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**Introduction**

The 2000-2005 Fayette County Healthy Start Impact Report summarizes our efforts on infant mortality, low weight birth and very low weight birth reduction and the elimination of perinatal health disparities with comprehensive strategies directed toward reducing related medical and socio-demographic risks.

To achieve the goal of reducing infant mortality and improving perinatal services, national common objectives are identified in addition to local strategies. They call for a reduction in the percentage of low birthweight infants, reduction in the use of alcohol, tobacco, and other drugs during pregnancy; increasing early initiation of and compliance with prenatal care; increasing the percentage of infants that are age-appropriately immunized; and increasing utilization of interconceptional (family planning) services.

The Fayette model focuses on addressing in a realistic and holistic way, the needs of participants. The project seeks to effect change not only in individuals through an enhanced understanding of the importance of prenatal care, healthy behaviors, and family planning, but also in the provider system of health and human services on which she depends. Integral to this service model are the multi-disciplinary Core Team, which serves as the interface between Healthy Start and hospitals (Pittsburgh, Pennsylvania and Morgantown, West Virginia), private practice physicians and community health centers.

Home visits are conducted with women whose pregnancies are considered to be high risk, and registered nurses and outreach workers visit the homes of low and very low birthweight infants, along with those whose mothers received no prenatal care. Outreach workers recruit clients to the Healthy Start system and serve as support persons to the participants, facilitating entry to the array of existing and enhanced services that reduce risk and improve the potential for a positive pregnancy outcome. Nutrition education is provided through the WIC program and in conjunction with the Healthy Start staff. Birth spacing, health education, mental health services and substance abuse services and referrals are essential program components.

An intensive outreach and public information campaign utilizing the local media, the telephone information Help Line, community events and community mobilization through grassroots participation in the Task Force increases community awareness.

The project design and implementation are the products of collaboration among the Fayette Community Health Improvement Partnership and their Perinatal Task force, state and local public officials, local hospitals and health care providers, health and human service agencies and the community. Healthy Start funds are used to expand, enhance and coordinate the elements of a continuum of care as well as to add innovative initiatives to fill gaps in service as they are identified.
I. Overview of Racial and Ethnic Disparity Focused on by Project

Despite the progress made over the last four years in addressing perinatal health, women in rural Fayette County, Pennsylvania continue to encounter numerous logistical and psychosocial barriers to prenatal care, including high poverty, high rates of inadequate health insurance, health care provider shortages, transportation problems (both access and travel distance), as well as health and human services systems that are inadequate to the myriad needs of the poor and low-income.

Fayette County, located in the southwestern quadrant of Pennsylvania, lies in the northeastern section of the Appalachian Region. A primarily rural area consisting of small towns, boroughs and townships, its geographic features range from the valleys of the Monogahela and Youghiogheny Rivers to the foothills and summits of the Laurel and Chestnut Ridge section of the Allegheny Mountains. Bordered on the south by West Virginia and the Maryland Panhandle, it is a region with a rich historical background dating back to colonial times.

Fayette’s early development can be traced to river traffic on the Monogahela and to construction of the National Road through the County in the early 1800’s as the young nation expanded toward the western frontier. A wave of new immigrants came to southwestern Pennsylvania during the coal boom, which started in the 1870’s. The Italians, Slovaks, Poles and African-Americans who came to work in the coal mines gave Fayette County an ethnic richness that continues to this day.

Once rich in natural resources such as bituminous coal, natural gas and timber, as well as an abundance of agricultural acreage, Fayette County has not fared well economically in the later half of this century. Many of the natural stands of timber were exhausted before conservation concepts were reorganized. Natural gas reserves and coal reserves were depleted to produce coke for Pittsburgh’s iron and steel mills. Later, strip mining reduced the suitable number of acres available for farming.

The collapse of the steel, coal and related industries in southwestern Pennsylvania in the 1970’s and 80’s, along with the demise of economically-viable family farming, struck hard in Fayette County. Over the last decade of the 20th century, Fayette’s welfare dependency rate has been surpassed in Pennsylvania only by Philadelphia. According to the PA Department of Public Welfare, 5.5% of Fayette’s residents receive TANF (Temporary Assistance for Needy Families) benefits. Many also receive other forms of government assistance such as food stamps, Medicaid and Social Security Disability. Poverty, long associated with rural Appalachia communities like Fayette County, became even more entrenched and fell hardest on those most vulnerable to its chronic influence: infants and children.

The association between poverty and increased risk for infant mortality in the United States was first noted at the turn of the 20th century. More recently recognized has been the disparity between the races and ethnic groups in the rate of infant mortality and other perinatal health factors that are attributed to differences in socio-economic status. In addition, other indicators such as educational levels and marital status are also related to an increased risk of an adverse pregnancy outcome. It is evident that many of these factors are present in Fayette County,
Pennsylvania. Disparate populations, as defined by Healthy People 2010, are those not only in terms of “race and ethnicity”, but also those “identified by differences occurring in education, income, disability, or living in rural/isolated areas”. (U.S. Department of Health and Human Services. Healthy People 2010: Understanding and Improving Health. 2nd edition Washington, DC: U. S. Government Printing Office, November 2000.)

In the Commonwealth of Pennsylvania, Fayette County is a classic example of a convergence of disparate socio-economic effects upon infants and children. A review of key economic and health status indicators such as children under 18 years of age receiving public assistance, infant mortality, low weight births, and births to single teens, reveals that Fayette County, is leading, or is among the top four problem areas of all the state’s 67 counties.

During the report period, the Project Area accounted for 31% of all infant deaths in Fayette County. The Project area accounted for 100% of African-American infant deaths in Fayette County.

- Fayette County is an area comprised of 790 square miles
- The county’s population of 148,644 consists of 59,969 households
- Females account for 52.1% of Fayette County residents
- Of the 5,131 live births among county residents during a three year period, 93.7% (4,812) were white, 5.6% (289) were African American, and less than 1% (30) were of another race
- Less than 1% (14) of live births was to residents of Hispanic origin (Division of Health Statistics, PA Department of Health).

NOTE: Fayette County target communities include Uniontown, Connellsville, Brownsville and Masontown. These communities are utilized because of their high population density of 3,777 persons/sq mi, as compared to the County average of 184 persons/sq. mi. During the reporting periods, these communities accounted for almost 25% of live births in Fayette County and 44.7% of all infant deaths in the County.

The infant mortality rate for Fayette County has, for a number of years, been higher than the State average and, on several occasions, was the second highest in Pennsylvania.

- Other persistent negative social conditions in the immediate area of Fayette County include a per-capita income of $9,791 (third poorest in PA)
- A median household income of $19,195 (2nd poorest in PA)
- A median family income of $23,578 (2nd poorest in PA)
- In Fayette County, 46.3% of the population earns less than $17,500 per year (highest percentage in PA) and only 52.3% of students continue their education after high school (5th lowest in PA)
- 5.8% (300) of live births were to teens less than 18 years of age (with African American teens twice as likely to deliver) and over 41% of resident births were to unmarried mothers (2nd highest in PA)
- Of households with children, 8.4% are headed by a single parent (3rd highest in PA).
Not content to allow the data alone to define the problem, the planning team sought input from the community through forums and focus group interviews.

Participants, all of whom were from the Fayette County Healthy Start Project Area, identified the following as factors contributing to infant mortality:

- Insensitivity of health care providers
- Racism and classism in the community at large
- Poverty and unemployment
- Lack of transportation
- Inaccessible services
- Lack of effective outreach by providers who are removed geographically and socially from the communities they seek to serve
- Failure of individuals and society to value each other and, particularly to prioritize the well being of children
- Substance abuse
- The need for an entity that would streamline administration and be culturally appropriate and sensitive to the needs of the individuals being served.

In 2000, Fayette County, Pennsylvania faced clear challenges. How to reach the Healthy Start goal of reducing infant deaths and how to eliminate health disparities and most recently how to reverse the cycle of an ever-widening gap between the races in these important health status indicators.

At the onset, experts determined that it required a comprehensive and intensive community-wide effort: The Fayette County Healthy Start Initiative.

Kim’s Story. . .

Kim is a 19 year old single white female pregnant for the third time. She hasn’t had a pregnancy test, but she knows the symptoms, and she has them all. She’s been there before—when she was carrying Michael, who is 18 months old now, and she lost her second child who was born prematurely.

...........She remembers the attitude of the staff when she went for prenatal care the first time….She’s in no hurry now to go back to there. She’ll simply go to the emergency room if she really feels sick, like she’s always done.

She’s not very happy about this baby. For that matter, she’s not very happy about herself........

After Michael was born, she went on welfare and moved into her own place. She felt alone and alienated…..She had looked for work, of and on, but the only job she could find paid minimum wage: part-time in a fast food restaurant. But….she could not afford to give up her welfare, pay more rent, pay for day care and lose her Medicaid coverage, so she gave up. She could get by on her welfare check.
She smokes two packs of cigarettes per day and knows it is not good for her baby. In fact, smoking might have contributed to the death of her second child. But that was the only escape she had from the drudgery of her life.

Then Marc came along.....Sometimes he had money and when he did, he was very generous. He refused to work for minimum wage.....called it a life for suckers. He didn’t tell her where the money came from, and she didn’t ask. But she worried about him.

..........Marc didn’t know about the new baby yet. She wondered when to tell him. She knew it would put a strain on their relationship.

Kim wants a better life, for herself and for Michael. She started going to church to find some direction. But the people send aloof and indifferent. She hasn’t been back recently.

Sometimes she thinks about her dream, at 16, of becoming a nurse. Now she’s just overwhelmed by the daily demands of her life....Her mother’s admonition - “Make something of yourself” – grows louder and louder. But how?

Kim was the model for the design of the Fayette County Healthy Start plan, and she remained the focus of our attention as we move into the fifth year of operation...

For her own sake and that of her children, one of them not yet born, Kim needs quality sensitive health care.

Our Multidisciplinary Core Teams see that she gets it-before and after her baby is born. And they find other services she and her children need.....pediatric care, mental health counseling, housing assistance, a supportive parenting program, health education, job training and childcare.

Much of the help that Kim needs, so desperately, she finds in her own community, through service that are selected, promoted and monitored by her neighbors who served on the Perinatal Task Force.

Through it all, from the news media, volunteers, professional and paraprofessional staff, Kim hears and feels the community’s concern for her and knows that her life and her children’s lives are valued.....Healthy Start’s goal is to help Kim take charge of her life…to make something of herself, in her words. Healthy Start is here to show her how.

II. Project Implementation
The organizational framework for the Fayette County Healthy Start program is designed to support the comprehensive, consumer-driven approach. It’s systemic and interactive in nature; that is, it provides for the involvement of community representation at all levels in the planning and implementation. All components (policy formulation, management, operations, and service delivery) are linked to ensure that management and program initiatives are responsible to the social, psychological, and economic realities of women residing in the Project area.

Outreach and Client Recruitment
A. Fayette County Healthy Start Outreach and Recruitment core service rationale is based on addressing perinatal health, targeting all women of childbearing age (10-44), all infants and toddlers up to two (2) years of age, and caregivers of infants residing in the project area and Fayette County. Specific targeted populations include pregnant and parenting women who are at risk for poor health and social outcomes (i.e., Medicaid recipients, the uninsured, the underinsured, victims of domestic violence, adolescents <15, substance abuse/addiction, medical/mental health conditions, and women who smoke during pregnancy.)

According to the 2000 U.S. Bureau of Census, Fayette County had a total population of 148,644. Fifty-two percent (76,767) were females and approximately 48% (70,600) were males. Children under the age of five years constituted 5.7% (8,454) of the population. The majority (95.3%) of Fayette County residents identified themselves as White, 3.5% as African-American/Black and approximately 1% identified themselves as Asian, Native Hawaiian and other Pacific Islanders or some other race or combination. Less than 0.4% self-identified as being of Hispanic or Latino origin. Approximately 17% of the total population lived below the poverty level while 23.3% (7,786) of children under 18 years of age lived below poverty. The percentage of Fayette’s children living below the poverty level was 2nd only to Philadelphia, Pennsylvania.

During the three-year period 2000-2002, there were 4,520 births to Fayette county residents and 41 infant deaths (37 white and 4 African-American). For the same period, the overall infant mortality rate for Fayette County was 9.07 infant deaths per 1,000 live births. However, African-American residents experienced a disproportionate infant mortality rate compared to Whites. The African-American rate was 17.1 compared to 8.7 for Whites during that time. 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.

![Infant Mortality Rate - Fayette County 2000 - 2002](image)

Note: There were no reported infant deaths for other racial/ethnic categories.
Source: PA State Health Department, Vital Statistics 2000 - 2002

Given the isolated, rural nature of Fayette County, many local residents were forced to seek health and human service providers outside of the county. In 2000, Healthy Start, Inc. became the grantee for the Fayette County Healthy Start initiative, working in conjunction with the local Consortium (Fayette Community Health Improvement Partnership).

Fayette County target communities include Uniontown, Connellsville, Brownsville and Masontown. These communities had a 2000 Census enumerated population of 27,983. Whites accounted for 89% of this population and African-Americans accounted for 9.2%. During 2000-2002, these communities accounted for almost 23% of live births in Fayette County.
Healthy Start, Inc., the grantee for Fayette Healthy Start, has provided oversight and key personnel and offered effective direct services to program participants and provided leadership in community collaborations efforts. Healthy Start, Inc. has been responsible for carrying out the day-to-day responsibilities of the project through onsite management staff centrally located in Uniontown, Pennsylvania (the county seat) and in partnership with the local Consortia. Fayette Healthy Start’s direct service model is a replica of the Pittsburgh/Allegheny County Healthy Start program.

Fayette Healthy Start worked to strengthen and expand collaborations with area health and human service providers in Westmoreland, Greene, Washington, Allegheny and Fayette Counties and the state of West Virginia, in order to maximize resources and coordinate referrals and support. Currently the perinatal health system in Fayette County is over burdened and several health care providers located in Fayette County have indicated they are at full capacity to serve Medicaid insured, uninsured, or under-insured clients. Most residents of Fayette still look to Uniontown Hospital for obstetrical services and to Laurel Pediatrics for pediatric care. Over the years, the hospital has sought to address the medical and social needs of high-risk women and their infants but they only have one birthing center. Because of the stress placed on the perinatal health system, many women find it necessary to cross county boundaries or even travel outside the State to access care. Therefore, the goal of Fayette has been to increase both intra- and inter-state networks of care for women and their infants.

For women of childbearing age and their infants, Healthy Start has provided a comprehensive continuum of family planning/interconceptional care, prenatal, obstetrical, pediatric, postpartum health care services and depression screening, through the coordination and/or expansion of existing services and the addition of needed new services. The Multidisciplinary Team has worked in tandem with the Family Health Council (located in Uniontown, the nucleus of the county) and community-based primary care services.

Through ongoing collaboration with public officials, hospitals, community health centers, private practitioners, school districts, and health and human service agencies, Healthy Start has established both professional and community-based partnerships in the Fayette service areas. These networks of care have resulted in services that were culturally and gender appropriate. The establishment of these partnerships helped to reduce barriers to access care and increased the utilization and community awareness of services to at-risk populations.

B. Outreach in Fayette County are non-traditional indigenous to the county. Indigenous staff provided services for Fayette during the period. The mountains, vastness of the area, lack of acceptable and accessible public transportation, low education levels, and diverse cultures and traditions demanded that outreach be intensive, creative and ongoing. Since Fayette lacked adequate and accessible transportation, Healthy Start’s staff utilized the Fayette Healthy Start vehicle for transporting program participants to medical and WIC appointments. Staff also referred program participants to the Fayette Area Coordinated Transportation (FACT) services for travel assistance. However, program participants were resistant to FACT referrals for the
following reasons: 1) welfare stigma 2) participant could only travel with one child and 3) availability of service hours.

Healthy Start’s Fayette Multidisciplinary Team utilized personal automobiles for home visiting. The Fayette Healthy Start vehicle traveled throughout the County (community canvassing) to find and locate those individuals and families most at need. If targeted participants were not at home staff left a doorknocker, flyer, pamphlet or brochure. All outreach/recruitment materials contained the Fayette Healthy Start logo and the Helpline telephone number. We requested that all interested persons call the Helpline number for additional information.

The Healthy Start Perinatal Systems Liaison (PSL) along with CHIP and the Perinatal Task Force (Consortia) members also performed outreach and recruitment. The grassroots participation of the Task Force was utilized to increase and heighten community awareness concerning infant mortality and health disparities. In addition, Task Force members recruited new members and referred pregnant or postpartum women for enrollment.

The Healthy Start Perinatal System Liaison (PSL) along with the CHIP/Consortia assisted the Team in identifying participants for program participation. Consortia members hosted annual community baby showers allowing us to enroll additional pregnant or postpartum women. Healthy Start case-managed program participants were also invited to these baby showers and these participants would often bring along a pregnant or postpartum friend who were not yet enrolled in Healthy Start. During the shower registration process, staff explained the Healthy Start program and enrolled interested guests into Healthy Start’s case management program. During each event, Healthy Start provided both transportation and childcare to ensure participation.

The Task Force made presentations describing Healthy Start services during community forums. These presentations were yet another vehicle used to recruit community participants. We also gave talks describing Healthy Start services to health and human service providers, public and parochial middle and high schools, sororities and fraternities, churches, community organizations and women’s clubs.

A key component of the intake and enrollment process has always been the Healthy Start Helpline. A trained listener/counselor (Information and Referral Specialist) employed by Healthy Start has provided support and information to help pregnant women and mothers with young children. The telephone contact number was widely publicized through the area as a source of information and counsel on any matter regarding pregnancy or parenting. The Healthy Start Helpline served as the primary point of intake and enrollment for case management/care coordination, resources, referrals and breastfeeding information.

The Information and Referral Specialist while staffing the Helpline, was responsible for completing initial intake forms during phone calls. After obtaining the participant’s approval/consent, they scheduled the initial home visit within a 48-hour time period. While the Information and Referral Specialist staffed the Helpline from 8:00 a.m. to 5:00 p.m. daily, the phone answered 24 hours a day. After business hours, an answering machine took names and telephone numbers and the calls were returned after 8:00 a.m. the next day.
During the initial enrollment visit, the Outreach Worker ensured confidentiality, explained the Healthy Start program services to all participants, secured required consents and authorizations, completed maternal health history and an initial risk assessment, and collected information on whether or not a participant had a medical home and/or health insurance. The Program Administrator completed quality assurance for each new enrollment chart. Charts then transferred to the Healthy Start multidisciplinary team for case management.

Healthy Start’s home visiting multidisciplinary team has built close participant relationships that were crucial for intervention. Efforts to aid intervention included scheduling visits at convenient times for participants and being consistent with visits, making reminder and follow-up calls for appointments and referrals, transportation services, developing personal referral networks, staying flexible, leaving door reminders whenever participants were unavailable, maintaining confidentiality, being non-judgmental, respecting their values, ensuring cultural and linguistic appropriateness and displaying a truly caring attitude.

Additional strategies to address interventions have been:
- Hiring indigenous community-based outreach workers
- Staff was cross-trained to perform all duties
- Healthy Start office located within the Healthy Start communities
- Facilitated transportation and childcare
- Established linkages with a broad array of health and human service providers through ongoing referral network collaborations
- Follow-up provided on medical appointments and enabling service referrals is ongoing
- Extensive training of program staff and CHIP/Consortia members as well as other program/agencies providers on topics such as Cultural Competency
- Provided intensive case management services to families affected by substance abuse and women who were experiencing depression.
- Developed referral network for children with special health care needs

Linkages and coordination of outreach services utilized an approach that initially interfaced with other agencies and organizations within our targeted communities. The main responsibility fell to the Perinatal Systems Liaison (PSL), whose duties included attending meetings, making presentations and promoting Healthy Start services. Secondly, the outreach workers took the most critical steps in the engagement process with program participants, and what occurred at the first assessment ultimately determined whether a participant would engage further in case management services.

In Fayette County, Healthy Start implemented interventions to improve community awareness and name recognition. The outreach and public information campaign utilized the local media, telephone information Helpline, community events, (i.e. health and reading fairs), and community mobilization through grassroots participation in the consortium. Memberships in the National Healthy Start Association (NHSA) and the Pennsylvania Perinatal Partnership (PPP), promoted Fayette Healthy Start at the national and state levels.

Fayette Healthy Start utilized the media to recruit potential community participants, heighten awareness and increase project visibility. The local cable television station and the newspaper
focused significant attention on the positive aspects of preventive health care for mothers and infants. Another outreach tool has been the Fayette Healthy Start Newsletter. The newsletter published quarterly, by Healthy Start staff was mailed to County residents and businesses. The newsletter featured the Healthy Start Logo, promoted the Healthy Start Helpline (telephone number) and urged pregnant women or mothers with infants up to the age of 2 years to enroll into the Fayette program.

C.
One of the greatest challenges for the successful initiation and implementation of outreach and recruitment for women in rural Fayette County were our encounters with numerous environmental and psychosocial problems. These problems made enrollment and retention difficult. Inadequate health insurance, provider shortages, transportation problems and inadequate human services have all been barriers for the women receiving these needed services. Malpractice insurance in addition has caused limited OB/GYN services in Fayette County. The departure of their largest practice has made pregnant mothers seek services in Allegheny County and West Virginia.

A major challenge Fayette Healthy Start faced has been our targeted population’s understanding of the availability of health care services in a changing health and human services environment. With the implementation of “Welfare Reform” and the advent of mandatory managed care for enrollees, the responsiveness of the Healthy Start service model has been crucial. Our population most at-risk faced tremendous challenges in understanding and adjusting to the changes that have occurred and will most likely 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 have all been factors that have influenced our participants’ distrust of the health and human service system. Participants feared they would come under the scrutiny of Fayette County Children and Youth Services (CYS) if they exposed these issues. Other retention barriers were that some of our participants were just not ready to change poor lifestyles or behavioral habits such as smoking, drinking or illicit drug use. The barriers to retention have been the same for both pregnant and interconceptional participants.

Case Management

A.
Fayette County was identified in 1999 by Healthy Start Inc. as a depressed area in regard to the Maternal Child Health (MCH) systems. Specifically, infant mortality, low weight births and overall health disparities existed in a capacity that deemed it eligible for application of federal Healthy Start funding.

Fayette County qualifies as a rural project area consisting of a mountainous environment. The residents must travel long distances to receive medical, social and behavioral health services. Specifically, the county is characterized by exorbitant rates of poverty, inadequate health
insurance, health care provider shortages, and little or no public transportation access. Combine this with an inadequate health and human service system and the result is poor perinatal outcomes for women and children, especially in the African American population. In fact, for the three-year period (1995-1997), the county infant mortality rates were 13.9 overall, but 18.9 for African Americans.

A variety of risk factors for expectant or current mothers exists in the county at an alarming level. Consider that during the three year period 2000-2002, approximately 30% of all women and 40% of African American women in Fayette County reported tobacco use while pregnant compared to 16% in Pennsylvania. The result of risky behaviors like smoking have contributed to the higher rates of preterm birth (10.2%) and numbers of births affected by congenital anomalies (66) during the most recent three year statistics available through PA Vital Statistics (2000-2002).

A major contributor to poor perinatal outcomes is the lack of available health care, access to health care providers, and inadequate health insurance. There are three hospitals serving the county and only one that offers childbirth services. These facilities are not easily accessible to the majority of the population. Many residents residing in Fayette County face seeking perinatal health care services outside of Pennsylvania in nearby West Virginia or must commute long distances to urban areas of adjacent counties, i.e., Allegheny and Westmoreland Counties, to obtain specialty care services.

Access to health and social service continues to remain an issue. Eligible women still refuse to use Fayette Area Coordinated Transportation (FACT). FACT is the county transportation provided for women who are on assistance through the County Assistance office. Women cite the inconvenience of scheduling at least a day in advance, the stigma associated with being on the “welfare bus,” and the restriction to have not more than one child accompany you.

Finally, while many Fayette County residents live in extreme poverty, which qualifies them for government assistance, a significant number of “working poor” are not eligible for services such as Medicaid. In these circumstances, many find adequate healthcare beyond their reach, and perinatal care is often neglected based predominately on cost.

The result of these factors was the development of a model designed to expand on system capacity to eliminate health disparities, reduce infant mortality, reduce low weight births, especially to African-Americans, alleviate access issues including transportation and insurance, heighten community awareness about the need for early prenatal care, and to foster linkages among health care providers.

B. Healthy Start Inc.’s case management is a key component within the multifaceted intervention and prevention model aimed at reducing health disparities, infant mortality rates, and incidents of low birth weights and other poor perinatal outcomes.

The goals of case management are to present participants with a single point of contact for multiple health and social service systems; advocate for participants to assure that a complete
range of services is provided by other social service delivery systems; and promote participant-driven systems that improve coordination of community resources. To effectively attain these goals, case management is delivered utilizing the home visiting strategy facilitated by a multidisciplinary team.

**Multidisciplinary Team Staffing**

<table>
<thead>
<tr>
<th>Position Title</th>
<th># of Positions</th>
<th>Full Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach Worker I</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Outreach Worker II</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Program Administrator</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>

Lack of access to care along with an extremely limited network of health and human service providers dictates the necessity of bringing services to the participants in their homes. Using a team method consisting of an outreach worker, registered nurse, program assistant and program administrator, the overlapping health and social problems can be addressed using specialized knowledge and skills. Outreach workers assist primarily with navigating the small, but complex social service industry. Nurses provide medical assessments for both mother and child and educate mom on factors related to poor birth outcomes and infant and child health and development.

New to case management in 2002 was the initiation of depression screening and referral services. The registered nurse screened all enrolled women for depression and appropriate referrals were made to the local mental health provider for further assessment and treatment if warranted.

C.

One major obstacle to the provision of case management services was the inability to maintain a stable office setting. The constant change in locale often frustrated both program and community participants and decreased their level of trust in Healthy Start as a dedicated and accessible service provider. In year four, a final location was obtained through outside funding sources, but coding restrictions have nullified its use as an office facility.

Another major contributor to a decreased impact on the case management intervention was the constant decrease in community health providers. Even as participants were identified and enrolled and access to care issues addressed, locating a medical provider was difficult at best. The best example of this is the availability of only nine (9) Obstetricians/ Gynecologists available to serve the approximately 30,000 women of childbearing (age 10-44) in Fayette County (PA Department of Health, 2000-03). To overcome this lack of available service, the Fayette County Health Improvement Partnership and Healthy Start’s Perinatal Task Force have joined to develop ongoing plans to make the necessary changes to the health service systems (refer to the Collaborations section of this document for more information).

Finally, and most important, was the fact that following the 2004 budget year, the project was “approved, but not funded” for future service. At that point services were discontinued immediately leaving over 300 women and 250 infants without service. However, the Perinatal
Task Force remained active and with their assistance many of the program participants were referred to the few available services. To further alleviate the burden, all women were reminded that the 24 hour Helpline was available to them and that guidance in many areas was available over the phone. The overall damage from this funding decision is yet to be determined. It is expected to be minimal as Healthy Start was able to reach out using alternative and creative means.

Fayette County residents present with a wide range of existing problems and there are a host of barriers to care as explained earlier. To alleviate barriers Healthy Start developed a comprehensive plan to alleviate these burdens.

To overcome these barriers the Healthy Start Inc. Fayette County program has put in place the following strategies:

- Hiring of indigenous paraprofessional workers to ensure trusting relationships are developed and individualized Plans of Care are invested in by the participant.
- Locating the core team office in the county seat, Uniontown, PA.
- Facilitation of transportation assistance utilizing a leased Healthy Start vehicle.
- Key linkages with a broad array of health and human service providers through enhancing referral networks and collaborations.
- Educating the community in current case management practices and needs.
- Intensive training for staff.
- Utilizing the Community Health Improvement Partnership and the Perinatal Task Force input to devise tailored, community case management plans.
- Hiring a licensed social worker in the next grant cycle to provide in home behavioral health counseling and education.

### Key Program Partners

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Capacity/Scope of Services</th>
<th>HS Target Area</th>
<th>Project Linkage and Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Family Partnership</td>
<td>Home visiting and case management of a maximum 125 - 1st time pregnant women</td>
<td>Fayette County</td>
<td>Registered Nurses serve 1st time pregnant women through children’s 2nd birthday</td>
</tr>
<tr>
<td>Early Intervention</td>
<td>Development specialists and nurses and approximately 180 children/family served per year</td>
<td>Fayette County</td>
<td>At -risk infants/children 0-3 years/child development specialist and nurses.</td>
</tr>
<tr>
<td>Early Head Start</td>
<td>Birth to 3 years of age and pregnant women. Capacity 300. Development specialist, nurses,</td>
<td>Fayette County</td>
<td>Members of the Perinatal Task Force and Referrals</td>
</tr>
<tr>
<td>Family Health Council</td>
<td>7000 visits per year. Prenatal care, delivery services, STI testing and treatment.</td>
<td>Fayette County</td>
<td>Family planning and referral system</td>
</tr>
<tr>
<td>Healthy</td>
<td>Hospice, six week post partum</td>
<td>Fayette</td>
<td>Referrals and</td>
</tr>
<tr>
<td>Program Name</td>
<td>Capacity/Scope of Services</td>
<td>HS Target Area</td>
<td>Project Linkage and Communication</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Beginnings Plus/ Fayette Home Care</td>
<td>checkups, approximately 1500 visits per year</td>
<td>County</td>
<td>Uniontown Hospital collaboration</td>
</tr>
<tr>
<td>EVEN Start</td>
<td>35 Capacity- Services children birth -8 years of age and/or 3rd grade, child care and early learning intervention (1 Special Needs Child)</td>
<td>Fayette County</td>
<td>Members of the Perinatal Task Force and Referrals</td>
</tr>
<tr>
<td>Family Beginnings Birthing Center</td>
<td>750 Prenatal care, delivery and postpartum follow-up</td>
<td>Fayette County</td>
<td>Members of the Perinatal Task and Referrals</td>
</tr>
<tr>
<td>Head Start</td>
<td>900 per year, Ages 4-5, Early education</td>
<td>Fayette County</td>
<td>Members of the Perinatal Task Force and Referrals</td>
</tr>
<tr>
<td>WIC</td>
<td>9 Clinics serviced 4600 women, infants, and children birth to 5, prenatal and postpartum. Nutrition counseling, food vouchers and client health assessment</td>
<td>Fayette County</td>
<td>Members of the Perinatal Task Force and Referrals</td>
</tr>
<tr>
<td>Fayette County Community Action Agency, Inc</td>
<td>Case Management / Self-sufficiency program provides the support mechanisms for at-risk families to attain higher levels of functioning and economic self-sufficiency</td>
<td>Fayette County</td>
<td>Members of the Perinatal Task Force and Referrals</td>
</tr>
</tbody>
</table>

**Health Education and Training**

A.

A founding principle of Healthy Start Fayette is the belief that we work in a community-driven framework. As a means of supporting this premise we draw our health education topics from the community which includes the program participants, perinatal task force, FCHIP, the Board of Directors and Healthy Start staff. It is through the topics and concerns they identified that we have been able to develop a comprehensive curriculum for decreasing infant mortality and associated risk factors.

Healthy Start Fayette built upon its connection with the community and our understanding of the concerns of our clientele by hiring indigenous paraprofessional and professional staff: 100% of our Multidisciplinary Team is native to the communities we serve.
As an agency we continued to develop upon the knowledge of our staff by providing health education, staff development and training as mandatory program components. We provide education geared to three distinct audiences: health professionals, paraprofessionals and the public. By modifying educational topics to the skill sets of each audience we were better able to provide health education that was internalized and implemented.

For the years 2000-2002 Fayette County had an infant mortality rate of 9.07 infants per 1,000 live births. However, African American residents experienced a disproportionate infant mortality rate compared to whites, 17.1 compared to 8.7 respectively. These statistics far exceed the national average of 4.5, 2.9 and 1.2, respectively. Community members and program participants indicated that there was a need for health education on a variety of topics to decrease the rate of infant mortality. In response to community requests Healthy Start Fayette equipped our Multidisciplinary Team with the knowledge and tools necessary to provide the community and program participants with accurate and up-to-date health information on a wide range of topics, including smoking, sexually transmitted infections (STIs), HIV/AIDS, immunizations, family planning, substance abuse, teen pregnancy, personal hygiene and nutrition. Healthy Start also recognized the need for regular classes/workshops for program participants that developed oral and written communication skills and these workshops emphasized that materials provided be designed for the community, be culturally appropriate and at a fourth grade reading level.

B.
Fayette County 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.

Comprehensive, skill-based, culturally appropriate health education was provided to the Multidisciplinary Team, health and human service providers, consumers, participants and medical personnel. Although federally required to provide trainings on sexually transmitted infections (STIs), HIV/AIDS, sudden infant death syndrome (SIDS), preterm labor, substance abuse, and smoking, Healthy Start has surpassed the baseline requirements by providing additional trainings on topics such as cultural sensitivity, health disparities, sexual abuse, domestic violence, mental health and postpartum depression.

The methods used to educate program participants were primarily one-on-one health education during home visits, group instruction, written material (at appropriate literacy levels) and referrals to other providers when applicable. In addition to education provided through case management, Healthy Start also provided health information through several events, including but not limited to health fairs, educational baby showers, conferences, dissemination of flyers, neighborhood canvassing, presentations, public information campaigns, utilization of local media, the Fayette County Healthy Start Newsletter, telephone vignettes and the use of the Fayette County Healthy Start Helpline. The Helpline provided health and breastfeeding information to anyone in the Healthy Start catchment areas. By utilizing our educational resources we were able to consistently reiterate healthy behaviors throughout the prenatal and interconceptional periods of our participants.
In our tenacity to ensure in-depth health education and training, Healthy Start continued to employ the knowledge of various health educators throughout Ohio, Pennsylvania and West Virginia. This allows for an unbiased perspective, fresh ideas and new insights.

During the 2000 grant year health education and trainings were overseen by the Program Administrator. However, for the majority of the grant period 2001-2004, health education was lead by the Training and Development Manager who was supervised by the Executive Director. The Training and Development Manager was responsible for scheduling in-service trainings, seminars and conferences for all Healthy Start staff, volunteers, community providers, consumers, and program participants.

The Training and Development Manager and the Multidisciplinary Team used the ecological model (shown below) that identified need and presented a framework for culturally appropriate health education and training on identified topics such as dental hygiene, teen parenting, fatherhood, and navigating the health system.

**Fayette County Healthy Start Social Ecological Model of Health**
Trainings are designed and tailored to complement the unique blend of Fayette County’s rural terrain, diverse racial and cultural make-up, and its characteristic health and financial disparities. Through the cooperation of the community and the Healthy Start Multidisciplinary Team we will continue to identify appropriate educational material and deliver health information in promotion of our goal of improving Fayette County’s knowledge, attitudes, behaviors and sound practices regarding perinatal and infant health.

C. The following table (Table 1) provides a comprehensive outline of the resources and events Healthy Start has utilized over the grant period to ensure successful outcomes. Included in the charts are identified needs and barriers having an impact on projected outcomes associated with eliminating health disparities, reducing infant mortality rates and low weight births, and ensuring overall positive perinatal outcomes.
### Healthy Start, Inc
Fayette County Healthy Start
Impact Report 2000-2004

**Interconceptional Care (Nutrition, Dental Hygiene, Family Planning/Contraception, Immunizations, Child Development & Safety)**

<table>
<thead>
<tr>
<th>Service</th>
<th>X(3)</th>
<th>X(5)</th>
<th>X(5)</th>
<th>X(4)</th>
<th>X(8)</th>
<th>WIC, 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, Primary Care Providers</th>
<th>61</th>
<th>88</th>
<th>186</th>
<th>187</th>
<th>185</th>
<th>235</th>
<th>881</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Violence &amp; Sexual Abuse</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Women's Center &amp; Shelter, Pittsburgh Action Against Rape</td>
<td>9</td>
<td>45</td>
<td>34</td>
<td>41</td>
<td>46</td>
<td>34</td>
<td>200</td>
</tr>
<tr>
<td>Sexually Transmitted Infections/ HIV/AIDS</td>
<td>X</td>
<td>X(2)</td>
<td>X(7)</td>
<td>X(6)</td>
<td>X(7)</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>yes</td>
<td>129</td>
<td>35</td>
<td>39</td>
<td>128</td>
<td>156</td>
<td>210</td>
</tr>
<tr>
<td>Medicaid, Temporary Aid for Needy Families &amp; the Health System</td>
<td>X(2)</td>
<td>X</td>
<td>X(2)</td>
<td>X</td>
<td>X</td>
<td>ACHD, Consultants, Department of Public Welfare</td>
<td>15</td>
<td>56</td>
<td>8</td>
<td>51</td>
<td>27</td>
<td>33</td>
<td>175</td>
</tr>
<tr>
<td>Pregnancy/ Parenting Teen Pregnancy &amp; Fatherhood</td>
<td>X</td>
<td>X(4)</td>
<td>X(3)</td>
<td>X(3)</td>
<td>X(4)</td>
<td>Family Health Council, Planned Parenthood of Western PA, Fatherhood Collaborative</td>
<td>33</td>
<td>45</td>
<td>120</td>
<td>116</td>
<td>129</td>
<td>119</td>
<td>529</td>
</tr>
<tr>
<td>Preterm Labor</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>University of Pittsburgh School of Nursing, Family Health Council, Inc., ACHD</td>
<td>yes</td>
<td>14</td>
<td>45</td>
<td>21</td>
<td>35</td>
<td>36</td>
<td>173</td>
</tr>
<tr>
<td>Staff Development (Cultural Competency, Confidentiality, CPR, Technical training, HRSA Webcast, Infection Control)</td>
<td>X(5)</td>
<td>X(5)</td>
<td>X(3)</td>
<td>X(6)</td>
<td>X(11)</td>
<td>University of Pittsburgh, Healthy Start Counsel, PA Department of Health, Wright State University, Allegheny County Health Department, American Red Cross, HRSA</td>
<td>yes</td>
<td>93</td>
<td>275</td>
<td>149</td>
<td>205</td>
<td>157</td>
<td>250</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X(2)</td>
<td>Healthy Hearts &amp; Souls, American Lung Association, PA Area Health Education Center (AHEC), American Cancer Society, Tobacco Free Allegheny County, March of Dimes, Pa Department of Welfare,</td>
<td>17</td>
<td>45</td>
<td>10</td>
<td>22</td>
<td>50</td>
<td>49</td>
<td>176</td>
</tr>
<tr>
<td>Student Nurse Training</td>
<td>_</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>University of Pittsburgh School of Nursing</td>
<td>191</td>
<td>--</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Family Links, Allegheny County Office of Children, Youth &amp; Families, Gateway Rehabilitation Center</td>
<td>yes</td>
<td>10</td>
<td>45</td>
<td>44</td>
<td>40</td>
<td>23</td>
<td>19</td>
</tr>
</tbody>
</table>
Barriers identified include discomfort with and distrust of the health system, being unclear with where to seek information, when to take action to safeguard your baby’s health, and how to wade through the medical and legal discussions and materials provided to improve or maintain the health of their family. In many cases, program participants have had bad experiences with the health care system, making it a barrier to seeking future health care.

Fayette Healthy Start made it a priority to educate health care providers on health problems associated with infant mortality. This has helped sensitise health care providers to the needs of their culturally diverse clientele thereby breaking down one of the most significant barriers to successful receipt of health education for our participants.

Transportation throughout the diverse terrain of Fayette County and childcare while attending educational seminars or presentations remain significant barriers, preventing participants from receiving health education. In order to address some of the economic, transportation and childcare barriers Healthy Start provided trainings in the home and community making trainings easily accessible. If trainings were provided outside the community Healthy Start provided program participants with transportation via van transport or bus tickets provided free of charge. Healthy Start also provided childcare during trainings as well as reimbursement for childcare service, allowing mothers to fully participate and absorb the information available at trainings. However, despite our best efforts, transportation remains wholly inadequate.

In order to reach high risk participants or individuals in the community, Healthy Start participated in a wide array of community functions including Healthy Start-sponsored educational baby showers, community health fairs, focus groups, community collaborations, dissemination of written materials on community-specified issues, fact sheets, brochures, and resources manuals. This enabled us to reach many participants and individuals who were unable to attend our training sessions and ensured that they received the most pertinent information.

The most significant barrier to Health Education was that Fayette Healthy Start did not receive funding to provide for this vital component which would decrease the risk factors contributing to infant mortality and morbidity. Consequently, Fayette Healthy Start was forced to rely on the education and training provided by Allegheny County Healthy Start and was thereby unable to fully utilize the local resources which may be more familiar and relevant to the concerns of participants residing in Fayette County.
Interconceptional Care

A. Since the inception of Healthy Start, Inc./Pittsburgh in 1991, the Healthy Start project has always recognized a need for interconceptional services for women and their infants. Healthy Start Inc.’s original application written in 1990 contained a comprehensive continuum of family planning, prenatal, obstetrical, pediatric and postpartum health care services for women of childbearing age (10-44), their infants/toddlers and the community. Fayette Healthy Start mirrors the same services through coordination of existing services and includes a case management system using indigenous support staff, outreach workers, nurses, and a program administrator that promoted ongoing one-on-one relationships.

Fayette County Healthy Start continued to focus its efforts on ensuring that all women and their infants/toddlers in Healthy Start communities had access to pre-conceptional, prenatal, postpartum and infant health care. Individuals and groups in Healthy Start communities participated in the development of initiatives to encourage behaviors that resulted in healthy babies. The provision of health care for individuals and families in Healthy Start communities was simplified by unifying the efforts of health care and social service providers.

Fayette County Healthy Start describes interconceptional care as the period from delivery through a baby’s 2nd birthday. However, Healthy Start, Inc. recognized that for a typical program participant, education on interconceptional topics, i.e., family planning and birth spacing had to begin during pregnancy. During the interconceptional period, home visiting activities, services, and interconceptional education varied considerably based on the woman’s stage of gestation when entering the program, their base of knowledge, and their motivation and ability to assimilate the provided material. The typical interconceptional woman was approximately 23 years old, was African American, never married, enrolled in Medicaid and is unemployed, and she may have had a past experience with a poor pregnancy outcome. During the project period, Fayette Healthy Start served 261 interconceptional women, and 423 infants 0-24 months.

These rural women lacked access to family planning services as well as primary care during the interconceptional period due to provider and transportation shortages, insurance issues, and a lack of consumer education resources. 1, 2 The lack of access to behavioral services for rural women also contributed to poor interconceptional health. Individual factors such as mental health and substance abuse also adversely impacted use of health services.

Fayette County Healthy Start aimed to motivate people, particularly young women, to assume control of their lives and take greater responsibility for their own health and the health of their infants, and to increase the accessibility and acceptability of existing services that would help achieve those ends. Our partnerships with local health providers, and healthcare facilities, the Community Health Improvement Program (CHIP), Department of Welfare, WIC and the State and local Health Departments were key in helping us achieve those goals.

B.
Direct Service staff such as nurses and outreach workers conducted interconceptional services for high-risk pregnant and postpartum women and their infants.

During the interconceptional period, staff provided the following services to families and infants and toddlers:

- Home Visits,
- Risk Assessments,
- Intervention strategies
- Health Education (on topics such as age-appropriate immunizations, oral health, second hand smoke, injury prevention, child safety, appropriate sleep positions, and SIDS.)

In addition, staff

- Identified and eliminated barriers to care,
- Provided transportation and childcare,
- Focused on newborn needs (feeding, changing and bathing),
- Observed baby’s responses and styles,
- Monitored infant growth and development (height, weight and head circumference),
- Ensured WIC enrollment and appropriate nutrition,
- Encouraged and advised on the importance of well baby appointments, immunizations and health check-ups
- Advised on the importance of delaying solid food
- Discussed infant teething, dental care and dental services
- Introduced baby’s capacity for positive and negative behaviors,
- Promoted healthy behaviors and counseled on infant safety.
- Conducted developmental screenings/ child development assessments.
- Referred participants to early intervention programs and other local programs that support children with special healthcare needs.

Staff taught pregnant women and their spouses or partners to identify the signs of pregnancy complications before they became serious. Outreach workers and nurses encouraged regular rest, appropriate exercise and personal hygiene related to obstetrical health; prepared parents for labor and delivery; prepared parents for early care of the newborn, encouraged appropriate use of the health care system; and encouraged families to make plans regarding subsequent pregnancies. Multidisciplinary Team members placed special emphasis on helping teens return to school and find employment. The nurses screened for depression and referred to treatment resources as needed.

C.
Identified participant barriers included lack of knowledge and skepticism about the effectiveness of prevention, inadequate or inappropriate utilization of health care services and low socioeconomic status. The convergence of poor socioeconomic conditions and the high-risk population made up the Fayette Healthy Start. Numerous barriers existed between
individuals/families and the care they needed. For example, the inability to pay for services caused many women to delay or even forgo prenatal care. Some also may not have realized the importance of prenatal or preventative pediatric care. A woman and her family may have been overwhelmed by the stresses of poverty. Concerns about feeding, clothing or even caring for the family, plus unemployment, crime and other issues can easily override the importance of basic preventative health care. Additionally, many families expressed concerns about how they have been treated due to their race, or because they relied on public assistance, and therefore were reluctant to seek services until their health problems became a crisis.

Provider barriers included a lack of culturally competent and diverse staff, a lack of training in patient prevention counseling, a lack of follow-up for individuals and families in addressing health care needs, and lack of knowledge about and linkage to community-based health and human services. In addition, some providers’ practices were seen as racially discriminatory by participants.

System barriers included fragmentation of health and human services, lack of coverage or inadequate reimbursement for services, lack of transportation, and inadequate health and human services resources within a community. The programs which were available had different application processes and eligibility requirements. Several of the Fayette Healthy Start target communities lacked sufficient numbers of obstetricians, pediatricians and/or behavioral health service providers. The managed care system of compartmentalized physical healthcare and behavioral healthcare services had also served as a barrier to coordinating and integrating services for participants. Confidentiality issues, many related to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996, also served as a major barrier to coordination of care.

Healthy Start aimed to overcome these barriers faced by our program participants. We assessed participant financial eligibility, such as Medicaid or Title X eligibility, for receipt of health care services and we provided health education on the importance of having a medical home. Systems barriers were addressed by assisting with transportation and child care and identifying available facilities as described above. In addition, we intervened with healthcare providers when discriminatory issues arose by becoming advocates for the individuals and families involved. For example, we accompanied participants on visits to health care providers or we followed-up on participants’ concerns of biased treatment.

Interconceptional Strategies for Achieving Objectives:

- Tracking the Participants’ Postpartum Visits (Refer to Intervention/ PP visits table attached)

- Having a six-week postpartum check-up is very important for interconceptional health care. The visit gives the doctor a chance to make sure that the mother is recovering well, physically and emotionally. It also gives the mother an opportunity to have her questions and concerns addressed.

- During the interconceptional period, Fayette Healthy Start tracked whether a woman had her postpartum check-up within six weeks of delivery.
If the postpartum appointment had not been scheduled; The Fayette Core Team staff initiated a series of activities. The activities were as follows:

- During the first home visit, the program participant and outreach worker/nurse called the doctor’s office and scheduled an appointment.
- The staff documented the appointment date on the Fayette Healthy Start Postpartum Visit Record Form and the Format for Case Review. The appointment date was presented during Case Review, and the Form is placed in the tickler system.
- At subsequent home visits, Core Team staff reminded the program participant of her upcoming appointment.
- Ten days before the scheduled appointment, the Core Team Program Assistant (PA) sent a reminder post card via U.S. Mail.
- Lastly, the Program Assistant (PA) placed a reminder telephone call one day before the scheduled appointment.

Tracking the Participants’ Medical Home (Refer to chart Intervention/medical home table attached)
This Healthy Start program ascertained whether a woman had chosen a family planning option during the initial assessment and during the enrollment visit. Family planning and birth control options were again addressed at home visits in the second and third trimesters, and at the infant’s first, second, and third home visits and on subsequent visits as needed. Healthy Start case managers followed up with a typical interconceptional participant at least seven times regarding her use of family planning.

Risk Determination
The following criteria are established for high risk assessment and ongoing case management through the baby’s second birthday.

The typical high risk infant/toddler usually was defined by, but not limited to: low birth weight/very low birth weight/preterm births; developmental delays; medical conditions (congenital anomalies, gastric reflux, failure to thrive, mother’s failure to follow-up medically, multiple acute infections, i.e., ear infections, asthma); infants born with positive toxicological screens; or mother’s use of alcohol and/or other drugs.

The typical high risk mother was characterized by: active use of alcohol and/or other drugs; smoking; mental health/mental retardation diagnosis; prior preterm birth; repeat pregnancy (within a 24-month period); pregnancy terminations (3 or more miscarriage/spontaneous abortions, loss history); domestic violence; medical conditions (insulin dependent, diabetes/gestational diabetes, hypertension, abnormal pap, HIV/AIDS), teens (17 years and younger); mothers greater than or equal to 35 years old; and multiple gestation (twins, triplets, etc.).

Based on risks and needs, our case managers provided appropriate education and referrals to enabling services to best help program participants overcome social, medical, and cultural obstacles. Assessed from day one at intake and throughout their case management enrollment period, outreach workers, and nurses were equipped to identify and refer our participants for
services within the differing communities. Fayette Healthy Start established protocols to assure that referrals for these enabling services are verified and that services are rendered.

The typical high risk father or male caregiver is characterized by: active substance abuse; mental health/mental retardation diagnosis; domestic violence; medical risk (insulin dependent diabetes, high blood pressure, HIV/AIDS), teens (17 years and younger); paroled or on probation for a serious criminal offense.

Tracking and Ensuring Newborn Visits
Fayette Healthy Start tracked whether an infant had a newborn visit from a Healthy Start nurse within four weeks of hospital discharge by first having a Release of Information and Authorization signed at the initial enrollment of a participant. This allowed the staff to call the participant. Staff obtained the estimated date of confinement (EDC) and other pertinent information. The worker began educating the mother to call our office upon the birth of her baby. If the mother didn’t call, staff placed a call to the participant, obtained the discharge information and documented the information in the participant’s chart and in the Format for Case Review. The participant’s information (dates to be contacted) was placed in the case management tickler system. The Tickler served as the vehicle to prompt a series of Core Team case management activities (home visits, reminder card and/or telephone calls). In addition, all visit dates were entered and maintained in the Healthy Start Management Information System (MIS).

Tracking Infant’s Medical Home
This program ensured that the infant had a medical home for well child care by gathering information from the mother immediately after delivery. The information was documented on the Postpartum Record Form and the Format for Case Review. If the infant did not have a medical home, the Healthy Start outreach worker provided the mother with names of pediatricians. The medical home information was presented at case review and transferred into the Management Information System. During the project period, 100% of infants enrolled had a medical home.

Tracking Immunization Status
The immunization status is tracked by the field staff. When the baby was born the nurses and outreach workers began documenting in the participant’s chart whether or not the infant received immunizations before leaving the hospital. If the baby’s immunizations were not up-to-date, the participant received information on and education about age-appropriate immunizations. The staff took mother and baby to appointments, provided child care, activated the tickler system, followed up with home visits, and transferred information to the Management Information System.

Additional Information for Interconceptional Care
Because the rate of postpartum depression (PPD) was high in the project area (30-45%), the Fayette Healthy Start program had a protocol for screening program participants for the disorder. The identification of mothers with PPD was extremely important because of the detrimental effects the illness can have on the mother, her baby, and the rest of her family. Mothers who screened positive for PPD were given referrals to mental health providers as soon as they would accept one. The staff monitored the mother throughout the interconceptional period whether she was in treatment or not, so as to determine risk to herself and others.
Depression Screening and Referral

A. In the Fayette County Healthy Start Project, depression screening and referral were not mandated components during the first grant cycle (2000-2004). However, postpartum depression was still being addressed. The Healthy Start nurses used the PRIME-MD instrument to screen the participants for depression and then made referrals to Chestnut Ridge Counseling Services, Inc. This intervention was modeled after the Pittsburgh/Allegheny County project and allowed the Fayette project to be ready for the next grant application in 2004 which would call for depression screening and referral.

B. The components of the intervention consisted of home visits by the Healthy Start nurses and their administration of the depression tool to the participants. Referrals were made for those participants whose scores indicated a need for further evaluation and would accept them. Resources needed to implement the intervention included the nurses, their transportation, the PRIME-MD screening tool, referral forms, and providers.

C. Inadequate transportation and long travel distances are barriers to implementing the referral component in Fayette County. Resources for mental health care in Fayette County are scarce. Chestnut Ridge Counseling Services, Inc. was the only available provider, making the time participants spent waiting for appointments very lengthy.

Local health Systems Action Plan

A. With regard to infant mortality in Fayette County, few attempts to address the problem were made prior to the implementation of the Healthy Start Initiative. Those attempts that were made, however well meaning, were non-systematic, inadequate and lacked the requisite concentrate and focus to successfully impact conditions responsible for the unacceptable high rates. During the initial process of developing the Healthy Start Initiative, community residents spoke emphatically of the need for a change in the health care environment. They stated, in effect, that the answer was not necessarily more sophisticated medical technology—it was a more humane, community-oriented, culturally sensitive care.

The impact of State and Federal “welfare reform” efforts is beginning to be felt in southwestern Pennsylvania, especially among the high-risk population targeted by the Healthy Start Initiative. Pennsylvania’s mandatory managed care for Medicaid recipients have been implemented, with individuals being pressured to choose one of three managed care organizations (MCO’s) for physical health. Those not choosing are arbitrarily assigned to an MCO, with which they may or may not be familiar. For behavioral health services, all Medicaid recipients were also assigned to a mandatory MCO (separate from their physical health MCO). A great deal of confusion is evident among Medicaid recipients as they attempt to navigate these new systems.

In addition to changes in the Medicaid system, many Healthy Start participants also are being impacted by dramatic changes in the public assistance program operated by the Pennsylvania Department of Public Welfare. The changes in the program, instituted five years ago, mandated
five-year lifetime eligibility with recipients performing 20 hours of community service after 24 months of benefits. While there are provisions for mothers with infants, the new welfare system has raised serious concerns among the target population.

Due to the geographic constraints of Fayette County, as well as Ohio and West Virginia, in terms of terrain, limited transportation and only one county hospital providing perinatal care, residents are seeking care in adjacent. High-risk pregnancy and situations in which the infant is suspected of needing neonatal intensive care at birth are sent to various Pittsburgh hospitals and also to Ruby Memorial in West Virginia. While Uniontown Hospital is providing perinatal care, they have no capacity for neonatal intensive care resulting in high-risk patients going outside the county. It is the intent of Healthy Start to continue working with the local Consortia to address these problems.

It should be noted that several health providers are recognized leaders in human services for Fayette County and have multiple offices/sites throughout this project area. They have a history of involvement with collaborative efforts designed to improve services for residents. Especially noteworthy is the Fayette Community Health Improvement Partnership (FCHIP), which serves as the Healthy Start Consortia in Fayette County. FCHIP will continue their emphasis on coordination, collaboration and shared responsibility.

Maternal child health care is apparent, but presents few linkages, which allow clients to move through the system with ease for understanding. Providers recognize client limitations and refer appropriately to existing agencies or resources. However, the general lack of coordination of services or long-term availability poses a difficulty for clients needing care.

Therefore, Fayette County needs to expand its current perinatal program to emphasize health promotion and disease prevention through early identification and provision of adequate and appropriate services to low-income women who have few alternatives for maternal/child care.

Fayette worked to strengthen and expand collaborations with area health and human service providers in Westmoreland, Greene, Washington, Allegheny, and Fayette Counties and the state of West Virginia, in order to maximize resources and coordinate referrals and support. Currently the perinatal health system in Fayette County is over-burdened and several health care providers located in Fayette County have indicated that they are at full capacity to serve Medicaid insured, uninsured, or under-insured clients. Most residents of Fayette County use to use Uniontown Hospital for obstetrical services and Laurel Pediatrics for pediatric care. Over the years, the hospital has sought to address the medical and social needs of high-risk women and their infants but they have only one birthing center. Because of the stress placed on the perinatal health system, many women find it necessary to cross county boundaries or even travel outside Pennsylvania to access care. Therefore, the goal of Fayette will be to increase both intra- and inter-state networks of care for women and their infants.

Through ongoing collaboration with public officials, hospitals, community health centers, private practitioners, school districts, health and human service agencies, Healthy Start has established professional partnerships as well as community-based networks that result in services that are culturally and gender appropriate. The establishment of these partnerships has reduced barriers
to access and increased utilization and community awareness of service to at-risk populations. The following agencies and organizations have established a relationship with Fayette Healthy Start to improve the health outcomes of women and their children by addressing the barriers and risk factors leading to infant mortality.

B. The following agencies and organizations have established a relationship with Fayette Healthy Start to improve the health outcomes of women and their children by addressing the barriers and risk factors leading to infant mortality:

Involved in the development of the Fayette Healthy Start Local Health Systems Action Plan (LHSAP) were Healthy Start staff, the Fayette Consortium and the Fayette Healthy Start Perinatal Task Force Members, Consumers, Local and State Health and Human Service Providers, Pennsylvania Perinatal Partnerships members (Title V and Healthy Start projects and the Pennsylvania Bureau of Family Health).

Key community partners, and public or private agencies assisting in the development of the Fayette LHSAP are: ARC of Fayette County, Diversified Human Services, Early Head Start, Early Intervention, Fayette Drug and Alcohol Commission, Fayette County MH/MR, the local Title X family planning agency, Family Health Council, Inc., Uniontown Hospital/Fayette Tobacco Coalition, Cornerstone Primary Care, Three Rives Med Plus and Gateway Health Plan both Medicaid Manage Care Organizations (MCO) the Pennsylvania Southwest Area Health Education Center and the Fayette/Greene Counties Child Death Review.

The key to identifying priorities in Fayette is the Healthy Start Perinatal Task Force. The Perinatal Task Force and the local Consortia (Fayette Community Health Improvement Partnership) meet regularly throughout the year. At each meeting, members receive orientation on the Healthy Start structure and are educated on the contributing factors for infant mortality and disparities in perinatal health.

The level of community concern and commitment to reducing infant mortality and eliminating disparities in perinatal health has been reflected in the continued involvement and contribution of countless volunteer hours by business, religious, political, consumer, community, and health and human service professional representatives on the Consortia and the Perinatal Task Force and the Healthy Start, Inc., Board of Directors.

Healthy Start uses the LHSAP to provide the consortium with priorities and direction. It is a community-based planning process that replaces the former top-down, programmatic centralized model with a responsive, outcomes-orientated model which share responsibility and focuses on the most efficient and effective use of regional public and private resources to build healthy communities.

Healthy Start Inc. established working collaborations. The Fayette County Community Health Improvement Partnership (FCCHIP) is an existing effective network of high level executives and decision makers and the State Health Improvement Partnership initiative (SHIP) is an initiative that involves voluntary community partnerships that are broad-based, locally organized and
managed organizations comprised of “key stakeholders” in local health and social services.

Fayette Healthy Start uses the Perinatal Task Force. To focus exclusively on the perinatal goals of women and infants and to provide a more bottoms-up perspective in regard to the specific needs of Fayette County women and their infants. These working relationships and collaboration remain strong and continue today. The Fayette Program Administrator is the link and attends all regularly scheduled meetings. At each meeting, Healthy Start provides programmatic and statistical updates and addresses any outstanding issues or concerns. It is noted that several health providers are recognized leaders in human services for Fayette County and have multiple offices/sites throughout this project area. They have a history of involvement with collaborative efforts designed to improve services for residents.

Especially noteworthy is the Fayette Community Health Improvement Partnership (FCHIP), which services as the Healthy Start Consortia in Fayette County. FCHIP will continue their emphasis on coordination, collaboration and shared responsibility.

Based on the needs assessment, the Perinatal Task Force has identified five (5) priority areas to focus their energies on over the project period.

These are:
1. Access to Care
2. Cultural Competence
3. Children
4. Behavioral Health
5. Community

The maternal/child health problem inherent to Fayette County is a complex of inadequate supply of perinatal services for low income women, greater than average need for such services due to high unemployment and poverty levels and a lack of awareness regarding problems associated with high-risk mothers. While it is important to establish linkages or coordination with providers, it is equally important to bring other providers to the area to provide comprehensive services from a centralized location for area residents.

**Consortium**

A.

To implement the consortium model in Fayette County, Healthy Start, Inc. chose to work in collaboration with the Fayette Community Health Improvement Partnership (FCHIP), an existing effective network, and the State Health Improvement Partnership initiative (SHIP). FCHIP organized in 1995 under the sponsorship of the Uniontown Hospital and the hospital’s foundation to assess the health care needs of Fayette County residents. FCHIP is recognized at the State level as a model for collaboration and advocacy for the improvement of health issues. The SHIP initiative involves the creation of community partnerships of “key stakeholders” in local health and social services.

The impetus behind the creation of local health improvement partnerships was to create an entity to monitor local health outcomes of programs and to create a collaborative approach to health planning that bridges the gap between local and state agencies. FCHIP conducted a county-wide
health care needs survey of 10,000 residents in addition to several focus groups which were formed to address specific health issues. The data obtained from the health care needs assessment led to FCHIP adopting the following goals:

- Improve the health status and quality of life of the residents of Fayette County
- Target the high risk factors for reduction by identifying the underlying or root causes and use these as the basis for developing health promotion strategies
- Promote the productive use of the existing community resources, rather than the duplication of efforts for the same community health improvement initiatives by several agencies or organizations working in competition or in isolation from other community groups and funded projects
- Develop partnerships at both the community level and at the state level in order to mobilize the private, non-profit and public sectors.

In 2000 the Perinatal Task Force was formed to focus exclusively on the perinatal health issues of women and infants. The Perinatal Task Force provided Fayette Healthy Start with a more bottom-up perspective as it involved health and human service providers, community advocates, and leaders from the private and public sectors from the surrounding communities as well as participants of the program. The Task Force assessed the service delivery and made recommendations on health promotion strategies for Healthy Start. Together these two groups FCHIP and the Perinatal Task Force, have served the women and children of Fayette County and worked together to meet the goals of Fayette Healthy Start.

B.
Healthy Start Fayette had a full-time Public Health Educator/Data Analyst dedicated to facilitating the activities of the Perinatal Task Force, data management, and health education. In 2003, the organizational structure was changed and the Public Health Educator/Data Analyst became the Regional Advocate dedicating 100% of the time to the Task Force. In 2004, additional structural changes were made and the Regional Advocate position changed to Perinatal Systems Liaison. This included more management responsibility of the Perinatal Task Force and allowed for full monitoring and implementation of the system by the Perinatal Systems Liaison with the oversight of the Program Administrator.

Additional resources allocated to the Perinatal Task Force included bimonthly lunch meetings in their community where Healthy Start provided nutritional supplements, transportation, and childcare. In addition, members received monthly reports so that they could monitor program success within their community. These reports included data on the number of participants, number of new enrollments, any new community resources, and monthly education topics.

C.
FCHIP has continued to support prevention efforts and intervention services in Fayette County by developing service capacity and fostering key linkages and collaboration among health and social service providers at both the state and local level.

FCHIP was organized to address the broad scope of county health issues and involves high-level executives and decision makers. Membership in FCHIP consists of twenty-three (23) volunteers.
who represent a variety of interests including non-profit hospitals, the Pennsylvania Department of Health, HMO’s, area businesses, the local economic development agency, education, government, drug and alcohol, MH/MR, aging, and other health and social service providers. The Perinatal Task Force specifically addressed maternal and child health issues particularly those that affected a typical program participant. Membership in the Task Force consisted of thirty (30) volunteers who represented some of the same programs as FCHIP, but these members provided direct services to families in the community. In addition, program participants were members of the Task Force assisting in program guidance and direction.

D.

1. From its inception, the Fayette Healthy Start Project realized that it needed the input of the community, providers and consumers in order to address the maternal and child health issues unique to this rural community. Seeking to replicate the proven method of community-driven approaches to addressing these issues, Fayette Healthy Start implemented a three-pronged approach to community involvement. This approach has allowed the Fayette Healthy Start Project to identify individuals, agencies and organizations that can lend their expertise to address perinatal health issues and eliminate those service barriers unique to this rural community. According to the Project Plan for the Consortium written in 1999, FCHIP served as the Healthy Start Consortium. This consortium designated a key task force (Perinatal Task Force) whose purpose was to offer their input concerning the needs of women and their families including identification of the risk factors associated with infant mortality in the targeted areas. The Fayette Consortia Model best utilized a “community-driven approach” that was sensitive to the at-risk family in rural Fayette County. The consortium has been in existence since the beginning of the project and has continued to function throughout the life of the project addressing maternal and child health issues.

2. The consortium was comprised of fifty-three (53) members who represented a wide-range of interests including consumers, health and social service providers, public and private organizations, community groups, business leaders and legislators. The FCHIP twenty-three (23) represented the “key stakeholders” and the Perinatal Task Force thirty (30) represented the grassroots community participation. Collectively these two entities comprised the consortium membership for Fayette Healthy Start. The current percentages of all members who represent the following categories are detailed in the chart below.

<table>
<thead>
<tr>
<th>Categories</th>
<th>State &amp; Local Government</th>
<th>Program/Community Participant</th>
<th>Community Based Organizations</th>
<th>Public Agencies</th>
<th>Private Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>3.3%</td>
<td>13.3%</td>
<td>23.3%</td>
<td>43.3%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>
During the period the racial/ethnic breakdown of the consortium was consistently one-third African-American and two-third Caucasian. The African-American population in Fayette County (the target ethnic/racial requisition) is less than 4%. Therefore, maintaining representation on the Consortium is imperative to ensuring appropriate cultural balance in membership.

3.
During the four-year period members discussed local health and service issues and potential corresponding agency strategies to address infant mortality, community need, membership recruitment and retention, participant satisfaction, provider performance, funding allocations, and special events to promote Healthy Start goals.

Both FCHIP and the Perinatal Task Force held regular meetings as determined by their members. Typically, FCHIP met quarterly and the Perinatal Task Force bi-monthly to discuss a broad range of issues and discuss health-related initiatives. Members’ primary responsibilities are to expand the knowledge of the group on current maternal and child health issues and trends. Members have identified resources in the community by developing partnerships among agencies and they created a referral process which has decreased service duplication and enhanced resource sharing. FCHIP as the “key stakeholders” continued strategizing ways to reduce gaps in services and resources within Fayette County focusing their attention on health improvement. Both FCHIP and the Task Force have completed annual surveys to identify
community needs, participant needs and review them comparatively to program services. As a result of the surveys members made recommendations to enhance service delivery (i.e., quality improvement and identification of primary concerns for the Fayette population). The results of these surveys were used in the Local Health Systems Action Plan, which drives programmatic objectives. Members received monthly reports, made suggestions, advised on program direction, and helped to identify goals for direct staff.

Both FCHIP and the Task Force are represented by most of the agencies serving women and children in the county. All members have signed commitments to work in partnership with the program and assist in carrying out the mission of Healthy Start. These relationships have been the catalyst for shaping Fayette Healthy Start’s ability to drive outcomes for women and their families in the county.

4.
The community strengths of Fayette Healthy Start that have enhanced consortium development encompassed several areas including; training/orientations, commitment of consumers, provider buy-in and involvement, and business community support. All of these factors have resulted in the success and ability of Healthy Start to recruit participants, change providers way of doing business, and marketing/media efforts.

During the four-year period all members who served on the consortium were oriented and received education/training on infant mortality and perinatal health risk issues annually at a Program Specific Orientation. The orientation serves as the primary method of delivering information and training to all members and it strengthens member knowledge and capacity to act as advocates for the Healthy Start program.

Consumer members served as the “Community Voice” and they were instrumental in highlighting the need for advocacy around health care, welfare, social security and parenting issues. The advocacy efforts of consumers resulted in Uniontown Hospital Birthing Center staff introducing new practices for new mothers after delivery including demonstrations and instructions for new mothers on how to bathe their babies in addition to providing an instructional video. In addition, consumers were extremely vocal about the need for Medicaid Managed Care Organizations to be involved. During the four year period, both Three Rivers/Med Plus and Gateway Health Plan participated as consortium members. Their staff attended consortium meetings and answered logistical and eligibility questions put forth by both staff and consumers. Also, the agencies have provided systems training for Fayette Staff and consumers. In addition, both consumers and the Managed Care Organizations’ (MCO) became acquainted with, supported, and utilized the Healthy Start referral process thereby increasing the number of Fayette County women that were receiving case management services and insured. Consumers participated in recruitment efforts by attending Fayette Healthy Start events and talking to community members, eligible families, and participants about the consortium and the vital role consumers play in the operations of Healthy Start.

The members who held business seats were equally as important and have been very supportive in assisting in the organization and development of media and communication efforts for Healthy Start. A representative from Channel 19 HSTV served as the Chair for the Perinatal Task Force
during the four-year period and aided in the production of six (6) public service announcements highlighting the Fayette Healthy Start Program.

5. During the four-year period the Consortium experienced the following barriers: lack of Healthy Start resources other than federal funding and maintaining broad racial/ethnic representation among members. The Consortium addressed these barriers by applying for additional funds through Foundations and targeting outreach and recruitment efforts towards minorities in the county. Member diligence to identify funds to purchase a home for the Fayette staff led to the attainment of permanent housing for Fayette Healthy Start operations in 2003. Difficulties in the racial/ethnic representation within the region make it difficult to achieve adequate representation of minorities. However, the Consortia targeted their outreach and recruitment efforts throughout the period to identify interested minorities in the Consortia and case management services. The minority membership of the Task Force was ranged from 0% to thirty-three percent (33%) during the four-year period. Although Fayette has reached its target for minority representation their struggle becomes maintaining that percentage.

6. The Consortia model in Fayette was replicated from the existing Pittsburgh/Allegheny County Healthy Start Consortium model. However, the Fayette model was designed to meet the needs of the Fayette population and community’s needs. The decision to replicate the Pittsburgh model was made because the strategies and activities employed by Pittsburgh/Allegheny had proven successful. Therefore, the Fayette Healthy Start employed these activities over the period not making any major changes. During the period Fayette Healthy Start ensured that consumers and residents were reimbursed for transportation and childcare while participating in meetings and activities. In addition, members received nutritional supplements during the bi-monthly meetings. This assistance, though small enabled consumers and residents to focus their attention on the program and retained them by decreasing the barriers to their participation at meetings and activities. These activities were implemented throughout the period with the allocation of Healthy Start federal funds, and occasionally Consortia members provided nutritional supplements or supplemented Healthy Start funds to assist.

In addition, Healthy Start held eight (6) baby showers during the four-year period, four (3) program specific and four (3) county-wide. The baby showers were the medium used by Healthy Start and the Consortia to educate participants and community residents on the objectives described in the Local Health Systems Action Plan (LHSAP). Consortium members took pleasure in planning and assisting with the baby showers and they appreciated the outcomes as expressed in their evaluations of the event.

Healthy Start also held four (4) volunteer recognitions designed by program staff to acknowledge volunteers for their service collaborations and support for the program.

7. Consumer input was obtained by the participation of a designated Fayette Consortia representative on the Board of Directors. The Healthy Start Board of Directors served as the central oversight for the Fayette and Pittsburgh/Allegheny projects during the period. The Board
of Directors ensured member involvement in all levels of the program by designating members to serve on the following five committees: Marketing, Finance, Quality Improvement, Personnel, and Executive. The Fayette representative participates with the Board to address the needs of the Fayette community and provides insight about issues and concerns from the Perinatal Task Force.

8.
Healthy Start utilized the suggestions of consumers by implementing program objectives to facilitate their ideas. Several of our program models and activities are examples of consumer suggestions. The following chart details the activities that the Fayette Community Health Improvement Partnership and Perinatal Task Force have participated in during the four-year period including identification of additional funds, outreach and recruitment, advocacy, and community activities.

<table>
<thead>
<tr>
<th>Components</th>
<th>Activity</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Activities</td>
<td>(6) Baby showers</td>
<td>(1,800) participants attended</td>
</tr>
<tr>
<td></td>
<td>(18) Community meetings</td>
<td>(252) members attended</td>
</tr>
<tr>
<td></td>
<td>(3) Health fairs</td>
<td>(1,000) attended</td>
</tr>
<tr>
<td>Outreach/Enrollment</td>
<td>(6) Community canvassing activities</td>
<td>(10,000) brochures, pamphlets distributed</td>
</tr>
<tr>
<td>Advocacy</td>
<td>(3) Congressional letters</td>
<td>(100) consumer resident signatures</td>
</tr>
<tr>
<td></td>
<td>(2) Medicaid cuts campaigns</td>
<td>(250) signatures</td>
</tr>
</tbody>
</table>

Collaboration and Coordination

A.
A central feature of the Fayette County Healthy Start design is collaboration; specifically the building of partnerships at the community level and among county-wide systems in order to create a seamless continuum for services for families at risk of infant mortality and health disparities. This has led, over the course of the initiative, to new and nontraditional institutional alliances.

During the planning process it was determined that the key element to continuation of the Healthy Start initiative when federal funding was withdrawn was the extent to which existing systems of care had been altered to accommodate the special needs of at risk women and infants. As a result Healthy Start, Inc. continues it broad based collaboration at the local, state and national levels.

The Healthy Start, Inc. Board of Directors determined that the Fayette County Healthy Start project would be the vehicle to strengthen ongoing collaborations, bridge gaps, obviate duplication, and enhance consciousness of the interrelated medical and social risk factors associated with infant mortality and move health and human service providers to adopt more holistic approaches.

B.
Collaboration has been and continues to be a primary role in the development, implementation and sustainability of Fayette County Healthy Start.
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.

At the local level, Healthy Start Fayette County has worked collaboratively with the Pennsylvania Perinatal Partnership and the Consumer Health Coalition to promote the Children’s Health Insurance Program (Title XXI) as well as holding numerous discussions with the three Medicaid (Title XIX) Managed Care Organizations to provide a seamless case management approach for families being served.

The health education component of Healthy Start has engaged in a number of partnerships to reach vulnerable teens and families where they congregate naturally; places where they can be reached in a non-stigmatizing, now-threatening way.

Healthy Start, Inc. collaborates with local School Districts. The services range from support for pregnant and parenting teens (females and males), health education classes, technical assistance in curriculum development and immunizations.

The federally funded community health centers in Fayette County, actively participates on the Fayette County Perinatal Task Force.

Uniontown Hospital collaborated with Healthy Start, Inc. on national health promotion such as Public Health Awareness Week and the national Second Hand Smoke Campaign.

The Fayette County Healthy Start program participated in the Fayette County perinatal initiative Communities that Care.

C.
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 State Health Department, the local Title V agency ensures effective coordination and shared resources with the Healthy Start program. The MCH Services Block grant funds represent approximately one-third of the local Maternal Child Health programs.
The Fayette County Healthy Start Help Line continues to serve as a primary link with the state information line. The Helpline is staffed from 8:00 a.m. to 5:00 p.m. daily, including weekends and holidays.

The health of mothers, infants, children and adolescents continues to be a major priority for the Commonwealth of Pennsylvania’s “Perinatal Partnership”. Since 2000, the PA Department of Health’s MCH Title V staff and the Pennsylvania Healthy Start Projects have initiated meetings for the purpose of coordinating plans and resources in an effort to enhance access to and utilization of perinatal systems in the state. The PA Perinatal Partnership meetings are ongoing.

The mission of the Partnership 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. The Health Insurance Portability and Accountability Act and medical liability issues related to access to care are examples of the Partnership focus. The Allegheny County Health Department Maternal Child Health Program Chief served as one of the co-chairs of the Pennsylvania Perinatal Partnership. The other co-chair represents Pennsylvania Healthy Start Projects.

The Pennsylvania Perinatal Partnership Publication entitled “Pennsylvania Healthy Start” continued to be an effective advocacy and educational document in 2004.

In 2003, the Partnership was 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 commitment and not simply in response to financial or regulatory requirements.

The Pennsylvania Perinatal Partnership, initiated sponsorship of a workshop in conjunction with Health Resource and Service Administration (HRSA), “Bridging Cultures and Enhancing Care in Pennsylvania”. The workshop brought together Pennsylvania Medicaid, SCHIP (State Children’s Health Insurance Plan), Department of Welfare, Health and Insurance Officials, Medicaid Managed Care organizations and SCHIP providers, Healthy Start and Title V staff to improve cultural/ethnic competency and sensitivity. A comprehensive resource guide including references and web sites was provided to participants and made available throughout the state.

Fayette County Healthy Start’s collaborations and service coordination included the University of Pittsburgh (Graduate School of Public Health, Behavioral and Community Health Science, Governors School and the School of Social Work).

The Area Health Education Center (AHEC) partners with Fayette County Healthy Start. The AHEC Clinical Director is a member of the Fayette Healthy Start Perinatal Task Force.

Fayette County Healthy Start continued to participate in the Home Visiting Network. Under the direction and guidance of the Healthy Start Executive Director and the Project Director, the Home Visiting Network composed of 42 maternal and child health and home visiting agencies
share information, train members, facilitate consumer provider resource information, provide legislative advocacy and managed care monitoring.

The Fayette County Healthy Start Program Administrator is on the Nurse Family Partnership Advisory Board. The Nurse Family Partnership initiative was spearheaded by the Governor’s Partnership for Safe Children. The Nurse Family Partnership, funded by the Pennsylvania Department of Welfare/Tangible Aid for Needy Families and the Pennsylvania Commission on Crime and Delinquency, the Nurse Family Partnership program provides home visiting to income eligible first-time mothers through a child’s second birthday.

The Fayette and Greene County Child Death Review Team (CDRT) serves as an interagency quality assurance team that reviews childhood deaths from birth to eighteen years of age. The Child Death Review Team provided Healthy Start data on infant deaths in the Project Area. The Healthy Start Executive Director serves on the Child Death Review Team.

In general, the political environment for Fayette County remains highly supportive. Elected officials attend regular meetings and community-based activities, inform about funding opportunities and make staff available to answer the concerns of consumers.

**Sustainability**

A. With regard to sustainability, Healthy Start, Inc. has participated in and pursued several efforts in an attempt to identify and obtain resources that can sustain Healthy Start, Inc. beyond reliance on federal funding.

Healthy Start, Inc. approaches sustainability and focuses on the following.

- Efforts to ensure sustainability with State authorities by advocating for increased services for children and maximizing Title V funding priority areas.
- Identification of the most successful program elements and documentation of their cost effectiveness with emphasis on key community-based services.
- Further exploration of a diversified funding base that includes insurance reimbursement, public program funding and private philanthropy

B. Since the creation of the non-profit Healthy Start, Inc., the Healthy Start, Inc. Board of Directors, the Fayette Community Health Improvement Partnership (C.H.I.P.), the six Regional Consortia, the Fayette County Perinatal Task Force, the Executive Director and other Key Personnel have made sustaining the non-profit a priority and they have assumed responsibility for this task.

Early on in the planning and implementation process it was recognized that foundation grants will not sustain a program over time. However, it was also recognized how extremely valuable foundation could be in supporting innovation approaches. Therefore, the involvement of the
corporate and philanthropic communities was sought and garnered. To date, they continue to
play a significant role in funding innovative approaches and demonstrations.

C.
Aggressive marketing efforts by staff and the expressed support by local news media of Healthy
Start’s approach heightened the receptivity of local funders to invest in prevention and early
intervention initiatives. Sustaining this interest has continued to be a priority for the grantee, the
Healthy Start Board of Directors and the staff.

Local churches, hospital, service providers, schools/colleges and businesses donated their offices
for Task Force meetings.

Area businesses, specializing in novelty items, have provided Healthy Start with incentives at
reduced cost or for free. The incentives were distributed at local health fairs, baby showers and
community days.

Healthy Start, Inc. was selected to receive $1,500 from one of the local television stations for an
education program. As determined by the Board and staff, the money was used to develop and
print a pamphlet on colds and flu, purchase special thermometers for case managed participants
and underwrote a breast cancer awareness campaign.

Healthy Start enjoys a rich relationship with several local universities and colleges. Staff
members from these institutions have donated their personal time, reviewed grants, provided
technical support, facilitated in-service trainings and provided access to and referred students
who were looking for field placement experience to Healthy Start, Inc.

A long-term sustainability effort involves the securing of $140,000 form two local foundations
(R.K. Mellon and one which wishes to remain anonymous). These funds were obtained so that
the Fayette County Healthy Start Initiative could purchase a facility to house the project in that
community.

Healthy Start, Inc. leases office space to Southwest Pennsylvania Area Health Education Center
(AHEC).

Healthy Start, Inc. is the fiscal conduit for the AmeriCorps program.

1.
In 1995, Healthy Start, Inc. approached Medicaid managed care organizations and their
licensing authorities to include Healthy Start services in their benefit plan and to encourage the
PA Departments of Public Welfare and Health to include Healthy Start as a required option for
Medicaid clients. The process has been slow and without results. To date, Healthy Start, Inc.
does not have a duly executed contract. We continue to be optimist that this collaboration will
move us in the direction of an ongoing source of revenue.

2.
Healthy Start, Inc. has developed specific “case statements” that include key elements of consideration for potential funding sources, policy makers and elected officials.

Healthy Start, Inc. has focused on identification of the most successful program elements and documentation of their cost effectiveness with emphasis on key community-based services.

Healthy Start, Inc. continues to explore a diversified funding base that includes insurance reimbursement, public program funding and private philanthropy.

The project expanded its programming efforts into Southwestern Pennsylvania. In 1999, Healthy Start, Inc. secured an infrastructure and capacity building grant for Fayette County, Pennsylvania. The following year, the non-profit Healthy Start, Inc. became the grantee for the Fayette County Healthy Start initiative. This rural disparities project is located approximately 50 miles south of Pittsburgh in Fayette County.

Healthy Start’s most success effort to date regarding long term sustainability involves the securing of $140,000 from two local foundations. These funds were obtained so that the Fayette County Healthy Start initiative could purchase a facility to house the project in that community.

### III. Project Management and Governance

A. 
The management and governance for the project’s implementation is as follows: Healthy Start, Inc. (non-profit), and the Healthy Start, Inc. Board of Directors, the Community Health Improvement Partnership (C.H.I.P.), the Perinatal Task Force and the Regional Consortia.

The non-profit Healthy Start, in its role as grantee, had the overall responsibility for the administrative and financial management of the grant. Healthy Start, Inc., a nationally recognized community-based participant driven program model, known for its leadership in the development of programs focused on high-risk women and children had been central to the Fayette project in its role as grantee.

Incorporated in 1991, Healthy Start, Inc. was designed to streamline the administration of health initiatives such as Healthy Start and other federal and state funded maternal and child health projects. Healthy Start Inc., had responsibility for hiring and training staff, the day-to-day program and fiscal operations.
B. In 1999, the non-profit Healthy Start, Inc. applied for and received a Health Resource and Service Administration (HRSA) Infrastructure and Capacity Building award, and in 2000 Healthy Start, Inc. became the grantee for an Eliminating Disparities in Perinatal Health project located in Fayette County, Pennsylvania 50 miles southwest of Pittsburgh.

The Healthy Start, Inc. Board of Directors composed of eighteen recognized leaders from established institutions and agencies in Allegheny and Fayette County, Pennsylvania. Members set policy, elected corporate officers, hired the executive director, and provided overall direction and approved the overall budget.

Members of the Fayette County Healthy Start community planning process, provided vital feedback from the community perspective, advised the Board, monitored program implementation and Core Team activities, made fiscal decisions for their communities, and assisted with community education and advocacy efforts.

C. Minimal changes were made to the Healthy Start, Inc. Board of Directors. Wilford A. Payne, the Executive Director of a local Federally Qualified Health Center continued to serve as Chair and Dr. Robert L. Thompson, a prominent local Gynecologist served as Vice Chair. All other officers remain the same and the incumbent community members were reelected. The Board held its annual retreat on April 29 and 30, 2004.

On June 30, 2003, the Healthy Start, Inc. Board of Directors’ accepted the resignation of the Executive Director, Michelle A. Jones. On July 1, 2003, the Board of Directors appointed the Fayette County Healthy Start Program Administrator, Cheryl Squire Flint, Interim Director. She continued in this capacity while the Healthy Start Board of Directors instituted a local and national search. And in February 2004, the Board of Directors made Ms. Flint’s interim appointment permanent.

Hired in 1997 for her administrative and data expertise, Artis Hall, the Pittsburgh Program Administrator resigned on September 24, 2004 to accept an Executive Director position with the Pennsylvania Department of Health. She has been replaced by a Clinical Coordinator, a Biostatistician/Data Analyst trained by Allegheny County Health Department personnel and an Information Technology Liaison.

After seven year’s with Healthy Start, the Controller resigned her position in March 2005. The Assistant Controller, Tonya Satterwhite applied for the position and continues in the role as “Acting” Controller.

In 2004, with the non-profit’s mature management/administrative infrastructure in place, it was felt that this was the time for the formal change in the actual grantee in order to provide for a seamless transition from county government to community-based non-profit.
Not only had Healthy Start successfully managed the Healthy Start grant for Fayette County, Pennsylvania, the Allegheny County Health Department continued to face serious cutbacks which had burdened and diminished its ability to devote resources to community initiatives beyond its primary mandate.

Thus, in December of 2004, with the blessings of the Allegheny County Health Department, it was the non-profit Healthy Start who applied as successor grantee for the Pittsburgh Healthy Start project with the Allegheny County Health Department taking on the role of advisor, providing technical expertise and funder for various Maternal Child Health projects contracting with Healthy Start, Inc. The process utilized is outlined below.

In March 2003, the Chair and Vice Chair of the Healthy Start, Inc. Board of Directors and the Executive Director commenced discussions with the Pittsburgh Project’s Grants Management Specialist and the Division of Healthy Start Program Officer on transitioning project funds and grantee responsibilities to the non-profit prior to the May 31, 2005 project end date.

On April 30, 2005, the HRSA Grants Management office transferred the remaining Pittsburgh Project funds from the Allegheny County Health Department to the non-profit Healthy Start, Inc. and on May 1, 2005, the Health Resource Service Administration (HRSA) Grants Management office succeeded grantee responsibility to the non-profit Healthy Start Inc.

D. The original fund distribution process developed and implemented in 1991 remained in place until April 1, 2005. At that time, the Allegheny County Health Department succeeded the grantee role to the non-profit Healthy Start.

The Health Department had the overall responsibility for the financial management of the grant and the non-profit had responsibility for the day-to-day fiscal operations. The six Regional Consortia advised on fiscal decisions for their communities and the Healthy Start, Inc. Board of Directors approved the overall budget. The Allegheny County Health Department Deputy Director, Administration provided fiscal oversight for all components of the project. Additional responsibilities included the yearly audits, billings to the county and budgets.

Invoices were reviewed by Healthy Start, Inc. program and fiscal staff prior to payment. The nonprofit received funds on a reimbursement system with the Health Department. The Healthy Start, Inc. check signing process, instituted in 1992 by the Board of Directors, stipulates that any check in excess of $200 requires two signatures. Checks, totaling two hundred dollars or more, must be signed by the non-profit Executive Director or the Controller and the Board Treasurer and Chair of the Finance Committee or another member of the Board Executive Committee. The Board Executive Committee is comprised of the Chair, Vice Chair, Secretary and Treasurer.

Completed time sheets were maintained for all staff. The Time Sheet reflected any time away from the office such as vacation, sick leave, personal and permission time (travel, training, etc.). These were reviewed and approved by the appropriate supervisor and were audited by the Controller on a monthly basis.
An inventory of all assets purchased under the grant, since inception (October 1, 1992), was prepared by the Accounting Clerk and reviewed by the Board of Directors Finance Committee.

The Controller provided fiscal oversight for all components of the project and oversees the audit, billings and budgets, manages the fiscal transactions for the organization and establishes vendor relationships. In the last seven years, there were no deficiencies or exceptions noted in the organization’s annual audits, reviews and reports. The Executive Director supervised the Controller who in turn supervised the Senior Accountant, Payroll Specialist and Accounting Clerk.

The composition of the Fiscal Department has changed according to the organizational needs. For the majority of this reporting period, Healthy Start’s Fiscal Department consisted of a Controller, Senior Accountant, Payroll Specialist and Accounting Clerk. The staff had overall responsibility for and directed the procurement and budgeting functions for the non-profit. They reviewed payment to providers to insure compliance and prepared accounts payable and receivables and payroll and managed financial transactions, established vendor relationships, coordinated audits and monitored contracted fiscal management.

E.
The use of contracted services became necessary when services generally provided by the grantee agency, the Allegheny County Health Department ceased. For example, when the Management Information System Administrator and the Chief of Bio-statistic resigned their positions Healthy Start contracted with an outside vendor until appropriate staff was identified.

F.
It is a fundamental principle of Healthy Start, Inc., that all services, program components, media campaigns, literature (flyers, posters, pamphlets and brochures) and vendors be culturally and linguistically appropriate and that sensitivity and diversity be maintained at all time.
## IV. Project Accomplishments
### Outreach and Recruitment

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategies and Activities</th>
<th>Responsible Staff/Partnerships</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>By5/31/2004, outreach and recruitment increase the number of new case managed to 1,300 in Fayette County Baseline: During 1999, 400 women were enrolled in the Healthy Beginnings Plus program. (Source: Family Health Council/Healthy Beginnings Plus Program records)</td>
<td>Strategies for Mother &amp; Infant Objectives: -- Aggressive community outreach and expansion county wide for high-risk women and infants. 1) Contacted 1,500 women of childbearing age (10-44) targeting African American women in the project area to provide information and education regarding the need for early prenatal care and pregnancy issues. 2) Enroll 300 eligible participants 3) Follow-up with pregnant women referred through the Helpline to assure Core Team contact within 48 hours 4) Conduct two focus groups to determine enrollment response time and evaluate the enrollment process</td>
<td>Helpline Information and Referral Specialist, Outreach Workers and Nurses Collaborations with local health and human service providers, i.e., Family Support Centers, Family Childhood Initiative, Early Head Start, physicians, hospital clinics, schools &amp; businesses</td>
<td>1) Accomplished 2) Enrolled 453 eligible participants 3) Accomplished 4) Accomplished – Healthy Start response time and enrollment process were discussed with the Perinatal Task Force and is ongoing</td>
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<tr>
<td>Challenges</td>
<td>Strategies and Activities</td>
<td>Partnerships</td>
<td>Outcomes</td>
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<td>Changing Demographics &amp; Unstable Housing</td>
<td>- Alter native contact information received from all participants (ongoing)</td>
<td>Community Action Southwest, Community Housing Resource Board, Connellsville Area Community Ministries, Connellsville Housing Authority, Connellsville Redevelopment Authority, Fayette Community Action</td>
<td>2001 -2004: 20% of all case managed participants self-reported unstable housing situations</td>
</tr>
<tr>
<td>Educational Opportunities &amp; Welfare Reform Effects</td>
<td>- Home visits are scheduled to address the time constraints of program participants</td>
<td>Career Links and Department of Welfare, Penn State University, Even Start, Head Start</td>
<td>2001 -2004: 73% of all case managed participants were enrolled in Department of Welfare Medicaid/HMO Programs 2001 -2004: 1.2% of all case managed participants’ self-reported need for educational assistance.</td>
</tr>
<tr>
<td>Health Care Under-utilization</td>
<td>- Inform clients of Health Care Providers who are sensitive to the beliefs and values of program participants, flexible in scheduling &amp; sensitivity to time constraints</td>
<td>Uniontown Hospital, Centerville Clinic, Cherrytree Pediatrics, Laurel Pediatrics, Private Practices, PA Health Department, Gateway Health Plan, Highmark Caring Foundation, Steps to a Healthier Fayette County, Adagio, Community Health Improvement Partnership, Med Plus</td>
<td>2001 -2004: 17% of all case managed participants lacked health insurance upon enrollment for HSI services 2001 -2004: 2.8% of all infants required assistance with obtaining medical insurance</td>
</tr>
<tr>
<td>Lack of Childcare</td>
<td>- Child Care referrals &amp; provisions</td>
<td>Child Care Information Service of Fayette County, Child Care Partnerships/CCIS of Allegheny County</td>
<td>2001 -2004: 36% of all case managed participants were employed and/or attended school</td>
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<tr>
<td>Lack of Trust</td>
<td>Home Visiting/Case Management - Minimum 15 home visits (averaging 1 hour) completed weekly</td>
<td>Healthy Start Multidisciplinary Team, Perinatal Task Force, HS1 Board of Directors, Area Churches, Schools</td>
<td>2001 -2004: 40,000 Home visits completed based on number individual field staff members x 15 home visits weekly= 10,000 per year rate</td>
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</table>

Grantee: Fayette County Healthy Start Inc.

Challenges: Outreach & Recruitment
## Case Management

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
</table>
| **By 5/31/04, increase to 91% the proportion of pregnant women in the project area who begin prenatal care in the first trimester of pregnancy.** *(Baseline: 87.2% of the women in Fayette County entered prenatal care in the first trimester of pregnancy; PA Department of Health 1995-1997)*. | **Strategy:** Outreach, Referrals, Broad-based collaborative effort, Support Services, Education, Public Relations | **Year 1 Progress:** 89.6%  
**Year 2 Progress:** 71.2%  
**Year 3 Progress:** 73.4%  
**Year 4 Progress:** 81.2% |
| **Activities:** | 1. Completed  
2. Completed  
3. Completed  
4. Completed  
5. Completed  
6. Completed as dollars available. |
| 1. Monthly, community canvassing will be conducted by outreach workers. Prenatal care information provided. (ongoing)  
2. Outreach workers will follow-up with pregnant women referred through the Helpline to assure contact and enrollment within 48 hours. (ongoing).  
3. Program Administrator will hold a series of meetings designed to unify efforts of health and human services providers in the provision of care to individuals and families in the project. (Twice/Year and as available).  
4. Provide transportation, child care and support services to case managed women on an emergency basis. (ongoing and as available)  
5. Disseminate educational packets that provide information on pregnancy, parenting, family planning, and other community-based services to all case managed women. (ongoing)  
6. Provide educational campaigns on early/regular prenatal care using radio, community newspapers, and printed resources placed in key locations, i.e., WIC offices, grocery stores, hospitals, etc. (ongoing) | | |
| **By 5/31/04, reduce the percentage of low birth weight infants born to women who reside in the project area to no more than 7%.* *(Baseline: For the period 1995-1997, 7.9% of births to Fayette County)*. | **Strategy:** Case Management, Education, Early Identification and Referral Services | **Year 1 Progress:** 8.0%  
**Year 2 Progress:** 6.0%  
**Year 3 Progress:** 7.9%  
**Year 4 Progress:** 7.7% |
| **Activities:** | 1. Completed  
2. Completed  
3. Completed  
4. Completed  
5. Completed |
| 1. Emphasize the importance of early enrollment in and compliance with prenatal care. (ongoing)  
2. Provide health education regarding the risks of smoking, nutrition and the signs of preterm labor to participants. (ongoing)  
3. Implement a curriculum that includes all key risk areas as part of prenatal teaching. (ongoing)  
4. Provide intensive case management for 100% | | |
residents were low birth weight, PA Department of Health.

| of substance abusing women enrolled in Healthy Start. (ongoing – home visits to occur more frequently) | 5. Refer 100% of substance abusing women enrolled in Healthy Start to therapy (ongoing as identified). |

| By 5/31/04, increase the percentage of completed referrals for a.) pregnant women, b.) children, and c.) children with special health care needs (CSHCN) to 70%.
(Baseline: Of all referrals made for pregnant woman and infants in Allegheny County, 61.7% were completed and 69.4% completed for CSHCN, Healthy Start MIS). | Strategy: Early Identification and Referral Services, Monitoring Protocols, Activities: 1. Program Administrator will hold weekly meetings with team members to review each new enrollment for the following needs/risks: lack of family support, Medicaid, housing, domestic violence, smoking, substance abuse, immunizations, family planning and any other infant mortality risk. (ongoing) 2. Team members will review charts to ensure compliance with the plan of care (ongoing, quarterly) 3. Team members will identify the appropriate provider and refer participants. (ongoing) 4. Helpline will identify women for enrollment, facilitate immediate referrals and follow-up as necessary. (ongoing) 5. Transportation will be provided to medical appointments. (ongoing) |

| a.) Pregnant Women Year 1 Progress: 70.8% Year 2 Progress: 71.4% Year 3 Progress: 69.5% Year 4 Progress: 65.2% | 1. Completed |
| b.) Children Year 1 Progress: 69.8% Year 2 Progress: 70.9% Year 3 Progress: 67.8% Year 4 Progress: 73.3% | 2. Completed |
| c.) CSHCN Year 1 Progress: 50.0% Year 2 Progress: 64.2% Year 3 Progress: 69.4% Year 4 Progress: 72.5% | 3. Completed |
| 1.完成了 | 4. Completed |
| 2. 完成 | 5. 完成 |
### Health Education

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Strategies and Activities</th>
<th>Partnerships</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transportation</td>
<td>• Provided transportation and maintained relationships with community allowing for a forum of multi-cultural providers and presenters who are culturally competent.</td>
<td>Healthy Start Staff, Allegheny County Health Department, FCHIP, Western Psychiatric Institute and Clinic, West Penn Hospital, Healthy Hearts &amp; Souls, Family Links, Gateway Rehabilitation Center, SIDS Alliance of PA, Community Connections for Families</td>
<td>• 580 participants were provided health education from 2000 to 2004</td>
</tr>
<tr>
<td>2. Awareness of resources</td>
<td>• Provided Staff and participant trainings on how to navigate the healthcare system.</td>
<td>Healthy Start Staff, Allegheny County Health Department, WIC, Family Links, University of Pittsburgh,</td>
<td>• 100 trainings which outlined resources our participants can utilize</td>
</tr>
<tr>
<td>3. Reaching high risk</td>
<td>• Healthy Start is able to reach high risk participants through educational activities in the community such as; focus groups, educational canvassing, baby showers and health fairs.</td>
<td>Healthy Start Staff</td>
<td>• 2 annual baby showers</td>
</tr>
<tr>
<td>4. Childcare</td>
<td>• Childcare was provided at 35 training events.</td>
<td>Healthy Start Staff</td>
<td>• 4 trainings on cultural competency from 2000 to 2004</td>
</tr>
</tbody>
</table>

- **Healthcare System:**
  - 580 participants were provided health education from 2000 to 2004.
  - 203 staff were trained in cultural competency between 2000 and 2004 and attended 14 hours of training.

- **Healthy Hearts & Souls:**
  - Provided healthcare and health education to high-risk participants through educational activities in the community such as; focus groups, educational canvassing, baby showers and health fairs.

- **Family Links:**
  - Provided healthcare and health education to high-risk participants through educational activities in the community such as; focus groups, educational canvassing, baby showers and health fairs.

- **Gateway Rehabilitation Center:**
  - Provided healthcare and health education to high-risk participants through educational activities in the community such as; focus groups, educational canvassing, baby showers and health fairs.

- **SIDS Alliance of PA:**
  - Provided healthcare and health education to high-risk participants through educational activities in the community such as; focus groups, educational canvassing, baby showers and health fairs.

- **Community Connections for Families:**
  - Provided healthcare and health education to high-risk participants through educational activities in the community such as; focus groups, educational canvassing, baby showers and health fairs.
### Interconceptional Care

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategies and Activities</th>
<th>Responsible Staff/Partnerships</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 5/31/2004</td>
<td>Strategy: Interconceptional Care, Outreach and Recruitment, Case Management and Health Education</td>
<td>Responsible Staff: MDT, OEA, Health Educator, Information Referral Specialist (IR), Operations Assistant, Data Analyst, Clinical Coordinator, Program Administrator</td>
<td>During the project period - 79% (336/423) of infants, two years of age received appropriate immunizations. 100% of infants had primary pediatric providers</td>
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<td>Baseline: 73% of Health Center participants two years of age between 1997-1999 were appropriately immunized</td>
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<tr>
<td>Project Period Objective</td>
<td>Strategies and Activities</td>
<td>Responsible Staff/Partnerships</td>
<td>Accomplishments</td>
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<tr>
<td>Challenges</td>
<td>Strategies and Activities</td>
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<td>Outcomes</td>
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<tr>
<td><strong>Participant Barriers</strong>&lt;br&gt;1. lack of knowledge and trust and skepticism about the effectiveness of prevention&lt;br&gt;2. inadequate or inappropriate utilization of health care services&lt;br&gt;3. poverty/low socioeconomic status.</td>
<td>1. Provide continual health education on the importance of having a medical home.&lt;br&gt;2. Monitor for receipt of health care services and we provide, assist with transportation and childcare&lt;br&gt;3. Assess participants’ financial eligibility (Such as Medicaid or Title X eligibility) and assist them in navigating through the application process.</td>
<td>Federally Qualified Health Centers, Family Health Council, Primary Care physicians, Specialists, Local Area Hospitals, Department of Public Welfare, WIC, Family Support Centers, Perinatal Task Force, Fayette County Health Improvement Partnership (FCHIP)</td>
<td>Overall Health Education</td>
</tr>
<tr>
<td><strong>Provider Barriers</strong>&lt;br&gt;1. Lack of culturally competent and diverse staff&lt;br&gt;2. Lack of training in patient prevention counseling&lt;br&gt;3. Lack of follow-up for individuals and families in addressing health care needs&lt;br&gt;4. Lack of knowledge about and linkage to community-based health and human services</td>
<td>1. Act as an advocate for the individuals and families involved.&lt;br&gt;2. Accompany participants on visits to health care providers&lt;br&gt;3. Follow-up on participants’ concerns of biased treatment.&lt;br&gt;4. Provide education to community providers via presentations on HSI services&lt;br&gt;5. Inviting them on site visits and providing opportunities for them to shadow outreach and nursing staff on participant visits</td>
<td>Federally Qualified Health Centers, Family Health Council, Primary Care physicians, Specialists, Local Area Hospitals, Department of Public Welfare, WIC, Family Support Centers, Perinatal Task Force, Fayette County Health Improvement Partnership (FCHIP)</td>
<td>Total Number of Provider Trainings Offered</td>
</tr>
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</table>
### Challenges

**System Barriers**
1. Fragmentation of health and human services
2. Lack of coverage or inadequate reimbursement for services
3. Lack of adequate public transportation
4. Inadequate health and human services resources within a community.

### Strategies and Activities

1. Participating./Partnering with various organizations to eliminate existing health disparities to promote more continuity of care
2. Assisted with transportation and childcare
3. Advocated for the establishment of primary health care centers in underserved Healthy Start communities through creation of partnerships between the private health care providers

### Partnerships

Federally Qualified Health Centers, Family Health Council, Primary Care physicians, Specialists, Local Area Hospitals, Department of Public Welfare, WIC, Family Support Centers, Perinatal Task Force, Fayette County Health Improvement Partnership (FCHIP)

### Outcomes

Women in a medical home with an ongoing primary care provider

### Consortium
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategies and Activities</th>
<th>Responsible Staff/Partnerships</th>
<th>Outcomes</th>
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</thead>
</table>
| By 5/31/2004, increase the degree of consumer participation as well as participation by racial/ethnic minorities in the work of the consortium on program policy directions for the Healthy Start Initiative to 33% (source: attendance logs) | Monitored number of participants  
- Monitored attendance  
- Monitored consumer participation  
- Held elections  
- Appropriately replaced members (if necessary)  
- Provided presentations in the community  
- Utilized radio and local newspapers  
Enabling Services  
- Provided transportation  
- Provided nutritional supplements at meetings  
- Provided childcare | Perinatal Systems Liaison, Healthy Start Multidisciplinary Team, Perinatal Task Force | Year 1  4.8% (1/21)  
Year 2  37.5% (9/24)  
Year 3  33% (9/30)  
Year 4  20% (6/30) |
| By 5/31/2004, increase the capacity (knowledge and skills) of the consortium members through provided training/education by 90% (source: attendance logs) | Brochures, Trainings, and Fact Sheets  
- Developed an educational/orientation manual for new members  
- Held new member orientation sessions  
- Distributed education fact sheets  
- Provided newsletters quarterly  
- Provided cultural competency training  
- Provided program baby shower  
- Provided county baby shower | Perinatal Systems Liaison, Perinatal Task Force | Year 1  100%  
Year 2  100%  
Year 3  100%  
Year 4  100% |
<table>
<thead>
<tr>
<th>Challenges</th>
<th>Strategies and Activities</th>
<th>Responsible Persons</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining racial/ethnic membership on the Perinatal Task Force</td>
<td>Identified local meetings in the community</td>
<td>Perinatal Systems Liaison, Fayette HS Staff, Consumers, Perinatal Task Force, FCHIP (Fayette Community Health Improvement Partnership)</td>
<td>Year 1 3 of 23 (13%) members were minority</td>
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<td></td>
<td>- Phone calls</td>
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<td>Year 2 4 of 24 (17%)</td>
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<td></td>
<td>- Attended community meetings</td>
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<td>Year 3 6 of 27 (22%)</td>
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<td></td>
<td>- Recruited partners</td>
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<td>Year 4 5 of 30 (17%)</td>
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<td></td>
<td>Educate community about Healthy Start</td>
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<td></td>
<td>- Presentations</td>
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<td></td>
<td>- Canvassing literature</td>
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<tr>
<td></td>
<td>- Recruited partners</td>
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<td></td>
<td>Participated in community events, health fairs</td>
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<td>Developed culturally appropriate brochures and pamphlets (providers, consumers)</td>
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<tr>
<td>Increasing Consumer Participation &amp; Retention</td>
<td>Outreach and Recruitment</td>
<td>Perinatal Systems Liaison, Fayette HS Staff, Consumers, Perinatal Task Force, FCHIP (Fayette Community Health Improvement Partnership)</td>
<td>Year 1 3 of 23 (13%) of membership were program participants</td>
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<tr>
<td></td>
<td>- Received Outreach worker referrals</td>
<td></td>
<td>Year 2 3 of 24 (12.5%)</td>
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<td></td>
<td>- Received partnering referrals</td>
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<td>Year 3 4 of 27 (11%)</td>
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<tr>
<td></td>
<td>- Healthy Start events</td>
<td></td>
<td>Year 4 3 of 30 (10%)</td>
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<tr>
<td></td>
<td>Enabling Services</td>
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<tr>
<td></td>
<td>- Provided transportation (vans, bus tickets)</td>
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<td></td>
<td>- Provided nutritional supplements at (18) meetings</td>
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<td></td>
<td>- Provided childcare to (6) consumers (services, reimbursement)</td>
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B. Mentoring Technical Assistance – see attached folder: Mentoring Materials

V. Project Impact

Because of the alarming statistics related to perinatal health in Fayette County, Healthy Start initially proposed to build system capacity to reduce infant mortality and low weight births. Specifically, the initiative proposed to build a perinatal system, develop service capacity to address gaps and barriers to service, to promote community involvement in preventing infant mortality and teen pregnancy and to foster linkages among health care providers. The models of Consortium and Care Coordination/Case Management were applied to accomplish these goals.

During the last project period, Fayette Healthy Start successfully used an approach that was systematic and interactive in nature and involved the fundamental elements in the provider and human services communities necessary to systematically address the problems of health disparities and postpartum care systems through support services. These services improved the chances of avoiding poor birth outcomes in low-income women and included home visits, nutrition and health education, psychosocial services, risk assessments, individual counseling for identified risks, referrals for needed professional resources and services as well as follow-up on the utilization of services.

The presence of Healthy Start and the networking, collaboration and enhanced public concern about health disparities and infant mortality have contributed to the overall well-being and the improved conditions/circumstances for residents of Fayette County. Perhaps more important, the Fayette experience continues to affirm the mortality in a community requires a “high tech/high touch” blend of quality medical care and sensitive, highly personal social and human supports.

In order to improve the healthy outcomes of women and their infants, Fayette Healthy Start implemented a three-pronged approach to community involvement, consisting of the Healthy Start, Inc. Board of Directors, the Fayette Community Health Improvement Partnership and the Perinatal Task Force. This unique approach has allowed the Fayette County Healthy Start project to identify individuals, agencies and organizations that can lend their expertise to address perinatal health issues and eliminated those barriers to service unique to this rural community.

VI. Local Evaluation Plan
Project: Fayette County Healthy Start
Reporting Period: June 1, 2000-May 31, 2004
Local Evaluator: Christine E. Ley, Ph.D., MPH

Section I: Introduction
Although the community assessment as well as maternal and child health data for Fayette County indicated high need for an integrated system of maternal and child health care and there was strong and enduring local leadership support though the Fayette County CHIP, the development and establishment of such a program as Healthy Start is a long-term project. The primary impact of the Fayette County Healthy Start has been the establishment of a program and its initial acceptance by the community and the families who are potential participants in the program.
The comprehensive and integrative model of the Healthy Start program is a potential benefit for rural communities such as Fayette County where there are few services and less integration of maternal and child health services than would be optimum. The Fayette County Healthy Start effectively addressed challenges to the establishment of the program during the first years of the project.

The Healthy Start project evaluation used a community-building approach for this project period in conjunction with technical assistance in the initial years of the project for the development and implementation of a data management system. The evaluation reviewed the following key questions: What are the challenges that Healthy Start faces in establishing their program? What are the factors contributing to these challenges? What are the strategies that Healthy Start uses to address these challenges?

Section II: Process

The methodology for the evaluation was the review of program records, documents, and key informant data. During the initial years of the project, the evaluation team also worked in collaboration with Healthy Start to develop some of the data management system, assisted with training and provided data analysis for reports and documents. In the later years of the project, these tasks were performed by the Healthy Start staff as the system became operational and staff were trained. The evaluation team also designed databases to capture information on the developed data instruments in collaboration with the Fayette County Healthy Start staff and provided training to the local staff for on site data entry. Primary data to evaluate the consumer participation and program outcomes are collected through data instruments for the project interventions, review of program records. Data sources for the consortia involvement include review of secondary data sources such as the minutes, documentation of training activities. The evaluation team also routinely reviewed secondary data sources. Secondary data sources included the Fayette County health data available from the Pennsylvania Department of Health as well as other Fayette County data as compiled by the health department and other departments in the Commonwealth of Pennsylvania. Birth certificate data and review of data related to infant mortality and maternal and pediatric hospital discharge data are among others. The Fayette County Healthy Start project team reviewed the data as available by the Fayette County health and human services such as the local hospitals, health programs, human services that were related to the project goals.

Section III: Findings/Discussion

The findings indicated that rural programs such as the Fayette County Healthy Start face many challenges in the establishment of their programs and the time-frame for implementation for rural programs often requires a more long term perspective than communities with more population, more financial resources and a larger infrastructure of health and human services.

The Fayette County leadership under the auspices of the Fayette County CHIP provided strong and sustained support for the Fayette County Healthy Start. However, as with most rural communities, the infrastructure for health and human services is limited with relatively few
professionals and services for collaboration. Therefore, rural communities such as Fayette County Healthy Start devote substantial time and staff resources in early implementation to determining the scope of collaboration that is feasible given the community resources, and working with community organizations to develop new services when resources are available and strengthen partnerships.

Outreach and recruitment of families for Healthy Start services also introduces an expanded need for more or different services from the established health and human services system. This is an ongoing process during early implementation as existing programs must determine their capacity to accept referrals from newly identified participants of Healthy Start and the limits of their own staff and resources to collaborate. Likewise, the Healthy Start program must be alert to the ability of community organizations to provide timely and effective services for their participants.

The balance between providing referrals and needed services to Healthy Start participants in view of the somewhat limited capacity of the community infrastructure to readily meet these demands is an important balance in the early years of implementation and requires ongoing communication and meetings with the collaborating organizations and partners of Healthy Start and the Healthy Start management and staff. Through this ongoing process of meetings and communication, the Healthy Start program and its partners developed referral patterns and collaborative planning and implementation for outreach and case management and other core services for the Healthy Start participants.

Establishment of trust in a new program is important for all programs; however, in a rural area, the establishment and continuity of trust is subject to more demands because of the logistical constraints in rural communities. The community infrastructure often has few established organizations with many demands, under-funded, working to address the mission of their own organizations. Rural communities also have the benefits of local leadership that often has longstanding ties to the community and its well-being. Rural community leadership for health programs such as Healthy Start also are often partnerships of many sectors of the community including business and for-profit organizations being advocates for quality health care for economic development and quality of life.

However, the leadership in rural communities also often faces the problem of too few available persons and many organizations needing volunteers for boards, committees and other community service. Volunteer “burn-out” and overload are risks for rural leaders who often serve several organizations. The Fayette County CHIP addressed some of these barriers by involving the existing organization of CHIP as integral to Healthy Start with a smaller core group devoted especially to Healthy Start. The Healthy Start program gained the expertise of a wide range of community leaders while preserving their time and resources by using their membership in the CHIP as a method to offer their guidance and leadership to the Healthy Start program.

The establishment of trust among community residents to enroll in Healthy Start also is a challenge for rural projects and is a long-term goal that evolves over time and the positive experiences of those families who are initial users of the program. Communities such as Fayette County that are in Appalachia and have the economic and health disadvantages of historical geographic isolation have a long history of receipt of short-term funding for various projects. As
with many rural communities with low tax bases and high poverty rates, Fayette County has had little financial ability to sustain many of these projects once the funding for the initial project has ended. Therefore, there is a degree of cynicism and reluctance on the part of community residents and eligible participants to promote or to enroll in the latest “new” program. Concerns both of establishing trust and relationships with the staff and fears that the services may end at a time that they have come to depend on the services create difficulties in recruiting families as the program becomes established.

These factors were elevated for the African American community that traditionally were both geographically and socially isolated and represented a minority in a primarily European American community. The Fayette County Healthy Start used many resources of time and staff to work with community outreach to the African American residents as well as establishing ties with African American community leadership. Staff members were recruited that were representative of the community and were able to facilitate enrollment in the program over time. Likewise, Healthy Start program management devoted many hours to developing the collaborative relationships with the leadership in the African American community in Fayette County. Over time with continued community outreach efforts and working with community organizations, the Fayette County Healthy Start was able to increase recruitment into the program.

The Healthy Start program also faced challenges in the early implementation with the recruitment and establishment of a stable program staff complement. Recruitment and retention of staff and building a staff that used the Healthy Start approach to delivery of maternal and child health services have been important accomplishments during this project period. Fayette County experiences the same health care workforce issues that are present in much of rural America, especially those communities with increased poverty rates.

The staffing problems of rural communities for programs such as the Fayette County Healthy Start are based on a small pool of local residents who have the qualifications for the positions, but more importantly, there is a general reluctance for more experienced persons to leave their current positions for a short-term grant funded program such as Healthy Start. There are relatively few health or human services professionals residing in the community. The overall educational level for Fayette County adults is one of the lowest in Pennsylvania.

As with most rural communities, there also are few organizations in the county that employ many professionals with the exception of the hospital, a few human services programs and the school districts. More experienced local professionals are not likely to leave their positions with more job stability and seniority since there are so few professional jobs in a rural community such as Fayette County and if the grant funding ended, there would be little opportunity for other local professional employment since few positions are available in the local area.

Likewise, the leadership of most community programs such as Healthy Start are reluctant to recruit and hire a non-local person for employment unless there are no local persons with those qualifications. The Fayette County Healthy Start leadership like most rural programs preferred to hire staff that knew the community, had ties to the area, and were known to others who would be working with or being served by the program.
As most new programs, there also were several staff changes in the early implementation in part due to the demands of a “start-up” that exceed those of a more established program. As the program accommodated these staff changes and staff development and training continued as well as more time with delivering Healthy Start services, a stable staff developed and the program implementation continued. Healthy Start addressed these challenges by ongoing participation of Healthy Start in local organizations such as the Fayette CHIP, reviewing the staffing needs of the program in the context of a rural community, and ongoing recruitment and training of local residents for staff.

The adaptation of the Healthy Start integrated model involving extensive community outreach and a commitment to ongoing home visiting also was a challenge due to the topography and geographic isolation and distances within the Fayette County area. Gaining community and resident trust in an array of many small communities that were geographically isolated and often socially isolated from the larger towns in the county was an ongoing activity that required communication with community leadership, collaboration with local partners that had a trusted presence in these communities, and outreach to individuals and families in the communities to provide information about the program and to address questions or concerns about enrollment.

Rural programs using the community-based approach for service delivery face time, staff and resource challenges. The time demands of staff travel to participants living in many small mountainous communities and to be “efficient” in time spent in traveling for home visiting were challenges as the program adapted to determine the scope of services and number of participants that were feasible to serve in a rural environment. The costs of delivery of services that include home visiting and community outreach to a dispersed population are high in terms of time, staff resources and programs such as Fayette County Healthy Start must address the often conflicting demands of providing a comprehensive service and the limited resources to do so.

The purpose of the evaluation was to describe the development of the Fayette County program and challenges that the program addressed during implementation. The description is based on the early implementation of the Healthy Start program in a rural county with increased poverty and relative geographic isolation so the findings and discussion are limited by these factors.

Section IV: Recommendation

The overall recommendation is the consideration of the increased time frame for many rural communities that may be required to reach full implementation of programs such as Healthy Start. Some rural communities do have comprehensive health and human services systems that have evolved especially during the past ten years and are able to use their system to readily implement programs with internal staff recruitment and cross-referrals within their system. However, many other rural communities such as Fayette County devote substantial time and resources to the development of partners within an infrastructure, gaining community trust, and delivering community education and outreach to build enrollment. While implementation of programs such as the Fayette County Healthy Start have been successful, the challenges are high during the early years of building a program.
Section V: Impact
The impact of the program is the establishment of the Fayette County Healthy Start that provides a comprehensive and community-based approach to maternal and child health that was not previously available in the county. Through the funding of Healthy Start, many of the needs for services for pregnant women and infants that the Fayette County CHIP had identified through community needs assessment for its residents are being provided. Likewise, the community consortia offers new opportunities for African American leadership in health services in the local community. The performance objectives and the ongoing review of maternal and infant data also provide oversight for community residents and Healthy Start partners to address new and emerging needs.

Section VI: Publications

N/A

VII. Fetal and Infant Mortality Review
Fayette County does not have an organized Fetal Infant Mortality Review. However, Fayette Healthy Start facilitates a local child death review. The purpose is to gain a better understanding of the factors that contributed to infant deaths through the systematic evaluation of individual cases.

VIII. Products

See attached folders: Board of Directors, Depression Screening & Referral, etc.)

IX. Project Data

See attached folder titled ‘Project Data’