HEALTHY START, INC. PITTSBURGH/ ALLEGHENY COUNTY
2005 - 2009 IMPACT REPORT

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I. Overview of Racial and Ethnic Disparity Focused on by Project

The Pittsburgh/Allegheny County Healthy Start program is designed as an intensive community-based effort to eliminate perinatal health disparities. Since beginning operation in 1991, Healthy Start continues to address the significant disparities that exist with regard to infant mortality, incidence of low weight births, preterm delivery, access to early prenatal care and the need for on-going community involvement.

Despite the progress made over the thirteen years prior to the 2005 Competition Application in addressing perinatal health, women residing in the target areas continued to encounter numerous logistical and psychosocial barriers to prenatal care: high poverty, high rates of inadequate health insurance, and health care provider shortages, as well as health and human services systems that are inadequate to the myriad needs of the poor and low-income.

The project proposed to expand system capacity to eliminate health disparities, especially in African-Americans, enhance the perinatal delivery system, develop service capacity to address gaps and barriers to service, promote community involvement, heighten community awareness about the need for early prenatal care, and to foster linkages among health care providers.

Please accept the following data from our original community needs assessment that lead to Healthy Start, Inc. Pittsburgh/Allegheny County's decision to focus on these disparities:

Allegheny County is located in the southwestern quadrant of Pennsylvania and covers a 730.90 square mile area. The County is characterized as primarily urban and suburban, although it has rural areas as well. The total population for Allegheny County from the 2000 U.S. Census was 1,281,666. The major urban area in Allegheny County is the City of Pittsburgh, a 55.38 square mile area with a 2000 U.S. Census population of 334,563. The majority of Allegheny County residents identified themselves as White (84%), 12.4% as Black (non-Hispanic) and 1.7% as Asian (non-Hispanic). Less than 1% of Allegheny County residents identified themselves as being of Hispanic origin.

For the three-year average (2000-2002), there were 299,250 women of childbearing age (10-44) residing in Allegheny County. African-American women constitute 14.73% (44,070) of this population. There was an average of 2,634 births to African-American women and 10,708 births to White women in the county. There is a significant racial disparity for infant mortality in Allegheny County. The infant mortality rate for Blacks (20.38 per 1,000) is almost four times that of whites (5.19 per 1,000).
In 1991, when the Allegheny County Health Department implemented the Healthy Start Initiative, specific neighborhoods of the City of Pittsburgh and surrounding municipalities within the county were selected to concentrate resources and efforts towards that population where problems were occurring.

The Healthy Start/Pittsburgh & Allegheny County Project Area encompasses six Service Areas, primarily within the City of Pittsburgh but including four municipalities in Allegheny, outside the city. Of the city’s 88 distinct neighborhoods, 45 are included in the Project Area. Together, these communities have been identified in a number of previous studies as those at highest risk for conditions that negatively affect pregnancy outcomes. In the Healthy Start Project Area (2000-2002) there were a total of 13,397 live births: 61.9 percent (5487) of the live births was African American while 38.1 percent was white and nonwhite.

For the three-year period (2000-2002), the Project Area accounted for one-half (49.9%) of all infant deaths in Allegheny County. The Project area accounted for over three-fourths (75.78%) of all African-American infant deaths in Allegheny County.

*Infant Mortality*: Infant mortality is a readily-available and widely used indicator of a community’s general maternal and child health status. An infant’s vulnerability to inadequate health care and nutrition, poor housing and other risks indicate that the infant mortality rate reflects a broad range of economic, social and medical conditions. Communities where there is a confluence of several problems, such as chronic poverty, high unemployment and low literacy, tend to have higher infant mortality rates than more advantaged communities.

During the three-year period 2000-2002, there were 13,199 births to Project Area residents and 167 infant deaths. The overall infant mortality rate for the Project Area was 12.65 per 1,000 live births. There was a clear disparity in infant mortality for African-Americans in comparison to that of whites. The African-American rate was 22.23 compared to the rate of 5.93 for whites. Disparities exist for neonatal (less than 28 days) and post neonatal (28-364 days) mortality as well. The neonatal mortality rate for African-American infants (16.58) is over three times (3.27) that of whites (5.06) and the post neonatal mortality rate for African-American infants (5.65) is six and one-half times (6.5) that of whites (0.87). As reflected in the chart below, the infant mortality rate, neonatal (less than 28 days) and post neonatal (between 28-364 days) death rates are well above the nation’s *Healthy People 2010* goals of 4.5, 2.9 and 1.2, respectively.
Low Birth Weight: Low birth weight (LBW) is a key indicator of newborn health status and is directly related to infant survival, health and development. LBW (birth weight less than 2500 grams) is the risk factor most closely associated with neonatal death; thus, improvements in infant birth weight can substantially contribute to reductions in the infant mortality rate. LBW is attributable to smoking, drug and alcohol abuse and poor nutrition. The percentage of LBW births in Pennsylvania for the three-year period 2000-2002 was 7.8% compared to 10.9% for all races in the Project Area. Of the 5,487 births to African-American women, 15.2% were low birth weight. African-American women were twice as likely to deliver a LBW infant versus White women (7.8%), which is disproportionate. LBW Infants have a greater risk of dying in their first year of life. The table below details LBW births by race in the Project Area during the period 2000-2002:

<table>
<thead>
<tr>
<th>Race</th>
<th>Low Birth Weight Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-Am</td>
<td>15.2%</td>
</tr>
<tr>
<td>White</td>
<td>7.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>6%</td>
</tr>
<tr>
<td>Native Am.</td>
<td>16.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Total Births n = 13,199, African-Am n = 5,487, White n = 6,914, Asian n = 496, Native Am. n = 37, Hispanic n = 198

Source: PA State Health Department, Vital Statistics 2000-2002

SIDS: Sudden Infant Death Syndrome (SIDS) is the leading cause of post neonatal death in infants. Studies have shown that the promotion of “safe sleep practices” can significantly reduce the incidence of SIDS related deaths. A Perinatal Period of Risk (PPOR) team was established to investigate and monitor fetal and infant deaths in Allegheny County. Smoking is the leading risk factor for infant deaths due to SIDS. Mothers who smoke during pregnancy are three times more likely to have a SIDS baby, and exposure to passive smoke from smoking by mothers, fathers and others in the household doubles the baby’s risk of SIDS. Other risk factors include
mothers who are less than 20 years old at the time of their first pregnancy, babies born to
mothers who had no or late prenatal care and premature or low birth weight babies. During the
three-year period 2000-2002, 15 infants died (2 White, 13 African-American) from SIDS in the
Project Area. (Source: 2003 Allegheny County Coroner's Report) SIDS accounted for 10.7% ofall African-American infant deaths during this time in the Project Area. African-American
babies are two times more likely to die of SIDS than white babies according to National Institute
of Child Health & Human Development.

Teen Parents: Single teen parenthood is a predictor of future economic hardship for both parent
and child. Young mothers are less likely to finish high school and are far more likely to be poor,
unmarried and to receive welfare for some period of time than those giving birth at later ages.
Children born to single teen mothers are more likely to be at risk for failure throughout their
lives. During the three-year period 2000-2002, births to teens 18 years of age and under in the
Project Area accounted for 9.5% of live births. There was an average of 20 births a year to teens
under the age of 15 in the project area for the same period. In terms of race, African-American
teens were almost four times more likely to birth an infant than Whites (16.9% for African-
Americans versus 4.3% for Whites). In Allegheny County, the age-specific birth rate for
African-American teens (57.7) ages 15 to 17 revealed a large disparity compared to White teens
(7.8).

Prenatal Care: Women who receive early and comprehensive prenatal care are significantly
more likely to deliver healthy, normal-weight infants. Early prenatal care can encourage good
health habits during pregnancy, can lead to early detection of medical problems and can become
a gateway to parenting support, education and assistance with nutrition, housing and other
services and support. The proportion of Project Area expectant mothers receiving early prenatal
care was higher than Pennsylvania for the period 2000-2002. Overall 87.4% of women residing
in the Project Area received first trimester prenatal care compared to 85.1% of women in
Pennsylvania. However, African-American women living in the Project Area were less likely to
seek early prenatal care than White women. During 2000-2002, only 81.6% of African-
American women received care in the first trimester of pregnancy compared to 91.8% for
Whites. African-American women fall short of the Healthy People 2010 objective of 90%.

For adequacy of prenatal care, an index is calculated using three variables – month prenatal care
began, prenatal visits and gestational age – 79.8% of Allegheny County women obtained
adequate prenatal care compared to 70.0% for Pennsylvania. This percentage is well below the
Healthy People 2010 target objective of 90%.
The lack of prenatal care is also a key maternal and child health status indicator. For the period 2000-2002, African-American women were three times more likely to receive no prenatal care than white women were. Other factors affecting the health and well-being of mothers and children are morbidity factors related to behavioral risks, i.e. tobacco use during pregnancy, birth defects, infant/child abuse and neglect, accidents, HIV/AIDS and other communicable diseases.

**Drug and Alcohol Use:** Women between 18 and 34 years of age have the highest pregnancy rate and substance abuse rate. Pregnant drug users often have miscarriages, premature births and low birth weight infants. In addition to the potentially serious consequences that addiction has on pregnancy outcomes, substance abuse on the part of the parent or caregiver places young children at extreme risk for neglect and or physical harm. Each year, 11% of all newborns, or 459,690, are exposed to illicit drugs. (Chasnoff, 1989) More than 739,000 women each year use one or more illicit drugs during pregnancy. (Gomby and Shiono, 1991) A substance-exposed infant is born more frequently than once every 90 seconds. (Schipper, 1991) According to the report on Infant/Neonatal Services and Utilization in Hospitals by The Pennsylvania Department of Health, Bureau of Health Statistics and Research, there were 270 live births exposed to illegal drugs before birth and 12 live births with Fetal Alcohol Syndrome in Allegheny County for the three-year period July 1, 2000 to June 30, 2003.

**Mental Health and Depression:** Depression in women of child bearing age is a significant public health problem due to its relatively high prevalence, its high rate of recurrence and its profound effect on functioning. Recent changes in public assistance requirements, “Welfare Reform”, have placed significant pressures on the very women who are least equipped to handle work-related mandates due to inadequate education, lack of marketable skills, or lack of adequate transportation and/or childcare. Depressive Disorder and Major Depression are the most prevalent diagnoses across age groups for both African Americans and Caucasians. Together they comprise 24.2% of clients served by Allegheny Health Choices for these two racial groups. Females, both African American and Caucasian, represent a disproportionately large percentage of the consumer base diagnosed with disorders involving depression. [Source: Allegheny
County Office of Behavioral Health] In 2003, 37-45% of the Project Area case managed women screened positive for Postpartum Depression. [Source: Healthy Start Depression Screening Database]

**Tobacco Use:** While smoking is associated with a number of serious health problems, smoking during pregnancy is particularly dangerous and is clearly linked to fetal and infant deaths. Smoking accounts for 20 to 30 percent of all LBW births in the United States. In Allegheny County, LBW births accounted for 15.6% of live births to women who smoked. This is nearly double the rate for women who do not smoke (8.5%). Other adverse lifelong effects on infants/children include mental retardation, physical growth retardation, asthma and other respiratory diseases. During the three-year period 2000-2002, approximately 18% of women in Allegheny County reported tobacco use while pregnant compared to 16.8% in Pennsylvania. For African-Americans, the number of women reporting tobacco use while pregnant was 25%. For teens ages 15 to 17, White teens are three times more likely to smoke while pregnant than African-American teens, 39% versus 13% respectively. Pittsburgh ranked worst in maternal smoking in a recent study by the Annie E. Casey Foundation. Of the 50 largest cities surveyed, Pittsburgh has the highest rate of maternal smoking. In 2000, 23.3% of the total births in Pittsburgh were to mothers who smoked during pregnancy.

**Birth Defects:** About 150,000 babies are born each year with birth defects in the United States. Both genetic and environmental factors can cause birth defects, however the cause of about 60-70% of them are unknown. Historical and recent studies have verified the underreporting of congenital anomalies on birth certificates, especially for defects that are not easily diagnosed at the time of birth. According to data collected by the Birth Defects Branch of the Centers for Disease Control and Prevention, approximately three percent of all live births result in the occurrence of a congenital anomaly. In Pennsylvania during 2002, two percent of all resident live births had a congenital anomaly or birth defect reported on the certificate of live birth. There were 229 occurrences of congenital anomalies or birth defects during the three-year period 2000-2002 in the Project Area. The breakdown of specific birth defects, by race, is listed in the table shown below.

<table>
<thead>
<tr>
<th>Type of Anomaly</th>
<th>White</th>
<th>African-American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Nervous System Anomalies</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Circulatory/Respiratory Anomalies</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Gastro-Intestinal Anomalies</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Uro-Genital Anomalies</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Musculoskeletal/Integumental Anomalies</td>
<td>31</td>
<td>55</td>
</tr>
<tr>
<td>Chromosomal Anomalies</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Other Anomalies</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>

**Child Abuse/Neglect:** Child abuse and neglect place infants/children at risk and is associated with poor performance in school, health problems and juvenile delinquency. Substantiated abuse/neglect cases included children that a judge or a child protective service staff person has determined were abused based on medical evidence, the investigation or an admission by the perpetrator. The Pennsylvania Department of Public Welfare found that 49 children died because of child abuse in 2002. In 74 percent of Pennsylvania cases, the abuser was in a parental relationship to the victim. In 2003, there were 1,653 reports of child abuse in Allegheny County. Of these, 249 or 15.1% were substantiated. Substantiated child abuse and neglect cases for children in Allegheny County were reported at a rate of 1.0 per 1000 for the three-year average 2000-2002 in the Project Area compared to a rate of 1.7 per 1000 reported for Pennsylvania.

**Injuries/Accidents:** From 1998 to 2002 there were 6 deaths to children between birth and 4 years of age due to motor vehicle crashes, drowning, fires, and homicides. There were more deaths among black children (4) than white children (2) in this age group. The accident and injury rate (per 100,000 of the population) for blacks is (30.2); nearly nine times that of whites (3.5).

<table>
<thead>
<tr>
<th>Mortality Due to Specific Injuries: Allegheny County – Persons Aged Under 1 Year</th>
<th>1998-2002</th>
<th>Deaths due to Motor Vehicle Crashes</th>
<th>Deaths due to Drowning</th>
<th>Deaths due to Fire and Smoke</th>
<th>Deaths due to Homicide</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
<td>Rate</td>
</tr>
<tr>
<td>White</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Black</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7.5</td>
<td>1</td>
<td>7.5</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.4</td>
<td>1</td>
<td>1.4</td>
</tr>
</tbody>
</table>

**HIV/AIDS:** For the period 2000-2002, there was a reported incidence in Allegheny County of 282 cases of AIDS. The AIDS incidence rate for the period 2000-2002 was 7.4 per 100,000 of the population compared to 12.0 for Pennsylvania. Declines since 1997 in AIDS incidence may be due to decrease in AIDS diagnosis attributable to improved antiretroviral therapy. In 2001, African-American deaths to HIV/AIDS were ten times that of whites according the Department of Health and Human Services. In 2002, more than half of all AIDS cases diagnosed were among African-Americans.

**Communicable Diseases:** Notifiable communicable diseases for Project Area are as follows: Table I. Disease Incidence and Average Annual Rate* for Project Area, 2000-2002.

<table>
<thead>
<tr>
<th>Notifiable Diseases</th>
<th>Total</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
<td>17</td>
<td>0.4</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>10,503</td>
<td>274.8</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>5,570</td>
<td>145.7</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>86</td>
<td>2.3</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>95</td>
<td>2.5</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>87</td>
<td>2.3</td>
</tr>
<tr>
<td>Measles</td>
<td>2</td>
<td>0.05</td>
</tr>
</tbody>
</table>

*Average annual rate per 100,000 Source: PA State Health Department, Vital Statistics 2000-2002
As illustrated in the table above, Chlamydia and Gonorrhea are the two most widespread STD’s in Allegheny County. For 2000-2002, as reported by the Allegheny County Health Department, the incidence for Chlamydia and Gonorrhea by race is shown in the table below:

<table>
<thead>
<tr>
<th>Race</th>
<th>Chlamydia</th>
<th>Gonorrhea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>7928 (74.7%)</td>
<td>4844 (86.3%)</td>
</tr>
<tr>
<td>White</td>
<td>2095 (19.7%)</td>
<td>611 (11%)</td>
</tr>
<tr>
<td>Unknown/Other</td>
<td>551 (2.7%)</td>
<td>162 (2.7%)</td>
</tr>
</tbody>
</table>

**Underinsured/Uninsured:** According to the 2003 Alliance for Health Reforms, 20.2% of African-Americans, 32.4% of Latin Americans and 11.7% of Caucasians Nationwide were uninsured in 2002. While many Allegheny County residents live in poverty, which qualifies them for government assistance, a significant number of “working poor” who, in addition to their conditions of poverty, are not eligible for services such as Medicaid. In these circumstances, many find adequate healthcare beyond their reach, and prenatal and perinatal care are often neglected based predominately on cost. In 2003, 11.8% of the population of Allegheny County was eligible for Medical Assistance. For the third and fourth quarters of 2004, the Pennsylvania CHIP maintains an enrollment of approximately 12,000 children between the ages of 0 to 18 in Allegheny County.

**Children with Special Health Care Needs (CSHCN):** The Pennsylvania Bureau of Family Health in its administration for the 2004 Maternal and Child Health Block Grant has placed special emphasis in addressing the infrastructure of children with special health care needs (CSHCN): identifying priority needs, gaps in CSHCN health care services and the health care delivery system, and gathering information on CSHCN. Criteria such as Very Low Birth Weight (VLBW), NICU admissions, Preterm Birth and congenital anomalies are, but not limited to, the contributing factors for the determination of CSHCN.

<table>
<thead>
<tr>
<th>Healthy Start Criteria</th>
<th>Percentage of Healthy Start CSHCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Low Weight Births</td>
<td>1.7%</td>
</tr>
<tr>
<td>Preterm Births (&lt;32 weeks gestation)</td>
<td>10.9%</td>
</tr>
<tr>
<td>Birth Defects and Congenital Anomalies</td>
<td>1.7%</td>
</tr>
<tr>
<td>NICU Admissions</td>
<td>12.7%</td>
</tr>
</tbody>
</table>


**Housing:** The Housing Authority of the City of Pittsburgh (HACP) is a municipal corporation charged with providing decent, affordable housing for low-income persons. HACP provides housing to 20,000 people and manages more than 6,000 public housing units. As of 2003, 2.5% of Allegheny County (31,266) residents received cash assistance and would be eligible for housing assistance, however, there is a gap of 11,266 residents who live in poverty and cannot get into public housing.

**Health Professional Shortage Areas/Medically Underserved Areas:** Health professional shortage areas are defined by four criteria: the proportion of the population below poverty level, the ratio of full-time primary care physicians to population, the infant mortality rate, and the fertility rate
of the population. Based on these criteria, Allegheny County had nine areas federally designated as Health Professional Shortage Areas in 2000, and now has twelve areas, as seen below:

<table>
<thead>
<tr>
<th>HPSA</th>
<th>Score</th>
<th>HPSA</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arlington Heights/St. Clair</td>
<td>19</td>
<td>Low Income Clairton</td>
<td>13</td>
</tr>
<tr>
<td>Hill District</td>
<td>17</td>
<td>McKees Rocks – Stowe</td>
<td>11</td>
</tr>
<tr>
<td>Manchester</td>
<td>17</td>
<td>South Pittsburgh Homeless</td>
<td>10</td>
</tr>
<tr>
<td>West End</td>
<td>16</td>
<td>McKeesport</td>
<td>7</td>
</tr>
<tr>
<td>Homewood Brushton</td>
<td>15</td>
<td>North Braddock</td>
<td>7</td>
</tr>
<tr>
<td>Hazelwood</td>
<td>14</td>
<td>South Braddock</td>
<td>7</td>
</tr>
</tbody>
</table>

There are 19 Service Areas in Allegheny County that are designated as Medically Underserved Areas.

According to the 2000 U.S. Bureau of Census, the Pittsburgh/Allegheny County Project Area had a total population of 374,595. Fifty-three percent (197,424) were females and forty-seven percent (177,171) were males. Children under the age of five years constituted 5.5% (20,404) of the population. The majority (66.7%) of Project Area residents identified themselves as White, 30% as African-American/Black and approximately 2.8% identified themselves as Asian, Native Hawaiian and other Pacific Islander. Those who self-identified as being of Hispanic or Latino origin accounted for 1.3%. There were 13,262 families and 9,300 families with a female householder, no husband present living below the poverty level in the Project Area. Of these families, 82.3% (18,561) had children less than 18 years of age living in poverty and 41% (9,276) had children less than 5 years of age living in poverty.

The vital statistics data from the Pennsylvania State Health Department describe prevalent norms of health status indicators as follows:

Table II. Prevalent Norms in Maternal, Infant and Child Population in the Project Area and Pennsylvania Related to Healthy People 2010 Target Goals

<table>
<thead>
<tr>
<th>Health Status Indicators</th>
<th>Project Area</th>
<th>Pennsylvania</th>
<th>2010 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal Death Rate (per 1,000 live births) (1998-2002)</td>
<td>6.4</td>
<td>6.7</td>
<td>4.1</td>
</tr>
<tr>
<td>Perinatal Death Rate (per 1,000 live births) (1998-2002)</td>
<td>7.9</td>
<td>7.3</td>
<td>4.5</td>
</tr>
<tr>
<td>Infant Death Rate (per 1,000 live births) (1998-2002)</td>
<td>7.9</td>
<td>7.2</td>
<td>4.5</td>
</tr>
<tr>
<td>Neonatal Death Rate (per 1,000 live births) (1998-2002)</td>
<td>5.9</td>
<td>5.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Postneonatal Death Rate (per 1,000 live births) (1998-2002)</td>
<td>1.9</td>
<td>2.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Child Death Rate (per 100,000 children 1-4)</td>
<td>24.4</td>
<td>29.0</td>
<td>18.6</td>
</tr>
<tr>
<td>Live Births to Mothers Who Received Early and Adequate Prenatal Care (2000–2002)</td>
<td>80.0</td>
<td>70.4</td>
<td>90.0</td>
</tr>
<tr>
<td>Percent of Births to Mothers Beginning Prenatal Care in First Trimester (2000 – 2002)</td>
<td>91.7</td>
<td>85.1</td>
<td>90.0</td>
</tr>
<tr>
<td>Low Risk First-Time Mothers Giving Birth by Cesarean(2002)</td>
<td>23.5</td>
<td>22.1</td>
<td>15.0</td>
</tr>
<tr>
<td>% Infants Born at Low Birth Weight (2000 – 2002)</td>
<td>8.3</td>
<td>8.0</td>
<td>5.0</td>
</tr>
<tr>
<td>% Infants Born at Very Low Birth Weight (2000 – 2002)</td>
<td>1.7</td>
<td>1.6</td>
<td>0.9</td>
</tr>
<tr>
<td>% Preterm Live Births (2000-2002)</td>
<td>10.9</td>
<td>9.8</td>
<td>7.6</td>
</tr>
<tr>
<td>% Live Births to Mothers Who Did Not Smoke During Pregnancy (2002)</td>
<td>82.8</td>
<td>84.2</td>
<td>99.0</td>
</tr>
</tbody>
</table>
Additionally, risk factor data reported from the 2002 Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) described several key health behavior indicators that influence the maternal, infant and child population in the City of Pittsburgh and Allegheny County.

Table III. Behavioral Risk Factor Surveillance System Comparing the City of Pittsburgh, Allegheny County, Pennsylvania, and Nationwide Statistics – 2002

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>City of Pittsburgh</th>
<th>Allegheny County</th>
<th>Pennsylvania</th>
<th>Nationwide</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Health Insurance</td>
<td>9.1</td>
<td>8.6</td>
<td>10.4</td>
<td>14.1</td>
</tr>
<tr>
<td>Currently Smoking</td>
<td>25.6</td>
<td>25.9</td>
<td>24.5</td>
<td>23.0</td>
</tr>
<tr>
<td>Obesity</td>
<td>24.5</td>
<td>26.0</td>
<td>23.9</td>
<td>22.2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8.9</td>
<td>9.6</td>
<td>8.1</td>
<td>6.7</td>
</tr>
<tr>
<td>Binge Drinking</td>
<td>17.6</td>
<td>18.4</td>
<td>16.9</td>
<td>16.1</td>
</tr>
<tr>
<td>Health Status</td>
<td>17.0</td>
<td>18.0</td>
<td>15.9</td>
<td>14.7</td>
</tr>
</tbody>
</table>

Women of Child Bearing Age: According to the 2000 U.S. Census Bureau, there were 304,168 women of childbearing age between 10-44 years residing in Allegheny County.

Table IV. Female of Childbearing Age for Allegheny County, 2000-2002

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>40,548</td>
<td>39,908</td>
<td>39,346</td>
</tr>
<tr>
<td>15-19</td>
<td>39,916</td>
<td>41,109</td>
<td>41,780</td>
</tr>
<tr>
<td>20-24</td>
<td>37,861</td>
<td>37,735</td>
<td>38,125</td>
</tr>
<tr>
<td>25-29</td>
<td>38,593</td>
<td>37,237</td>
<td>37,171</td>
</tr>
<tr>
<td>30-34</td>
<td>43,097</td>
<td>41,625</td>
<td>40,935</td>
</tr>
<tr>
<td>35-39</td>
<td>49,714</td>
<td>47,762</td>
<td>46,464</td>
</tr>
<tr>
<td>40-44</td>
<td>54,439</td>
<td>52,812</td>
<td>51,574</td>
</tr>
<tr>
<td>Total</td>
<td>304,168</td>
<td>298,188</td>
<td>295,395</td>
</tr>
</tbody>
</table>

(Source: 2000 Census. Pennsylvania State Data Center, Penn State Harrisburg for non-census years.)

Marital Status: Marital status figures prominently in perinatal outcomes. Single mothers, especially those under 20, are at risk of economic hardship for both themselves and their new child. An average of 32% of births in Allegheny County was born to unmarried women during the three-year period 2000-2002. This compares to an average of 33% of births to unmarried women in Pennsylvania for the same period.

Immunizations: Pediatricians in Allegheny County choose not to immunize when an infant is sick to avoid further health risks. The lack of financial resources and inadequate transportation make traveling to pediatric appointments difficult. Women are forced to choose between taking their child for an age-appropriate immunization or a sick visit. Therefore, they choose to take their infant for sick visits and neglect the immunization visit. For 2000-2002, 77% of children had age-appropriate immunizations. For children below poverty, 71.7% had age-appropriate immunizations for the same period according to the
Federal Interagency Forum on Child and Health Statistics. In Pennsylvania, 69% of African American children and 77% of white children between 19 and 35 months of age were age-appropriately immunized.

TANF: According to “The State of the Child in Pennsylvania: a 2004 Guide to Child Well-Being in Pennsylvania” publication, 1 out of every 15 children under the age of 18 received TANF (Temporary Assistance for Needy Families) in Allegheny County. This is comparable to the rate for Pennsylvania (5.6). Children receiving TANF are the poorest of poor children. The TANF program provides cash welfare payments for needy children under 18 who would otherwise be deprived of parental support and care. Recipients (with few exceptions) must work as soon as they are job ready or no later than two years after coming on assistance.

Education: Parents who drop out of school create the potential for negative long-term consequences for their children. Those who drop out of high school are less likely to have employment consistently into their twenties and the jobs available do not generally pay well. The 2000 Census reported that 18.9% of the Project Area’s 25-and-over population did not achieve a high school diploma or GED. This is comparable with 18.1% for Pennsylvania. In the City of Pittsburgh, there were 850 African-American and 999 White graduates in 2003. The high school dropout rate of 1.8 per 100 enrolled students for Allegheny County is comparable to Pennsylvania’s dropout rate of 2.1 per 100 students for the 2002-2003 school years. In 2002, 33.9% of Allegheny County’s public school students received a High School Diploma. There was an active student population of approximately 172,197 for this period. Of the low income student, 5.7% receive TANF. Thirty-one (31) percent of public school students were eligible for free and reduced school lunches.

Employment: The unemployment rate is widely regarded as a key indicator of economic well-being. It indicates the difficulty that parents and other child caregivers are likely to experience in finding jobs. According to the 2000 Census, the unemployment rate for the County was 5.9 percent. This is almost one and one half times higher than Pennsylvania’s percentage of 4.2% for 2000. The 1999 per capita income was $22,491 compared to $20,880 for Pennsylvania residents.

The labor force participation rate (number of all persons working full-time, part-time, or unemployed but actively looking for work divided by some segment of the population) in Allegheny County was 58.5%. According to the 2000 U.S. Census Bureau, 54.5% of females ages 16 years and over were in the labor force in Allegheny County.

Status of the Perinatal Health Care Delivery System

Hospitals: For the reporting period, July 1, 2002 through June 30, 2003, area hospitals reported the following capacities:

<table>
<thead>
<tr>
<th>Facility</th>
<th>Live Births</th>
<th>Well-Infant Bassinets</th>
<th>NICU Level 2</th>
<th>NICU Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alle-Kiski Medical Center</td>
<td>511</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Allegheny General Hospital</td>
<td>1,377</td>
<td>38</td>
<td>19</td>
<td>271</td>
</tr>
<tr>
<td>Children's Home of Pittsburgh</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>157</td>
</tr>
<tr>
<td>Children's Hospital of Pittsburgh</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Forbes Regional Hospital</td>
<td>1,202</td>
<td>20</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Jefferson Regional Medical Center</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Healthy Start, Inc.
H49MC04495

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Clients</th>
<th>OB</th>
<th>PP</th>
<th>WIC</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magee-Women's Hospital of UPMC Health System</td>
<td>7,746</td>
<td>104</td>
<td>19</td>
<td>373</td>
<td>40</td>
</tr>
<tr>
<td>Mercy Hospital of Pittsburgh</td>
<td>1,837</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Ohio Valley General Hospital</td>
<td>258</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sewickley Valley Hospital</td>
<td>917</td>
<td>23</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St. Clair Memorial Hospital</td>
<td>1,350</td>
<td>30</td>
<td>5</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>UPMC Presbyterian Shadyside</td>
<td>1,059</td>
<td>17</td>
<td>3</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Western Pennsylvania Hospital</td>
<td>2,088</td>
<td>32</td>
<td>0</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td><strong>County Total</strong></td>
<td><strong>18,346</strong></td>
<td><strong>316</strong></td>
<td><strong>65</strong></td>
<td><strong>875</strong></td>
<td><strong>118</strong></td>
</tr>
</tbody>
</table>

Community Health Centers (CHC):
Primary Care Health Services, Inc. has 14 CHC sites throughout Allegheny County. There are currently 208 pregnant women being served for the 2004 period. The client capacity for Primary Care Health Services, Inc. is 20,000. In 2003, of the 14 sites, 5 provide OB/GYN services. For those sites there were 215 pregnant clients served. Of these, 182 received postpartum follow up care. Seventy-nine (79) clients received WIC services.

The following is a map of the Healthy Start project area. The map reflects project boundaries and shows the relation to the city/county, and the location of the major local health providers identified above.

Transportation: Although there is a public transportation system, some parts of the city are less than accessible to people without automobiles. Compounding the problem is the fact that most local public housing communities are physically isolated from surrounding neighborhoods. These factors make it cumbersome, tedious and often impossible to travel from a Healthy Start community to a neonatal or pediatric care provider. It presents even more of a problem when mothers, lacking child care, must bring along their children when getting to a medical appointment.

The public bus system in Allegheny County is the Port Authority Transit. Recently, the Port Authority in Pittsburgh has threatened to drastically increase fares and reduce services due to a lack in statewide funding for public transportation. Because of the service reductions, the Port Authority will close one of its five bus divisions and eliminate about 500 jobs. ACCESS will reduce its workforce by 150 positions. The Port Authority has an operating deficit in excess of 30 million dollars, and they attribute this to years of reduced state funding.

Childcare: Allegheny County has certified 808 childcare programs. Eight out of 808 are respite care centers for children with Special Needs. Childcare Partnerships for Allegheny County has only provided subsidies for 2600 children, which is underserved.

Translation Services: The Managed Care Organizations: UPMC 4U, Gateway, and MedPlus offer Translations Services in Allegheny County. The capacity of the services of the three organizations is approximately 1,000 clients both duplicated/unduplicated.
II. Project Implementation

Core Services

Outreach & Client Recruitment

A. Healthy Start, Inc. Pittsburgh/Allegheny County has responded to the comprehensive needs of our participants and consumers based on a series of poor health and social wellness outcomes disparaging women. These disparities in health, education, and socioeconomics disproportionately affect African Americans primarily, but also other minority and poor groups. This is remarkable given the fact that the City and County are home to some of the world's most renowned medical and social service institutions including specialty providers for women.

Expert evaluation and assessment of our region, the services provided by Healthy Start, and input from our Consortium and Board of Directors shapes the Outreach and Client Recruitment strategies that we employ. Each delivery system has been developed with the intent of identifying those most at-risk, engaging/enrolling them into Healthy Start and retaining them in the program for a period of time necessary to improve their overall well-being including the assurance of access to necessary health and social service services and meeting individual Plan of Care goals.

Healthy Start’s Multidisciplinary Team travels throughout Allegheny County locating pregnant/postpartum women, fathers and caregivers of infants/toddlers during canvassing activities. If persons are absent or away from home, the Team leaves Healthy Start information containing the Healthy Start logo and Helpline phone number.

Team members target male and female program/community participants by making program information available to community service outlets such as, barbershops, beauty and nail salons, clothing stores, community events, playgrounds, community recreational centers, laundromats, and local youth sports programs.

The Healthy Start Perinatal System Liaison (PSL) and the Consortia assist the Team in identifying community participants for program participation and host community events such as clothing drives, health education series, and community baby showers.

The Team develops community-based participant relationships with area schools, faith-based organizations, local community health centers and hospital outreach programs. Another productive recruitment method is continued collaboration with community-based medical centers and family support centers.

The Team hosts monthly Family Focus Nites which are open to program/community participants. Family Focus Nites are interactive group activities that offer an evening or afternoon of discussion and reflection based on family or character-building topics. Family
Focus Nites provide a safe environment allowing participants to communicate and process positive information and incorporate it into a healthy lifestyle plan of action.

The Healthy Start 24-hour Helpline is the primary point of entry into Healthy Start and serves as a vehicle to provide valuable resource information. An Information and Referral Specialist (IR) staffs the Helpline and is responsible for completing the initial intake form during phone calls. After obtaining the participant’s approval/consent, they schedule the initial home visit within a 48-hour time period. While the IR staffs the Helpline from 8:00 a.m. to 5:00 p.m. daily, the phone answers 24 hours a day. After hours, an answering service takes names and telephone numbers of callers and the IR returns the call within 24 hours.

Finally, Healthy Start Inc. has a Marketing Committee composed of Board members and consumers who review all material utilized for health messages, brochures, flyers and educational material to insure it meets the appropriate 4th grade reading level. They also, ensure that information is culturally sensitive and addresses the needs of the Healthy Start communities at large. Programmatically, the project periodically conducts surveys and focus groups for participant input on targeting and recruitment of eligible families.

B. Within the project area, one of the greatest challenges encountered for enrollment and retaining participants has been the changing demographics. Within Allegheny County, several public housing communities that were physically located within Healthy Start neighborhoods closed or downsized. This impact caused relocation of families who were then lost to the Healthy Start system when they moved. This was coupled with the transient nature of our population. As a result, the previously successful strategy of community canvassing or "door-knocking" in low-income housing communities was proving costly and insufficient. Therefore, targeted canvassing with smaller groups of team members during community events increased. The size of the teams were dependant on the size and number of expected eligible participants attending.

The availability of participants to engage in program services was hampered due to required work and/or school hours as necessary by Pennsylvania’s Welfare Reform Initiative, “Welfare to Work.” Impacts of welfare reform and the requirements that mother’s join the workforce has hindered our ability to enroll our families and even precluded some who were interested from participating in the Healthy Start program. The population most-at-risk also faces a tremendous challenge in understanding and adjusting to the changes that have occurred and will occur in the future.

In some cases, community perception, prior treatment experiences, shortage and/or lack of minorities in the work place have proven to be barriers. Personal substance abuse issues, mental health issues, such as depression, homelessness, domestic abuse or poor housing environments continue the distrust of the health and human service system. They fear they will come under the scrutiny of Allegheny County Children, Youth, and Families Services (CYF) if they expose these
issues. Other retention barriers may be that women and men are just not ready to change poor lifestyle/behavioral habits, such as smoking or illicit drug use. The barriers to retention are the same as those for enrollment as describe above. They are the same for both pregnant and interconceptional participants.

The proposed linkages and coordination of outreach services utilizes a three-prong approach that initially interfaces with other agencies and organizations within our targeted communities. The main responsibility falls to the Perinatal Systems Liaison (PSL), whose duties include attending meetings, making presentations and promoting Healthy Start services.

Secondly, the outreach workers will take the most critical step in the engagement process with program participants, and what occurs at the first assessment ultimately determines whether a participant will engage further in case management services. The Team interfaces with participating hospitals, private practice physicians, family planning clinics, business, human services providers and community health centers developing a personal referral network for program participants.

Key Personnel members, especially the field manager, are responsible for developing more formal working relationships with area providers. They include meetings to discuss the referral, responsibilities and communication functions for each provider. Agreements are both formal and informal with a letter of agreement signed by both parties’ executive staff when necessary.

Finally, the Healthy Start 24 hour Helpline navigates health and human services, assisting continued linkages and coordination of services for program and community participants residing in the project area and Allegheny County.

Please refer to the chart on the following page detailing Healthy Start, Inc.'s Outreach and Client Recruitment linkage and coordination scheme.
Linkage and Coordination Plan

Healthy Start Service Area

HEALTHY START TEAM

Service Area Composition

IT Liaison
MIS Support
Program Assistants/Data Abstractors
Administrative Support

Data Sources

Interventions

Components

Healthy Start, Inc.
H49MC04495

Healthy Start Service Area

North Side Service Area
Center City Service Area
East End Service Area
South Side Communities Service Area
Western Communities Service Area
Duquesne/Braddock Service Area

Healthy Start Consortia
Healthy Start, Inc. Administration
Board of Directors

HEALTHY START TEAM

Perinatal Systems Liaison
Field Managers/Nurse(s)
Social Worker
Outreach Workers
Male Initiative Program

Information and Referral Specialist

Helpline

Outreach Enrollment & Assessment

Mother/Father Status?

Prenatal
Postpartum/Interconceptional

Data Sources

Hospitals/Community Health Centers
Schools/Universities/Colleges
Specialty Providers
Public Health Services
Community Organizations

Service Area Consortia
Faith-Based Community

Initial Contact/Enrollment Form
Consent to Refer, Schedule and/or Receive Services
Authorization to Release Information
Prenatal Appointment Schedule
Summary of Immunizations
Format for Case Review
Interagency (Community) Referral
Intra-agency (Male Initiative Program, Social Worker) Referral
Face Sheet
Maternal Health Record
Risk Assessment (Initial/Postpartum)
Prenatal Visit Information
Labor & Delivery
Postpartum Visit Record
Pediatric Birth Record
Pediatric Visit Information Progress Notes

Participant Intake Form
Service Agreement
Consent to Release/Obtain Information
Consent to Release Information to Government Agencies
Consent to Receive Services
Risk Assessment
Referral (Intra-agency/Interagency)
C. Healthy Start recognizes the ongoing need to reassess outreach to community participants. Therefore, several new strategies were employed to increase awareness and enhance name recognition. These strategies included a canopy adorned with the agency logo, addition of the website address on fact sheets/flyers/brochures, and expansion of newsletter distribution. The funds to support these strategies were made possible through local partnerships with state legislature. In addition, the teams’ were on site and dressed in the company’s signature royal blue t-shirts, hats, and visors at the City’s highly recognized health and social awareness events. These events included the following:

- Health Promotion Day at (3) Federally Qualified Health Centers
- State Senator Wayne D. Fontana “Fontana Fest”
- State Representative Jake Wheatley, Jr. “19th Legislative District Community Day”
- Six regional community baby showers
- Highmark Blue Cross Blue Shield “Walk for A Healthy Community”
- State Senator Jane C. Orie “Annual Kids Expo”

These additional strategies proved to increase our visibility and recognition to over 37,061 community contacts from Year 2 to Year 3.

No matter the strategy used to recruit it is the retention of these potential families for enrollment. Evidence over our 18 year history suggests that it takes a competent and diverse staff to adequately engage mothers and families at the first contact and throughout their service time.

Healthy Start’s home visiting multidisciplinary team (MDT) builds close participant relationships that are crucial for retention. The program makes every effort to ensure cultural and linguistic appropriateness. Aiding retention includes scheduling visits at convenient times for participants and being consistent with visits, making reminder and follow-up calls for appointments and referrals, staying flexible, leaving door reminders whenever participants are unavailable, maintaining confidentiality, being non-judgmental, respecting their values and displaying a truly caring attitude. Additional strategies to address retention:

- Hiring indigenous community-based outreach workers (90% of Pittsburgh/Allegheny Healthy Start staff lives in the Project Area Communities)
- Facilitating transportation and childcare
- Establishing linkages with a broad array of health and human service providers through ongoing referral network collaborations
- Follow-up on medical appointments
- Extensive training of program staff and regional consortium members as well as other program/agencies providers on topics such as Cultural Competency
- Providing intensive case management services to adolescents, families affected by substance abuse, women who are experiencing depression and for families with children experiencing developmental difficulties.
D. With regard to resources and events Healthy Start, Inc. has an infrastructure in place to facilitate Outreach and Recruitment efforts regardless of outside resources, events or deficits to local, county or state government. As was the case in 1991, word of mouth referrals from former and existing participants remained the strongest tool for identifying and enrolling eligible families. Our commitment to quality internally allowed for continued success. Healthy Start continued to develop education and other materials for distribution, all of which were reviewed and approved by the Marketing Committee of the Board of Directors.

Healthy Start, Inc. made a commitment at the initiation of the four year cycle to enhance or broaden partnerships with other agencies and institutions sharing the same principles to improve conditions for high risk families in Allegheny County. Moreover, we sought to formalize the relationships through development of new, innovative programs and Memorandums of Agreement (MOAs)/ Understanding (MOUs).

To highlight this we refer to the application for and acceptance of a federal award to provide responsible parenting and healthy marriage through the Promoting Responsible Fatherhood Initiative of the U.S. Office of Family Assistance. This federally-funded program was formed with genuine partnerships. Our partners include a federally qualified health center (FQHC), domestic abuse agency focusing on offenders and a faith-based institution. The additional partners are consumed by the overall mission of Healthy Start, Inc. and through their hard work with families have contributed greatly to outreach and client recruitment within the target area.

**Case Management/ Care Coordination**

A. Case management of program participants was designed with the knowledge that program participants faced numerous challenges across a broad spectrum of systems impacting their well-being. For expectant and parenting mothers, psychosocial, medical and socioeconomic risks are coexisting and prevalent. Healthy Start has acknowledged through years of experience, local evaluation and input from the community that these women and men needed assistance from a team of individuals, each having an area of expertise. Therefore the concept of a multidisciplinary team approach was again implemented during the previous grant cycle.

Healthy Start recognized specifically that depression during the perinatal period was especially prevalent amongst the target population. In fact, internal evaluation of data based on regular depression screening showed that up to 45% of women assessed scored positive for signs and symptoms of depression. Moreover, we determined that those who were depressed were more likely to engage in risky behaviors such as the use of tobacco, alcohol and other drugs. For these reasons Healthy Start implemented a staff training regimen to provide all home visiting team members with the tools needed to adequately address signs and symptoms of depression including de-escalation techniques, suicide assessment, and referral coordination.
At the conclusion of project year three it also became apparent through internal/external evaluation, staff and participant disclosures and from the Consortia that three additional and critical areas need be addressed. These three areas included early intervention, adolescent care, and child protection service coordination. Therefore, Healthy Start explored options to develop specialty personnel committed to improving conditions for families involved with any one or all of these issues. By year 4 the position of Early Intervention Case Management was created. The primary responsibility of the position was to assess children for delays and coordinate specialty care for those indicating as behind developmentally. As is the case with medical care parents are often apprehensive to work with outside agencies for fear of stigma or blame. This person works to break down those barriers and also assist families with implementation of developmentally appropriate practices such as tummy time that will aid in their child's growth and attachment.

Also in project year, Healthy Start identified individuals within outreach worker roles to train for the purposes of specialty care for teen mothers/ fathers and for families who have child protection services involved due to allegations or instances of abuse and neglect. By the end of year 4 these individuals were hired and trained. With the grant award for the current grant cycle these persons have been hired as the Teen Advocacy Specialist and Family Service Specialist. Each will focus on improving outcomes specific to their target population including, but not limited to assuring high school graduation or obtainment of a GED, healthy parenting practices, avoidance of drug or alcohol use, and treatment for any emotional/behavioral/mental health conditions.

B. Central to Healthy Start’s case management is the commitment to deliver referral, maintenance, prevention, and intervention services through the Multidisciplinary Team approach. Teams are made up of a Core and/or Male Initiative Program (MIP) Outreach Worker (OW), Registered Nurse (RN), a Bachelor of Social Work (BSW), a Licensed Social Worker (LSW), Male Program Specialist, Early Intervention Case Manager and a Field Manager (FM). Assisting the team are the Information and Referral Specialist, Program Assistant/Data Abstractors (PA/DA), and an Administrative Assistant. As a whole they work together to assure that women, men, children and their families secure access to the medical care and human services necessary to promote healthy family lifestyles. Separately, each member of the team is responsible for assuring that the needs of each individual and family are being met.

Home visiting: Home visiting continues as the primary method for delivering case management services. Visits generally last 45 to 75 minutes. The total number of home visits is dependent upon the established level of risk and enrollment period of the participant. The home visit agenda is driven by the use of the Plan of Care, the Health Education curriculum, and the current risks and strengths of the participant. It is through this method that participants receive essential counseling and guidance.
**Health education:** Health education is a key activity for each home visit and is delivered by outreach workers, social workers, specialty positions and nurses. Staff is highly trained on a variety of maternal/child health, social, and mental health topics which are related to birth outcomes, infant and child health and development, and child safety. Specific topics based on the culture of the participant and their families include, but are not limited to immunization, breastfeeding, prenatal ailments such as hypertension, labor and delivery expectations, fathers supporting mothers, postpartum depression, teen parenting, child care, and nutrition.

All program participants receive, at minimum, education on the topics of Infant Mortality, Smoking Cessation and Secondhand Smoke, prevention, and referral for testing of HIV and STIs (Sexually Transmitted Infections), Preterm Labor, Back to Sleep/Safe Sleep and preventing SIDS, Substance Abuse prevention, Mental Health and Depression, Domestic Violence. Other topics covered on a regular basis and with all program participants are Immunizations, Nutrition, Breastfeeding, Child Abuse and Prevention, Family Planning/Birth Control, Child Safety & Injury Prevention, Child Development, Positive Parenting, Dental and Oral Health, and Employment Preparation and Maintenance.

**Lactation Consultation:** Healthy Start, Inc. assumed overall management of the evening lactation consultation (LC) program from the local Title V which lost funding to support the program in project year 4. Certified LCs are available between 5pm and 8am. LCs provide education and counseling to any women accessing the 24-Hour Breastfeeding Helpline. Evening call loads can be as little as 5, but as high as 25. For those program participants receiving assistance the information is shared for care coordination and follow-up purposes.

**Student Interns/Volunteers:** Healthy Start, Inc. planned for a renewed investment of student through internships and volunteer agreements to enhance case management and care coordination. Over the four year period we hosted students in the areas of Applied Developmental Psychology, Social Work, Nursing, Public Health, Medical, Management Information Systems and the AmeriCorps Program. These students contributed to the case management by providing clinical assessments during home visits and during groups programs, designing current, culturally sensitive health education materials, facilitating participant satisfaction surveys, and coordinating outreach and recruitment efforts in the communities.

C. Healthy Start, Inc.'s approaches to case management via home visiting, the delivery of a health education curriculum, the use of individualized plans of care, and depression screening alone have been rigorously evaluated locally and nationally. The results or outcomes have been proven over the last 18 years with improved conditions visible during the prior grant cycle. These evidence-based, best practice models have been shared locally and nationally through presentations made by members of the key personnel team, the executive director, consortia members, and the project's local evaluator.
The Male Initiative Program’s (MIP) efforts to increase paternal involvement through care coordination are producing desirable outcomes. In fact, outreach and recruitment efforts have produced a significant increase in enrollment. 110 men were actively enrolled up 111% from Project Year 1 (53 men enrolled). For many men, barriers to spending time with children and family are rooted in lack of health insurance, education and general socioeconomics. Providing life skills development via home visits and group Family Focus Nites effectively alleviate these stressors. Of great importance has been the increase in health insurance enrollments for men of 54%, an increase of 19% from 2003 and meeting our calendar year 2006 goal.

Other accomplishments specific to MIP relate to the enhanced Management Information System for the collection and analysis of data. Prior to the project year 1 MIP implemented a system different form the maternal and child health component. In order to better serve, evaluate and sustain male-based programs the following occurred:

- Began Three Phase Process to Develop a Complimentary Evaluation System for Male-based Programming
- Established coding system to collect data in Participant Information Management Systems (PIMS) database
- Established Referral and Enrollment Database (Excel)
- Established Participant Demographic and Characteristics Database (Excel)
- Established Depression Screening & Referral Database (Access)
- MIP staff received training on and implemented use of case management/ data collection forms
- Generated more sophisticated enrollment and case management reports
- Data entry was initiated directly into maternal and child PIMS (Participant Information Management System) database;
- Further trained and implemented use of case management/ data collection tools
- Utilize data queries to generate reports for HRSA Continuation Application 2007

D. Within the project area, one of the greatest challenges encountered has been the changing demographics. Within Allegheny County, several public housing communities that were physically located within Healthy Start neighborhoods closed or downsized. This caused relocation of families who were then lost to the Healthy Start system when they moved. The transient nature of our population has also proved a challenge. Another has been participants’ availability due to Pennsylvania’s Welfare to Work Initiative. Requirements that mothers join the workforce has prevented some who were interested from enrolling the Healthy Start program. The population most-at-risk also faces a tremendous challenge in understanding and adjusting to the changes that have occurred and will occur in the future.
In some cases, community perception, prior treatment experiences, shortage and/or lack of minorities in the work place have proven to be barriers. Personal substance abuse issues, mental health issues, such as depression, homelessness, domestic abuse or poor housing environments prevent participants from disclosing their situations. They fear they will come under the scrutiny of the local child protection agency if they expose these issues. Other retention barriers are a reluctance to change poor lifestyle/behavioral habits, such as smoking or illicit drug use. The barriers to retention are the same as those for enrollment as described above. They are the same for both pregnant and interconceptional participants. For details on overcoming these obstacles please refer to section.

The following general programmatic strategies are utilized by Healthy Start Inc. to address participant barriers to service:

- Employ indigenous and paraprofessional workers.
- Establish linkages with a broad array of community-based health and human service providers in the targeted areas to build extensive referral networks
- Employ two social workers and other specialized employees to meet the mental health, developmental and substance needs of participants and teenagers.
- Target fathers and partners of female participants and provide intensive case management.
- Facilitate transportation and child care (Healthy Start, Inc. vans, bus tickets, etc.)
- Monitor attendance of medical/behavioral health appointments.
- Train program staff, consortia members, program and community participants, as well as other program/agency providers on issues related to maternal and child health.

The charts on the following pages detail the protocols, processes and strategies utilized successfully within Healthy Start, Inc.'s case management/ care coordination services:
Pittsburgh/Allegheny County Healthy Start
Intake and Enrollment Process

Components

- Helpline (Initial Intake completed)
- Demographic Information
  - Age
  - Race/Ethnicity
  - Marital Status
  - Educational Level
  - Employment Status
  - Involvement of F.O.B.
  - Primary Healthcare Provider
  - Health Insurance Status
  - E.D.D. (Estimated Date of Delivery)
  - Interconceptional Information
  - Department of Public Welfare Status
  - Women Infants and Children Enrollment Status
  - Best time of day to contact

- Outreach Enrollment and Assessment Team (OEA/Male Initiative Program [MIP])
- Outreach Worker: Prepare for and go on enrollment visit.

- OEA/MIP: Assures confidentiality,
  Determine risk status, complete charting & paperwork, including Case Review Format

Data Sources

- Initial Contact/Enrollment Form
- Consent to Refer, Schedule and/or Receive Services
- Authorization to Release Information
- Prenatal Appointment Schedule
- Format for Case Review
- Interagency (Community) Referral
- Intra-agency (Male Initiative Program, Social Worker) Referral
- Face Sheet
- Maternal Health Record
- Risk Assessment (Initial/Prenatal)
- Prenatal Visit Information
- Progress Notes

- OEA/MIP: Give participant chart and Internal Transfer Form to Field Manager for approval.
  Quality Assurance Completed

- Healthy Start Core Team/MIP for Case Management

- Referrals/info. Requests sent out by OEA/MIP:
- IT Liaison
- MIS Support
- Program Assistants/Data Abstractors
- Administrative Support

- Participant Intake Form
- Service Agreement
- Consent to Release/Obtain Information
- Consent to Release Information to Government Agencies
- Consent to Receive Services
- Risk Assessment
- Referral (Intra-agency/Interagency)

- Mother/Father Status?
  - Prenatal
  - Interconceptional/Post Partum

- Phone Call
- Potential Healthy Start Participant

Healthy Start, Inc.
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**Health Education**

A. Health Education is an essential part of the Healthy Start community-based model. The health education component primarily involves providing health education and training to Healthy Start Personnel, Board of Directors, Consortia, and community partners; developing and providing individualized health education for program participants; and community-wide distribution of relevant health education materials. Since beginning operation in 1991, the initial charge of Healthy Start, Inc. was to conduct focus groups of residents, business persons and community leaders to assess the community's perception of its needs. Information gathered in these community-based settings combined with information reported from local service providers and state/local health agencies were used to structure the Health Education and Training program. The Health Education and Training component regularly employs these community-based focus groups to obtain valuable feedback on current health education materials and assess developing needs in the community.

Healthy Start currently operates in many communities where there is a confluence of problems such as chronic poverty, high unemployment, low literacy, and inadequate health care and nutrition. As such, our Health Education and Training program is developed to be culturally competent and sensitive to these populations. The Health Education and Training component utilizes health education materials that are produced by Healthy Start professional staff to ensure the appropriateness of these materials for our target population. All materials are produced at a third grade reading level to ensure consumer competency. In addition, these educational materials are designed and developed to be instructional and user-friendly in order to maximize their impact and usefulness for participants and community members.

After initial assessment of the community’s opinions on health education needs, Healthy Start formed a Marketing Committee composed of communication and marketing professionals with experience in the communities that we serve. The purpose of this committee is to ensure that all literature and health education materials that are used in the Health Education and Training component meet the above outlined criteria and are community-friendly. This approach to developing health education materials has proven to be an effective means of producing literature to educate program participants and community members.

The Health Education and Training program is responsible for the initial training of all Healthy Start personnel. In addition, we offer a variety of continuing education trainings and events to ensure that staff members, the Board of Directors and our community partners are informed on the most current health information. The topics of these regular trainings are determined based on assessment of community needs and any new health information relevant to maternal child health.
B. Healthy Start has remained committed to providing health education and training to our community with the intention of improving their knowledge of risk factors associated with poor birth outcomes and infant death. We recognize that the skills and knowledge of our staff members are critical to accomplishing this objective. Comprehensive, skill-based, culturally appropriate trainings are conducted to educate and update at basic and advanced levels the Multidisciplinary Team, health and human service providers, consumers, participants, and medical personnel. Although federally mandated to provide trainings on sexually transmitted infections (STIs), HIV/AIDS, sudden infant death syndrome (SIDS), preterm labor, substance abuse, and smoking, Healthy Start has continued to surpass these requirements by providing additional trainings on topics relevant to our communities’ needs, such as health disparities, sexual abuse, domestic violence, and mental health.

The curriculum is comprehensive and was developed to meet the diverse health information needs of preconceptional, pregnant, postpartum, and interconceptional women residing in our targeted project area. The curriculum and training plan ensures that the staff has the ability to provide case management and care coordination based on their thorough knowledge of risk factors leading to negative birth outcomes and provide a more professional approach in educating the program participant.

The following table shows the trainings and attendance records for staff trainings for the current project period.

<table>
<thead>
<tr>
<th>Training</th>
<th>Collaborative Agencies</th>
<th>Number Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health/Mental Health</td>
<td>Western Psychiatric Institute &amp; Clinic(WPIC), Women's Behavioral Health Care</td>
<td>20  22</td>
</tr>
<tr>
<td>Dialectical Behavioral Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interconceptional Care (Nutrition, Dental Hygiene, Family Planning /Contraception, Immunizations, Child Development &amp; Safety)</td>
<td>WIC, WPIC, Allegheny County Health Department, Alliance for Infants and Toddlers, Office of Child Development, Family Health Council, Planned Parenthood of Western PA, Caring Foundation, Private Dental Providers, Specialist, Primary Care Providers</td>
<td>32  29  27  64</td>
</tr>
<tr>
<td>Domestic Violence &amp; Sexual Abuse</td>
<td>Women’s Center &amp; Shelter, PAAR, Maternal and Child Health Bureau - Technical Assistance</td>
<td>27  76  68  86</td>
</tr>
<tr>
<td>Topic</td>
<td>Organization</td>
<td>36</td>
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<tr>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>Sexually Transmitted Infections/ HIV/AIDS</td>
<td>PA Mid-Atlantic Training Center, Allegheny County Health Department, Center for Minority Health, Pittsburgh Aids task Force, Pittsburgh Aids Center for Treatment, University of Pittsburgh Graduate School of Public Health</td>
<td></td>
</tr>
<tr>
<td>SIDS</td>
<td>Magee Women’s Hospital, SIDS Alliance of PA, Allegheny County Health Department, Primary Care Health Services, Inc.</td>
<td>29</td>
</tr>
<tr>
<td>Preterm Labor</td>
<td>University of Pittsburgh School of Nursing, Family Health Council, Inc., ACHD</td>
<td>36</td>
</tr>
<tr>
<td>Staff Development (Cultural Competency, Privacy/Confidentiality HIPAA, CPR, Technical training, HRSA Webcast, Infection Control)</td>
<td>University of Pittsburgh, Healthy Start Counsel, PA Department of Health, Allegheny County Health Department, American Red Cross, HRSA, Emergency Medical Services of White Oak PA, Hory, Springer&amp; Mattern, P.C.</td>
<td>67</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Healthy Hearts &amp; Souls, American Lung Association, PA Area Health Education Center (AHEC), American Cancer Society, Tobacco Free Allegheny County, UPMC McKeepson, March of Dimes, Pa Department of Welfare.</td>
<td>16</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Family Links, Substance Abuse Program, CYF, Gateway Rehabilitation Center, Greenbriar Treatment Center</td>
<td>33</td>
</tr>
</tbody>
</table>

The Healthy Start, Inc. Multidisciplinary team conducts health education on all of the required health topics during home visits. Health education topics provided to program participants address the risk factors that are associated with preterm labor, unplanned or ill-timed pregnancies, the effects of using tobacco, alcohol and other drugs before and after a pregnancy, domestic violence and its effects on children and childbirth, sexually transmitted infections (chlamydia, gonorrhea and syphilis), and HIV/AIDS. It also addresses pregnancy related issues, the importance of early and continuous prenatal care, the importance of breastfeeding and contraception methods and use.

*Male Initiative Family Focus Groups:* Healthy Start, Inc. has made a pledge to not only working with women and children, but also fathers to facilitate behavioral changes and changes in outcomes for the entire family unit. Healthy Start, Inc.’s commitment to using the bottoms up...
approach, led us directly to our community leaders to seek answers. Our local communities said: “It takes two people to make a baby...it’s going to take two people to effectively raise that baby...we believe in the impact of our fathers.” Healthy Start believes that the role the father plays in his child’s life is not only important during their infancy but important across the life course. Unfortunately, men rarely have a background to prepare them for their role in the family. Their family of origin, and the culture that they grew up in, did not likely involve the type of parenting they are being called on to provide for their children; they have no role models from which to draw. If a father is to helpfully support his partner during this impactful time and be a beneficial contributor in his children’s lives, he needs mentoring, education and support. MIP’s Family Focus Nights/Life Skills Groups serve as a vehicle to impregnate this preparation, education, and support.

Our Family Focus Nights/Life Skills Groups use participatory teaching methods in order improve the infant mortality rate (IMR) and negative risks associated with our participants. Our Focus Groups typically are run using the following approaches: Presentations followed up by Group Discussion, Video followed up by Group Discussion, and Group Activities. By varying the topics as well as our approach when conducting the Life Skills Groups, HSI has continued to engage and retain participants in our program. HSI has served 335 participants on topics that have included but are not limited to: the ABC’s of Better Parenting, Reducing the Risk of SIDS, Child Development Series, Domestic Violence and its Impact on Kids, Conflict Resolution Series, Effective Communication Series, Summer Safety, Recognizing and Preventing Sexual Assault Among Children, Healthy Relationships, Budgeting, the Signs and Symptoms of Depression in Men, Power of Movement in Your Child’s First 2 years: Infant exercise, The impact of Racism on Infant Mortality, What you really want to know about Depression, How to achieve wellness during the holidays, and recognizing and preventing sexual assault among children just to name a few.

HSI has developed an innovative qualitative method for measuring the effectiveness of health education administered during care coordination services and Family Focus Nights/Life Skills Groups using computer interactive health games. These games not only allow us to get a gauge on the education our participants are retaining but also give us a new, fresh, and unique approach to health education. Although pamphlets, videos, or other health education methods can provide participants with a great deal of didactic content, the computer interactive health games have exposed participants to essential content repeatedly. The computer interactive health education games have provided participants opportunities to actively recall, rehearse, and learn new skills in an environment that allowed participants to see the consequences of every choice they make. These games range from game show style games with the gain or deletion of points to a simulation/role playing style game in which participants act out possible outcomes. Because our Family Focus Nights/Life Skills Groups are built to engage and educate the entire family, we frequently use our computer interactive health games to encourage healthy competition.
Surprisingly, on every occasion the men have proven victorious and defeated their MOB counterparts proving that men are just as eager to learn and be involved in learning about their children and their MOB’s pregnancy if given ample opportunity. The computer interactive health education games have proven to be more effective than any other form of mediated or face to face health education because it offers the combination of interactivity, entertainment, challenge, decision making, and feedback while encouraging learning.

Three mediating factors have been shown to improve the link between health knowledge and health behavior and the computer interactive health education games have been designed to improve these factors.

- The first factor is involvement. Activities that increase active participant involvement motivate them to acquire more information about the topic, pay greater attention to the information about it, and increase their probability of behaving in accordance with that information.

- The second factor is the belief that changes in health behavior will actually lead to positive outcomes. With the majority of participants being high risk, many are culturally molded to have a negative outlook on medical advice. These computer interactive health education games can show participants the positive outcomes that can be experienced as a result of proper prevention and self-care; it can show that behavior can indeed affect health and well-being.

- The third factor that strengthens the correlation between knowledge and behavior is self-efficacy. Participants that have a strong sense of self-efficacy regarding health and self care are more likely to have a healthy lifestyle, see and follow medical advice when ill, avoid life crises, cope with crises when they do occur, and establish closer social ties so that social support is available to buffer against illness. Conversely, those with low health self-efficacy believe they are helpless and therefore are more likely to become ill and to cope ineffectively with medical problems.

When people learn new information and believe they are efficacious enough to apply it successfully, they are more likely to try and succeed. The computer interactive health education games help our participants rehearse behaviors in a controlled environment and allow them to experience successful consequences as a result of their own decisions.

The following figure illustrates the goals of our computer interactive health education games including their potential effects on mediating factors that can influence health behaviors and outcomes. It also illustrates the interrelationships among the emotional, social, cognitive,
Healthy Start, Inc.
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behavioral, and physiological outcomes expected with the games. Arrows show the hypothesized direction of influence and show that the game playing is expected to enhance self-concepts, self efficacy, knowledge and skills, and communication and social support, mediating factors that can, in turn lead to improved health behaviors and outcomes.

Healthy Start has developed several programs aimed at the male partners who are critical to the support system of women and their babies. A strong bond with a nurturing caregiver is one of the most important determining factors in positive outcomes for children, including the loving care of fathers who want to build and maintain relationships with their mothers. Our Male Initiative Program (MIP) helps educate fathers or other men involved in the life of the child about their importance in the health and well being of their closest family members.

A collaborative effort has also led to the development of the Promoting Responsible Fatherhood (PRF) initiative in our community. PRF focuses on involving fathers in the lives of their families by promoting responsible parenting; encouraging financial stability; supporting healthy marriages activities; improving relationships between fathers and their children; and helping fathers/male caregivers overcome barriers that often prevent them from being an effective and nurturing parent. In its first year PRF provided case management and health education services to 165 male caregivers in Allegheny County.
One key objective of this project is to reduce infant mortality rates by offering programs and services that meet the complex needs of our participants. This project period we added Early Intervention Services to our case management and health education services. The EICM (Early Intervention Case Manager) provides services to infants, toddlers, and their families that encourage the development of the child. The Early Intervention Case Manager participated in an Ages and Stages (ASQ) three day workshop; there she received extensive knowledge and training on the ASQ and its effectiveness in meeting the developmental needs of infants/toddlers served by Healthy Start Inc.

Staff development training on the Ages and Stages Screening Tool was provided to the Healthy Start Nurses and Outreach workers. This training was provided to educate staff about Healthy Start’s early intervention screening process and how the Ages and Stages tool is utilized in providing service to participants.

Experts were used to speak on pregnancy-related issues to meet the health education needs of staff. A two day Domestic Violence training was conducted on-site by a representative of the Maternal and Child Health Bureau (MCHB) Division of Health Start and Perinatal Services with technical assistance provided by Rivera, Sierra & Company, inc. under contract to the Health Resources Services Administration (HRSA). The objective of the workshop was to enhance the awareness of the relationship between domestic violence and perinatal care. The Medical Director of Primary Care Health Services, Inc. conducted training on Sudden Infant Death Syndrome (SIDS). The training was a home visitors' guide to educating parents and caregivers about infant safe sleep.

All Healthy Start, Inc. staff members were required to attend CPR/AED First Aid Trainings. The Chief of Emergency Medical Services of White Oak, PA was the facilitator of this training. Course curriculum included five modules: Adult First Aid, Environmental Emergencies, Adult/Child CPR with Mask, Adult/Child AED, and Infant CPR with Mask. Upon successfully completing the training attendees are given a two year certification card by the American Heart Association.

Health Education trainings for the program participants are co-sponsored in collaboration with other health care and human resource service providers, community based hospitals and health centers, behavioral treatment facilities, and family support centers. Healthy Start partners with Primary Care Health Services, Inc. (PCHS), Greater Allen African Methodist Episcopal Church, and the Domestic Abuse Counseling Center (DACC) to provide education on healthy marriages and co-parenting activities to families throughout Allegheny County. Collaborative efforts such as these have enabled the Healthy Start project to minimize the duplication of efforts and services among service providers, to examine broader issues around infant mortality and have improved trust and communication among agencies providing services in the project area.
Healthy Start Consortia members attended a full day retreat focusing on having positive intimate relationships and creating and acknowledging positive self images. The training and retreat was attended by more than 35 members. Members were engaged in games, activities, and creative art expression to improve their knowledge and ability to manage personal relationships.

In June 2009, Healthy Start, inc. Key Personnel, Board and Consortia members attended a local workshop presented by the Disney Institute. The innovative training included team-building exercises, case studies and methods that focused on three key program outcomes: Knowledge, Comprehension, and Application. Funding for this training was provided by State Senator Wayne D. Fontana. Senator Wayne Fontana represents four of the six Healthy Start target areas.

Finally, the operation of a 24 hour Helpline which assists more than 2,500 people annually provides health education information to callers throughout Allegheny County. Serving as a resource and referral network, information is given out to participants about the service availability in the six Healthy Start Regions along with a host of other services and how they can be accessed. If callers are put on hold they will be treated to a variety of health education vignettes while waiting for their call to be answered. The Helpline is a vital link between the Healthy Start Multidisciplinary Team, and the families, mothers, expectant mothers, men and children of the communities that are served by Healthy Start. In addition, the Helpline serves as a breastfeeding helpline staffed with certified lactation consultants who answer inquiries. The Helpline remains the primary point of entry for women into Healthy Start.

C. Beginning with prenatal care and continuing through the infants' second year of life, we have implemented evidence-base practices to reduce disparities. The Pittsburgh Healthy Start Model has proven effective at addressing perinatal health in our community. Healthy Start recognizes the value in teaching medical practitioners and public health professional nationally about the uniqueness of the program. Therefore, Healthy Start seeks out every opportunity to submit competitive abstracts to public health and medical organizations for presentations. Healthy Start staff has educated over 5,000 professionals nationally about our program.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Conference(s)/Audience(s)</th>
<th>Presenter(s)</th>
<th>Location(s)</th>
<th>Date(s)</th>
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</thead>
<tbody>
<tr>
<td>Healthy Start, Inc. Program Overview</td>
<td>Graduate School of Public Health; Behavior and Community Health Sciences</td>
<td>Key Personnel</td>
<td>University of Pittsburgh</td>
<td>February 2005</td>
</tr>
<tr>
<td>Healthy Start, Inc. Program Overview</td>
<td>Community Home Visiting Physicians; University of Pittsburgh Medical System</td>
<td>Key Personnel</td>
<td>Pittsburgh, PA</td>
<td>March 2005</td>
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<tr>
<td>Legislative Updates: HSI Best Practice Model – Community Impacts</td>
<td>U.S. Congress Members: Santorum, Specter, Doyle, Hart, Murphy, Murtha, Shuster</td>
<td>Key Personnel, Consumers</td>
<td>Washington, D.C.; Pittsburgh, PA</td>
<td>March-September 2005-07</td>
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<tr>
<td>Legislative Updates: HSI Best Practice Model – Community Impacts</td>
<td>PA Congress Members: Orie, Wheatley, Fontana</td>
<td>Key Personnel, Consumers</td>
<td>Pittsburgh, PA</td>
<td>May – September 2005-07</td>
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<tr>
<td>Building a Comprehensive Service System for Rural, Appalachian, African American Pregnant Women &amp; Their Families</td>
<td>Rural Minority &amp; Multi-Cultural Health Conference</td>
<td>Executive Director</td>
<td>New Orleans, LA</td>
<td>May 2005</td>
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<tr>
<td>Healthy Start, Inc. Program Overview and Community Impact</td>
<td>Braddock Community Rotary Club</td>
<td>Executive Director, Field Managers</td>
<td>Braddock, PA</td>
<td>June 2005</td>
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<tr>
<td>Crafting a Culturally Competent Communications Tool</td>
<td>PPHA – PA Public Health Association.</td>
<td>Licensed Social Worker</td>
<td>Pittsburgh, PA</td>
<td>September 2005</td>
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<td>Creating Partnerships Between Data Analysts &amp; Public Health Professionals</td>
<td>PPHA</td>
<td>Data Analyst</td>
<td>Pittsburgh, PA</td>
<td>September 2005</td>
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<td>Building the MCH Workforce Through Learning Communities</td>
<td>Association of Maternal and Child Health Professionals</td>
<td>Executive Director, Program Evaluator</td>
<td>Washington, D.C.</td>
<td>March 2006</td>
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<tr>
<td>Model Programs to Promote Mental Health in Young Children</td>
<td>Association of Maternal and Child Health Professionals</td>
<td>Clinical Coordinator, Field Manager</td>
<td>Washington, D.C.</td>
<td>March 2006</td>
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<tr>
<td>Engaging Communities and Consumers in the Health Planning Process</td>
<td>Interactive TV Workshop at sites throughout PA, OH, MD, WV, and NJ</td>
<td>Perinatal Systems Liaison, Executive Director</td>
<td>University of Pittsburgh</td>
<td>Spring 2006</td>
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<tr>
<td>Interconceptional Care for Fathers</td>
<td>CityMatCH</td>
<td>Field Manager</td>
<td>Providence, RI</td>
<td>August, 2006</td>
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<tr>
<td>Recruitment &amp; Retention: Overcoming the Barriers for At</td>
<td>CityMatCH</td>
<td>Field Manager</td>
<td>Providence, RI</td>
<td>August 2006</td>
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<td>Forgotten Families: Addressing the Needs of Parents and Children Impacted by Incarceration</td>
<td>Association of Maternal and Child Health Professionals; HRSA Grantee Meeting; CityMatCH</td>
<td>Perinatal Systems Liaison, Information Technology Liaison</td>
<td>Arlington, VA; Crystal City, VA; Denver, CO</td>
<td>March 2007; August 2007; August 2007</td>
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<td>Promoting, Developing &amp; Sustaining</td>
<td>Arizona Fathers &amp; Families Conference</td>
<td>Field Manager</td>
<td>Phoenix, AZ</td>
<td>February 2007</td>
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<td>Innovative Practices of Care for Fathers/ Male Caregivers</td>
<td>Healthy Start, Inc.</td>
<td>HRSA Grantee Meeting; CityMatCH</td>
<td>IT Liaison, Field Manager</td>
<td>Crystal City, VA; Denver, CO</td>
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<td>Advancing Women’s Health Through Technology</td>
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<td>Infant Mental Health: Putting the Pieces Together</td>
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<tr>
<td>Community Partnerships: Reducing Cancer Disparities for African American Women</td>
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<td>Emerging Practices in Perinatal Substance Abuse</td>
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<td>Building a Comprehensive Community Collaboration Model: Rural and Urban Models that serve to eliminate infant mortality</td>
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<td>Preconception Chronic Disease Prevention and Management for African American Women</td>
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<td>Enhancing MCH Outcomes Through Collaborative Programs &amp; Activities: A Quantitative and Qualitative Perspective</td>
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<tr>
<td>Promising Practice: Men in Maternal and Child Health Programs</td>
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<td>Environmental Health and MCH: Healthy Start Strategies</td>
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<tr>
<td>Moving Male Involvement Forward: Methods for Making It Work</td>
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<tr>
<td>Building a Comprehensive Local Health Systems Action Plan</td>
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<tr>
<td>NHSA Male Involvement/ Dads Matter Initiative National Cohort: Research Working Group</td>
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</tbody>
</table>
D. Healthy Start has participated in a variety of local and national events over the grant period that has ensured successful outcomes. These include our Annual Cultural Sensitivity Symposium, which is outlined in the table below.

<table>
<thead>
<tr>
<th>Grant Year</th>
<th>Title</th>
<th>Topic</th>
<th>Presentation Description</th>
<th>Audience</th>
<th># of Attendees</th>
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<tr>
<td>2006</td>
<td>Working with Diverse Populations</td>
<td>Cross Cultural Interventions</td>
<td>Chemical Dependency: Substance use disorders as a brain disease, barriers and ethnic difference that inhibit commitment to treatment</td>
<td>Program Participants</td>
<td>182</td>
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<tr>
<td>2007</td>
<td>Working with Diverse Populations</td>
<td>Health Literacy Awareness and Sensitivity</td>
<td>Health Literacy: What it is, Why it matters, How you can help</td>
<td>Health Care and Human Service Providers</td>
<td>189</td>
</tr>
</tbody>
</table>

The objectives of the Cultural Sensitivity Symposia were to increase the acceptance of culturally linguistic and appropriate services and standards that reduce healthcare disparities. Through cultural competency training, health care providers learn methods for communicating with patients when cultural and language barriers exist. Cultural competence emphasizes the idea of effectively operating in different cultural contexts, and altering practices to reach different cultural groups. Being competent in cross-cultural functioning means learning new patterns of behavior and effectively applying them in the appropriate settings. Along with literacy level, a person’s cultural background can play a significant role in his or her ability to comprehend and adopt healthy lifestyle behaviors.
The symposiums brought together community representatives, researchers, health care and human service providers, policy makers and scholars from as far as Ohio, Pennsylvania and West Virginia, to address the realities of low health literacy, mental health and drug dependance and those effects on society.

The Symposium demonstrates the impacts of cultural beliefs, values, attitudes, traditions, language preference, and health practices, and the affects of how people communicate, understand and respond to health information. The symposium was an instrument to help health organizations and practitioners recognize and apply knowledge that is linguistically and culturally appropriate to produce a positive health outcome.

**Interconceptional Care**

* A. The project area realizes significant disparities with regard to poor birth outcomes, especially those that result in pre-term, low weight births. For these infants normative development is compromised and they face both short and long term consequences with their cognitive, social and physical skills. In general, our participants, 98% of which are living in poverty, are at risk of compromised infant care, attachment/ bonding and appropriate parenting. These factors also attribute significantly to poor or lagged development. The consequences for these children are potentially devastating and are attributed to academic failures, increased use of alcohol, tobacco and other drugs, lack of employment and poor social skills. However, with early detection and intervention many of these developmental obstacles can be overcome by age two.

Living in the Allegheny County/Pittsburgh metropolitan area are women who have access to renowned medical institutions. Still, women experience problematic navigation of the health and human services system and they continue to face numerous individual socioeconomic factors such as: a cycle of poverty, poor/inadequate housing, inadequate education and poor lifestyle, behavioral habits, i.e., smoking and substance abuse, mental health conditions, poor birth spacing, domestic abuse and lack of family support, causing impact and contributing to poor interconceptional health. They also may not access the health care system because of the negative/ impersonal ways they have been previously treated because of race or socioeconomic status.

For these and other reasons Healthy Start, Inc. offers a comprehensive system of interconceptional care focusing both on the infant and the parents/caregivers. These include social and clinical assessments of child and adult, developmental screens for children and a focus on assuring that specialty medical, behavioral and social services are available and utilized. To implement the spectrum of services Healthy Start, Inc. employs a multidisciplinary team
approach that includes, but is not limited to, outreach workers, nurses, social workers and key personnel members with a variety of health and human service specialties.

During the interconceptional period, multidisciplinary team members will provide the following services to infants and toddlers: home visits, risk assessments intervention strategies, and health promotions and health education such as: age appropriate immunizations, oral health, second hand smoke, injury prevention, and child safety.

In addition, multidisciplinary team members identify and eliminate barriers to care, provide transportation and childcare, educate on appropriate sleep position and SIDS, focus on newborn needs (feeding, changing and bathing), observe baby’s responses and styles, monitor infant growth and development (height, weight and head circumference), ensure WIC enrollment and appropriate nutrition and oversee well baby appointments, immunizations and health check-ups.

Also, multidisciplinary team members advise on the importance of delaying solid food, discuss infant teething, dental care and dental services, introduce baby’s capacity for positive and negative behaviors, utilize the Ages and Stages Developmental Screening Tools, conduct child development assessments, measure personal-social, fine motor-adaptive, language and gross motor progress, refer to early intervention programs, provide links with other local programs that support children with special health care needs and promote healthy behaviors and counsel on infant safety.

B. Healthy Start, Inc. continues to service a high volume of families. On any given day more than 800 women, 700 infants and 110 men are openly enrolled into our program. Most of these families are categorized as "high risk," meaning that medically or psychosocially they are living with challenges that could negatively impact their health and/or well-being, even resulting in death.

As noted above it takes well-trained, specialized staff members to effectively assess, educate, refer and coordinate care for such fragile families and individuals. Healthy Start continually evaluates its programs and systems to determine effectiveness. Upon review it was apparent that especially during the interconceptional period we needed to further diversify our team. The first noted change was the addition of the Early Intervention Case Manager (EICM). This change resulted from our internal review that showed an increase of infants and toddlers scoring as "behind" on the Ages & Stages Developmental Screening tools conducted by nurses. However, our participants were hesitant to accept referrals to the county's early intervention unit. The apprehension was due to a fear of being reported to child protection services, a failure to accept that help was necessary, or a generalized anxiety of being negatively labeled as a bad parent.
The Healthy Start administration recognized that nurses needed to focus more fully on postpartum clinical assessments, family planning and preconceptional health. A child's delay tends to consume the entire home visit and the focus shifted away from the mother or caregiver's health. So for the 90 or more children assessed to have developmental delays, the EICM would be referred to internally and assigned coordination of their specialty care. The Early Intervention Case Manager (EICM) provides specialized support to high-risk infants through their second year of life ensuring they are enrolled in the health care system for appropriate care and follow-up. The EICM works with participants to: enhance the overall development of their child with an emphasis on identifying individual needs; enhance knowledge about child development and factors pertinent to the growth of their child and learn skills to encourage the development of their child; and provide early support and intervention in the home and help with utilization of available community services and resources including the county's early intervention service provider.

C. Healthy Start uses a variety of evidence-based methods throughout the implementation of the core services. Unique to the interconceptional period is the use of the Ages & Stages Developmental Screening Tool. Healthy Start Inc.’s Early Intervention Program utilizes the Ages and Stages Questionnaire (ASQ) to screen infants and toddlers who are at risk for developmental delays. The ASQ is a series of 19 parent-completed questionnaires designed to screen the developmental performance of children in the areas of communication, gross motor skills, fine motor skills, problem solving, personal-social skills, and overall development across time. Based on Relevant Psychometric Research, The Ages and Stages Questionnaire have received the Assessment Rating of “A-Reliability and Validity Demonstrated”. Concurrent validity was assessed by comparing the ASQ to the Giselle, Bayley Scales of Infant and Toddlers, and Stanford-Bitnet; the ASQ showed an 88% agreement with the standardized assessments. The Ages and Stages Questionnaire is approved and validated by the EPSDT Screening Guidelines Committee for use nationally in the EPSDT program.

D. The Alliance for Infants & Toddlers (AIT), Allegheny County's designated early intervention coordination provider, has been an asset to the implementation of EI services at Healthy Start. AIT administration and staff have welcomed our case manager and ensured that communication has been ongoing and flexible. Working within confidentiality and HIPAA standards has been a non-factor and coordination of care for our participants has been the focus. The result has been improved referral and retention of participants and their children in EI services for both AIT and Healthy Start. Moreover, we have seen an increased spirit of cooperation between the AIT staff and our outreach and nursing teams. While verbal exchange of information has always been open, the sharing of comprehensive developmental plans with the outreach workers and nurses has improved our ability to support necessary intervention approaches. These support systems can be as simple as reassurance to a mom or the provision of transportation assistance to specialty medical appointments such as a physical/speech therapy.
Finally, the relationship has allowed for our team to educate the AIT in-home staff on the culturally sensitivity approach that we take and give concrete insight into the challenges our participants face and how to best work with them.

*Lactation Consultants:* Healthy Start, Inc. was faced with an unexpected opportunity to enhance our existing breastfeeding support services and education. Due to a loss of Title V funding the Allegheny County Health Department was forced to cut the Evening Lactation Consultant Program. Healthy Start has administered fiscally and via management of the Helpline coordination of the program since 1991. Rather than face the loss of a valuable resource to both program and community participants in Southwestern, PA Healthy Start, Inc. obtained funds from a local foundation to continue services through May 2009.

Lactation Consultants are available anytime from 5PM to 8AM for women needing breastfeeding counseling, education and support. The 24-Hour, on-call service assists more than 2,500 women annually.

**Depression Screening & Referral**

A. This Healthy Start program decided on our approach to depression screening and referral by taking into account the factors in our participants' environments. These would include the shortage of psychiatrists which causes long waiting times for appointments, lack of transportation, the myths and stigma associated with mental health, doctors' apprehensiveness about screening and subsequent treatment of pregnant women with mental health issues, and the difficulty navigating systems. On the positive side, most of our participants' insurance plans cover mental health services and there is a large psychiatric hospital in Pittsburgh - Western Psychiatric Institute and Clinic; and many community mental health centers. Our program strives to provide the means for participants to be screened for depression, to be educated about options, and to eliminate the barriers that prevent them from accessing care.

B. For the core service of depression screening and referral, this Healthy Start program uses social workers, outreach workers, and nurses to screen our female participants using the Edinburgh Postnatal Depression Screen. The outreach workers in the male initiative program screen our male participants using the PHQ-9.
Edinburgh Postpartum Depression Scale (EPDS)

**Source:** Cox, JL, et al. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry. 1987;150:782-786. [Click here for the EPDS.]

**Description:** The EPDS was developed for screening postpartum women for depression in outpatient, home visiting settings, or at the 6-8 week postpartum examination. It is a 10-item self-report rating scale that is also sensitive to change in severity of depression over time. While it is used predominantly in the postnatal setting, the EPDS can also be used to screen for depression during pregnancy, terminal illness, in fathers, to assess dysphoria in adoptive parents, and has been validated for use in non-postnatal women, as well as mothers and fathers of toddlers. The EPDS has been used cross-culturally, and has been translated into 23 languages, although all translations have not been validated. It also deliberately does not contain self-report items related to somatic symptoms.

**Scores:** Major depressive disorder (cutoff: 8.5-15.0); minor depression (cutoff: 8.0-9.0). A positive score on item 10 indicates that immediate intervention is required.

**Accuracy:** According to a review of validated screening instruments by Boyd et al, the EPDS had the following sensitivity (testing positive), specificity (testing negative), and positive predictive values (actual disease based on 13% prevalence rates):
- Sensitivity: 59%-100%; Specificity: 49%-100%; Positive predictive value 19%-92%

**Time frame:** It takes approximately 5 minutes to complete the EPDS.

**Cost of the tool:** Free.

Patient Health Questionnaire (PHQ-9)

**Source:** Kroehnke K, Spitzer RL, Williams JBW. The PHQ-9: Validity of a Brief Depression Severity Measure. J Gen Intern Med. 2001;16:606-613. [Click here for a sample of the PHQ-9.]

**Description:** The PHQ-9 is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which derives its scoring system from the 9 DSM-IV criteria for depressive disorders. While the PHQ-9 demonstrated strong sensitivity, specificity, and positive predictive value scores, longitudinal studies are needed to ascertain sensitivity to change. A benefit of using the PHQ-9 in postpartum women is that while it has not been validated in this setting, it is a validated depression screening tool that is linked to DSM-IV criteria, and therefore as a screening tool, can be reimbursed for billing purposes. Sensitivity, specificity, and positive predictive values were similar in the primary care and obstetrics-gynecology samples.

**Scores:** Minor depression (cutoff: 0-9); moderate/moderately severe depression (cutoff: 15-19); severe depression (cutoff: 20-27). A positive score on the question, "Thoughts that you would be better off dead or of hurting yourself in some way" counts if present at all, regardless of duration.

**Accuracy:** According to Kroehnke and colleagues, the PHQ-9 had the following sensitivity (testing positive), specificity (testing negative), and positive predictive values for major depression, with scores >10:
- Sensitivity: 88%; Specificity: 88%; Positive predictive value: 31%-51% – depending on cutoff

**Time frame:** The PHQ-9 takes less than 3 minutes to complete. [Spitzer et al, 1999]

**Cost of the tool:** Free.
Participants are screened when they first enroll in the program and then according to their scores after that. Workers follow a protocol to determine the course of action based on the participant's score. If the score indicates further intervention is needed, the worker will ask the participant if she/he would like to speak with their own doctor or be directed to a community mental health provider. If neither option is suitable for the participant, the worker will offer the services of the Behavioral Health Dept. at this Healthy Start. If this option is acceptable to the participant, a referral to the social workers is written. It is then the goal of the social worker to educate and support the participant until she/he is willing to see a doctor or is stable and tells the social worker that the services are no longer needed. The support is needed during the time the participants must wait for an appointment so that they do not become too discouraged and decide that it is not worth the effort to see a doctor. Due to the shortage of psychiatrists, some participants have had to wait 8 weeks before they see one. Staff will volunteer to accompany participants to their first mental health visit to offer support and assist them with the process.

C. This Healthy Start partnered with Women's Behavioral HealthCARE at the Western Psychiatric Institute and Clinic to have our staff trained in dialectical behavior therapy skills, an evidence-based practice developed to help people with social skills, emotion management, and changing behaviors. These skill sets were chosen because our participants needed tools to help them cope until they could be seen by a mental health practitioner or just because the lack of these skills subjected them to having preventable problems. These skills were also valuable to the staff that might never see participants make any changes which invites staff burn-out. These trainings were then held in 3 different locations state-wide. In order to have follow-up on these first trainings, a webcast was conducted and then archived. A CD of the webcast was then produced so that new hires could be trained when the archived webcast was no longer accessible.

In order to facilitate timely mental health care, this Healthy Start implemented a co-location pilot project to provide free psychiatric services for our participants within our offices. The Healthy Start CARES project provided the office space, transportation, child care, referrals, and scheduling for the service. The psychiatrists and psychiatric nurse were from Women's Behavioral HealthCARE and they provided the assessment and treatment of our participants. The psychiatric staff used evidenced-based, validated assessment tools when screening our participants. They included the Edinburgh Postnatal Depression Scale, Maternal Gratification Scale, the MOS SF-12, the Prime MD, the Mania Rating Scale, and the SIGH-ADS.

Our participants were offered the opportunity to have a psychiatric evaluation and prescriptions within 2 weeks of accepting a referral to the service. Feedback from the participants was very good. On the client satisfaction survey the average score was 32 out of a possible 35, with a higher score indicating higher satisfaction with our services. It was also a good learning experience for the doctors and nurse who were surprised at the seriousness of the illness present in our participants, and also the amount of trauma and grief that was uncovered. An
article about the Healthy Start CARES project is about to be published in the journal *Psychiatric Services*.

Just underway is the telehealth project. This program has purchased 10 telehealth monitors which will be given to participants who have depression and one other chronic health issue such as asthma, hypertension, diabetes, or weight. The participant will answer questions on the monitor on a regular basis and the information will be fed to a secure website. The Behavioral Health Dept. will monitor the information. The goal of the project is to help participants become more involved in their own health care, improve their conditions, and enable them to talk to their health care providers from a more informed position.

D. Resources that facilitated the above mentioned interventions were the Pennsylvania Perinatal Partnership who funded the statewide DBT trainings and the co-location project; and Women's Behavioral HealthCARE who provided the manual for the DBT trainings and the personnel for the DBT trainings and the co-location project. An event that facilitated the telehealth project was a panel hosted by Waynesburg University in southwestern Pennsylvania. The university invited speakers to tell their nursing classes about home visiting and working in community health. The manager of this Healthy Start's Behavioral Health Dept. was a panelist along with a person who oversees the telehealth program at the local VA hospital. The VA telehealth manager put the Healthy Start manager in touch with the monitor manufacturer.

**Core Systems**

**Local Health Systems Action Plan**

A. The LHSAP is used to set priorities in the Healthy Start case management and health education core service interventions, to establish goals and objectives and to map the progress on those goals, to guide Consortia engagement and direction, and for key stakeholders and community engagement.

Priorities in the LHSAP were identified through various sources. The ACHD Needs Assessment, Healthy Start case management data, Pennsylvania Department of Health Family Division of Maternal and Child Health Block Grant Needs Assessment, and established Healthy People 2010 maternal and child health goals and objectives. For Healthy Start, input from the Consortia remains a driving force in identifying priorities in the LHSAP. Through a survey, the regional Consortia’s were asked to rate the level of importance in their community of those risk factors that lead to infant mortality. Their response included Immunizations (24%), Interconceptional Health (21%), Substance Abuse (16.24%). smoking (12.18%) and Welfare Reform (9.13%).
B. The LHSAP focused on four keys areas for improvement: Cultural Competence, Behavioral Health with a focus on perinatal depression, Access to Care, Community Health Integration. Improving maternal and child health outcomes were ranked as a high priority. Direct health services were proposed along with education and training for patenting, childcare and family issues such as violence and abuse prevention.

C. Healthy Start utilizes both the state and local Title V needs assessments to develop priorities for the plan and strategies to improve them.

D. The LHSAP identified health improvement priorities and encouraged development of a coordinated system of prevention, social and personal health services in the county’s perinatal system.

<table>
<thead>
<tr>
<th>Year</th>
<th>Priority Area/ Systems Building Activities</th>
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<tbody>
<tr>
<td>2005</td>
<td><strong>1. Cultural Competence</strong></td>
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<tr>
<td></td>
<td>• Provide a Cultural Sensitivity Conference &amp; Training for all HSI Staff (Continuing Education Units) and program participants.</td>
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<td></td>
<td>• Enhance collaboration with Fatherhood Collaboration via University of Pittsburgh Office of Child Development and the School of Law’s Child Support Law Clinic</td>
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<td></td>
<td>• Coordinate housing assistance for program participants by partnering with City of Pittsburgh and Allegheny County Housing Authorities.</td>
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<td></td>
<td>• Enhance referral system for vocational training and employment maintenance.</td>
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<td></td>
<td><strong>2. Behavioral Health</strong></td>
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<td></td>
<td>• Helpline education /Telephone – vignettes on Drugs &amp; Alcohol/smoking/LBW</td>
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<tr>
<td></td>
<td>• Monthly case conferences on smoking cessation</td>
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<td></td>
<td>• Mid-Atlantic – Provide Substance Abuse Training (CEU’s) for staff.</td>
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<td></td>
<td>• Clean Air for Healthy Children training for staff</td>
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<tr>
<td></td>
<td>• Mandatory HIV/AIDS and confidentiality</td>
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<td></td>
<td>• Develop literacy level brochures for drop-off sites on ATOD/Smoking &amp; Pregnancy/ Fact sheets /LBW/Second Hand smoke</td>
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<td></td>
<td>• Western Psychiatric Institute and Clinic training on Dialectical Behavioral Therapy</td>
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<td></td>
<td>• Introduce &amp; train staff on Substance Abuse Instrument.</td>
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<td></td>
<td><strong>3. Access to Care</strong></td>
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<td></td>
<td>• Ensure every participant has a medical home.</td>
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<td></td>
<td>• Provide bus tickets to participants for hosted and approved activities, prenatal visits, appointments, etc.</td>
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<tr>
<td></td>
<td>• Provide van transportation to participants at focus groups or consortia meeting activities.</td>
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<td></td>
<td>• Provide or Reimburse for childcare to participants. (Activities, etc.)</td>
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<td></td>
<td>• Educate 100% of participants on housing. (housing, referrals)</td>
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<td></td>
<td>• Provide reminders to participants about medical appointments.</td>
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<tr>
<td></td>
<td>• Participate in outreach activities in collaboration with local health providers.</td>
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<tr>
<td></td>
<td>• Increase awareness about access to care. (newsletter, presentations, training)</td>
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<td></td>
<td><strong>4. Community Health</strong></td>
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<tr>
<td></td>
<td>• Work with guidance counselors in school system (targeted communities)</td>
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<td></td>
<td>• Screen 750 women using the Edinburgh Postnatal Depression Scale</td>
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<tr>
<td></td>
<td>• Screen 110 men using PRIME MD tool.</td>
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<td></td>
<td>• Train staff on suicide and crisis management</td>
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<td>• Hire BSW.</td>
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<td>Year</td>
<td>Priority Area/ Systems Building Activities</td>
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<td></td>
<td>• Family planning training.</td>
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<td>• Distribute Condoms.</td>
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<td></td>
<td>• Continue to enhance crisis management plan.</td>
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<td></td>
<td>• Reminder Cards for postpartum check-ups.</td>
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</table>

**2006**

1. **Cultural Competence**
   - Cultural Competence training for all HSI staff, program and community participants.
   - Provide a child support guest speaker to discuss court issues during family focus nights.

2. **Behavioral Health**
   - Advocate for more Treatment centers to increase staff development sensitivity for special needs population.
   - Continue relationships with special needs providers (e.g. case conferences with The Alliance for Infants and Toddlers Early Intervention Services)
   - Staff training – NICU/Preterm Labor/Poor birth spacing
   - Male focus group – effects of smoking and substance abuse on the family.
   - Consortia training – smoking cessation/LBW/substance abuse/second hand smoke

3. **Access to Care**
   - Provide referrals for participants to transportation and childcare programs. (Childcare Partnerships, SPOC)
   - Provide bus tickets to participants for hosted and approved activities, prenatal visits, appointments, etc.
   - Provide van transportation to participants at focus groups or consortia meeting activities.
   - Provide or reimburse for childcare to participants. (Activities, etc.)
   - Provide reminders to participants about medical appointments.
   - Participate in outreach activities in collaboration with local health providers.
   - Increase awareness about access to care. (newsletter, presentations, training)

4. **Community Health**
   - Male mentoring experience for males 12-18.
   - Coordinate agency referrals for male services.
   - Educate local service providers regarding depression/suicide.
   - Develop a mental health support group through MIP
   - Develop an anger management component.
   - Monthly family gathering/family support element
   - Create a male focus group to develop brochure on breast-feeding.
   - Impact statement.

**2007**

1. **Cultural Competence**
   - Develop a cultural sensitivity and awareness fact sheet for local community providers.
   - Cultural Competence training for all HSI staff, program and community participants.

2. **Behavioral Health**
   - Update all staff for CEU’s on substance abuse.
   - Develop brochures for drop-off sites on LBW/Secondhand smoke.

3. **Access to Care**
   - Maintain and enhance relations with providers (i.e. community health centers, support centers, churches) and assist to enhance the program participant’s relationship.
   - Provide bus tickets to participants for hosted and approved activities, prenatal visits and appointments, etc.
   - Provide or reimburse for childcare to participants.
   - Provide reminders to participants about medical appointments.
   - Participate in outreach activities in collaboration with local health providers.
   - Increase awareness about access to care. (newsletter, presentations, training)

4. **Community Health**
<table>
<thead>
<tr>
<th>Year</th>
<th>Priority Area/ Systems Building Activities</th>
</tr>
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</table>
| 2008 | • Male participants design, implement and coordinate male seminar/trainings  
|      | • Increase male mentoring services for young men.  
|      | • Community Outreach  
|      | • Evaluation Component |
|      | 1. Cultural Competence  
|      | • Cultural Competence training for all HSI staff, program and community participants.  
|      | • Publish successes/accomplishments summary sheet and present to future medical professionals via University of Pittsburgh’s School of Medicine & Graduate School of Public Health.  
|      | 2. Behavioral Health  
|      | • Lessons Learned Publication – Reductions/recovery/LBW – review -Tracking & Monitoring  
|      | • Consortia focus group on Substance Abuse  
|      | • Evaluation Component  
|      | 3. Access to Care  
|      | • Provide reminders to participants about medical appointments.  
|      | • Participate in outreach activities in collaboration with local health providers.  
|      | • Increase awareness about access to care. (newsletter, presentations, training)  
|      | 4. Community Health  
|      | • Male participants design, implement and coordinate male seminar/trainings  
|      | • Evaluation Component  
|      | • Presentation at Volunteer Appreciation Night  
|      | • Impact Statement |

E. The Healthy Start, Inc. staff, Board of Directors, and Consortia are primarily responsible for working towards the goals of the LHSAP. Through their efforts the perinatal service delivery system is a better one in Allegheny County. The Cultural Competency Symposiums have influenced hundreds of health and human service professionals alone. Over 800 providers are now considering literacy and impacts of mental health disease and assuring that their approaches are sensitive and without prejudice.

Our behavioral health system has changed greatly due to the advocacy activities of Healthy Start staff and it's Board of Directors. Through ongoing collaborations with institutions like the University of Pittsburgh Medical Centers mothers are not having their children removed from their homes and placed in foster care for accessing necessary mental health treatment. And, while the system is slow to change overall with regard to long waiting list (up to 3 months in some cases), Healthy Start has the ability to make referrals for our families that will be received and responded to in a more timely manner.

Immunizations for our infants and toddlers, especially African Americans, have been deficient at best. Transportation, lack of knowledge and sensitivity of service were major barriers preventing children from receiving age-appropriate vaccinations. Healthy Start targeted those areas using mass education efforts of program participants and consumers. Empowered staff delivered the education and was able to follow up with well-baby appointments using reminder cards and
enhanced data management systems. Under the direction of two Board members, both directors of Federally Qualified Health Center networks (14 total) we were able to ensure that referrals for medical homes were timely and reliable. As a result, we increased our percentage of children immunized from 53% in 2004 to 82.5% in 2009.

Finally, community health was greatly affected as Healthy Start committed to a truly family centered approach. The involvement of fathers and male caregivers is essential to the outcomes of women and children. These men have a great influence on mothers and the daily decisions they make to access and receive medical, behavioral and social service care. However, fathers and caregivers who feel they have no means to "provide" for family are more likely to be negligent or absent. Therefore, through targeted care coordination and education strategies conducted by the Male Initiative Program and in conjunction with the consortia and Board we have seen the number of men with health insurance rise from 47% in 2004 to nearly 70% in 2009. It is noted that this is in part to the commitment of the managed care, welfare and employment providers in joining us as we bring families together with one common focus and vision of elimination health disparities.

**Consortium**

A. As a pre-cursor to the Healthy Start Initiative, in 1989, 1990 and 1991, consumers, hospitals, community health centers, private practitioners, social service agencies, school districts, local clergy, local and state governmental officials and community leaders held a series of 12 town hall meetings.

The purpose for the meetings were to

- mobilize the African American community,
- educate the target community about infant mortality and low weight births
- develop collaborative and cooperative relationships with local agencies,
- identify Service Area Consortium members
- establish collaborative and cooperative relationships with the Pennsylvania Department of Welfare and Health, the PA State Department of Planning, Evaluation and Development, Medicaid and Maternal and Child Health programs.
- appoint members to the Pittsburgh/Allegheny County Central Consortium.
- ascertain why a city with a world renowned medical center and a research/teaching university had an infant mortality rate that rivaled some third world countries.
- come to an understanding as to why women were not accessing service.

From the town hall meetings, it became clear that Allegheny County and Pittsburgh City residents
• wanted to reduce infant mortality/deaths and to reverse the cycle of an ever-widening gap between the races
• needed to be involved in the implementation and planning process
• sought to develop and implement a cultural sensitivity training curriculum that would ultimately effect institutional change.
• lacked trust in local (health and human) service providers
• wanted to hire staff from the target communities
• wanted improve the economic status of individuals who resided in the project area
• believed until there was a realization that every life had value, "babies would continue to die"

The concerns expressed by the "community" were addressed with the formation of Healthy Start, Inc. a separate non-profit structure. The establishment of this non-profit has the advantages of flexibility and greater community input.

To an extraordinary degree, Healthy Start, Inc., secured involvement and "buy-in" from the community it hoped to serve, but the road to that accord was not smooth. Misunderstanding, miscommunication, and an understandable level of distrust pervaded the early months. However, when the Planning Team and the Project Area Consortium expanded to include the additional members, some of whom had been the Project's most vocal critics, both groups came to focus on common concerns and issues. In a relatively brief period of time each Service Area Consortium developed a unique service plan for its community and, at the same time, contributed significantly to the overall project.

B. In the beginning the Project area was comprised of six service areas, primarily within the City of Pittsburgh, and included four municipalities in Allegheny County, outside the City. These areas were targeted because they accounted for 43% of the infant deaths in Allegheny county, and 79% of those within the city. Given the fact that the project covers six separate and distinct geographic locations, community representation from these areas was an important factor in achieving credibility among the target populations. Black and white females and males of varying ages and community-based entities organized under the auspices of Healthy Start, Inc. came together as a structured focused body to accomplish the goad and objectives of Healthy Start, and united in a collective effort to apply resources and strengthen towards the implementation of Healthy Start.

• Service Area Consortia: each of the six regional consortiums was comprised of at least 23 members and no more than 30 members that broadly represented the region's neighborhoods and diverse constituencies. The guidelines used to select members for each consortium were: 6/consumers individuals, 2 neighborhood organizations, 2
religious leaders, 2 business representatives, 4 teens, 2 elected officials, 2 health or human service providers and 3 members at large.

- The Project Area Consortium (referred to as the Central Consortium) consisted of 6 representatives of the service area consortia, one at-large community representative and community leaders from the public and private sectors. The members, numbering no less than 18 and no more than 22, were appointed by the Chairperson of the Allegheny County Board of Commissioners; except for the 6 community members who were nominated by the service area consortia. The membership serves, by virtue of their position, as representatives of local organizations and institutions such as government, medical, health and human service providers, private philanthropy and education.

As the initial advisory arm of the Healthy Start program, the Central Consortium was responsible for ensuring that the systematic, strategic vision of the project was realized throughout the program initiatives. They set project direction, advised on project activities and promoted community outreach and public awareness of infant mortality and of initiatives to reduce it.

The Central Consortium acted to create the non-profit organization, Healthy Start, Inc. to manage the Healthy Start project. "Creation of the Board of Directors allowed the Central Consortium to shift from governance and oversight to a supporting action group."

The composition of the Healthy Start, Inc. Board of Directors was determined early in the project's initial development when community members suggested that the representatives to the Board needed to meet certain criteria. The suggested criterion was predominately women and the majority African-American. The geographic and organizational membership was designed to give maximum voice to community concerns and solutions while involving neighborhood organizations, hospitals, medical society, community health center, United Way, HS Regional Consortia, and most importantly, consumers/participants of the project services and residents of the targeted neighborhoods.

Currently, eighteen members comprise the Healthy Start, Inc. Board of Directors. Their primary function is to set policy and approve program recommendations from Key Personnel and the 6 Regional Consortia. The Board composition is as follows: 7 African American females, 5 Caucasian females, 4 African American males and 2 Caucasian males. These 'active volunteers" are consumers (6), religious leaders (1), business person (1), marketing (1), educator (2), elected official (1), physician (1), finance (1), Health Department (1) and health and human service provider (3).
Officers (Chair, Vice Chair, Secretary and Treasurer) are elected via secret ballot and they, in turn, appoint members to the following Standing Committees: Finance, Personnel, Marketing and Data, Evaluation and Quality Assurance/Improvement. As required by the By-Laws, the Board Chair appoints a three member Nominating Committee. The Healthy Start, Inc. Board of Directors terms is for a period of three years with provisions for a second term.

C. Designed to function throughout the life of the Healthy Start project, the Consortia serve as Project Advocates and make recommendations to the Board through the Executive Director.

Supporting the "bottom-up" approach, the organizational framework for Healthy Start is designed to support the comprehensive, participant-driven approach of the project. It is systematic and interactive in nature, providing for the involvement of community representation at all levels of planning and implementation. All organizational components, policy development, management, operational and service delivery are linked to ensure that all management and program initiatives are responsive to the social-psychological realities of the at-risk population.
In their advisory capacity, the Consortia worked with the outreach teams to monitor program implementation and recommended necessary changes or modifications. They served as the central line between the Healthy Start Project and the community, acting as regional advocates for the project's initiatives.

Consortia members:
• design and implement services, identify gaps in services, monitor program implementation and assist with community education and advocacy
• participate in focus groups, draft By-laws and serve on the Board of Directors
• evaluate providers and programs, recommend change, if necessary, thereby improving quality and service utilization.
• strengthen and enhance community systems of maternal and infant care
• challenge communities to fully address the medical, behavioral and psychosocial needs of women and infants by increasing awareness of infant mortality.
• streamline and coordinate services between public and private agencies
• build partnerships of commitment among families, volunteers, businesses and health care/social service providers.

Community members also provide insight regarding effective program implementation strategies. The Healthy Start structure, while seemingly complex in nature, is aligned to ensure that all management and program initiatives are responsive to the needs and realities of the at-risk participant.

The essence of the Consortia focuses on community involvement and inclusion, new approaches to issues and a creative structure that lends itself to flexibility. The Board, made up of broadly based representation of the community, connects Healthy Start to each of the targeted service regions.

Collaboration has been, and continues to have, a primary role in the development and implementation of Healthy Start, Inc. It is through these efforts that the Pittsburgh/Allegheny County Healthy Start project has been able to minimize the duplication of effort and services among groups that would normally compete against each other. These linkages and service integration have resulted in an improvement in the delivery of services for those families that are most vulnerable.
D. A major strength that has enhanced consortium development is the Consortia's ability to act as the "eyes and ears" of the community and serve as the "voice" for advocacy for the at-risk population.

- Consortia members lead mobilization efforts and initiatives to enhance knowledge of infant mortality in their communities.

Throughout the lifetime of this project, the community has been responsible for assisting the Team in outreach activities, identifying and referring potential staff, reviewing marketing materials, overseeing/monitoring financial matters, heightened awareness about the effectiveness of the Healthy Start program, educated consumer about the need for early prenatal care, low birth weight babies, preterm labor, health disparities and infant mortality.

Having achieved the main shared vision of grassroots participation and involvement by the community in establishing and carrying out programs is major community strength. Success can only be achieved through ownership, empowerment, and collective responsibility. The shared decision making of the members has led to a greater understanding of, and commitment to, the project goals.

Another major strength that has enhanced Consortia development is our ability to identify services targeted toward reducing social, physical, emotional, and psychological risk factors, as well as enhancing community and individual sensitivity and commitment to the quality of life.

Partnerships have emerged, strengthened, and created a network of service collaboration, innovation and change in the way service providers do business. The role of the nonprofit has combined the strengths of a larger bureaucracy with the flexibility of a community-based public/private entity in which participants and providers have a shared voice in maintaining the vision of the project.

Team building is accomplished through a variety of approaches. Ongoing training develops the members' capacity to participate and operate more effectively. Training has also provided the framework for understanding the stages of Consortia development from formation to implementation.

The direct involvement of consortia members and Healthy Start staff has fostered greater and more open communication. The communities' willingness to improve communication continues to be an important factor in positive team building. It has helped focus the consortia and staff on the common purpose, raised the level of trust, and provided valuable feedback on program effectiveness, activities and available community resources, etc.
E. To an extraordinary degree, Healthy Start secured involvement and "buy-in" from the community it hoped to serve, but the road to that accord was not smooth.

- Misunderstandings, miscommunication, and an understandable level of distrust pervaded the early months. Predictably, however, when the team and Consortium expanded to include additional members, some of whom had been the most vocal critics, both groups came to focus on common concerns and issues, and in a relatively brief period of time each Consortium had developed a unique service plan for its community and at the same time, contributed significantly to the overall Project Plan.

The most common barriers that participants/consumers encounter in consortia involvement are the very same things that the typical Healthy Start participant faces—transportation and childcare. In an attempt to overcome these barriers, transportation and childcare support are available and Consortia and Board meetings are scheduled conveniently.

Natural conflicts during the decision making process have led to consensus building resulting in the development of new options and ways of working together.

F. Since the onset of the project, Healthy Start, Inc. has employed the following strategies and activities to increase and maintain participant, resident and consumer participation.

- The Pittsburgh/Allegheny County Healthy Start project remains committed to make this project truly community-based and participant driven. An assessment drawn from community forums and focus groups confirmed, significant improvement in infant mortality rates required more than a medical model; it required attitudinal change and commitment on the part of the entire community. To achieve such change and sustained commitment required cooperative involvement of the community in both planning and implementation.

Other strategies utilized by the Healthy Start team to maintain participant, resident and consumer participation are as follows:

- continuous participant/consumer involvement.
- increased job opportunities and health career training activities for participants and consumers.
• an enhanced role in policy decisions and community leadership in directing the delivery of health services.
• regular scheduled meetings,
• active participation in long term strategic planning
• accompany the Team on community outreach activities,
• approve outreach/marketing materials such as health education flyers, pamphlets and brochures,
• active roles in National Evaluations, surveys, symposiums, baby showers, fall flings, health fairs, trainings and forums
• participating and providing insights on program effectiveness.
• the hiring of a full time staff person (Perinatal Systems Liaison) to do the work of the Consortia
• the development of a Volunteer Database. This database centralizes Consortia information, filters data and makes it readily accessible when needed, tracks members, monitors their attendance and volunteer hours.

Each year the Healthy Start Administration says "Thank You" to those volunteers who donate their time, treasures and talents to the project. This special event, Volunteer Recognition, is held at a central location in down town and each member receives a Certificate of Appreciation and a small token/memento to commemorate the occasion.

G. When this community based non-profit was just a drawing board concept, everyone involved knew that if the program was to succeed all residents residing in the County must come to the realization and affirm that: every life had value, recipients of service must live in and be recruited from target communities, that training and staff development must be ongoing, that health and human services must be user friendly, that physicians and medical personnel must provide care and service in a culturally sensitive manner and that legislation, policies and procedures must have grassroots input. Today, these principles remain as the driving force and hallmark of Healthy Start, Inc.

Therefore, starting with the planning phase and continuing to date, efforts were made to secure consumer participation.

• Invitations and flyers were mailed and distributed to area neighborhood, churches, housing communities, tenant associations, individual "gatekeepers" and civic organizations. In addition, announcements (PSA) were placed on local urban radio stations and cable television and several local community newspapers, such as the Pittsburgh Courier, announced dates and time of upcoming town meetings and forums.
• Also, the University of Pittsburgh Graduate School of Public Health conducted a telephone survey. Interviewed were consumer, participants, females and males of varying ages and races residing in the project Area who identified factors contributing to infant mortality.

• Consumer's suggestions and recommendations, from the above listed activities, helped to establish the priorities that guided the development of the Comprehensive Plan and its implementation over an 18 year period.

• Utilizing the "bottom-up" approach the organizational framework for Healthy Start functions to support a comprehensive participant driven approach and maintains community representation at all levels of the project.

• The essence of the consortia focuses on community input, involvement and inclusion, new approaches to issues, thinking outside the box and a creative structure that lends itself to flexibility. The Consortia, made up of broadly based representation from the community, connect Healthy with each of the 6 targeted regions/service areas. Of the 18 member Board of Directors, 8 of the representatives are participants, consumers or community-based representatives from the Project service areas.

H. Healthy Start, Inc. utilizes participant/consumer input and suggestions in helping to formulate policies and procedures and program operations that guide this community-based, participant driven non-profit organization.

**Collaboration and Coordination with State Title V**

A. *Allegheny Child Death Review Team (CDRT):* The Allegheny County Health Department, the local Title V, is the state's designee to facilitate the child death review process. Healthy Start, Inc. continued to serve as an active member of the CDRT. The Executive Director, Field Manager and IT Liaison served as the HS representatives and assured that all infant deaths were reported on and reviewed within the standards of confidentiality. Moreover, Healthy Start worked with the other representatives that included health, human service, law enforcement and education to develop action plans to reduce the number of preventable infant deaths. The result were shared experiences and improvements in cultural sensitivity of service provision by medical professionals, expansion of the referral network, improved communication between Healthy Start participants/staff and human service providers, and retooling of protocols to identify and access treatment for at-risk families for infant death. Since 2005, more than 400 infant deaths were reviewed by the CDRT.

*Lactation Consultation:* Due to a loss of Title V funding the Allegheny County Health Department was forced to cut the Evening Lactation Consultant Program. Healthy Start has
administered fiscally and via management of the Helpline coordination of the program since 1991. Rather than face the loss of a valuable resource to both program and community participants in Southwestern, PA Healthy Start, Inc. obtained funds from a local foundation to continue services through May 2009.

Lactation Consultants are available anytime from 5PM to 8AM for women needing breastfeeding counseling, education and support. The 24-Hour, on-call service assists more than 2,500 women annually.

The Home Visiting Network is a collaborative effort of the Allegheny County Health Department, Healthy Start, Inc., and other home visiting agencies throughout Allegheny County. The mission of the HVN is to provide an efficient health care and social support delivery system to families by coordinating the resources among existing maternal and child health programs. The HVN meets quarterly to network and address issues that arise in the communities we serve. Healthy Start, Inc. is represented by a social worker in our Behavioral Health Dept. at these meetings. Each year the HVN provides a training seminar to home visiting agencies. In 2006 the seminar was titled "Breaking through Red Tape: Understanding systems to better serve your clients." In 2007 the seminar was called "Home Visiting and Infant Safe Sleep Environments". The topic for the 2008 Spring Seminar was “Autism, Infant Development, Infant Mental Health, and Infant Crying Message.” The topic for the 2009 seminar was “Physical Safety and Emotional Wellbeing: Tips for Home Visitors.” Healthy Start, Inc. played a key role in planning the 2009 seminar, as one of the social workers was on the planning committee responsible for organizing this event.

B. In the Commonwealth of Pennsylvania, the Bureau of Family Health within the Department of Health is responsible for the Maternal and Child Health Services Title V Block Grant. The Allegheny County Health Department (ACHD), the local Title V agency, administers the Maternal and Child Health (MCH) program for Allegheny County, thus ensuring effective coordination and shared resources with the Healthy Start program. The MCH Services Block grant funds represent approximately one-third of the local MCH programs.

Collaboration has been and continues to be a primary role in the development, implementation and sustainability of Healthy Start, Inc. Enhanced collaboration between established health and human service providers was one of the major results that emanated from the development of public-private partnership. These partnerships provided consumers and participants in the Project Area with a more integrated system of care. In addition, it brought structural changes to the relationships between Healthy Start, Inc and established health providers through formalized agreements starting with the Allegheny County Health Department.
The Allegheny County Health Department, the Healthy Start, Inc. grantee until May 1, 2005, is also the local Title V Maternal and Child Health agency as well as the Local WIC provider for Allegheny County. In the beginning, this relationship/collaboration ensured effective coordination with the Healthy Start project.

In an effort to secure diversified funding, Healthy Start, Inc. collaborated with the PA Department of Health and the local Title V provider, the Allegheny County Health Department and submitted an application for Project Launch. This effort was not successful; however, sustainability efforts continue, as the needs of the Project are great.

**Sustainability**

A. It has been an ongoing annual process to establish a contract with Medicaid managed care organizations. Pennsylvania legislation does not provide for community-based, non-clinical agencies eligibility for third-party reimbursement. Individual agency contracts with managed care providers can be negotiated, but has been unfruitful to this point.

Currently, Healthy Start’s plan to achieve third party reimbursement includes working with the Pennsylvania Department of Health, Pennsylvania Perinatal Partnership (PPP), National Healthy Start Association, and the Healthy Start Board to develop a service delivery model that is reimbursable according to Medicaid standards and requirements.

B. The Healthy Start, Inc Board of Directors and the Executive Director are responsible for all Project sustainability efforts. Efforts to date are as follows: The project continues to focus efforts to ensure sustainability planning with State Authorities by advocating for increased services for children and maximizing Title V funding for priority area. In 2006, Healthy Start, Inc. secured a five year grant award, from the Administration of Children and Families, Office of Family Assistance, to enhance male based programming in Allegheny County. Specific “case statements” that include key elements of consideration for potential funding sources, policy makers and elected officials have been developed. The nonprofit continues to explore a diversified funding base that includes insurance reimbursement, public program funding and private philanthropy.

Also, the six regional consortia, the advisory arm have leveraged four years of involvement in the Highmark “Walk for a Healthy Community” which is a fundraising campaign to get the broader community mobilized and active in healthy behaviors. The consortia makes no upfront investments to participate but is rewarded with a 100% return on their hard work and dedication to get funds raised and families out walking. This walk is a program of a major insurance provider in Western Pennsylvania Highmark Blue Cross Blue Shield. This promising venture has been highly successful and has been gaining momentum every year since participation began in 2004. More importantly, this activity has heightened awareness about the program in the broader
community and secured a potentially rewarding partnership with a major funding contributor for public health initiatives in our geographic area.

In the Commonwealth of Pennsylvania, the Bureau of Family Health with the Department of Health is responsible for the MCH Services Title V Block Grant. The Allegheny County Health Department, the local Title V agency, administers the MCH program for Allegheny, thus ensuring effective coordination and shared resources with the Healthy Start project. The MCH Services Block grant funds represent approximately one-third of the local MCH programs.

The health of mothers, infants, children and adolescents continues to be a major priority for the Commonwealth of Pennsylvania’s “Perinatal Partnership”. Over the past several years, the PA Department of Health’s MCH Title V staff and the federally funded PA Healthy Start Projects have been meeting for the expressed purpose of coordinating plans and resources in an effort to enhance access to and utilization of perinatal systems in the state.

C. While the acquisition of third party billing has been arduous Healthy Start continues to enhance communication with managed care agencies. In fact, Healthy Start has collaborated with the MCOs on special projects benefitting the maternal and child health population. Recently, Healthy Start has worked with UNISON MedPlus, UPMC Western Psychiatric Institute & Clinic and the RAND Corporation to develop a perinatal depression project aimed to integrate psychiatric treatment into a community-based setting. Ultimately, the outcomes of the project were disseminated across a broad array of health and social service providers. It is the intention of all partners that the services be restored and funded via the managed care industry.
III. Project Management and Governance

A. In its role as grantee, Healthy Start has overall responsibility for the governance, administrative, financial management and for the day to day program operations. The Board of Directors is comprised of 18 members. One of those members represents the Fayette Project. Six Board members are consumers. New members are recruited based on specific member qualifications: community/consumer, public health expertise and business/philanthropic experience.

The Regional Consortia Chairs provide vital feedback from a community perspective, monitor program implementation and assist with community education and advocacy efforts. It should be noted that the primary function of the PSL position is to work closely with Consortia and to serve as the means of communication and coordination between Project staff and the Consortia. The Executive Director provides direct supervision and training to the PSL. The Executive and Administrative Assistants support ongoing Consortia activities.

Working with the Board, the Executive Director coordinates and provides oversight and direction for all components of the Healthy Start grant including the Consortia, daily program operations, fiscal, evaluation and data collection. The Controller provides fiscal oversight for all components of the project and oversees the audit, billings and budgets in addition to managing the fiscal transactions for the organization and establishes vendor relationships. The Evaluator is responsible for adapting best practices, coordinating collection of quantitative and qualitative information regarding participants and measuring progress toward meeting project objectives.

As the project grew, existing professional staff continued to maintain current efforts while expanding in other areas. The creative and diverse talent of Healthy Start has enabled the project to be on the cutting edge of service delivery.

*Please refer to the Healthy Start, Inc. Organization chart on the following page for more details*
B. The diversity in the configuration and roster of the Board of Directors and Consortium proved essential to fiscal and program management. Two members are Executive Directors for Federally Qualified Health Center networks and others include the Chief Financial Officer of the YWCA, School District Superintendent, Chief of Obstetrics and Gynecology, Public Health Administrator for the Allegheny County Health Department and Chief Legislative Aide to State Senator to name a few.

These working "volunteers" have provided the leadership and insight necessary to move forward the agendas of Healthy Start, Inc. that include sustainability, program expansion, and audit oversight.

The primary means of communication between the consortium, the Board of Directors and staff are through program reports and formal meetings. The Board meets a minimum of six times per year and the Executive Committee meets as required.

<table>
<thead>
<tr>
<th>HSI Staff Involved</th>
<th>Committee</th>
<th># of Meetings</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education &amp; Training Coordinator and Executive Director</td>
<td>Marketing</td>
<td>6</td>
<td>Approved Radio/Media campaign</td>
</tr>
<tr>
<td>Human Resource Manager, Field Manager, Program Manager, and Executive Director</td>
<td>Personnel</td>
<td>4</td>
<td>Job Descriptions/salary recommended</td>
</tr>
<tr>
<td>Controller and Executive Director</td>
<td>Finance</td>
<td>4</td>
<td>Review and monitor program budget. Submitted recommendations for budget reallocations.</td>
</tr>
<tr>
<td>Executive Director as needed</td>
<td>Nominating</td>
<td>1</td>
<td>Made recommendations for Board Membership</td>
</tr>
<tr>
<td>Executive Director, Perinatal Systems Liaison. Other Key Personnel and outreach staff involved as needed</td>
<td>Consortia</td>
<td>52 Combined</td>
<td>Review consortia by laws, community activities, orientations, attend National HS Association Meetings</td>
</tr>
<tr>
<td>Field Manager, Field Manager and Executive Director</td>
<td>Quality Improvement</td>
<td>4</td>
<td>Review statistical reports and monitor program efficiency.</td>
</tr>
<tr>
<td>Executive Director</td>
<td>Executive</td>
<td>4</td>
<td>Bring recommendations for final resolution of policy matters.</td>
</tr>
</tbody>
</table>

Healthy Start, Inc. Key Personnel, the Executive Director, the Controller, the Field/Program Manager(s), Behavioral Health and Human Resource Managers, the IT Liaison and the Perinatal Systems Liaison, attend each Board meeting and are available to respond to questions.

C. No changes in management and governance occurred during the four year grant period.
D. During 2005, the transition was made for the receipt of federal funding from the Allegheny County Health Department to Healthy Start, Inc. Along with this transition came more responsibility of maintaining and tracking these funds. To help facilitate this added responsibility, we developed a set of procedures to aide in a smooth transition.

These procedures were the responsibility of our fiscal department with guidance provided by both the Board of Director's Executive and Finance Committees. Our fiscal department, which consists of a 4-person team, includes the Controller, the Staff Accountant, the Payroll & Benefits Specialists, and the Accounts Payable Clerk. This 4-person team took command of the tasks at hand to ensure the accuracy and timeliness of our federal funding.

We created a weekly timetable of events that needed to be met in order to appropriately distribute funds. As we pointed out the major steps in the process of distribution of any given week, we broke down those major steps further so that we could pinpoint areas of strength and/or improvement zeroing in on those areas needing improvement and determining the best course of action.

A bidding process, based on federal funding guidelines, provides us with competitive pricing from a resource of vendors. This bidding process goes into effect with the anticipated purchase of an item that is over $200.00. Once we receive at least 3 bids to consider, we make a decision on which one best fits our project. It's not necessarily the most reasonably priced bid, but rather the one that improves our program as a whole.

Once the bidding process is complete a purchase requisition form is required to complete all purchases made for our program. This form keeps track of where funds need to be distributed and also keeps us in compliance.

Over time, we have revisited the entire process to verify we are in compliance and to see if adjustments to the process need to be made. This is to ensure that everyone is on the same page and are in unison toward a common goal.

E. Of particular note was the need to obtain outside technical assistance for the development and implementation of our paperless database management system, PIMS. The IT Liaison served as the development coordinator, but expertise in programming and software management was necessary. Moreover, the data collection system and mechanisms had to be user-friendly with outreach, nursing, social work and administrative personnel capable of adapting to the system. Likewise, the system itself had to be pliable as new programs, staff and ultimately data collection tools were created.
F. Cultural competency of contractors and program staff was not an issue during the grant period. Healthy Start implements a selection process for all vendors and contractors. For example, in accordance with the Healthy Start, Inc. By-laws, new auditors are identified every five years. The sealed bid process and pre-proposal meetings are arranged by the Controller and the Executive Director. Members of the Board’s Finance and Executive Committees and Healthy Start’s Key Personnel and Legal Counsel participate in the interviewing and selection process.

With specific attention to staff, Healthy Start, Inc. employs an indigenous hiring practice to assure that individuals are representative of the communities and families we serve. Over 90% of our staff was hired from within the original target area in 2005. That number changes from year to year, but has not been below 80%. The Personnel Committee of the Board of Directors provides oversight and support in the development of sound hiring and employment policies and procedures.

IV. Project Accomplishments see Work Plans for both Project Implementation and National Performance Measures (NPM) following section B.

A. Addressing Barriers and Lessons Learned: Participant barriers to obtain a medical home include lack of knowledge of the service system, skepticism about the effectiveness of prevention, inadequate or inappropriate utilization of health care services, illnesses including Postpartum Depression (PPD), Major Depression, and those dually diagnosed with a mental health disorder and substance abuse. The convergence of the poor socioeconomic conditions and the high-risk population that make up the Healthy Start Project area create an environment where poor perinatal outcomes flourish. Many families express concerns about their experiences and with how they have been treated by health and professionals due to their race or because of their economic status. These conditions create reluctance to seeking services until health problems become a crisis and for many of Healthy Start’s population empowerment and motivation to overcome this fear is nonexistent.

Within the project area, one of the greatest challenges encountered has been the changing demographics. Within Allegheny County, several public housing communities that were physically located within Healthy Start neighborhoods closed or downsized. This caused relocation of families who were then lost to the Healthy Start system when they moved. The transient nature of our population has also proved a challenge. Another has been participants’ availability due to Pennsylvania’s Welfare to Work Initiative. Requirements that mothers join the workforce has prevented some who were interested from enrolling the Healthy Start program. The population most-at-risk also faces a tremendous challenge in understanding and adjusting to the changes that have occurred and will occur in the future.
In some cases, community perception, prior treatment experiences, shortage and/or lack of minorities in the work place have proven to be barriers. Personal substance abuse issues, mental health issues, such as depression, homelessness, domestic abuse or poor housing environments prevent participants from disclosing their situations. They fear they will come under the scrutiny of the local child protection agency if they expose these issues. Other retention barriers are a reluctance to change poor lifestyle/behavioral habits, such as smoking or illicit drug use. The barriers to retention are the same as those for enrollment as described above. They are the same for both pregnant and interconceptional participants.

A major barrier for providers is the “office-based” approach to treatment and education. Many providers offer services at a central location and are unable or unwilling to travel to the homes or communities of those most need of service. For Healthy Start participants, making basic travel arrangements is a challenge. A lack culturally competent and diverse staff, available follow-up for participants in addressing health care needs, and a deficiency in linkage to community-based health and human services supports leave participants without consistency of care. Healthy Start is able to fill these voids by utilizing new and existent community partnerships with health care providers and expanding the knowledge base of our staff.

System barriers include fragmentation of health and human services, lack of coverage or inadequate reimbursement for services, lack of transportation, and inadequate health and human enabling resources within a community. The multitude of programs has different application processes and eligibility requirements and being pregnant or having children often times deems a participant ineligible. For fathers, obtaining employment is especially difficult due to past criminal records or lack of education. Several target communities have insufficient numbers of obstetricians, pediatricians, behavioral/mental health, and employment training service providers with more services dwindling rather than expanding. The current insurance system of compartmentalization for preventative medical care and behavioral health services has served as a barrier to coordinating and integrating services for participants.

The following general programmatic strategies are utilized by Healthy Start Inc. to address participant barriers to service:

- Employ indigenous and paraprofessional workers.
- Establish linkages with a broad array of community-based health and human service providers in the targeted areas to build extensive referral networks
- Employ two social workers (LSW/ BSW), Teen Advocate and Family Service Specialist
- Target fathers, and partners of female participants and provide intensive case management.
- Facilitate transportation and child care (Healthy Start, Inc. vans, bus tickets, etc.)
- Monitor attendance of medical/behavioral health appointments.
• Train program staff, consortia members, program and community participants, as well as other program/agency providers on issues related to maternal and child health.

B. HRSA National Evaluation: Healthy Start, Inc. was one of 8 project sites selected to participate in the evaluation. Sites were selected based on their ability to implement fully the required core services and systems. The evaluation consisted of two distinct processed; the completion of satisfaction services and a site visit and assessment. Both were coordinated via the contracted evaluators; Mathematica Policy Research, Inc. and Abt Associates.

Healthy Start program participants were extremely compliant with the project meeting the goal of an 80% response rate. Much of this success is due to the commitment of the Consortia who assisted the evaluation team in locating participants and helping them to call in for the survey. Just as importantly was the completion of the site visit and assessment. All members of the agency including Board, Consortia, home visiting or case management and male-based program staff were involved. Interviews and focus groups were conducted. As a result, Mathematica and Abt evaluators were able to understand the impact of the Healthy Start, Inc. best practice models.

Healthy Start, Inc. Completes MCHB/HRSA Feasibility Study: At the request of Dr. Elizabeth M. Duke, Administrator of the Health Resources and Services Administration, the Allegheny and Fayette County projects participated in the Clinical Indicators Feasibility Study. This national evaluation was conducted with the intent of determining the common health measurements collected by Healthy Start and other HRSA-funded projects for assessment and reporting purposes. Of the 60 grantees selected, Healthy Start, Inc. was one of only two Healthy Start projects selected and capable of meeting the demands of the evaluation as outlined by evaluation contractor, John Snow, Inc.

Over a 3-month period Healthy Start staff collected, analyzed and developed a comprehensive report. As a result, Healthy Start was able to show the potential for the other approximately 100 sites to collect information specific to 1st Trimester Entry into Prenatal Care, Hypertension, Diabetes and Immunizations. Full results are expected to be released by the end of 2009.
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Calendar Year Objectives</th>
<th>Strategies, Activities, Person Involved</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 6/01/09, maintain at 85% of total enrollment, the number of pregnant</td>
<td>By 12/31/2005, 85% of the enrolled pregnant and interconceptional</td>
<td>Outreach (OR), Case Management (CM)</td>
<td>Year 1 Progress: 83%</td>
</tr>
<tr>
<td>and postpartum women who are African American (AA).</td>
<td>women into case management services will be African American.</td>
<td>Activities, Persons Involved:</td>
<td>Year 2 Progress: 84%</td>
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<tr>
<td>Baseline: Of the 776 pregnant and postpartum women enrolled into case</td>
<td>By 12/31/2006, 85% of the enrolled pregnant and interconceptional</td>
<td>Neighborhood canvassing – Multidisciplinary Team (MDT)</td>
<td>Year 3 Progress: 86%</td>
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<td>management services 79% or 616/776 were African Americans. (Source:</td>
<td>women into case management services will be African American.</td>
<td>Helpline – Information and Referral Specialist</td>
<td>Year 4 Progress: 87%</td>
</tr>
<tr>
<td>HSI/MIS, 2004)</td>
<td>By 12/31/2007, 85% of the enrolled pregnant and interconceptional</td>
<td>Health Fairs – MDT, Perinatal Systems Liaison (PSL)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>women into case management services will be African American.</td>
<td>Consortia Events – Spring and Fall Orientations;</td>
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<tr>
<td></td>
<td>By 12/31/2008, 85% of the enrolled pregnant and interconceptional</td>
<td>Key Personnel</td>
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<td></td>
<td>women into case management services will be African American.</td>
<td>Hospital Outreach – MDT</td>
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<td></td>
<td></td>
<td>Database Management – IT Liaison</td>
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<td></td>
<td></td>
<td><strong>Collaborating Providers:</strong> Allegheny County Health Department (ACHD),</td>
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<td></td>
<td></td>
<td>Magee Women’s Hospital, Children’s Hospital of Pittsburgh</td>
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<tr>
<td>By 06/01/09, increase to 92.5% the percentage of infants born to African</td>
<td>By 12/31/2005, 85% of infants born to African American program</td>
<td><strong>Strategies:</strong> OR, CM, Health Education (HE)</td>
<td></td>
</tr>
<tr>
<td>American (AA) program participants at term, of normal weight, and without</td>
<td>participants at term, of normal weight, and without preventable</td>
<td>Activities, Persons Involved:</td>
<td></td>
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<tr>
<td>preventable congenital defects.</td>
<td>congenital defects.</td>
<td>Home Visits – MDT</td>
<td></td>
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<tr>
<td>Baseline: Of the 655 infants born to African American program participants</td>
<td></td>
<td>Risk Assessments – MDT</td>
<td></td>
</tr>
<tr>
<td>545 or 83% were at term, of normal weight, and without preventable</td>
<td></td>
<td>Referral and Monitoring Prenatal Care – MDT</td>
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<tr>
<td>congenital defects. (Source: HSI/MIS 2004)</td>
<td></td>
<td>Establishing a Medical Home/ Primary Care Physician (PCP) – Information</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>and Referral Specialist</td>
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<td></td>
<td></td>
<td>Assistance with Insurance and WIC – MDT</td>
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<tr>
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<td></td>
<td>Specialized Case Management (Substance Abuse and Teens) – MDT</td>
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<td></td>
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<td>Case Reviews/ Case Conferences – MDT</td>
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<td></td>
<td>Transportation/ Child Care – MDT</td>
<td></td>
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<td></td>
<td></td>
<td>Database Management – IT Liaison</td>
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<tr>
<td></td>
<td></td>
<td><strong>Collaborating Providers:</strong> FQHCs, Hospitals, WIC Program, Private</td>
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<tr>
<td></td>
<td></td>
<td>Physicians</td>
<td></td>
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<tr>
<td>By 06/01/09, increase to 90% those interconceptional</td>
<td>By 12/31/2005, 83% of the interconceptional program participants will</td>
<td><strong>Strategies:</strong> IC, CM, HE</td>
<td>Year 1 Progress: 81%</td>
</tr>
<tr>
<td></td>
<td>receive family planning</td>
<td></td>
<td>Year 2 Progress: 86%</td>
</tr>
</tbody>
</table>
| Activities, Persons Involved: | Year 3 Progress: 83%  
Year 4 Progress: 85% | Year 1 Progress: 84%  
Year 2 Progress: 84.5%  
Year 3 Progress: 91%  
Year 4 Progress: 91% |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Healthy Start, Inc.</strong></td>
<td><strong>Strategies:</strong> Interconceptional Care, Case Management, Health Education</td>
<td><strong>Collaborating Providers:</strong> FQHCs, Adagio Health, Planned Parenthood of Western PA, Primary Care physicians, Area Hospitals</td>
</tr>
<tr>
<td><strong>Baseline:</strong> Of the 505 interconceptional program participants, 402 or 80% (402/505) received family planning services through a medical provider. (Source: HSI/MIS, 2004)</td>
<td><strong>Activities, Persons Involved:</strong> Home Visits – MDT, Referral and Monitoring – MDT, Establishing a Medical Home – MDT, Case Reviews/Case Conferences – MDT, Educating local medical and health providers – MDT, PSL, Key Personnel, Transportation and Child Care – MDT, Database Management – IT Liaison</td>
<td><strong>Collaborating Providers:</strong> FQHCs, Adagio Health, Planned Parenthood of Western PA, Primary Care physicians, Area Hospitals</td>
</tr>
<tr>
<td><strong>By 12/31/2005, increase to 88% the percentage of sexually active teens (18 years or younger) who have selected a method of contraception after delivery</strong></td>
<td><strong>Baseline:</strong> Of the 81 active teen program participants (18 years or younger), 66 or 81% (66/81) selected a method of contraception after delivery. (Source: HSI/MIS, 2004)</td>
<td><strong>Strategies:</strong> Interconceptional Care, Outreach and Recruitment, Health Education, Case Management</td>
</tr>
<tr>
<td><strong>By 12/31/2006, increase to 88% the percentage of sexually active teens (18 years or younger) who have selected a method of contraception after delivery</strong></td>
<td><strong>By 06/01/09, increase to 90% the number of 2-year-olds who have received their DTaP, MMR and Hep B immunizations (Diphtheria, Tetanus, Pertussis; Measles, Mumps, Rubella; Hepatitis B).</strong></td>
<td><strong>By 06/01/09, increase to 95% the percentage of sexually active females (18 years or younger) who have selected a method of contraception after delivery.</strong></td>
</tr>
<tr>
<td><strong>By 12/31/2007, increase to 90% the percentage of sexually active teens (18 years or younger) who have selected a method of contraception after delivery</strong></td>
<td><strong>By 12/31/2008, increase to 93% the percentage of sexually active teens (18 years or younger) who have selected a method of contraception after delivery</strong></td>
<td><strong>By 12/31/2005, increase to 75% the percentage of 1-year-olds who have age-appropriate immunizations.</strong></td>
</tr>
<tr>
<td><strong>By 12/31/2008, increase to 93% the percentage of sexually active teens (18 years or younger) who have selected a method of contraception after delivery</strong></td>
<td><strong>By 12/31/2005, increase to 75% the percentage of 1-year-olds who have age-appropriate immunizations.</strong></td>
<td><strong>By 12/31/2006, increase to 80% the percentage of 1-year-olds who have age-appropriate immunizations.</strong></td>
</tr>
<tr>
<td><strong>By 12/31/2009, increase to 90% the number of 2-year-olds who have received their DTaP, MMR and Hep B immunizations (Diphtheria, Tetanus, Pertussis; Measles, Mumps, Rubella; Hepatitis B).</strong></td>
<td><strong>By 12/31/2006, increase to 80% the percentage of 1-year-olds who have age-appropriate immunizations.</strong></td>
<td><strong>By 12/31/2007, increase to 90% the number of 2-year-olds who have received their DTaP, MMR and Hep B immunizations (Diphtheria, Tetanus, Pertussis; Measles, Mumps, Rubella; Hepatitis B).</strong></td>
</tr>
<tr>
<td><strong>By 12/31/2008, increase to 93% the percentage of sexually active teens (18 years or younger) who have selected a method of contraception after delivery</strong></td>
<td><strong>By 12/31/2007, increase to 90% the number of 2-year-olds who have received their DTaP, MMR and Hep B immunizations (Diphtheria, Tetanus, Pertussis; Measles, Mumps, Rubella; Hepatitis B).</strong></td>
<td><strong>By 12/31/2008, increase to 93% the percentage of sexually active female (18 years or younger) who have selected a method of contraception after delivery.</strong></td>
</tr>
<tr>
<td><strong>By 12/31/2009, increase to 90% the number of 2-year-olds who have received their DTaP, MMR and Hep B immunizations (Diphtheria, Tetanus, Pertussis; Measles, Mumps, Rubella; Hepatitis B).</strong></td>
<td><strong>By 12/31/2009, increase to 90% the number of 2-year-olds who have received their DTaP, MMR and Hep B immunizations (Diphtheria, Tetanus, Pertussis; Measles, Mumps, Rubella; Hepatitis B).</strong></td>
<td><strong>By 12/31/2009, increase to 90% the number of 2-year-olds who have received their DTaP, MMR and Hep B immunizations (Diphtheria, Tetanus, Pertussis; Measles, Mumps, Rubella; Hepatitis B).</strong></td>
</tr>
</tbody>
</table>

**Collaborating Providers:** FQHCs, Adagio Health, Planned Parenthood of Western PA, Primary Care physicians, Area Hospitals
Baseline: Of the 301 two-year-olds, 161 or 53% (161/301) have received age-appropriate immunizations. (Source: HSI/MIS, 2004)

By 12/31/2007, increase to 85% the percentage of 1-year-olds who have age-appropriate immunizations.

By 12/31/2008, increase to 90% the percentage of 1-year-olds who have age-appropriate immunizations.

Participation in National Campaigns – MDT, Health Educator
Helpline – MDT, PSL
Telephone Vignettes – I&R Specialist
Transportation and Child Care – MDT
Database Management – IT Liaison

**Collaborating Providers:** ACHD, Magee
Women’s Hospital, Children’s Hospital of Pittsburgh, FQHCs, Local Health Providers,

Baseline: Of the 232 AA pregnant participants enrolled into case management, 83.8% initiated prenatal care in the first trimester (Source: HSI/MIS, 2004)

By 6/1/09, increase to 90% the proportion of African American pregnant women who begin care in the first trimester of pregnancy.

Baseline: Of the 232 AA pregnant participants enrolled into case management, 83.8% initiated prenatal care in the first trimester (Source: HSI/MIS, 2004)

By 12/31/2005, increase to 96% the proportion of African American pregnant women who begin care in the first trimester of pregnancy.

By 12/31/2006, increase to 87% the proportion of African American pregnant women who begin care in the first trimester of pregnancy.

By 12/31/2007, increase to 88% the proportion of African American pregnant women who begin care in the first trimester of pregnancy.

By 12/31/2008, increase to 90% the proportion of African American pregnant women who begin care in the first trimester of pregnancy.

**Strategies:** Outreach and Recruitment, Case Management, Health Education

**Activities, Persons Involved:**
Home Visits – MDT
Nurse Evaluation using Ages and Stages Developmental Screening Tool – Nurses, Clinical Coordinator
Risk Assessment – MDT
Referral and Monitoring – MDT
Database Management – IT Liaison

**Collaborating Providers:** FQHCs, Hospitals (Magee, West Penn, Shadyside), WIC Program, Private Care Physicians

Year 1 Progress: 82.5%
Year 2 Progress: 87%
Year 3 Progress: 89.6%
Year 4 Progress: 90.7%

PP Progress: 90.5%
### MCHB National Performance Measures (NPM) - Project Implementation Worksheet

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Calendar Year Objectives</th>
<th>Strategies, Activities, Person Involved</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NPM #17</strong></td>
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</tbody>
</table>
| By 6/01/09, 95% of all enrolled children from birth to 18 will have a medical home. | By 5/31/2006, at least 84.5% of all enrolled children will have a medical home.  
By 5/31/2007, at least 87.8% of all enrolled children will have a medical home.  
By 5/31/2008, at least 90% of all enrolled children will have a medical home.  
By 5/31/2009, at least 92.5% of all enrolled children will have a medical home. | **Strategies:**  
Outreach (OR), Case Management (CM), Interconceptional Care (IC)  
**Activities, Persons Involved:**  
Home Visits – MDT  
Risk Assessments – MDT  
Referral and Monitoring Prenatal Care – MDT  
Establishing a Medical Home/ Primary Care Physician (PCP) – I&R Specialist, MDT  
Assistance with Insurance and WIC – I&R Specialist, MDT  
Specialized Case Management (Substance Abuse and Teens) – MDT  
Case Reviews/ Case Conferences – MDT  
Transportation/ Child Care – MDT  
Database Management – IT Liaison | Year 1: 94.2%  
Year 2: 94.4%  
Year 3: 94.4%  
Year 4: 93.1%  
PP Progress: 93.2% |
| **Baseline:** 98.46% (899/913) percent of children 0-2 years of age with a medical home in 2004. (Source: Healthy Start, Inc. PIMS/MIS)  
**Baseline:** 91.6% (1237/1351) percent of women participants who have an ongoing source of primary care in 2004. (Source: Healthy Start, Inc. PIMS/MIS)*  
*Added to document change in performance measure language to include children from birth to 18. |  |  |
| **NPM #20**              |                          |                                        |          |
| By 06/01/09, at least % of enrolled women will have a medical home for primary and preventative health care. | By 5/31/2006, at least 90% of enrolled women will have a medical home.  
By 5/31/2007, at least 92% of enrolled women will have a medical home.  
By 5/31/2008, at least 94% of enrolled women will have a medical home.  
By 5/31/2009, at least 96% of enrolled women will have a medical home. | **Strategies:** OR, CM, IC, Health Education (HE)  
**Activities, Persons Involved:**  
Home Visits – MDT  
Referral and Monitoring – MDT  
Case Reviews/ Case Conferences – MDT  
Educating local medical and health providers – MDT, PSL, Key Personnel  
Advocacy – MDT  
Transportation and Child Care – MDT  
Database Management – IT Liaison  
Collaborating Providers: FQHCs, Adagio | Year 1: 91.8  
Year 2: 93.1%  
Year 3: 94.4%  
Year 4: 95.3%  
PP Progress: 95.2% |
### NPM #21

**Baseline:** 93.3% or 1261/1351 program participants required and received a completed referral in 2004 (Source: Healthy Start PIMS/MIS).

**By 12/31/09, increase to 85%** the number of the program participants who require and receive a completed referral.

<table>
<thead>
<tr>
<th>Year</th>
<th>Goal</th>
</tr>
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<tbody>
<tr>
<td>2006</td>
<td>At least 51% will have a completed referral</td>
</tr>
<tr>
<td>2007</td>
<td>At least 59% will have a completed referral</td>
</tr>
<tr>
<td>2008</td>
<td>At least 67% will have a completed referral</td>
</tr>
<tr>
<td>2009</td>
<td>At least 75% will have a completed referral</td>
</tr>
</tbody>
</table>

**Strategies:** HE, CM, IC, Staff Training

**Activities, Persons Involved:**
- Home Visits – MDT
- Community and Regional Group Presentations – Key Personnel
- Family Focus Nights – Male Program Specialist
- Written Materials – Health Ed. & Training Coord., MDT
- Referral and Monitoring – MDT
- Case Reviews/ Case Conferences – MDT
- National Awareness Campaigns – Agency-wide
- Transportation and Child Care – MDT
- Database Management – IT Liaison

**Collaborating Providers:** Similar CM Agencies, ACHD, FQHCs, Other Local Health and Human Service Providers

**Year 1:** 93.9%  
**Year 2:** 89.3%  
**Year 3:** 89.8%  
**Year 4:** 89.9%

**PP Progress:** 89.9%

### NPM #36

**Baseline:** 83.49% or 683/818 pregnant program participants had a prenatal visit in the 1st trimester in 2004 (Source: Healthy Start PIMS/MIS).

**Healthy Start Initiative goal is 75%**

**By 06/01/09, increase to 95%** the percentage of pregnant program participants having a prenatal care visit in the 1st trimester.

<table>
<thead>
<tr>
<th>Year</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>At least 88.5% of program participants will have 1st trimester care</td>
</tr>
<tr>
<td>2007</td>
<td>At least 89% of program participants will have 1st trimester care</td>
</tr>
<tr>
<td>2008</td>
<td>At least 89.5% of program participants will have 1st trimester care</td>
</tr>
<tr>
<td>2009</td>
<td>At least 90% of program participants will have 1st trimester care</td>
</tr>
</tbody>
</table>

**Strategies:** OR, CM, IC

**Activities, Persons Involved:**
- Home Visits – MDT
- Referral & Monitoring
- Risk Assessment – MDT
- Referral and Monitoring – MDT
- Database Management – IT Liaison

**Collaborating Providers:** FQHCs, Family Health Centers, Hospitals (UPMC Hospital System, West Penn/Allegheny Hospital System, Shadyside), WIC Program, Private Care Physicians

**Year 1:** 82.5%  
**Year 2:** 87%  
**Year 3:** 89.8%  
**Year 4:** 90.7%

**PP Progress:** 90.9%

### NPM #50

**Baseline:** 2.9% or 62/2054 participants had a live birth.

**By 06/01/09, of the live births to program participants no** VLBW

<table>
<thead>
<tr>
<th>Year</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>Less than 4.8% infants will be VLBW</td>
</tr>
<tr>
<td>2007</td>
<td>Less than 4.6% infants will be VLBW</td>
</tr>
</tbody>
</table>

**Strategies:** OR, CM, IC, HE

**Activities, Persons Involved:**
- Home Visits – MDT

**Year 1:** 2.9%  
**Year 2:** 3.1%  
**Year 3:** 1.7%  
**Year 4:** 2.2%
<table>
<thead>
<tr>
<th>NPM #51</th>
<th>By 6/01/09, By 6/01/09, the infant mortality rate (IMR) for live births to program participants will not exceed the Healthy People 2010 Goal of 4.5/1,000. Baseline: The percent of singleton live births to program participants weighing less than 2,500 grams (LBW) will not exceed 6.5%. Baseline: The percent of singleton live births to program participants weighing less than 2,500 grams was 8.09% or 60 out of 741 births in 2004 (Source: Healthy Start PIMS/MIS). Healthy Start Initiative goal is 8.9%.</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NPM #52</td>
<td>By 6/01/09, By 6/01/09, the infant mortality rate (IMR) for live births to program participants will not exceed the Healthy People 2010 Goal of 4.5/1,000. Baseline: The percent of singleton live births to program participants weighing less than 2,500 grams (LBW) will not exceed 6.5%. Baseline: The percent of singleton live births to program participants weighing less than 2,500 grams was 8.09% or 60 out of 741 births in 2004 (Source: Healthy Start PIMS/MIS). Healthy Start Initiative goal is 8.9%.</td>
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</table>
**Baseline:** The IMR for 2001-2004 was 4.87 or 16 deaths out of 3283 live births for program participants. (Source: Healthy Start PIMS/MIS).

| NPM #52 | By 6/01/09, the neonatal mortality rate for live births to program participants will not exceed the Healthy People 2010 Goal of 2.9/1,000. Baseline: The neonatal IMR for 2001-2004 was 3.35 or 11 deaths out of 3283 live births. (Source: Healthy Start PIMS/MIS). | By 5/31/2006, the neonatal mortality rate will not exceed 11.8 By 5/31/2007, the neonatal mortality rate will not exceed 11.1 By 5/31/2008, the neonatal mortality rate will not exceed 10.4 By 5/31/2009, the neonatal mortality rate will not exceed 9.8 |
| Strategies: | OR, CM, IC, Consortium, HE | **Year 1:** 0 **Year 2:** 2.3 **Year 3:** 0 **Year 4:** 1.8 |
| Activities, Persons Involved: | Home Visits – MDT Child Death Review Team – Executive Director, IT Liaison Perinatal Periods of Risk Team – Executive Director, HS Board Vice Chair, Program Evaluator Infants Mortality Work Group – LSW, PSL, Executive Director, Program Evaluator Referral and Monitoring – MDT Community Canvassing – MDT Health Fairs – MDT, PSL, Health Educator Helpline – Information and Referral Specialist |
| Collaborating Providers: | SIDS Alliance, National SIDS Hotline, Pennsylvania Perinatal Partnerships (PPP), Magee Women’s Hospital, Children’s Hospital of Pittsburgh, ACHD Child Death Review, Consumer Safety Commission |

**NPM #53**

By 6/01/09, the post-neonatal mortality rate for live births to program participants will not exceed the Healthy People 2010 Goal of 1.2/1,000.

| By 5/31/2006, the post-neonatal mortality rate will not exceed 4.9 By 5/31/2007, the post-neonatal mortality rate will not exceed 4.6 By 5/31/2008, the post-neonatal mortality rate will not exceed 3.6 By 5/31/2009, the post-neonatal mortality rate will not exceed 3.0 |
| Strategies: | OR, CM, IC, Consortium, HE | Year 1: 4.1 Year 2: 1.1 Year 3: 0 Year 4: 3.6 PP Progress: 3.6 |
| Activities, Persons Involved: | Home Visits – MDT Child Death Review Team – Executive Director, IT Liaison Perinatal Periods of Risk Team – Executive Director, HS Board Vice Chair, Program Evaluator Infants Mortality Work Group – LSW, PSL, Executive Director, Program Evaluator Referral and Monitoring – MDT Community Canvassing – MDT Health Fairs – MDT, PSL, Health Educator Helpline – Information and Referral Specialist |
| Collaborating Providers: | SIDS Alliance, National SIDS Hotline, Pennsylvania Perinatal Partnerships (PPP), Magee Women’s Hospital, Children’s Hospital of Pittsburgh, ACHD Child Death Review, Consumer Safety Commission |

Evaluator
Infant Mortality Work Group – LSW, PSL, Executive Director, Program Evaluator Referral and Monitoring – MDT Community Canvassing – MDT Health Fairs – MDT, PSL, Health Educator Helpline – Information and Referral Specialist

**Collaborating Providers:** SIDS Alliance, National SIDS Hotline, Pennsylvania Perinatal Partnerships (PPP), Magee Women’s Hospital, Children’s Hospital of Pittsburgh, ACHD Child Death Review, Consumer Safety Commission.
Baseline: The post-neonatal IMR for 2001-2004 was 1.52 or 5 deaths out of 3283 live births. (Source: Healthy Start PIMS/MIS).

By 5/31/2009, the post-neonatal mortality rate will not exceed 4.0

Director, HS Board Vice Chair, Program Evaluator
Infant Mortality Work Group- LSW, PSL, Executive Director, Program Evaluator
Referral and Monitoring – MDT
Community Canvassing – MDT
Health Fairs – MDT, PSL, Health Educator
Helpline – Information and Referral Specialist

Strategies: OR, CM, IC, Consortium, HE

Activities, Persons Involved:
Home Visits – MDT
Child Death Review Team – Executive Director, IT Liaison
Perinatal Periods of Risk Team – Executive Director, HS Board Vice Chair, Program Evaluator
Infant Mortality Work Group- LSW, PSL, Executive Director, Program Evaluator
Referral and Monitoring – MDT
Community Canvassing – MDT
Health Fairs – MDT, PSL, Health Educator
Helpline – Information and Referral Specialist

Collaborating Providers: SIDS Alliance, National SIDS Hotline, Pennsylvania Perinatal Partnerships (PPP), Magee Women’s Hospital, Children’s Hospital of Pittsburgh, ACHD Child Death Review, Consumer Safety Commission

NPM #54

By 6/01/14, the perinatal mortality rate per 1000 live births will not exceed the Healthy People 2010 Goal of 4.5

Baseline: The perinatal mortality for 2001-2004 was 2.43 or 8 infant deaths out of 3283 live births. (Source: Healthy Start PIMS/MIS).

By 5/31/2006, the perinatal mortality rate will not exceed 4.9
By 5/31/2007, the perinatal mortality rate will not exceed 4.6
By 5/31/2008, the perinatal mortality rate will not exceed 4.3
By 5/31/2009, the perinatal mortality rate will not exceed 4.0

By 5/31/2006, the perinatal mortality rate will not exceed 4.9
By 5/31/2007, the perinatal mortality rate will not exceed 4.6
By 5/31/2008, the perinatal mortality rate will not exceed 4.3
By 5/31/2009, the perinatal mortality rate will not exceed 4.0

By 5/31/2006, the perinatal mortality rate will not exceed 4.9
By 5/31/2007, the perinatal mortality rate will not exceed 4.6
By 5/31/2008, the perinatal mortality rate will not exceed 4.3
By 5/31/2009, the perinatal mortality rate will not exceed 4.0

Strategies: OR, CM, IC, Consortium, HE

Activities, Persons Involved:
Home Visits – MDT
Child Death Review Team – Executive Director, IT Liaison
Perinatal Periods of Risk Team – Executive Director, HS Board Vice Chair, Program Evaluator
Infant Mortality Work Group- LSW, PSL, Executive Director, Program Evaluator
Referral and Monitoring – MDT
Community Canvassing – MDT
Health Fairs – MDT, PSL, Health Educator
Helpline – Information and Referral Specialist

PP Progress: 1.8

Collaborating Providers: SIDS Alliance, National SIDS Hotline, Pennsylvania Perinatal Partnerships (PPP), Magee Women’s Hospital, Children’s Hospital of Pittsburgh, ACHD Child Death Review, Consumer Safety Commission

Year 1: 7.3
Year 2: 1.1
Year 3: 0
Year 4: 1.8
V. Project Impact

A. Systems of Care

1. The Healthy Start program uses an array of approaches to enhance collaboration. The community consortia represent multiple organizations, including health, human services, business, government, faith-based, as well as consumers. The Healthy Start staff is involved in many community organizations and task forces that represent programs serving the Healthy Start communities; these include task forces related to health disparities, fatherhood, child development, health professional education, and mental health, among others.

The Healthy Start health education and outreach program is another important strategy to enhance collaboration; Healthy Start offers training that is relevant to the maternal and child health and cultural competency training that is offered to community partners also serving Healthy Start families. The Healthy Start program also participates regularly as members of community panels, conferences, community forums, health fairs and testimony for public health issues; these also are approaches encouraging collaboration.

The Healthy Start program also is supportive of collaborative proposal writing and grants writing with partners serving families and collaborates with technical assistance, as a partner for referrals or collaborative service delivery. The Healthy Start, Inc. Promoting Responsible Fatherhood and Healthy Marriage Initiative are a prime example. Working in tandem with Healthy Start are Primary Care Health Services, a federally qualified health center, Greater Allen African American Episcopal Church, a faith-based institution, and the Domestic Abuse Counseling Center, the leader in counseling/education services for offenders in Pennsylvania. Together, the partners deliver Responsible Parenting (case management/care coordination) and Healthy Marriage activities (Prevention and Relationship Enhancement Program) and, less formally, Economic Stability (referral & monitoring, indigenous hiring, in-home education & counseling).

Awarded in September 2006 the partners have strived to fully implement the activities and program strategies as outlined in the original application and in accordance with the projected timelines. While the partnership has faced several substantial obstacles for program implementation many of the objectives were met or significant progress made.

Collaborative student training is another vehicle for collaboration. Over the four year period we hosted students in the areas of Applied Developmental Psychology, Social Work, Nursing, Public Health, Medical, Management Information Systems and the AmeriCorps Program. These students contributed to the case management by providing clinical assessments during home visits and during groups programs, designing current, culturally sensitive health education
materials, facilitating participant satisfaction surveys, and coordinating outreach and recruitment efforts in the communities.

The Healthy Start program also is active in public relations with the community through its distribution of newsletter to community residents, providers, and those interested in Healthy Start; Healthy Start program Board of Directors, and staff also frequently serve as panelists for news programs, radio, and other programs that are joint efforts promoting quality of life in Healthy Start communities.

Healthy Start also sponsors and participates in national promotions and community events:

- **National Women’s Perinatal Health Check-up**
- **Take Your Loved One to the Doctor’s Day**.
- **National Children's Oral Health Week**
- **Domestic Violence Awareness Month**
- **World AIDS Day**
- **National Child Abuse Prevention Month**
- **National Breast Cancer Awareness Month**

2. The Healthy Start program had an intensive case management system that had been operational for more than ten years at the beginning of this project period. Services with local health, human services, education, community leadership groups, and local government officials were well-established. During this project period, the service integration changes have been enhancements to the case management system as well as more in-depth services to specific populations.

Healthy Start has increased the scope and depth of its services to boys and men during this project period. The Male Initiative Program offers a community-based approach to men who are parents of children who are participants of Healthy Start. The program mission is to offer preventive services in a holistic fashion to men who are usually experiencing educational, employment and interpersonal problems as well as learning skills as a parent to a young child. In many cases, the men also lack health insurance, may have a history of substance use, substandard or unstable housing arrangements.

To enhance male-based programming Healthy Start applied for and was funded through the U.S. Administration for Children and Families, Office of Family Assistance the Promoting Responsible Fatherhood and Healthy Marriage Initiative (PRF). The 2006 award provided an additional capacity to case manage 350 families and deliver marriage and co-parenting education to 250 individuals and couples each year. Equally as important was the opportunity to provide a continuum of care for families who would have been ineligible to receive Healthy Start services.
after the child turns two. PRF serves all families in Allegheny County who have children up to the age of five. An internal referral process was developed and initiated at the initiation of the initiative.

Preventive mental health services continued to be an emerging strength of service integration for Healthy Start. Although initial concern was based on symptomatic cases of severe depression, and other serious mental health issues of participants and their partners, the Healthy Start program has evolved during this project period to include screening for depression among all participants, women and males and to provide counseling and referrals for therapy, medication or other community-based programs such as faith-based counseling, support groups.

Moreover, Healthy Start expanded its staffing plan with the development of a behavioral health "unit". Over the past four years the program grew from one licensed social worker to a team of four. Expansion occurred gradually with the addition of a bachelor's level social worker. By year four two outreach worker positions were given specialty case loads focusing on teens and families involved with child protection services.

Healthy Start has developed and expanded community partnerships with traditional services for mental health such as the Western Psychiatric Institute and Clinic, a national leader in the treatment of depression; these partnerships have included a focus on postpartum depression identification and treatment as well as cross-training of Healthy Start and WPIC providers and other community partners about the signs, symptoms and treatment of postpartum depression and its symptoms and cultural issues involved with postpartum depression among African American women. All staff members are trained on the use of techniques derived from the Dialectical Behavior Therapy (DBT) concept. The techniques provide the skills necessary to assist participants in crisis with de-escalation along with coping strategies during difficult experiences.

The techniques are flexible and useful across genders, races and ages. Cultural competency in the screening and treatment of depression has been a central theme of the collaboration of WPIC and Healthy Start as they work together to develop and implement effective models of care for families using Healthy Start services.

Interconceptional care also has expanded during this project period as the Healthy Start program continues to develop and increase its relationships with the local pediatric and child development community. Healthy Start uses an interdisciplinary approach for children and the nurse screening protocols emphasize child developmental milestones, infant mental health and parenting, and the preventive health of children including a medical home and immunizations. Most notably has been the recent (year 4) acquisition of an onsite early intervention specialist. The Early Intervention Case Manager serves multiple roles for families. First and foremost the EICM has the advanced skills and tools to assess children for developmental delays. With many
families hesitant to engage county EI services, the EICM serves as a liaison between parent and agency helping parents to understand the role of the provider. On the other hand the EICM works to ensure that messages and services are delivered to the parent in a culturally competent and sensitive manner. Once a treatment plan is developed by the EI agency the case manager offers support to the parent during home visits and phone calls to assist them "practice" using skills such as tummy time and positive parenting. An internal referral process is used to coordinate specialized care for the families.

The integration of depression screening and treatment, violence prevention education and referrals, as well as a protocol for prenatal parent education promotes the well-being of both the parents and the children in the interconceptional period. Health promotion for the mother includes assurance of postpartum care, a primary care provider, referrals for health needs such as chronic disease management, educational counseling and referrals and employment counseling and referrals.

3. a. The Healthy Start program has been instrumental in the enhancement of many collaborative partnerships within the Pittsburgh/Allegheny County region. The partnerships related to maternal health involve those with all the local hospitals serving obstetric and gynecological needs, these include tertiary sites as well as community facilities, the federally qualified community health centers offering primary care to women, the Allegheny County Health Department programs for maternal and child health, nutrition, WIC, chronic disease, infectious diseases, (including sexually transmitted infections, and immunizations) family planning programs such as the Family Health Council, the Tile X grantee. The Healthy Start program also collaborates with the Mid-Atlantic HIV/AIDS Education and Training Center.

The Healthy Start program also has acted as a leader in facilitating other key relationships in the child health and child development community especially related to the concerns of African American families and children. Healthy Start is in a unique position of a long-term relationship with families during the prenatal period through the infant and toddler stage, the program has the capacity to impact preventive health and mental health for children through preventive interventions with the parents during the prenatal period as well as early childhood. The Healthy Start program has continued to strengthen its ties with the local pediatric facilities including Children’s Hospital of Pittsburgh, all tertiary sites for neonatal intensive care, early intervention services for Allegheny County, the Alliance for Infants, PA SIDS Alliance, Pressley Ridge, Auberle Center, Family Resources, Fatherhood Collaborative, PA Dept of Public Welfare, PA Department of Children, Youth and Families. The increased emphasis on fatherhood and the screening and detection of depression and violence prevention efforts also has been important strategies that have grown during this project period.
Healthy Start’s central focus has been the inclusion of consumers as decision-makers in the program planning, implementation, and assessment. The Healthy Start Board of Directors includes many community leaders and residents who are active in offering their voice to the community health decisions. The Consortia members include representatives of the Young Men and Women’s African American Heritage Association, Head Start/Early Head Start, Focus on Renewal Community Health Centers, Family Support Centers, Council of Three Rivers Indian Center, The Pittsburgh Public School Board of Education, the Woodland Hills School District, local faith-based leaders serving the Healthy Start neighborhoods among others.

**Infant Safe Sleep Church Outreach Committee:** HSI has worked in collaboration with the Allegheny Health Dept, SIDS of PA, the Children’s Hospital of Pittsburgh, the University of Pittsburgh’s Center for Minority Health, the Pennsylvania State Health Department, Hilltop Health Ministries, St Benedict the Moor, Greater Allen AME Church, United Bidwell Presbyterian Church, Bethany Baptist Church, Hilltop Health Clinic, Tree of Life Missionary Baptist Church, and Mt. Zion Baptist Church just to name a few. The purpose was to develop a comprehensive communication and support plan that will promote healthy sleep conditions for infants. Also, the group intended to develop and assess the impact of specific strategies in implementing safe sleep guidelines in high risk communities within Allegheny County.

HSI helped to build the collaboration with African American church leaders to gain community acceptance of the SIDS/infant safe sleep message as well as helped to distribute support materials to physicians (Obstetricians, Pediatricians, Family Practice) that would supply them with tools to provide a consistent repetitive and culturally appropriate message about infant safe sleep to their patients. Healthy Start, Inc. also helped to provide in-home/family child care providers serving infants education and guidance about infant safe sleep by distributing *Babies Sleep Safest On their Backs: A Resource Kit for Reducing the Risk of Sudden Infant Death Syndrome in African American Communities* and collaborated to hold train the trainer sessions for church health ministry representatives. HSI also led the committee in promotion of the infant safe sleep message via placards on public transportation and public service announcements on local radio stations whose primarily demographics include African Americans.

Healthy Start also has had strong relationships with the community centers based in many of the Healthy Start neighborhoods; these programs offer recreation, health, tutoring, after school and other child care, employment and training referrals, as well as host many community events and groups such as health fairs, children’s classes, clubs and support groups. Healthy Start has long-term ties with several local programs such as these including Hill House, Greater Allen A.M.E. Church, Hosanna House, Kingsley Association, Boys and Girls Clubs, YMCA, YWCA, Urban League, Gwen’s Girls (preventive services for young African American girls), local ministerial associations, and the family support centers based in Healthy Start neighborhoods. These ties reinforce the community and consumer participation that is central to the Healthy Start program.
mission. These ties also serve as important links to outreach for new families for Healthy Start programs as well as offer recreation, education, childcare, and faith-based services for Healthy Start families to assure quality of life.

Participant Highlight: Because of the relationship that was developed between this program and one of our participants, when she was invited to talk about her experience with Healthy Start at our annual Volunteer Recognition she accepted the invitation. She told our volunteers that she had been clean and sober for 42 months, is raising a perfectly healthy child alone, is working from home doing social justice work, and is a nursing student at the local community college. The volunteers don't often get to hear what has happened with our participants from the participants themselves so it was very edifying for our volunteers to hear how their support of our work has affected someone in the program. She became involved with agencies that make up our consortia by letting them know that their work helped her overcome obstacles in her life - grief, an absentee father, and addiction. They were able to experience the gratitude felt by this participant; Healthy Start provided something for her and now she was providing something for Healthy Start.

4. a. Healthy Start serves as an advocate for all participants to assure that they receive the services that they need for optimum health for their children and themselves. The Healthy Start staff regularly receives in-service education and training regarding changes to intake and referral and eligibility requirements for all services e.g. child care, economic assistance, substance and mental health services, health insurance, among others. Healthy Start also regularly invites key health and human services professionals to provide training and technical assistance to Healthy Start as the participant needs arise or new procedures are implemented. Likewise, Healthy Start also works in collaboration with local and state partners to address eligibility issues for populations such as those served by Healthy Start. These may involve meetings with the PA Department of Health, Public Welfare, or county programs serving health or human services for the participating families. The case management system of Healthy Start involves screening, referral and home visits, case review, assistance provided with completing forms, assistance for participants to complete data required for eligibility for Medicaid, Title X, assistance with the application process, accompany participants to visits with health care providers, advocate for primary care within underserved communities.

b. The major barriers to participants utilizing accessing services are financial (lack of insurance or being underinsured), structural (lack of health care providers or facilities nearby), personal (importance an individual places on preventative care or biased treatment previously received by a health care provider or institution) and institutional (practitioners investing in the health and well-being of the communities they live in and around).
We assess participants’ financial eligibility for TANF, Medical Assistance, Food Stamps, WIC or Title X, for receipt of services. Enhancing this coordination Healthy Start has maintained constant communication with insurance providers and the various managers responsible for assuring timely and accurate responses to all applications or inquiries.

Structural barriers are addressed by assisting with transportation, child care, and identification of available health facilities for meeting the needs of the entire family. Additionally, structural barriers have been addressed by establishing or advocating for necessary institutions like primary health care centers in underserved Healthy Start communities. Through partnerships between the Allegheny County Health Department (ACHD) Maternal Child Health program and private health care providers, and hospitals, Federally Qualified Health Centers (FQHCs) have expanded over the last four years.

Just as important is the fact that Healthy Start staff is constantly abreast of new or existing programs and training is provided on referral processes or providing direction for obtaining these enabling services. To address personal barriers, we provide education to program and community participants to increase awareness of community-based service providers and the importance of utilization. In addition, we intervene as necessary when conflicts between participants and providers arise by becoming advocates for the individuals and families involved. For example, we may accompany participants on visits to health care providers or follow-up on participant’s concerns of biased treatment.

Healthy Start offers the following enabling services to assure such compliance with care:

- Obtaining health care insurance (i.e., assist with identifying carriers of service and completing health insurance applications)
- Identifying available and affordable health care providers (i.e., hospital clinics, community-based or federally-funded health centers)
- Referring and monitoring of referrals to assess levels of compliance.
- Developing strategic plans to assist participants with reception of care. This includes overcoming social, emotional, and cultural barriers preventing care.
- Coordinating transportation services (i.e., distribute bus tickets, transport participants using Healthy Start vans to needed medical appointments, etc.)
- Providing childcare services during Healthy Start group activities, referral and follow-up to the Child Care Partnership program to obtain child care subsidy, and assist participant with utilizing appropriate family or community supports for child care needs.

Healthy Start’s care coordination/case management is multidisciplinary and team members are trained to assist participants with a host of social, emotional and behavioral issues
From initiation of contact, Healthy Start Inc. assesses the individual to determine their baseline status. Referrals for those necessary enabling services begin at that point and are monitored throughout the enrollment and care coordination effort. Healthy Start ensures that all enrolled participants are presented with a variety of assistive services and assures that those persons remain compliant with care offered to them.

Referral Management: Central to Healthy Start’s case management is the commitment to deliver referral, maintenance, prevention, and intervention services through the Multidisciplinary Team approach. Teams are made up of a Core and/or Male Initiative Program (MIP) Outreach Worker (OW), Registered Nurse (RN), a Bachelor of Social Work (BSW), a Licensed Social Worker (LSW), Male Program Specialist, and a Field Manager (FM). Assisting the team are the Information and Referral Specialist, Program Assistant/Data Abstractors (PA/DA), and an Administrative Assistant. As a whole they work together to assure that women, men, children and their families secure access to the medical care and human services necessary to promote healthy family lifestyles. Separately, each member of the team is responsible for assuring that the needs of each individual and family are being met.

All referrals made are documented on the Healthy Start referral form. The top section of this form includes the program/agency name and address to which the referral is being made, the name and office address of the staff person who is making the referral, the participant contact information, a checklist of enabling services requested, and a section for pertinent comments. The bottom section of the referral is to be completed by the referral agency and indicates if services were initiated and the agency’s contact information.

This form is a three-part form – white, yellow and pink. The white copy is sent to the referred agency requesting that it be returned to Healthy Start with a written response indicating the level of services being provided to the participant. The pink copy is retained, logged into referral database maintained by each program assistant, and then placed in the participant chart. The yellow copy is submitted to the data abstractors and entered into the Healthy Start central MIS. When/if the written response (white copy) is received it is placed in the participant chart and becomes part of the permanent record. Staff is required to track referrals made and follow-up on receipt of services as part of their case management responsibilities. For referrals that received no response or services pending the program assistants and team members are prompted to make contacts to the referred agency as well as the participant to inquire as to status of the referral and make any necessary arrangements for services to begin. Statuses of referrals are discussed as part of the weekly case conferences. At the case conferences alternative plans are developed for all referrals that have not had services initiated.

d. Team members record referrals on the data collection forms located on their Thinkpads which are part of the participant record and entered into the Healthy Start Participant
Information Management Systems (PIMS). The PIMS database is a key instrument and serves as a constant monitoring system for the tracking of referrals made and services rendered. Home visiting staff are prompted via the Thinkpad at each visit to ascertain the status of the referral and respond as necessary ensure finality. The IT Liaison and Program Assistant/Data Abstractors provide monthly reports to the Field Manager and Executive Director summarizing the status of each referral made by Healthy Start Team members. The status of the referral is documented and updated in the database.

Within Healthy Start itself referrals are made to utilize the specialized services provided by MIP and the LSW. The verification of services is documented, tracked and maintained in the same manner as other referrals. In addition, both MIP and the LSW maintain a referral log for their own accountability.

5. a. Healthy Start family input is sought on an ongoing basis; all participants are encouraged to report concerns and needs to the Healthy Start program office; participants are able to attend meetings in their neighborhoods and provide input to Healthy Start. Consumers serve as Board members for Healthy Start. Staff is hired from the local neighborhoods and former participants are current staff.

Healthy Start has an extensive network of partner organizations within Pittsburgh/Allegheny County and conducts in-service programs, community events, staff trainings, and consumer satisfaction with Healthy Start families and those residents living in Healthy Start neighborhoods. Healthy Start is a facilitator of events and services that address cultural competence and regularly conducts cultural competency programs for its staff and other providers who serve Healthy Start families.

Healthy Start Inc. has a Marketing Committee composed of Board members and consumers who review all material utilized for health messages, brochures, flyers and educational material to insure it meets the appropriate 4th grade reading level. They also, ensure that information is culturally sensitive and addresses the needs of the Healthy Start communities at large. Programmatically, the project periodically conducts surveys and focus groups for participant input on addressing needs and program improvements.

Sensitivity to cultural, linguistic and gender needs for this project period have focused on increased services for the African American male in Healthy Start communities. The Male Initiative Program targets fathers who are likely to need extensive support in the fatherhood role. The program uses the Healthy Start approach of home visiting and case management with male program specialists, program resources e.g., prisoner reintegration, male behavioral health, and child support/legal support. The monthly family focus nights offer education on social and health topics and offer an informal mentoring and support network for new fathers.
b. Consumers are members of the Consortia and contribute to the development of assessment and intervention. Healthy Start also receives comments through community forums, focus groups, and meetings with neighborhood consumers. The Healthy Start families are active in the design and methods involved in local evaluation. The local evaluation studies conducted during this project involved a survey of consumer satisfaction with Healthy Start services and referrals and a study of the needs for baby items and other tangible goods. Healthy Start participants reviewed the study topics, questionnaires, methods for data collection, and reports and provided suggestions for all aspects of the studies. Consumers also provide input regarding all Healthy Start interventions including the Helpline, health education, and case management and referrals on an ongoing basis; approaches include phone calls, post-cards, questionnaires, focus groups, or community meetings.

B. Impact to the Community

1. Healthy Start has a long-standing interest in community awareness of services and resources. The services are neighborhood-based and provide a presence of a core team within the local neighborhoods. Healthy Start outreach workers wear Healthy Start uniforms (monogrammed baseball caps, umbrellas, attaché cases, blue shirts and khaki pants) so as to easily identify. Healthy Start participates in numerous community events in the Healthy Start neighborhoods such as job fairs, health fairs, and community days as part of the overall public relations of the program. Outreach and recruitment efforts involve canvassing the communities and sponsoring educational and informational services, specific training to address individual and community needs, distribution of brochures and fact sheets to communities, hiring of local residents as Healthy Start staff, provide van service and travel throughout the project area and county to provide information regarding need for early and regular prenatal care. Healthy Start also participates in several local collaborations with health and human services providers, family support centers, family childhood initiative, Early Head Start to foster sharing of knowledge and health education for participants. The Healthy Start program also collaborates with providers for specialty services such as those involving substance use, family violence and incarceration, justice and legal system, employment and vocational resources.

The Pittsburgh/Allegheny County Healthy Start Helpline has been a remarkable resource for residents in the county, state and nationally. Healthy Start staffs the Helpline Monday through Friday from 8:00AM to 5:00PM daily. After hours, an answering service takes names and telephone numbers. Telephone calls are returned within 24 hours, excluding holidays. Primarily the Helpline is a portal to county resources that include public welfare, homeless and hungry prevention, mental health and employment as a sample. It also serves as the intake point for all persons requesting enrollment into one of our programs.
In addition, the Helpline serves as the initial contact for Allegheny County residents who seek breastfeeding support. Program efforts are coordinated with the Allegheny County Health Department (ACHD), the Maternal Child Health Bureau (MCHB), and the Women Infants and Children (WIC) Breastfeeding Program that provides skilled lactation consultants. The lactation consultants provide breastfeeding support to callers. Healthy Start received nearly 75,000 calls overall with almost 10,000 devoted to breastfeeding support during the four year project period.

**The Healthy Start Helpline Task List**

- Navigates the health and human service provider system.
- Promotes the need for early and consistent prenatal care to the targeted participants and to the community participants at large.
- Refers callers to the location of service needs and facilitate access to these services.
- Provides a vehicle for evaluating both the reach of the project’s public information effort and the effectiveness and acceptability of the services provided.
- Serves as a point of entry for enrollment into Healthy Start Case Management services.
- Completes Healthy Start initial intake information forms.
- Provides information, referrals and emotional support to individual callers.
- Provides active listening to encourage and facilitate women’s and children’s entrance into the health care system.
- Maintains accurate and confidential information records.

2. **Efforts in the Community**: Healthy Start's commitment to our communities is not only realized by our diversity, but our efforts to enhance services in our communities. Healthy Start participates each year in the Highmark Walk for Healthy Communities; hosts the annual Cultural Competency Symposium where topics such as "Health Literacy: The Silent Epidemic" and "Working with Diverse Populations: Cross Cultural Interventions" are the focus; hosts the annual Volunteer Recognition to honor members of the Board of Directors, Consortia, Task Force, Participants, Volunteers and Political figures; Children, Youth and Families United Families Celebration; and Goodwill Industries Coalition for Working Families Annual Social Service Networking. In 2008, the Perinatal Systems Liaison for Fayette County, organized a Leadership Training Seminar where members of the Allegheny County Consortia and Fayette County Task Force, came together and participated in a one-day training that focused on leadership and training skills. Because of the success of this event, beginning in 2009 this event
will be annual. Also in 2008, the Allegheny County Consortia hosted an Information Day for the Participants in Allegheny County enrolled in all programs at Healthy Start. Participants were afforded the opportunity to participate in workshops such as Dress for Success, Resume Writing and Interviewing Techniques. Participants also had the opportunity to speak with various agencies in Allegheny County that provided information on student loans, employment and education.

3. **Diversity:** Diversity in the Healthy Start organization is vital to our success. Healthy Start's commitment to cultural competence and sensitivity is further realized in the composition of the Board of Directors (Figure 3), Consortia and Task Force. The Board of Directors, Allegheny County Consortia and Fayette County Task Force is comprised of members of various professional backgrounds and ethnicities. Because of their diversity and indigenous qualities, their voices are heard loud in our communities. The success of the Healthy Start organization is realized through them and carried out by the Healthy Start staff.

*Figure 3: Board of Directors*

*Commitment to Staff:* Healthy Start's commitment to our communities extends to our employees and their families. In 2007, Healthy Start adopted and introduced to staff an Employee Assistance Plan under our current health insurance provider, AETNA. Employees and their families are afforded the opportunity to take advantage of services covered by the EAP at no charge. Services such as: counseling, financial planning, training and member discounts are available to staff and are completely confidential. Employees may access services by telephone or internet 24 hours a day. In addition to confidential telephone and internet consultations, under this plan, employees are entitled to five (5) in person counseling sessions at no charge. Healthy Start recognized the need to introduce these services to our employees to enhance their health and well being. In addition, the EAP offers a wealth of educational materials that employees may use to assist their participants. The EAP was received well by staff.

In 2008, in preparation for the Highmark Walk for Healthy Communities and with the support of Key Personnel, the Human Resource Department introduced "Team Building" events to staff.
The purposes of these team building events are to enhance team effectiveness. Activities such as team building puzzles, games and education are the focus. These exercises have enhanced team effectiveness and further opened the lines of communication between staff and management. Unexpectedly, these events have created healthy competition between staff members and the different programs of Healthy Start. The feedback from staff is overwhelmingly positive.

4. From the beginning, the Board of Directors and Consortia's shared vision has been to encourage grassroots participation and involvement by the community services in establishing and carrying out programs. The commitment of cultural competence and sensitivity begins with understanding the demographics of the participants and demographics of staff. Pittsburgh Participants are represented in Figure 1; Pittsburgh Staff is represented in Figure 2:

**Figure 1: Pittsburgh Participants**

The hiring of indigenous worker, those with a direct connection to their communities, is a key factor to success for Healthy Start, Inc. Indigenous workers are employed as Outreach Workers, Social Workers, Field Managers, Nurses and other support staff. As illustrated, the demographics of participants to staff, is very similar in Allegheny and Fayette Counties.
C. Impact on the State

The health of mothers, infants, children and adolescents continues to be a major priority for the Commonwealth of Pennsylvania’s “Perinatal Partnership.” The Pennsylvania Perinatal Partnership (PPP) has been acknowledged as a national model of Healthy Start/Title V collaboration. The organization is an authentic partnership between Healthy Start and Title V that emanated from member commitment. The mission of the PPP is to “improve perinatal health outcomes in Pennsylvania through collaboration, intervention, joint strategies and advocacy.” Participants include representatives from the Healthy Start projects, Medicaid (Healthy Beginnings Plus), County/Municipal Health Departments and the State Health Department Maternal and Child Health Program. Healthy Start continues as an active member in the PPP, working toward the common goals of enhancing Maternal and Child Health services and systems statewide.

Outcomes of this partnership have been extensive and include the acquisition of additional funding to improve outcomes for women and children, especially around perinatal depression. Healthy Start, Inc. has played an integral role throughout the last four years in three key areas. First, Healthy Start, Inc. facilitated via a contract with the PPP to provide educational conferences on the topic of Fetal Alcohol Spectrum Disorders. Three sessions were held across the state and highlighted the experience of community participants living with or caring for children diagnosed with one of the spectrum disorders.

Second, via a collaboration with UPMC Women's Behavioral Health, a comprehensive training system on the use of Dialectical Behavior Therapy to assist women with perinatal depression was implemented throughout the state and using various media. This module expanded throughout the four years and both Healthy Start and Women's Behavioral Health received a pilot grant to provide integrated psychiatric services to program participants in a community-based setting.

Last, we were contracted by the PPP to engage and interview fathers or partners living with women diagnosed with depression. Their views were tabulated and the outcomes used to produce a perinatal depression tool kit. Plans are underway for the toolkit and other materials to be available the internet.

The PPP, in 2006, developed the Perinatal Depression Project with the intent of influencing and enhancing service provision across the state. The project focuses on five key program components: Provider Training; Resource and Capacity Development; Innovative Approaches to Care; Public Awareness Campaign Planning; and Statewide Planning for Systems Change.
D. Impact on Eliminating Disparities in Perinatal Health

The Pittsburgh/Allegheny County Healthy Start program is designed as an intensive community-based effort to eliminate perinatal health disparities. Since beginning operation in 1991, Healthy Start continues to address the significant disparities that exist with regard to infant mortality, incidence of low weight births, preterm delivery, access to early prenatal care and the need for ongoing community involvement.

Despite the progress made over the last 17 years in addressing perinatal health, women residing in the target areas continue to encounter numerous logistical and psychosocial barriers to prenatal care: high poverty, high rates of inadequate health insurance, and health care provider shortages, as well as health and human services systems that are inadequate to the myriad needs of the poor and low-income.

Allegheny County continues to have a horrible, serious problem as described on February 15, 1991 by the Children’s Defense Fund: Pittsburgh, Pennsylvania ranked worst of forty-six cities reporting a black infant mortality rate. This rate was more than 1.5 times the national black rate of 17.9 death per 1,000 live births and higher than the rate found in forty-one other nations, including Panama, Chile and North or South Korea.

However, Healthy Start, Inc. continues to make progress in reducing rates or maintaining perinatal health outcomes for women and children in Allegheny County. To achieve our goals we implement fully the interventions of outreach and recruitment, case management, interconceptional care, health education, depression screening and referral, the Consortium as well as systems and efforts including a local health systems action plan, collaboration with the State Title V program and the Statewide Pennsylvania Perinatal Partnership (PA Healthy Start and Title V programs).

More importantly, statistical analyses of our efforts continue to provide evidence suggesting that the Healthy Start model is an effective method of reducing infant mortality rates, increasing access to care for mothers and infants and, ultimately, decreasing the gap in racial health disparities.

Please consider the following charts comparing perinatal outcomes of Healthy Start, Inc. program participants to those of Allegheny County community participants, and the Healthy People 2010 Goals.
**Infant Mortality Rates**

**Healthy Start Vs. County (All Races, Black, White)**

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**Sources:** Healthy Start, Inc. Participant Information Management System; PA Department of Health Vital Statistics*

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**Infant Mortality Rates Allegheny County (by Race)/ Healthy Start**

- **Black (County):** 18.4
- **White (County):** 5.7
- **Healthy Start:** 4.2

*Sources: Healthy Start, Inc. Participant Information Management System; PA Department of Health Vital Statistics*
Infant Mortality Rates:
Healthy Start, County, HP 2010 Objective

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<th></th>
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<th>County</th>
<th>HP 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003 - 2007</td>
<td>4.2</td>
<td>7.7</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Sources: Healthy Start, Inc. Participant Information Management System; PA Department of Health Vital Statistics*

Low Birth Weight
Healthy Start vs. County (All Races, Black, White)

Sources: Healthy Start, Inc. Participant Information Management System; PA Department of Health Vital Statistics*
E. Local Government Role

Healthy Start, Inc. made a concerted effort to increase the involvement and commitment of local and state legislators to reducing infant mortality rates and eliminating health disparities. Over the course of the four year nearly all of the local and state government officials representing the target area were invited to our community offices for a tour, program overview and candid discussions related to their ability to impact policy that benefits their constituent base. Moreover, Healthy Start developed relationships with many of the legislative aides; those most likely to move forward agendas in support of our mission.

Examples of successes resulting from these efforts include:


- Negotiations with the Pennsylvania House Chair of Insurance for fee-for-service or third party billing policy changes to include community-based, home visiting programs, including those funded through Title V.
✅ Letters of Commitment and Agreement for the expansion of our male-based programming via the Promoting Responsible Fatherhood Initiative funded by the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance.

✅ Support in identifying and receiving several small county and state grants (Department of Community and Economic Stability; Community Development Block Grant).

✅ Active membership on the Consortia increased and through their efforts and contacts assisted with the implementation of community activities to recruit, enroll and educate potential program participants (Fontana Fest; 18th District Community Days, etc.).

**F. Lessons Learned**

Over the last 18 years significant progress has been made in the City of Pittsburgh and Allegheny County to improve conditions that result in positive birth and life outcomes for mothers, children and families. However, the gaps in disparities and the causal relationships still exist in 2009 (see figure below).
While some issues remain stagnant Healthy Start is in tune with the ever-changing demographics, systems of care and policy initiatives. For these reason, Healthy Start, Inc. has dedicated significant resources to the enhancement of sophisticated Management Information Systems/ Technology and Personnel Development.

The ability to input and abstract data for purposes of community analyses has always been critical with regard to adjusting the scope and type of services to address specific individual and community needs. In the demonstration and first replication phases Healthy Start, Inc. was advised of these needs by the Consortia or Board. While effective, the data to support the insight our community leaders was not readily available causing a delay in formalizing partnerships, collaboration or securing additional funding.

From 1997 to 2004 the data collection process was streamlined yet comprehensive and assured that we gathered valuable data necessary to develop local and federal reports. Over the last grant period, 2005 - 2009, the goals was to further enhance our Participant Information Management System (PIMS) to a. host data on Healthy Start owned and operated servers and b. to collect and input into the serves data immediately or in "real time."

The Participant Information Management System (PIMS) is a Web-based password protected database system that enables outreach workers to collect data in the participant’s home through the use of portable touch screen Thinkpad computers. The PIMS system eliminates paper costs, creates the ability to upload data directly into the database from the Thinkpad after the home visit, enables the supervisors to review data and provide quality assurance, and allows for instantaneous database querying. Since January 12, 2009, Pittsburgh/Allegheny County outreach workers and nurses have used the Thinkpads in the participant’s home, and they have been well received by staff and participants.

The results of the efforts to enhance these systems has proven worthwhile. Over the last four years Healthy Start has expanded its partnership base and added several programs or components to the existing agency structure. These include, but are not limited to, the acquisition of the Promoting Responsible Fatherhood Initiative, Healthy Start CARES, and the Lactation Consultation program.

One of the key ingredients of a successful organization is the ability to establish relationships within the communities. In 2007, the mantra for Healthy Start, Inc. was "Putting the Pieces Together" and the mantra for 2008 was "It's All About the Relationships". Under this premise, Healthy Start, Inc. continues to be successful in establishing and maintaining relationships within our communities.
Over the years, employees who have moved on in their professional careers, continue to be committed to the mission of Healthy Start. These former employees provide technical assistance to Healthy Start in the areas of fiscal, grant writing, day care, educational training for staff and medical. Although the employment relationship has ended, a professional collaboration has emerged.

These former employees continue to show their support to Healthy Start by their involvement with outreach events such as; The Highmark Walk for Healthy Communities, Fontana Fest and Jake Wheatley Community Appreciation Day. In addition, former employees continue to give support by referring participants to all programs of Healthy Start, refer prospective employees and educate on the programs of Healthy Start. Their commitment extends beyond participants and community efforts.

In 2008, a former employee, who is also a Registered Nurse, administered Flu Shots for the staff of Healthy Start. In the future, Healthy Start hopes to offer Flu Shots not only to staff, but their families as well. This is another example of our commitment to staff, participants and community.

VI. Local Evaluation
A. The evaluation activities during this project period included attendance/participation at weekly management meeting for the Pittsburgh /Allegheny County Healthy Start project; this forum involves all key personnel from the project e.g. director, training, data management, operations, behavioral health, fiscal, human resources as well as evaluation. The weekly meeting provides an opportunity for planning, review of operations, as well as ongoing quality control and accountability.

The group assesses opportunities for funding, presentations, and partnerships that are of interest to Healthy Start. The evaluator works collaboratively with all team members with specific focus on data collection regarding emerging issues, sustainability for request for funding opportunities, and writing progress reports and grant applications as well as presentations and articles about Healthy Start.

The evaluator also attended other local Healthy Start project meetings such as those sponsored by the Healthy Start consortia, the Healthy Start trainings and Webinars offered locally and by national MCHB, and the conferences offered by Healthy Start such as those regarding health literacy and cultural competence. The evaluator participated in site visits by other Healthy Start grantees, community partners from Pennsylvania and Allegheny County health departments, representatives of local maternal and child health programs, and funders.
Dr. Ley was a member of the national committee, Healthy Start National Evaluation Advisory Committee that served in consultation with the contractor conducting the evaluation of the National Healthy Start Program. She attended other national meetings including AMCHP and CityMatch for further training as well as to make presentations about the Healthy Start project.

The evaluator attended the annual national Healthy Start grantee meetings and participated in meetings regarding evaluation as well as national meetings for the Healthy Start Association.

Dr. Ley was a co-author and presenter for national presentations about the Pittsburgh/Allegheny County Healthy Start during this project period including

- “Reducing adult health disparities by effective case management with African American pregnant and parenting adults” presented at the Academy for Health Equity, June 26-27, 2008, Denver, Colorado;
- “Preconception chronic disease management for African American women”, presented at the Preconception Care Annual Conference, September 28-October 1, 2007, Oakland, CA;
- “Building MCH competencies with the Healthy Start Model”, presented at the National Healthy Start Meeting, June 14-16, 2006, Arlington, VA.

Dr. Ley worked with the Healthy Start team to complete the annual grant progress reports as well as to complete applications for funding for sustainability, including a five-year program that has expanded Healthy Start community services for parents of children who had “aged-out” of the Healthy Start project and more services for fathers and other caregivers of children 0-5 years of age.

The evaluator in collaboration with Healthy Start staff and others completed two articles about the Pittsburgh/Allegheny County Healthy Start project that are now in press for 2010 with the Journal of Social Work and Public Health:

- “Healthy Start Program Participation: the Consumers’ Perspective”
- “Community-based Perinatal Depression Services for African American Women: the Healthy Start Model”.

B. See Healthy Start Local Evaluation Report (Attachment A on additional Flash Drive)
VII. Fetal and Infant Mortality Review

Healthy Start, Inc. is an active member of the Allegheny County Child Death Review Team (CDRT). We have participated with the CDRT since its inception in 1997. Pennsylvania requires that each county establish or be an active member of a CDRT. Contracts are provided by the state department of health to local Title V or other health and human service providers for facilitation of the meetings. In Allegheny County, meetings are held monthly with the purpose of discussing the deaths of all children 19 years of age or younger. Special emphasis is placed on infant deaths or those that could have been prevented i.e. homicide, accident, etc.

On the team are representatives specializing in maternal and child health including, but not limited to obstetricians/ gynecologists, neonatologists, and pediatricians from the major health systems (University of Pittsburgh Medical Centers, West Penn/ Allegheny Health System), administrators for child protection services, the medical examiner's office, along with the county mental health and early intervention providers. Together, we review all infant deaths and reports are developed depicting the cause of death, family demographics, disparities, and risks associated with deaths. Ultimately, the team determines from these reports and reviews the major factors contributing to deaths and prepares strategic plans to prevent future occurrences.

Examples of these strategic plans include health promotions and awareness campaigns, policy initiatives, and formalization of community-based partnerships. In Allegheny County, a majority of the infant deaths were due to extreme prematurity followed by sudden infant deaths (SIDS) or sudden unexpected infant deaths (SUIDS). CDRT reports support the fact that the rates of disparity are significantly higher for African-Americans or non-Hispanic Blacks. With less than 20% of the population categorized as black, typically more than half of all infant deaths have been to those ethnicities and races. For that reason, Healthy Start, Inc. offers expertise with assuring that strategic plans are culturally sensitive.

Major accomplishments of the CDRT over the grant period include:

- Enhanced protocols for the reporting, investigation and communication between agencies and authorities for all SIDS/ SUIDs deaths.
- Enhanced referral networks among providers on the CDRT for the purposes of case management/ care coordination of Healthy Start families.
- Dissemination of infant mortality reports and successful program and policy strategies to reduce these rates to local and state legislators.
- Increased knowledge of maternal depression and its impact on infant death.

**Health Disparities and Infant Mortality Working Groups:** The main focus of the Health Disparities Working Groups is to host an annual one-day event in honor of National Minority Health Month. This event is free and open to the public with the target audience being members.
of the Healthy Black Family Project and local Latino communities. Healthy Start, Inc. has participated on the Infant Mortality Working Group from 2004 until 2007. The center was unable to carry on with the working groups after 2007. The Infant Mortality working group consisted of various agencies within the community whose focus is child and maternal health (i.e., Healthy Start, Inc., Resource Mothers Program, Nurse Family Partnerships, etc). At the events the objective of the Infant Mortality Working Group was to educate pregnant women and their families about the importance of prenatal care, nutrition and physical activity during pregnancy, infant safe sleep, and how to deal with Post-partum Depression.

VIII. Products - see Flash Drive sent separately via Fedex

IX. Project Data - see HRSA Electronic Handbooks (EHBs)