according to where the expired child was residing. Secondly, this effort would be most attainable when specific mandates allow for agencies to share information when there is a potential for child abuse.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Seattle-King County Department of Public Health | City/State: | Seattle, WA |
| Contact Person: | Kathy Carson<br>MCH Coordinator | Telephone: | (206) 296-4677 |
| Small Group: | Improving Public Health Systems in Urban Communities | | |

**1. Initiative Name:** CHILD Profile

**2. Describe the initiative.**

The goal of the Children's Health, Immunization, Linkage, and Development (CHILD) Profile is three-fold: to provide families with educational reminders and incentives to obtain immunizations and well-child services, to link providers to a database of immunization and well-child information so that every opportunity to give preventive services is utilized, and to link providers of special care services to a database of eligibility and service information to promote coordination of care for special needs families. When a mother delivers a child in King and Snohomish Counties she is given a colorful growth chart which has each recommended well-child visit and immunization listed with room to fill in the baby's height and weight. Newborns are enrolled in CHILD Profile via the entry of the birth certificate, and reminder letters are sent to families at intervals that correspond with recommended well-child and immunization schedules. The second module of CHILD Profile, immunization tracking, is currently in the development phase; and in Fall, 1993, the Health Department will begin entering immunizations in the new system. Pilot testing of the module and linkage to the CHILD Profile database will be done by private providers and clinics during the same time period.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Seattle-King County Department of Public Health and the Snohomish Health District are the primary partners, in cooperation with the Washington State Department of Health, the Seattle Area Hospital Council, public and private health care providers, and interested groups such as the Junior League and Safeco Insurance. The Profile utilizes funding from a variety of sources, including the Robert Wood Johnson All Kids Count Initiative, Centers for Disease Control Infant Immunization Initiative, and State High Priority Infant Tracking Project. These groups have agreed to work collaboratively, building on relationships that have been developed over time, because they all saw the potential for ineffectiveness and duplication if all interested parties didn't work together.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Linkage with the State's electronic birth certificate system.<br><br>How overcome? Still problematic. Having to process their raw data in weekly downloads instead of an on-line link, so some of their work is duplicated by us. There are delays in the system that interfere with all of the first mailings being on time. | Barrier 2: Linkage to Health Department's mainframe system.<br><br>How overcome? Still problematic. Integration of all data systems will not be possible until we can do this. |

**5. How is it funded?** General state funds; Private source: Robert Wood Johnson All Kids Count Initiative; Other: Medicaid Administrative Match.

**What is the approximate annual budget for this initiative?** $400,000.00 (during this developmental phase).

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Even though the project has just been sending reminders since January and the tracking module is not yet operational, the effort has brought together a wide variety of interested people and has received a lot of political support. Parents have called the Kid Care referral line to request help getting into care and have had very positive reactions to the materials. Satisfaction surveys will be done in 1994.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

A population-based system has many public health benefits, but is an enormous undertaking. Communities might want to join together into regional information consortia in order to reduce the burden on any one.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Spokane County Health District | City/State: | Spokane, WA |
| Contact Person: | Lisa M Ross<br>Nursing Supervisor | Telephone: | (509) 324-1657 |
| Small Group: | Improving Primary and Preventive Care for Children | | |

**1. Initiative Name:** Nutrition Services for Children with Special Health Care Needs (CSHCN)

**2. Describe the initiative.**

The Spokane community has developed a collaborative case management model to work with children with special health care needs. The missing link was the special nutrition needs of the children once they were discharged. Parents would bring their child home only to have them re-admitted with problems compounded by nutritional concerns. SCHD recognized this need and developed a program within the MCH/CSHCN arena. Two nutritionists (one FTE) makes home visits to children with special health care needs and to children who attend the Neuromuscular Center. A preliminary nutrition screen can indicate the need for an in-depth assessment. Referrals received by the CSHCN nutritionists come from a variety of health care sources (see linkages). Children with special health care needs commonly experience nutrition-related problems such as failure to thrive, neuromotor feeding difficulties, gastrostomy tube feedings and other special dietary restrictions. The nutritional assessment includes a comprehensive interview with the parents/care givers, anthropometric evaluations, physical observations, analysis of laboratory values, diagnostic tests, and medication effects on nutritional status. A nutrition care plan in coordination with FFSP's and IEP's is developed. Coordinating with the family and all involved health care professionals is essential to ensure continuity of nutritional care. Implementation, education and monitoring are an integral part of the assessment process. Special trainings and state of the art equipment ensure quality.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages exist between the Children with Special Health Care Needs nutritionists and all area hospitals, WIC Programs, Children with Special Health Care Needs staff, public health nurses, area pediatric nutritionists, the local Neuromuscular Center, physicians, HeadStart, therapists, home health agencies and schools. Collaboration is very effective in the community due to a progressive health district and CSHCN/MCH Programs that are seen as leaders in preventive health in Spokane County.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: The biggest barrier is funding.<br><br>How overcome? A proposal was made to the Office of Children With Special Health Care Needs to pilot this initiative. The balance needed is funded by Spokane County Health District. | Barrier 2: Justifying the need for nutrition services for children with special health care needs in the home.<br><br>How overcome? As more medically fragile infants and children are surviving and being cared for in their homes, and the movement towards family-centered care become a reality, the State Office of Children with Special Health Care Needs and the local community continue to support the initiative. |

**5. How is it funded?** City/County/Local government funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $56,654.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Children with special health care needs have had decreased hospitalizations due to a more stable nutritional status. They are better able to resist infections and participate more fully in therapies which benefit the long-term outcomes for success and productivity. The program continues to receive referrals from multiple sources at an increasing rate. This program could easily justify another full-time nutritionist serving children in their homes.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Definitely. Coordination works more efficiently if the program is located with the local CSHCN/MCH Programs. If this is not possible then a strong link with these programs is a must.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Springfield-Green County Health Dept | City/State: | Springfield, MO |
| Contact Person: | Rosalind Sivils | Telephone: | (417) 864-1431 |
| Category: | Improving Access to Health Care | | |

**1. Initiative Name:** LINK (Let's Invest Now in Kids) Clinic

**2. Describe the initiative.**

Our 1991 Maternal Child Needs Assessment showed 5,292 children were eligible for medicaid reimbursement and only 1,066 of those children were attended by a physician. A community coalition was formed (hospitals, physicians and Health Department) to address this community need. MCH Block Grant Funds were redirected to start a primary medicaid childrens clinic. HCY (Healthy Child Youth) exams are performed as well as minor illness visits for treatment. Staff consists of one (FTE) Nurse Practitioner in collaborative practice with the Health Department physician, one registered nurse and one clerk. Recent cost effectiveness study of 1,600 children demonstrated for every dollar spent at LINK the cost for same illness at hospital emergency room cost seven dollars.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Coalition formed with local hospitals, physicians and the Health Department. Yes, because LINK has been able to keep minorly ill children from utilizing the emergency room for these illnesses convincing both the hospitals and physicians of necessity and cost effectiveness of the clinic.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Getting money to establish the LINK Clinic. | Barrier 2: Establishing necessary linkages with medical providers of secondary and tertiary health care services. |
| How overcome? By gaining approval from City Council to redirect a block of MCH funding to establish this clinic. | How overcome? Through working with the local medical society and hospitals. |

5. **How is it funded?** City/County/Local government funds; Third part reimbursement.

**What is the approximate annual budget for this initiative?** $157,014.00 FT 1993-94

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

From July 1, 1992 to June 30, 1993, 3,619 client visits. 400 children are currently on waiting list. Expansion is planned using volunteer craftsmen from the community to rennovate the building. Implementation of a volunteer program by working with the Junior League to write a training manual and to plan to train volunteers to be utilized in both the current day and the planned evening clinics.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. Utilizing nurse practitioners for HCY exams and to diagnose and treat minor illnesses in collaboration with physicians can save medical dollars and enable children unable to obtain a physician with their medicaid card to enter the health care system.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | St. Paul Public Health Department | City/State: | St. Paul, MN |
| Contact Person: | Lynn Bahta<br>Coordinator | Telephone: | (612) 292-7711 |
| Small Group: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Hepatitis B Perinatal Prevention Program

**2. Describe the initiative.**

St. Paul houses a large SEA (Southeast Asian) population in which morbidity for Hepatitis B is significant (approx. 1 of 7 SEA is a carrier of Hep B). Vertical transmission (mother to infant) perpetuates this disease and the risk of chronic disease is highest when the disease occurs in infancy or childhood. The goal of this initiative has been to reduce the incidence of perinatal transmission of Hep B in St. Paul's population. This has been primarily accomplished by assuring that infants who have been vaccinated in the hospital and are offspring of carrier moms complete their Hep B series. Other activities of this program include investigating, screening and vaccinating the household contacts of reported HB, Ag + pregnant or just delivered women, educating those identified as carriers as to how to care for themselves and protecting others, and providing community education to parents via groups such as, HeadStart and Early Childhood and Family Education.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Major linkages have included the State Health Department and the Hepatitis B Coalition. The state has been key in developing a reporting system in which we get the reported clients. Reporting institutions include health care providers working with and testing pregnant women and hospital who have vaccinated infants. The Hepatitis Coalition has been a vital element in raising the awareness of both the professional community and the general public. They have campaigned for universal vaccination of infants and have conducted special projects targeted to increase SEA awareness of Hep B. Collaboration with health care providers has been critical in order to gain information needed in follow-ups of infants and other household contacts.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Language/communication - the major population involved has been the Southeast Asians, particularly Hmong those who often speak little English and differ in health practices.<br><br>How overcome? A Hmong bilingual education assistant has been specifically assigned to the program to assist the public health nurse in follow-up, investigations, and education. | Barrier 2: Lack of professional community awareness - health care providers are confused or unsure of testing and interpretation of tests and when to immunize.<br><br>How overcome? We've worked closely with the Hep B Coalition who has on staff an MD who has kept current on the issues. Monthly meetings have been held at the public health agency and topics are presented by various experts from the community to assist health care providers in working with clients and Hepatitis B issues. |

**5. How is it funded?** Other Federal funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?**

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Clinic and hospital-based reporting has become very reliable. More parents are aware of what and why their newborn got vaccinated. All newborns (100%)* of HBs, Ag reported mothers received their first vaccine in the hospital. Almost 90%* of these newborns received their second dose within two months of the recommended date of the vaccine immunization - conforming to the IAP goal of vaccination guidelines. On average, 85%* of these infants have completed the series (not including for lost-to-follow-up and moved families.)

* Data provided by Minnesota Department of Health/Dan Gestwick, Hep B Coordinator.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

It can. The requirements needed to make it work are commitment, perserverance, collaboration, and bilingual assistance. It does not require high technical ability/access. Until recently, we obtained data from the state who kept a computerized database of all reported HBs Ag + mothers. There are plenty of educational materials available in multi-languages - both from the CDC and the Hepatitis B Coalition (612/292-7377).

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Pinellas County Public Health Unit | City/State: | St. Petersburg, FL |
| Contact Person: | Claude Dharamraj MD | Telephone: | (813) 823-0401 Ext. 308 |
| Small Group: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Florida's Healthy Start Initiative In Pinellas County, Florida

**2. Describe the initiative.**

The Pinellas County Public Health Unit (PinCPHU) plays a major role to assure that county residents have a healthy start. Included in the essential parts of the Healthy Start Initiative are Universal Prenatal Screening at first prenatal visit and postnatal screening at birth and Care Coordination for those at-risk. Professional staff of the Health Unit provided initial Healthy Start training and orientation to all hospitals and obstetrical providers in the County, emphasizing the importance of the prenatal and postnatal screening for health and environment factors associated with morbidity and mortality. Then the PinCPHU created a Healthy Start team to provide care coordination to the pregnant women and children identified at-risk through the screenings. A Senior Community Health Nursing Supervisor heads up an enthusiastic care coordination team of Community Health Nurses and clerical support staff whose purpose is to complement and support the prenatal and infant health care services that women and children receive. Since the case managers have personal contact with the family, they provide specific information to help fill particular needs. Examples of the services provided by the Healthy Start nurse case managers include: home visits to provide nursing assessments; counseling; support and liaison to private providers; assistance in referrals for medical care needs; free immunizations; or developmental assessments; referrals to WIC, and for nutritional counseling; arrangements for transportation assistance; arrangements for free childbirth and parenting education.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Pinellas County was one of the initial counties in Florida to receive funding for its coalition (1992), an organization which draws its membership from medical, government, education, business, insurance, consumers, and media sectors of the community. The responsibilities of the Coalition include assessing community need, developing a community-based service delivery plan, selecting and monitoring health care providers, ensuring integration of local providers and services, and emphasizing positive patient outcomes. The Healthy Start Coalition just submitted their service delivery plan to the State.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Reluctance of private providers to participate. | Barrier 2: Came at the same time as managed care proposal, enormous competition between prenatal care providers and hospitals who want the market of "Medicaid" patients. |
| How overcome? Education of prenatal care providers, liaison with their office, feedback of what is happening to their patients. | How overcome? Medicaid reimbursement for prenatal care and delivery has increased, which makes these patients a desirable market. |

**5. How is it funded?** General State funds; MCH block grant funds; Other Federal funds; Private source(s): Juvenile Welfare Board.

**What is the approximate annual budget for this initiative?** $1,000,000,00.

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

Participation has been excellent; since its inception (April 199292), over 3,677 positive Healthy Start prenatal and postnatal screenings were referred to the Health Unit for care coordination in partnership with their original medical provider. As a result of networking through the Coalition strong public/private partnerships have evolved. Shared responsibility in providing prenatal care and child health care is resulting in new initiatives such as opening of prenatal care clinics in private hospitals accepting indigent and Medicaid women, who for the first time, have the freedom of choosing their providers. It is too early to evaluate success, since the goal is to improve maternal and child health birth outcomes such as low birth weight, infant mortality, teen pregnancy, and encouraged early entrance into prenatal care, as well as provide family support. It needs a long term evaluation.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. It is a State initiative. It is very similar to the Hawaii initiative or to the Federal Healthy Start or other state (Rhode Island) initiatives, which have already been proven to work.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | San Joaquin County Health Department | City/State: | Stockton, CA |
| Contact Person: | Jogi Khanna MD MPH | Telephone: | (209) 468-3411 |
| Small Group: | Improving Access to Health Care | | |

**1. Initiative Name:** Comprehensive Community Linked Public Health Services

**2. Describe the initiative.**

The goal o this project is to reach the people who are virtually unreachable. Many of these people are at high risk for developing STD, HIV, TB, high infant mortality, low infant birth weight, potential drug addicted babies and other communicable diseases.

The necessity for a Mobile Van Clinic was first identified by STD outreach staff. They found these clients were unable to utilize standard care services. The work and sleep hours of this population conflicts with the hours regular services are available. When they do present during traditional clinic hours, they have difficulty with the routine. Often times, particularly if they are drug abusers, they leave prior to completion of evaluation and treatment.

A Mobile Van Clinic can help bring service to these clients at a time more likely to meet their needs and in a less structured setting.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Public Health's Van Clinic's major linkage is with "Seeds of Hope," a community-based organization that provides community outreach workers and food service at the van clinic site and follow-up for these patients.

An agreement was also reached with the Police Department to avoid sites when the van clinic is there. This action is necessary to attract the target population and has been very effective.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Staff safety, cross-training and flexibility.<br><br>How overcome? Sincere desire on the part of Public Health and staff to reach the population and help with their needs. Cross-training workers. Regular meetings to discuss concerns/issues. | Barrier 2: Developing a non-traditional service.<br><br>How overcome? Community linkages. Identifying and utilizing community resources. Identifying the target population and their needs. |

5. **How is it funded?** City/County/Local government funds; General state funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $50,000.00 +

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

An analyses of data collected during a survey with this population indicates people utilizing the Van Clinic do not generally utilize other available services (clinics, offices, etc.).

The major accomplishment of this project thus far is in reaching the identified population and successfully linking them with a wide range of needed services.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

In a similar setting, with dedicated, flexible staff and community linkages this program should be adaptable to other communities. A Program Specialist is needed to provide leadership and full support. Staff and supportive agencies need to be carefully selected. Training manuals developed for similar projects may be helpful.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.


Health Department: Tacoma-Pierce County Health Department City/State: Tacoma, WA

Contact Person: Christiane Hale PhD, Chief, Office of Community Assessment Telephone: (206) 591-6426


Small Group: Improving Primary and Preventive Care for Adolescents

**1. Initiative Name:** Latino Youth Summer Intern Program

**2. Describe the initiative.**

Eight at-risk Latino young people who were entering either 11th or 12th grade were chosen for an intensive summer program of team-building, self-esteem enhancement, and training as health interviewers and certified blood pressure screeners. The program is still in its first summer, but initial indicators are that at-risk youth can successfully conduct health interviews with at-risk communities.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were established with several community organizations within the Latino community to establish the network needed for the community surveys, with Washington State University's extension program for team-building and self-esteem enhancing activities, and with the American Red Cross and the American Heart Association to ensure that the training met their standards for certification. The last two organizations conducted the actual testing and certification of the summer interns.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Lack of experience within the agency in establishing this type of program. | Barrier 2: Pressures the interns themselves faced to engage in activities more highly regarded by peers than the internship program. |
| How overcome? By seeking assistance and advice from groups with such experience, especially the WSU extension service. | How overcome? By intensive counseling with youth and their families and by encouraging them to make choices with positive impacts on their now promising futures. |

5. **How is it funded?**

**What is the approximate annual budget for this initiative?** $32,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

We have seen interns make positive choices to stay with the program in the face of intensive peer pressure to do otherwise. Its major accomplishments to date have been (1) successful completion of all certification activities by all interns and (2) design and implementation of a household health survey for approximately 200 Latino households.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

It should work with appropriate planning and coordination. We would be glad to share curriculum information, survey instruments (English and Spanish), and other materials as appropriate.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Department of Health & Environment City/State: Toledo, OH

Contact Person: Bob Pongtana Telephone: (419) 245-1754

Category: Improving Access to Health Care

**1. Initiative Name:**

**2. Describe the initiative.**

A. The introduction of Midwives into our Prenatal Care Unit, also the linkage of our service to a Local III facility (Toledo Hospital) - Networking.
B. The addition of three Pediatric Clinics staffed by doctors and residents of the Medical College - Networking.
C. The addition of a "Well Woman" Clinic staffed by midwives, with an educational emphasis.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Collaboration has been very effective due to good planning, the flexibility of staffing from all agencies, and a positive environment.

**4. What have been the greatest barriers faced in implementing this initiative?**

| Barrier 1: | Barrier 2: |
|---|---|
| How overcome? | How overcome? |

**5. How is it funded?** City/County/Local government funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance).

**What is the approximate annual budget for this initiative?** $400,000.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The increase in clients in the Prenatal Clinics. Working with the Midwives and Toledo Hospital in the Prenatal Clinic has helped in the implementation of the Well Woman Clinic. Also working with MCO to staff the Pediatrics clinics has been a result of working with the Midwives and effectively in their clinics.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

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|---|---|---|---|
| Health Department: | Pima County Health Department | City/State: | Tucson, AZ |
| Contact Person: | Kathleen Malkin RN MS | Telephone: | (602) 624-8328 |
| Small Group: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Prenatal Care Initiative (PNI)

**2. Describe the initiative.**

The PNI is a collaborative effort between the Pima County Departments of: Health, Medical Assistance, Kino Hospital and Pima Health Systems (The County AHCCCS HMO, Arizona's version of Medicaid). Outreach services are provided in a high-risk target area by Public Health aides who are bilingual and culturally sensitive to the population. They educate the community on the importance of early and continuous prenatal care and assist women to obtain prenatal care. If a woman is denied AHCCCS (Arizona Health Care Cost Containment System), the PNI pays for her prenatal care and delivery at Kino Hospital. During the pregnancy and postpartum period, case management is provided by Public Health Nurses who are also bilingual and culturally sensitive. The nurses teach the women about pregnancy, birth control, infant care and how to obtain needed resources. Bus passes and child care vouchers are provided to women for whom lack of transportation and child care present barriers to obtaining prenatal care.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages were made between the Health Department, Medical Assistance, Kino Hospital and Pima Health Systems to provide outreach, case management and prenatal care to high-risk women. Linkages were made with various other community agencies to enhance the outreach/case management efforts and to provide needed resources to clients. Linkages with the bus company were helpful in providing a means of transportation to clients via bus passes. Linkages with a local day care provider to provide child care while the client went to prenatal-related appointments was not successful - clients refused to utilize the service, primarily for cultural reasons.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Differing means/styles of communication between county departments.<br><br>How overcome? 1) Development and utilization of common forms. 2) Establishment of regular meetings between workers. 3) Signing of release of information forms by clients to facilitate sharing of pertinent information. 4) Support for the program by top officials. | Barrier 2: Difficulty in publicizing program to target population. This population tends to isolate themselves and are difficult to reach.<br><br>How overcome? 1) Efforts of outreach workers: meeting with key community leaders/groups, families, individuals, business people. Posting fliers in the neighborhoods. 2) Meeting with various social services agencies and other groups regarding program. 3) Media coverage in newspaper and on TV at beginning of program. 4) Word of mouth - clients informing families and friends of the PNI. |

**5. How is it funded?** City/County/Local government funds.

**What is the approximate annual budget for this initiative?** $400,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

In the time the PNI has been in operation, referrals have been received on 1,052 women: 68% of these were assisted to obtain AHCCCS and 98 (9.3%) were in the notch group for whom the PNI covered the cost of their prenatal care.

Outcome data shows a 48% increase in AHCCCS enrollment in the target area, a 17% increase in the number of women receiving 9 or more prenatal visits: a 46% decrease in the numbers of low birth weight babies and a 32% decrease in the number of premature infants in the target area.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, I think the PNI could be implemented in any community. There first needs to be a strong commitment by those involved to provide prenatal care and a willingness to be flexible and compromise when needed. Different parts of the PNI already exist in many communities e.g. case management that could serve as a starting point to develop a comprehensive prenatal initiative project.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

Health Department: Tulsa City-County Health Department City/State: Tulsa, OK

Contact Person: Joyce A Reed CNM MS MPH Telephone: (918) 744-1000 Ext. 1800

Category: Improving Primary/Preventive Care for Children

**1. Initiative Name:** Oklahoma Immunization Action Plan

**2. Describe the initiative.**

To fulfill Oklahoma's commitment to the Year 2000 goals of immunizing 90% of our children before they reach their second birthday. Tulsa City-County Health Department's support of this goal was the basis for the development of the "Immunization Coalition of Tulsa County." The coalition developed 5 program elements/goals with objectives, action plan and plan of evaluation of each element. The goals consisted of: 1) improving access, 2) expansion of services, 3) missed opportunities, 4) tracking, and 5) motivation. The action plan was developed with a time frame, responsible lead agency members and resources available.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The Immunization Coalition of Tulsa County is composed of representation from public and private/health and service providers. Representation includes the Department of Human Services Day Care Licensing Unit, the Tulsa Metropolitan Chamber of Commerce, the Tulsa County Social Services Department, the Tulsa Housing Authority, the Tulsa Indian Resource Center and the Morton Comprehensive Health Services. This dynamic group utilizing input from the Oklahoma State Department of Health has been able to complete action steps in all program elements before their time frame.

**4. What have been the greatest barriers faced in implementing this initiative?**

| | |
|---|---|
| Barrier 1: Unable at this time to access Oklahoma Birth Certificate information for tracking purposes.<br><br>How overcome? Currently working with the Oklahoma State Department of Health with legal input to remove this barrier. | Barrier 2: Requirement by all providers that legal guardian be present for immunization.<br><br>How overcome? Developed pilot project that would enable legal guardian to give consent and provide health history so that immunization can be provided while child is at day care center. |

5. **How is it funded?** MCH block grant funds; private sources: Private companies providing motivation incentives.

**What is the approximate annual budget for this initiative?** $97,999.00 from OSDH through TCCHD.

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

1) Improving access - evaluation due July, 1994. Fourteen day care centers desired to be part of the pilot project, only 7 were chosen. 2) Two new sites were added to provide immunization services doubling objective of one provider. 3) Immunization information packet developed and supplied to all Tulsa hospitals for post-partum distribution. 4) Continued work on this goal with progress in overcoming barrier. 5) Donated incentives obtained from goal of 4 businesses and is ongoing and the number of businesses participating is expanding.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

The Immunization Coalition of Tulsa County exemplifies how provider agencies, business and community leaders can support and further efforts for our community, state and nation in meeting the Year 2000 goal for childhood immunization levels.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Commission of Public Health<br>Department of Human Services | City/State: | Washington, DC |
| Contact Person: | Patricia Tompkins RN MS | Telephone: | (202) 673-4551 |
| Small Group: | Improving Access to Health Care | | |

**1. Initiative Name:** D.C. Healthy Start Resource Parent Program

**2. Describe the initiative.**

The District of Columbia Healthy Start (DCHS) is based on an aggressive outreach and social support system to attack the root causes of Infant Mortality. Toward this end, in June of 1993, twenty-two community residents concluded an intensive six-week Resource Parent program of this magnitude to take place in the District of Columbia. Resource Parents are salaried outreach workers, who conduct home visiting and case finding in their neighborhoods to identify at risk pregnant women and families; provide information and guidance about health and social concerns and help families access needed services. Resources Parents assist their clients during pregnancy, through the time of labor and delivery, and then work with the new mother and her family to promote positive parenting skills and preventive child health care. The Healthy Start nurse case managers provide support and supervision to the Resource Parents.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

The 31-module program was implemented with the assistance of a variety of providers to include Georgetown University Children's Medical Center, Income Maintenance Administration, D.C. General Hospital, Child Protective Services, Commission of Mental Health Services, etc.

The training program was adapted from the Cora Training Program developed by the National Commission to Prevent Infant Mortality. DCHS staff expanded this concept by developing an intensive six-week program.

The Resource Parent training program could not have been successful without the collaborative efforts and support of the D.C. Health and Social Services Community.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Downsizing and personnel regulations.<br><br>How overcome? Since the government is in a posture of "downsizing" it was impossible to hire staff through the normal procurement procedure. Therefore, through a collaborative agreement with the University of Cooperative Extension Services, a Resource Parent program was established. | Barrier 2: Lack of acceptance by the professional community.<br><br>How overcome? There is a belief among some professionals that community residents should not be hired to provide care in their communities. Some feel that confidentiality and objectivity will be breached. Mechanisms were put in place to immediately facilitate a strong working relationship between the Resource Parents, on a rotating basis, provide support in following up missed appointments in every clinic. In addition, a referral form was developed so that public health nurses can assign specific tasks and thus would involve the Resource Parent in the co-management of families. |

**5. How is it funded?** Other Federal funds

**What is the approximate annual budget for this initiative?** $500,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

It is too early to evaluate the full impact of the program. However, during the first community sweep early in implementation, the Resource Parents identified 50 pregnant women not receiving prenatal care. These women were referred to Services and will be followed. In addition Resource Parents have begun to improve compliance with clinic appointments by calling and visiting women prior to their scheduled appointments. Furthermore, the Resource Parents follow-up by telephone or home-visit all broken pre-natal and Infant Care appointments at three neighborhood health centers and D.C. General Hospital Clinics.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

This initiative is a must for other urban communities. The initiative promotes economic development by training community residents for an entry level career in health. Also, the initiative promotes community ownership and self-healing. As part of community empowerment, communities were provided this opportunity to recommend residents for the training.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Wichita-Sedgwick County Department of Community Health | City/State: | Wichita, KS |
| Contact Person: | Trudy Baker RN C<br>Supervisor of Clinic Services | Telephone: | (916) 268-8342 |
| Small Group: | Reducing and Treating Substance Abuse | | |

**1. Initiative Name:** Case Management Program for Drug Affected Women and Infants

**2. Describe the initiative.**

The Case Management Program for Drug Affected Women and Infants is a primary prevention/early intervention outreach effort of the Health Department. This project coordinates community-based services to provide comprehensive care for women of childbearing age who are at-risk for drug involvement during pregnancy. Project staff consist of a Case Manager, RN, and an Addiction Specialist. With participation from several care providers services are coordinated to meet the specific needs of the client focusing on: Health care/education and counseling, social skill building and counseling, social services, career training, and supportive services. Clients range in age from 14-42, and have from 0-5 children, from 0-21 years of age. While anyone can refer clients for services, client referrals largely come from area hospitals, SRS and Maternal and Infant Program Clinic staff. Funding for our project was secured by Project Freedom from the Bureau of Justice Assistance with matching funding from Wichita SRS, USD 259, and City Wichita. As knowledge of the project gained momentum self-referrals have begun to emerge.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

This project was the concept of the Drug Affected Baby Task Force of Project Freedom. The Task Force was instrumental in securing the project design and funding. They also serve as the governing committee for the project. The Task Force membership is comprised mostly of the services utilized by staff to assist clients. Yes, the collaboration has been effective. The Task Force meets monthly to network and solve problems that exist with drug affected women. A large percentage of the organizations involved attend meetings.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Fear of being reported to law enforcement, Child Protective Service.<br><br>How overcome? Case Manager works with SRS and Child Protective Services.<br><br>Focus is to help client work within the system to get needed assistance, utilizing community agencies. When patient is enrolled in program and following through, no threat of report to CPS. | Barrier 2: Housing/Transportation.<br><br>How overcome? Clients are transient. Often difficult to locate. Initiating a method for tracing "hard to reach clients" through other service providers such as SRS and WIC.<br><br>Team members provide transportation to appointment, assuring client participation. Goal is to move clients towards independence. |

**5. How is it funded?** City/County/Local government funds; Private Source(s): U.S. Justice Assistance, SRS, and USD 259.

**What is the approximate annual budget for this initiative?** $100,000.00

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The case management team serves as the one identified central point of entry to all medical and social services in Wichita-Sedgwick county for drug-involved women and their children. Referrals are received from hospitals, and other Task Force members, as well as self-referrals. A formalized "Memorandum of Agreement" has been developed with participating agencies. Once client rapport is established, clients are more receptive to treatment center care. The fear element is alleviated.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. The Drug-Affected Baby Task Force has all the players involved, and the mother and child are the center. All the agencies pull together to make sure the patient continues to be the focus. No need for competition. This leaves the case management program free to do their job.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | State of Delaware, Div of Public Health | City/State: | Wilmington, DE |
| Contact Person: | Carol Pearson | Telephone: | (302) 995-8673 |
| Small Group: | Improving Primary and Preventive Care for Young Children | | |

**1. Initiative Name:** Door-to-Door Blood Lead Screening

**2. Describe the initiative.**

Door-to-door blood lead screenings, conducted May-July '93, in a targeted area of Wilmington, have yielded a 30% elevated rate, ten times the state-wide level of elevated blood leads from public health clinic screens. The targeted census tract was determined by a lead risk assessment tool based on the proportion of houses built prior to 1950, and taking into account the number of people per household and number of children under 6 years of age.

The unique aspect of Wilmington's door-to-door screening is their success in utilizing an outreach team of bilingual staff, known to the community from their HIV/AIDS outreach. A week before the lead screening team arrives, the outreach group identify homes with children under 6 years who are willing to participate in the screening. The screening team can concentrate their efforts and time on education in housekeeping interventions and safety factors related to de-leading homes, rather than on marketing the program to each home as they go. In addition to blood lead screening, an environmental survey was conducted using an XK-3 lead-in-plant analyzer.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages with community centers included Latin American Center, Wilmington Jaycees, Weed and Seed Program, St. Anthony's Community Center, Booth Social Services, Hilltop Neighborhood Center, Los Abuelos Center, and many other community centers and agencies.

A major linkage was established with Brandywine Counseling, Inc. who provided the bilingual outreach staff who went door-to-door ahead of the screening team to identify children needing screening. These linkages have been very effective in gaining community acceptance.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Acceptance and communication issues in a largely Latino population.<br><br>How overcome? Advance publicity, appearances by staff at community centers, and mainly through efforts of bilingual outreach staff. | Barrier 2: Working out the logistics of scheduling when working with two teams; outreach setting up for screening teams.<br><br>How overcome? This was difficult in such a short time of operation. Mainly through meetings between the groups to work at the coordination. |

**5. How is it funded?** Other Federal funds; Private source(s): CDC Lead Prevention

**What is the approximate annual budget for this initiative?**

**6. How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

This program has identified a large percentage of children with elevated lead who have not been reached through traditional clinic screening efforts. In several situations, the screening team entered homes where paint was being burned off. The child's lead level in one instance was 45.9mcg/dl and the father's was in the 50's. Both were admitted to the hospital for chelation therapy.

**7. Do you think that this initiative would work if implemented in another urban community? Why?**

Yes, it is applicable in any urban community.

## 1993 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiatives in the area of maternal and child health. Please be as neat and succinct as possible, as this form will be reproduced as is for distribution to all conference participants.

| | | | |
|---|---|---|---|
| Health Department: | Westchester County Health Dept | City/State: | Yonkers, NY |
| Contact Person: | Dr Jean Hudson and Alda Lee | Telephone: | (914) 593-5150 |
| Small Group: | Improving Outcomes of Pregnancy | | |

**1. Initiative Name:** Primary Care Initiative-Healthy Babies

**2. Describe the initiative.**

The goal of the PCI is to achieve the best possible maternal and infant outcomes. PCI staff conduct outreach educational activities in at-risk communities to inform and advise appropriate residents and organizations about prenatal services. PCI workers assist pregnant women through the process of obtaining medical and Social Services they are entitled to, including help with barriers such as transportation, language (workers are bilingual) and assistance with paper work.

**3. In planning and implementing this initiative, describe what linkages with other agencies and sectors were established. Has the collaboration been effective? Why or why not?**

Linkages with the WIC program have been established and have been very effective for both programs - PCI helps to overcome barriers and schedule appointments; WIC refers women to PCI. Linkage with the area hospital that has prenatal services has been improved, e.g., restricted application times to a few hours per week; PCI assists with paper work so an appointment can be done by telephone, at the time the woman completes the application.

**4. What have been the greatest barriers faced in implementing this initiative?**

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|---|---|
| Barrier 1: Hospitals restricting access by limiting times and days they will make appointments.<br><br>How overcome? Meeting with hospital staff at all levels, including the Hospital CEO and the Deputy Commissioner of the Health Department. | Barrier 2: Women from other countries understanding the importance of early prenatal care and understanding that it is available in this country regardless of status.<br><br>How overcome? Community Health worker who speaks the language; going to churches, food pantries, putting up fliers; building trust and helping the women get through the system any way we can. Intensive follow-up. |

5. **How is it funded?** Private source(s): New York State Department of Health Grant.

**What is the approximate annual budget for this initiative?** $277,750.00

6. **How do you know that this maternal and child health initiative has been successful? What have been its major accomplishments to date?**

The number of women helped into prenatal health care since January, 1993 has been over 350. Many women are undocumented and not English speaking. Their access to hospitals has been increased by helping with language barriers and assistance with Social Services paperwork.

7. **Do you think that this initiative would work if implemented in another urban community? Why?**

Yes. The need is there; many women are unable to negotiate the Health Care System and DSS. They need to understand they may be eligible for prenatal care under PCAP and the importance of seeking that care.

# APPENDIX A: 1993 Conference Planning Committee

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## APPENDIX B: 1993 Conference Program

### "Improving Urban MCH Linkages"

Sunday, September 12, 1993

| | | |
|---|---|---|
| 1:00pm - 1:45pm | **"What Works" Small Group Leaders Orientation** | **Freer Suite** |
| 2:00pm - 5:00pm | **Optional Workshops (pre-registration is required)** | |
| | I. Cultural Diversity in Urban MCH | **Renwick** |
| | II. Urban MCH Data - Needs Assessment | **Smithsonian** |
| 4:30pm - 7:30pm | **Conference Registration** | **Phillips Foyer** |
| 5:00pm - 5:30pm | **Orientation for New** CityMatCH **Members** | **Freer Suite** |
| | CityMatCH Executive Committee to the Board of Directors | |
| 5:30pm - 7:30pm | **Welcoming Reception**<br>Funded by the National March of Dimes Birth Defects Foundation | **Phillips Ballroom** |

Monday, September 13, 1993

| | | |
|---|---|---|
| 7:00am - 8:00am | **Registration & Continental Breakfast** | **Freer Suite** |
| 8:00am - 8:45am | **Introductory Remarks** | **Phillips Ballroom** |
| | **Carolyn Slack, MS, RN**<br>Co-Chair, 1993 Urban MCH Leadership Conference<br>Administrator, Family Health Services<br>Columbus Health Department<br>Columbus, OH | |
| | **Mohammad Akhter, MD**<br>Commissioner of Public Health<br>District of Columbia Commission on Public Health<br>Washington, DC | |
| | **Audrey Hart Nora, MD, MPH**<br>Assistant Surgeon General<br>Director, Maternal & Child Health Bureau<br>Health Resources and Services Administration<br>Rockville, MD | |
| 8:45am - 9:00am | **1993 Conference Overview** | |
| | **Magda G. Peck, ScD, PA**<br>CityMatCH Executive Director<br>Co-Chair, 1993 Urban MCH Leadership Conference<br>Chief, Section on Child Health Policy<br>University of Nebraska Medical Center<br>Omaha, NE | |
| 9:00am - 10:00am | **Emerging Roles of Urban MCH Leaders** | |
| | **Ed Ehlinger, MD, MPH**<br>Director, Division of Personal Health Services<br>Minneapolis Health Department<br>Minneapolis, MN | |
| | **Elvin Plank, RN, MPA**<br>Administrator, Clinical Services<br>Health & Hospital Corporation<br>Indianapolis, IN | |
| | **Virginia Caine, MD**<br>Interim Director, Division of Public Health<br>Health & Hospital Corporation<br>Indianapolis, IN | |
| | **Kathryn Vedder, MD**<br>Chief of Maternal and Child Health<br>PHS Regional Office, Region V<br>Chicago, IL | |
| 10:00am - 10:30am | **Break** | **Freer Suite** |

| | | |
|---|---|---|
| 10:30am - 12:00pm | **Panel I. Importance of Urban MCH Linkages: Lessons Learned**<br><br>**Paul Melinkovich, MD**<br>Associate Health Director<br>Community Health Services<br>Denver Department of Health & Hospitals<br>Denver, CO<br><br>**Mary Evans**<br>Coordinator<br>Infant Mortality Prevention Center<br>Department of Public Health<br>Des Moines, IA<br><br>**Virginia Bowman, RN, MPH**<br>Chief, Maternal and Child Health Programs<br>Allegheny County Health Department<br>Pittsburgh, PA<br><br>**Ann Vetter, RN, MSN**<br>Child Health Coordinator<br>City of Austin Health & Human Services Department/<br>Travis County Health Department<br>Austin, TX | **Phillips Ballroom** |
| 12:00pm - 1:30pm | **Ask-A-Colleague Luncheon** | **National A & B** |
| 1:45pm - 3:00pm | **Panel II. Improving Urban MCH Linkages: Child Health in Orange County - A Public/Private Partnership**<br><br>**Len Foster, MPH**<br>Deputy Director of Public Health<br>Orange County Health Care Agency<br>Santa Ana, CA<br><br>**Anthony R. Edmonds**<br>MCAH Program Operations Manager<br>Orange County Health Care Agency<br>Santa Ana, CA<br><br>**David H. Ward, DDS**<br>Private Practice Dentist<br>Santa Ana, CA | **Phillips Ballroom** |
| 3:15pm - 5:00pm | **"What Works" Small Groups I: Going Beyond Urban MCH Profiles**<br>Success Stories: Linkages<br><br>* For location see Monday, September 13, 1993 divider. | * |
| 6:30pm - 8:30pm | CityMatCH Board of Directors Meeting for outgoing and newly elected members | **Suite TBA** |

Tuesday, September 14, 1993

| | | |
|---|---|---|
| 7:00am - 8:00am | **Continental Breakfast** | **Freer Suite** |
| 8:00am - 8:15am | **Announcements and Overview of Day 2** | **Phillips Ballroom** |
| | **Carolyn Slack, MS, RN**<br>Co-Chair, 1993 Urban MCH Leadership Conference<br>Administrator, Family Health Services<br>Columbus Health Department<br>Columbus, OH | |
| 8:15am - 10:00am | **Panel III. The Role of Urban Health Departments in Medicaid Managed Care** | **Phillips Ballroom** |
| | **Magda G. Peck, ScD, PA**<br>CityMatCH Executive Director<br>Chief, Section on Child Health Policy<br>University of Nebraska Medical Center<br>Omaha, NE | |
| | **Mary Lou Hennrich, RN, MS**<br>Director, Primary Care Health Services<br>Multnomah County Health Division<br>Portland, OR | |
| | **Lillian Shirley, RN, MPH**<br>Director of Family Health Services<br>Boston Department of Health & Hospital<br>Boston, MA | |
| 10:00am - 10:30am | **Break** | **Freer Suite** |
| 10:30am - 12:15pm | **Panel IV. National Health System Reform: What Does it Mean for Cities?** | **Phillips Ballroom** |
| | **Elice D. Hubbert, MPA**<br>Project Coordinator, CityMatCH<br>Section on Child Health Policy<br>University of Nebraska Medical Center<br>Omaha, NE | |
| | **1993 CityMatCH Survey: Managed Care and MCH in U.S. Cities - Preliminary Findings** | |
| | **Catherine Hess, MSW**<br>Executive Director<br>Association of Maternal and Child Health Programs<br>Washington, DC | |
| | **Sara Rosenbaum, JD**<br>Senior Staff Scientist<br>George Washington University<br>Center for Health Policy Research<br>Washington, DC | |
| 12:30pm - 2:00pm | **CityFriends Host Luncheon** | **Phillips Ballroom** |

| | | |
|---|---|---|
| 2:00pm - 4:00pm | **"What Works" Small Groups II: Profiles Plus**<br>Success Stories: Urban MCH Initiatives | * |
| | * For location see Tuesday, September 14, 1993 divider. | |
| 5:00pm - 8:00pm | **Urban MCH Networking Session** | **Phillips Ballroom** |
| 5:00pm-8:00pm | **Urban MCH Sharing Tables: Displays of Profiles, Other New Initiatives** | **Phillips Ballroom** |
| 6:00pm-7:00pm | **1993 CityMatCH "SpotLights" Presentations** | **Phillips Ballroom** |

Wednesday, September 15, 1993

| | | |
|---|---|---|
| 7:30am - 8:30am | **Regional Urban MCH Planning Breakfast** | **Phillips Ballroom** |
| 8:45am - 10:15am | **CityMatCH Annual Business Meeting** | |
| 10:15am - 10:30am | **Break** | **Phillips Foyer** |
| 10:30am - 12:30pm | **Panel V. Violence in Urban America: What Communities Can Do** | **Phillips Ballroom** |
| | **Patricia A. Tompkins, RN, MS**<br>Chief, Office of Maternal and Child Health<br>Commission of Public Health<br>DC Department of Human Services<br>Washington, DC | |
| | **Kwame Obeng**<br>**Bryant Anderson**<br>**Amour Smallwood**<br>Youth Leadership and Development Institute<br>Washington, DC | |
| | **Alvin Whitley**<br>Youth Program Coordinator<br>Youth Leadership and Development Institute<br>Washington, DC | |
| | **Sean Gordy**<br>Youth Outreach Coordinator<br>Youth Leadership and Development Institute<br>Washington, DC | |
| 12:30pm - 1:30pm | **Ask-A-Colleague Luncheon II** | **National A & B** |
| 1:30pm - 2:00pm | **Closing Remarks** | |
| | **Kathy Carson, RN**<br>Immediate Past-Chairperson<br>CityMatCH Board of Directors<br>Coordinator, Maternal & Child Health<br>Seattle/King County Department of Public Health<br>Seattle, WA | |
| 2:00pm | **Final Adjournment** | |
| 2:15pm - 5:00pm | **Field Visits to Area MCH Programs**<br>(optional, pre-registration is required) | **Hotel Lobby** |
| 2:30pm - 4:00pm | **1993-1994 CityMatCH Executive Committee to the Board of Directors Meeting** | **Omni Club** |

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- ☐ F025 Forging an Urban MCH Partnership: 1991 Urban Maternal and Child Health Leadership Conference (out of print)
- ☐ G004 Strengthening Urban MCH Capacity: Highlights of the 1992 Urban Maternal and Child Health Leadership Conference
- ☐ G005 What Works II: 1993 Urban MCH Programs -- Maternal and Child Health Programs in Major Urban Health Departments: Focus on Immunizations
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