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Introduction

New Haven, Connecticut has been implementing successfully all core services in a federal Healthy Start project since 1997. During the time period 2001 – 2005, the Community Foundation for Greater New Haven (The Foundation) secured funding from three separate Healthy Start competitions: Eliminating Disparities in Perinatal Health, Interconceptional Care: High Risk Women & Their Infants, and Depression Screening and Intervention. While its competitive applications were successful in achieving funding, the original applications called for a combined budget of $7.6 million dollars. Its leadership had to modify the project plans to accommodate the funded level of $5.2 million.

During the 2001-2005 project period NHHS was awarded the Interconceptional Care: High Risk Women & Their Infants Grant (93.926K). Implementation of activities funded by this competition are designed to: (a) build on lessons learned from the first years of Healthy jStart implementation; (b) integrate all activities into a unified Healthy Start approach; and (c) leverage federal, state and local resources. This application included references and/or brief explanations on how the activities associated with Eliminating Disparities create an infrastructure on which to advance improvement efforts in the area of Interconceptional Care.

NHHS provided interconceptional services through seven subcontracts with provider sites. The two hospitals and two health care centers are subcontracted to provide care coordination to interconceptional women. The New Haven Health Department’s Maternal and Child Health Division is subcontracted to provide outreach services to interconceptional women. The New Haven Family Alliance is contracted to hire Community Health Advocates to conduct outreach and enrollment to interconceptional women residing in isolated neighborhoods and public housing developments and finally, Life Haven Shelter provides counseling and support services for empowerment of women who live in the homeless shelter.

The 2001 – 2005 implementation period represents a transformative era for our Healthy Start project. The primary service innovation occurred on April 15, 2002 when we shifted our model from a “case management” model to a “care coordination” model. Our approach to outreach, case finding, and health education proved to be exceptional. However, the community’s maternal and child health systems remained disconnected. Healthy Start participants were dropping out of care. Some participants experienced service duplication while others did not engage in the full range of services available to them. The number of participants was overwhelming the case managers and their ability to navigate the maternal and child healthcare system. Expanding case management services would not produce a viable solution: more case managers would not resolve any of the issues with the healthcare system, and more case managers would only increase the cost of the model.

The NHHS project leadership improved the maternal and child healthcare system by implementing a care coordination model. The care coordination model tracks the health
and social service interventions of a woman and her child through an otherwise fragmented system. Four components exist to the model: 1) client identification; 2) intake/assessment; 3) referral; and 4) enrollment and retention in care. The care coordination model relies upon a networked database, available to all NHHS providers and has been expanded to include the Male Involvement Network. The database provides real-time access to participant information (e.g., intake, assessment, referrals, immunization records); offers tools and reports for NHHS staff to streamline participant monitoring; and improves system efficiency by calculating a risk assessment score (i.e., low, moderate, high). The risk assessment score allows NHHS staff to develop an appropriate care plan as well as to assign the appropriate “intensity” of case management and/or care coordination. The database tracking tools which track linkages to referrals allow Outreach Workers to be contacted in the event that a participant misses a primary care, support service or even a well-child appointment.

The above model for providing interconceptional care services was implemented during this time. During the 2001-2005 project period, NHHS learned that no intense case management services were available for interconceptional women and their infants. During the previous project period NHHS was able to offer outreach and care coordination services to this population but this was not enough for some of the highest risk families. In addition, the other support services available in this community funded through the Department of Social Services only focus on the pregnant woman. Therefore, once the woman delivered her baby, support services would end. Also all NHHS staff was required to work with both pregnant and interconceptional women. For the 2005-2009 project period NHHS has modified the interconceptional care model to include one case manager who will be designated to work exclusively with the highest risk interconceptional women and one care coordinator who will be working exclusively with moderate to high risk interconceptional families.

NHHS also learned that the prenatal care/women’s health and pediatric services within the subcontracted institutions that serve the most people were very fragmented. The prenatal and pediatric clinics operated in isolation of each other. Because of the way the systems were set up within the institutions, it made reaching and tracking interconceptional women difficult. All of the care coordinators were stationed in the prenatal clinic areas and were supervised by clinic staff. This made it difficult to move back and forth between the prenatal care areas and the pediatric care area. Having mobility between the systems is critical in being able to provide a continuum of service for the mother and child. The NHHS Perinatal Partnership is charged with working on these challenges within the institutions. In response to our experience so far the Partnership has requested that a worker be assigned specifically to the pediatric clinic at Yale New Haven Hospital and focus only on interconceptional women and their families. Therefore NHHS has modified the interconceptional care model to reflect this recommendation. The Hospital of Saint Raphael’s has also responded to this long acknowledged challenge by integrating all of the ambulatory care services into one area, which is now known as the Saint Raphael’s Healthcare System Family Health Center. The Care Coordinator now has access simultaneously to pregnant and interconceptional women and infants.
The prior NHHS grant funded a community health advocacy program currently operated by the New Haven Family Alliance. With the absence of the Interconceptional grant for 2004-2009, Community Health Advocates (Health Advocates) will be incorporated into the NHHS program within the context of the Community Consortium. Their work will center on identification of prenatal women early in the first trimester, and on women during the interconceptional period. Community Health Advocates will become a volunteer core of women and men who will become better trained to identify potential and actual candidates for the Healthy Start programs. Based on our experience with paid Health Advocates in the 2001-2005 grant, our lessons learned tell us that this programmatic service is critical to our outreach, educations, and identification of high risk women. Retaining this particular service in the next round of funding is also critical to institutionalizing knowledge in communities where Healthy Start participants reside. Thus, It is our plan to build on the success and size of our consortium by identifying a select group of (5 -10) women and men who would be trained to become volunteer Health Advocates. In doing so, we will strengthen our efforts in outreach and participant identification by infusing these advocates with a cadre of skills that will enable them to serve their communities. The program will also enable Health Advocates to build their own knowledge and capacity for entry level jobs in the broader community.

Health Advocates will receive education, support, and coaching necessary to establish a solid foundation as trained intermediaries of the NHHS program. The existing Health Advocate orientation will be augmented by sponsorships to participate in the local First Thursday’s forums, which are designed to provide lay and grassroots professionals with the skills they need to become certified prevention specialists. While some may aspire to be better trained professionals, others may just want a way to give back to their communities.

New Haven Family Alliance is a community-based organization known throughout New Haven for its work in the area of family preservation, case management, self-sufficiency programs, and advocacy. New Haven Family Alliance plays a critical role in the Male Involvement Network. The Male Involvement Network recognizes the importance of father involvement on the emotional development of children, and encourages fathers to take active roles in the development of their children (far beyond paying child support). Healthy Start’s relationships with community providers such as the New Haven Family Alliance as well as the community healthcare providers creates opportunities to market NHHS services to high risk populations (i.e., racial/ethnic, geographic communities).

As a strategic (and institutionally driven) plan, the Foundation has recently launched a 10-year initiative called “First Years First” (FYF) as a direct result of the success of Healthy Start. The initiative is designed to facilitate the development of children (ages 0 – 8) who meet physical, emotional, social, and educational benchmarks. Four program strands drive the initiative (and complement other institutional efforts to support children and families): family literacy, medical homes (i.e., Healthy Start), early child care, and

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1 It is reasonable to assume that many of these Health Advocates will be drawn from current or former participants of Healthy Start services. Health Advocates will become ambassadors for the program in three neighborhoods, Farnum Courts, Quinnipiac Terrace and Eastview Terrace. These neighborhoods have been selected because we were able to implement community consortiums at each of these public housing developments during the previous grant period. These are also the communities where large numbers of African American, Caribbean, and Afro-Latin women reside.
changing public policy. The Foundation has set a goal to raise $20 million over a 10-year period to sustain these approaches – each of which was selected as a result of a community dialogue and a focus on “evidence-based” approaches. Additionally, the Foundation is committed another initiative, the “Child Outcomes Tracking Project” (COTS) that will look at NHHS families and follow the families and children from birth to entry into kindergarten. The project will look at the different programmatic interventions for the child over the development years to see if there the programs assist children in school readiness.

2 The Connecticut Voices for Children is the managing partner of Ready, Set Grow – CT Kids!, a public awareness campaign that is rallying support for reinvestment to meet the needs of young children and their families. [See www.readysetgrowctkids.org]. Seventy eight (78%) of infants and toddlers are cared for in someone’s home. The Foundation supports the Family Child Care Network – designed to turn home-based child care into a powerful tool for school readiness (including proper health). The Yale Child Study Center evaluates the Family Child Care Network effort to track quality and impact. The Connecticut Humanities Council is the lead partner to implement the Motheread/Fatheread program – which builds on the passionate desire of parents to be the best first teacher for their child.
The following figure shows the components of the system and the interface between providers and the database network.

New Haven Healthy Start Care Coordination and Plan Implementation Model

Major Health and Supportive Service Provider Network

- NHHD, MANOS, NHFA

Major Providers and Provider Network

- NHHD – 3 centralized outreach workers + HUSKY workers + MANOS intense case management / workers + pedi immunization
- YNHH (non-HS funded OWs) + HS Care Coordinator
- HSR (non-HS funded OWs + HS Care Coordinator
- FHHC (non-HS funded CMs) + HS Care Coordinator
- HHHC (non-HS funded CMs) + HS Care Coordinator
- NHFA – Community Health Advocate

Planning and Collaboration

- New Haven Communities/targeted neighborhoods
- Consortium Support and Development
- Title V MOU – model replication for MCH programs
The care coordination model expands our community’s limited maternal and child health resources by increasing efficiency and more appropriately matching up services to participant need. Since 2002, over 2,658 women and 1,600 infants have received NHHS care coordination services. Our community’s maternal and child healthcare providers function now more than ever as a network of care (e.g., use universal assessment forms, depression screening, use database, training) and NHHS participants experience a seamless system. Moreover, the care coordination model: a) may be used as the model for all State Department of Public Health Title V (MCH) funded programs; b) served as the basis for two other Connecticut communities who applied for federal Healthy Start funds for the 2005-2009 competition; and c) has drawn interest from Managed Care Organizations such as Anthem Blue Cross / Blue Shield.

Our data-driven approach and our consumer-driven Consortium (200+ strong) maintain a sharp focus on what is relevant to the maternal and child health needs of the community.

I. Overview of Racial And Ethnic Disparity Focused On By Project

Identify the racial, ethnic or other disparities that your project focused on. Highlight from your initial community needs assessment the data that led to your community’s decision to focus on the identified disparities.

NEEDS ASSESSMENT - New Haven Demographic and Statistical Data Table

<table>
<thead>
<tr>
<th>Variable</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Other</th>
<th>(N) Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990 Census Data for each of the following</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population by Racial Distribution</td>
<td>70,263</td>
<td>47,157</td>
<td>17,242</td>
<td>13,054</td>
<td>130,474</td>
</tr>
<tr>
<td># Women of Reproductive Age (WRA)</td>
<td>18,795</td>
<td>13,024</td>
<td>4,761</td>
<td>3,882</td>
<td>40,462</td>
</tr>
<tr>
<td>% Children under 18 in families with incomes below Federal Poverty Level (FPL)</td>
<td>18.1%</td>
<td>40.9%</td>
<td>49.3%</td>
<td>49.0%</td>
<td>10,128</td>
</tr>
<tr>
<td>1996 – 1998 (Three Year Average) for each of the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Live Births</td>
<td>380</td>
<td>738</td>
<td>507</td>
<td>62</td>
<td>1,814</td>
</tr>
<tr>
<td># Births to Teens 18 and younger</td>
<td>10</td>
<td>78</td>
<td>51</td>
<td>-----</td>
<td>152</td>
</tr>
<tr>
<td># Live Births to women entering care in the first trimester</td>
<td>317</td>
<td>465</td>
<td>343</td>
<td>49</td>
<td>1,253</td>
</tr>
<tr>
<td># Live Births with No Prenatal Care</td>
<td>40</td>
<td>170</td>
<td>95</td>
<td>11</td>
<td>351</td>
</tr>
<tr>
<td># Infant Deaths under one year of age</td>
<td>5</td>
<td>14</td>
<td>4</td>
<td>-----</td>
<td>20</td>
</tr>
<tr>
<td># Neonatal Deaths (28 days or less)</td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>-----</td>
<td>15</td>
</tr>
<tr>
<td># Post Neonatal Deaths (29 to 364 days)</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>-----</td>
<td>5</td>
</tr>
<tr>
<td># infants born weighing 2500 grams or less</td>
<td>30</td>
<td>105</td>
<td>46</td>
<td>6</td>
<td>199</td>
</tr>
<tr>
<td># infants born weighing 1500 grams or less</td>
<td>6</td>
<td>30</td>
<td>10</td>
<td>-----</td>
<td>49</td>
</tr>
<tr>
<td># infants born less than 37 weeks gestation</td>
<td>33</td>
<td>108</td>
<td>62</td>
<td>6</td>
<td>223</td>
</tr>
<tr>
<td>Age Appropriate Immunization Rates of Children (From Birth to 2 years) for 1996</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data is not collected by race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>69%</td>
</tr>
</tbody>
</table>
Located in the south central region of Connecticut, New Haven is the state’s third largest city, with a total population of approximately 130,474. New Haven is 21 square miles in size, borders the Long Island Sound and lies at the fork of Interstates I-91 and I-95, approximately 150 miles from Boston and 74 miles from New York City. New Haven consists of 20 different neighborhoods.

As evidenced by the initial needs assessment, New Haven was an area that could benefit greatly from a program targeting women and infants to ensure their health and well-being. The following themes highlight major findings from the needs assessment around social and economic indicators, and are critical to understanding the factors that contribute to maternal and child health in the area:

- **New Haven maintained an unacceptably high rate of infant mortality:** 11.2 deaths per thousand live births, which is 62.3% higher than the state rate.

- **African Americans in New Haven were disproportionately impacted by infant death:** while only 41% of all live births in 1996-1998 were to African American mothers, this population experienced 70% of all infant deaths.

- **New Haven children were having children:** Approximately one in every five births was to a teenager (aged 13 to 19).

- **New Haven was becoming increasingly diverse:** The African American and Hispanic populations increased by 18% and 63% from 1980-1990 in their racial/ethnic groups, respectively, while the White population decreased by 6%.

- **Poverty levels were high:** The overall poverty rate (21%) was more than three times the statewide rate (6%). In addition, the nation was entering into an economic downturn, and New Haven’s poverty was further exacerbated.

- **Education levels were low:** Nearly one-third of all City residents over age 24 did not have a high school diploma.

- **New Haven’s children were at risk:** Compared to other towns in Connecticut, children in New Haven were at greater risk of abuse, neglect, crime, poverty, and academic failure.

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3 All population data cited is from the 1990 US Census unless otherwise indicated. 2000 Census Redistricting information indicated that the New Haven population was 123,626 in 2000, representing a population decrease of 6,848 people between 1990 and 2000.
Population
Demographic Profile

Race and Ethnicity
The residents living in the project area were of a diverse range of racial and ethnic backgrounds. There are 54% percent of residents in the New Haven project area who are White, 36.1% African-American, 13.2% Hispanic, and 10% other identified races and ethnicities. These statistics represent a distinction from the racial and ethnic picture of the State, which had almost an 80% population of Caucasian residents.

Table 1 illustrates that all non-White groups grew in population in New Haven during the ten-year interval between 1980 and 1990. The most significant increases in racial groupings between 1980 and 1990 were African American (+18%), Asian/Pacific (+151%) and Other (+1121%). In addition, Hispanic ethnicity—which the Census Bureau collects as a separate data set from race—increased by 63%, which indicates a substantial positive influx of Hispanic individuals into New Haven, as well. As the non-White population grew in New Haven, the Caucasian population in New Haven diminished by 6%, indicating a trend toward even greater diversity in New Haven.

This trend continued into the millennium: 2000 data reported the Caucasian population as 53,723, African American as 46,181, Native American as 535, Asian/Pacific as 4,898, Other as 13,460, and Hispanic as 26,443. This represented a 23% decrease in the Caucasian population from 1990 to 2000 and an increase of all non-White populations (62% increase in Hispanic population, a 51% increase in Asian population, a 48% increase in Native American population, a 41% increase in Other population).

Table 1: New Haven Population Change by Ethnic Status

<table>
<thead>
<tr>
<th>Group</th>
<th>1980</th>
<th>1990</th>
<th>Change</th>
<th>% Change in Racial Group</th>
<th>% Change in Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>126,109</td>
<td>130,474</td>
<td>4,365</td>
<td>------</td>
<td>3.50%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>74,120</td>
<td>70,026</td>
<td>-4,094</td>
<td>-6%</td>
<td>-3.2%</td>
</tr>
<tr>
<td>African-American</td>
<td>39,958</td>
<td>47,334</td>
<td>7,376</td>
<td>18%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Native American</td>
<td>320</td>
<td>362</td>
<td>42</td>
<td>13%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Asian/Pacific</td>
<td>1290</td>
<td>3,243</td>
<td>1,953</td>
<td>151%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Other</td>
<td>779</td>
<td>9,509</td>
<td>8,730</td>
<td>1121%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Hispanic (may be any race)</td>
<td>10,042</td>
<td>16,350</td>
<td>6,308</td>
<td>63%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Source: 1990 US Census

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4 2000 Census Redistricting information.
5 The 1980 and 1990 Hispanic figures may not be directly comparable, due to the incomplete reporting of the race of the Hispanic population in 1980. The discrepancy in totals results from a shift in the Census data collection.
Poverty
Poverty levels were high in the New Haven project area. New Haven’s overall poverty rate (21%) was more than three times the statewide rate (6%). In 1996, the Department of Economic and Community Development determined that New Haven’s nominal per capita income of $21,884 was 64.6% of the State per capita income, giving New Haven the eighth lowest per capita income in the State, ranking it 161 out of 169 Connecticut towns.6

Of the children enrolled in the New Haven School District, 57.5% were eligible for free or reduced price meals, compared with 25.3% of students in the State.7 One-third of families in New Haven were headed by single females, and 75% of those families had children under the age of 18. Poverty rates in the City were even more pronounced in the federally-designated Empowerment Zone (EZ)8, ranging from 27% to 51%, with 50% of children under age 6 living in poverty.

Data from the Consumer Price Index Report stated that inflationary impact of the economic climate would be reflected in higher costs for food, transportation and healthcare. This would have a direct effect on the fixed income population; increasing stress factors, i.e., depression, alienation, and economic status of family or individual. The at-risk client population would undoubtedly increase as companies continue to scale back employees. Job loss and retention continued to be a major concern.

Children
In New Haven, children under the age of 18 accounted for 23.7% of the total population. Data from the New Haven School District (representing 89.2% of total student population in New Haven) showed that 87.5% of students were minorities with a high representation of African American students (57.4%) and Hispanic students (27.8%). An estimated 27.7% of New Haven school district students lived in homes where English was not the primary language spoken (compared with 12.3% Statewide).9

Compared with the State, the children of New Haven enter life with much greater risks to health; much greater risk of abuse, neglect and involvement with violent crime; a greater likelihood of growing up in poverty; and a much higher risk of failing academically (see Table 2). A family’s socio-economic status is a leading predictor of children’s educational outcomes, and is demonstrated in the academic performance levels of New Haven’s students.

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6 http://www.state.ct.us/ecd/research/ceis/income/pci.html, 1996
8 Empowerment Zone program is a HUD economic and community development program.
9 The figures on New Haven Public Schools represent approximately 89.2% of New Haven’s total student population and were drawn from the New Haven School District Strategic School Profile, 1998-1999.
Table 2 Indicators of Child Well-Being: Comparison of New Haven v. Statewide Rates

<table>
<thead>
<tr>
<th>Indicator of Child Well-Being</th>
<th>New Haven Rate</th>
<th>State Rate</th>
<th>WORSE than State Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juvenile Violent Crime Arrests (per 100,000 youth 10-17,1996-98)</td>
<td>2,185</td>
<td>451</td>
<td>384%</td>
</tr>
<tr>
<td>Welfare Benefits (% of all children receiving welfare, 1998)</td>
<td>28.9</td>
<td>7.0</td>
<td>313%</td>
</tr>
<tr>
<td>Child Abuse / Neglect (per 1,000 children, 1998-99)</td>
<td>6.2</td>
<td>2.2</td>
<td>182%</td>
</tr>
<tr>
<td>Below CAPT Basic Level (% of all 10th graders, 1998-99)</td>
<td>64.1</td>
<td>26.8</td>
<td>139%</td>
</tr>
<tr>
<td>% Single-Parent Families (1990 Census)</td>
<td>46.4</td>
<td>20.0</td>
<td>132%</td>
</tr>
<tr>
<td>Births to Teen Mothers (% of all births, 1997)</td>
<td>18.7</td>
<td>8.3</td>
<td>125%</td>
</tr>
<tr>
<td>High School Dropouts (% leaving school in 1997-98)</td>
<td>6.8</td>
<td>3.5</td>
<td>94%</td>
</tr>
<tr>
<td>Meeting CAPT Goal (% all 10th grade students, 1998-99)</td>
<td>1.7</td>
<td>15.3</td>
<td>89%</td>
</tr>
<tr>
<td>Child Deaths (per 100,000 children ages 1-14, 1993-97 avg.)</td>
<td>43.0</td>
<td>24.1</td>
<td>78%</td>
</tr>
<tr>
<td>Infant Mortality (per 1,000 births, 1996-1998)</td>
<td>11.2</td>
<td>7.0</td>
<td>63%</td>
</tr>
<tr>
<td>Low Birth Weight (per 1,000 births, 1997)</td>
<td>107.9</td>
<td>73.4</td>
<td>47%</td>
</tr>
</tbody>
</table>

Source: Connecticut Association for Human Services 2000 Data Book.

Education and Unemployment
The socio-economic indicators pointed to the need for better living, social, and educational environments for children. These needs extended to adults, as well. Twenty-nine percent (29%) of City residents over age 24 did not have a high school diploma. Unemployment rates in New Haven (in 1990) were 13.8% and 12.4% for men and women with children, respectively. In 2000, unemployment was estimated to be 3.3% in New Haven as compared to the State unemployment rate of 2.4%. Employment rates varied within the City, though, and often reached 90% in areas that contained public housing authority developments.

A small proportion of New Haven’s job losses in the manufacturing sector were replaced by an emerging biotechnology industry. But jobs in this employment sector require an education and skill level that is beyond the skill base of most residents in the Healthy Start-New Haven project area. New Haven’s largest employers are its academic and health care institutions. The city is home to numerous institutions of higher education such as Albertus Magnus College, Quinnipiac College, Southern Connecticut State University, and Yale University. Dominant medical facilities are the Hospital of Saint Raphael, a community-based teaching hospital, and Yale-New Haven Hospital, a world-

renowned medical research and teaching hospital. Aside from its wealth in medical care institutions, the employment industry that was most significant to New Haven’s Healthy Start program was the city’s rich base of non-profit and human service organizations. These organizations represented a viable sector of the city’s economy, providing both employment opportunity and critical services to New Haven residents. However, the full capacity of this service sector had not being achieved, and in many cases its viability was threatened. This presented a direct threat to the health of women and infants living in New Haven's Healthy Start project area.

As the Connecticut Department of Public Health Title V Needs Assessment report underscored, the socio-demographic indicators were critical to understanding the factors that contribute to morbidity and mortality risks. It was also these socio-demographic indicators that were critical to understanding the need for services and information in New Haven and identifying gaps. To further elucidate the socio-demographic indicators in direct relation to maternal and infant health, we turn now to women of childbearing age.

*Women of Childbearing Age*

The 1990 Census Bureau data identified 40,462 women of childbearing age in the project area (31.0% of total New Haven residents). Table 3 provides a racial and ethnic breakdown of these women. Consistent with the overall demographics of the New Haven population, over half of the women of childbearing age in New Haven were non-White (32% African American, 12% Hispanic, 10% Other).

Socio-demographic factors of these women are important indicators of the health status of these women, and the health status of the beginnings of life for New Haven children.

**Women of childbearing age in New Haven were largely afflicted by high poverty rates, low education rates, and substantive drug abuse.**

In one six-neighborhood area of New Haven that had been extensively researched, 9,158 women of childbearing age were receiving Medicaid in 1997 (representing 42% of WCBA of those neighborhoods and 23% of total New Haven WCBA). Additionally, in those six neighborhoods, 12% of women of childbearing age were living in Public or Section 8 housing.

Maternal education is an excellent indicator of the prevalence of low birth weight or other poor birth outcomes. In the aforementioned six-neighborhood area of New Haven, 31.3% of the women of childbearing age were equipped with less than a High School education.

<table>
<thead>
<tr>
<th>Race / Ethnic Origin</th>
<th># Childbearing-Age Women</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>18,795</td>
<td>46%</td>
</tr>
<tr>
<td>African American</td>
<td>13,024</td>
<td>32%</td>
</tr>
<tr>
<td>Hispanic Origin</td>
<td>4,761</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>3,882</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>40,462</td>
<td>100%</td>
</tr>
</tbody>
</table>

12 The six neighborhoods included in this information are Dixwell, Dwight, Fair Haven, Hill, Newhallville, and West Rock.
Although a significant population of women of childbearing age lacked a high school diploma, 33% of New Haven’s families were headed by single females, and 75% of the single female heads of households had children under the age of eighteen. It should also be noted that 10,128 children under 18 years of age in New Haven (33%) lived in families below the Federal Poverty Level.

As recorded in the Fetal Infant Mortality Review by the Department of Public Health, Yale-New Haven Hospital Women’s Center (providing perinatal care to over 50% of the women in inner-city New Haven) indicated severe substance abuse in the population of New Haven women of childbearing age. Between 1991 and 1994, 68% of 2,927 women tested positive for alcohol, tobacco, or other drugs. Of these, 35.5% reported that they smoked more than half of a pack of cigarettes per day during their pregnancy and 22.6% reported drinking more than one drink per occasion during their pregnancy. The use of these substances is closely associated with poor birth and infant health outcomes.

*Perinatal health status*

**Infant mortality**

Between 1996-1998, New Haven demonstrated an infant mortality rate of 11.2 deaths per 1,000 infants. Trends indicated a slight decrease in the infant mortality rate since 1994-1996, when 11.4 deaths per 1,000 infants were recorded. This decrease was consistent with the findings of the 2000 Title V Needs Assessment, which found that the IMR is decreasing in the State of Connecticut, as well (State IMR dropped from 9.0 to 7.0 deaths per 1,000 live births from 1986 to 1998). Consistent with the Title V findings, the IMR of New Haven was slightly lower than the 11.4 deaths per 1,000 infants recorded in 1994-1996. Despite the slight decrease, the IMR for New Haven remained 62.3% higher than the IMR for the State.

Table 4 indicates the number of live births and the number of infant deaths (<1 year of age) for each racial and ethnic grouping. IMR was not calculated by racial/ethnic breakdown because three infants were counted twice, thereby invalidating the IMR for each racial category. However, the finding of an increased IMR rate to African American mothers arises from this data. While 41% of all live births in 1996-1998 were to African American mothers, 70% of infant deaths were to children of African American mothers. In assessing the perinatal health status of the City of New Haven, researchers found that low birth weight, number of teen births, and use of prenatal care were important indicators for risk of infant mortality.

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14 Title V, p. 76-77.
Almost 70% of all infant mortality is associated with low birth weight, and the Statewide Title V Needs Assessment identified that while infants of low birth weight constituted less than 7% of all live births in the United States, they accounted for almost 60% of all infant deaths.16

In New Haven, 12.3% of live births occurred after less than 37 weeks of gestation in 1996-1998. This incidence of low birth weight was significantly higher than State levels. New Haven showed 11.0% of infants weighing 2500 grams (compared with State approximation of 7%). An additional 2.7% of New Haven infants weighed less than 1500 grams, a very low birth weight. The risk of death for infants within this birth weight category is 200 times higher than among normal-weight newborns.

Table 5 provides a closer look at the racial and ethnic breakdown of the New Haven birth weight data and presents the marked disparity along racial and ethnic lines. The data shows that premature children are more likely to be born to African American mothers than to White or Hispanic mothers. While 9% of live births to White mothers were premature, 15% of live births to African American mothers were premature. Additionally, while 8% of live births to White mothers weighed less than 2500 grams, 14% of infants born to African American mothers weighed less than 2500 grams.

<table>
<thead>
<tr>
<th>Race / Ethnic Grouping</th>
<th>Number of Infant Live Births</th>
<th>% of Total Live Births</th>
<th>Number of Infant Deaths (&lt;1 year age)</th>
<th>% of Total Infant Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>380</td>
<td>20.9%</td>
<td>5</td>
<td>25%</td>
</tr>
<tr>
<td>African American</td>
<td>738</td>
<td>40.7%</td>
<td>14</td>
<td>70%</td>
</tr>
<tr>
<td>Hispanic Origin</td>
<td>507</td>
<td>27.9%</td>
<td>4</td>
<td>20%</td>
</tr>
<tr>
<td>Other</td>
<td>62</td>
<td>0.3%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>1,814</td>
<td></td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Percentages of Premature Infants, Infants Weighing less than 2500 grams, and Infants Weighing less than 1500 grams in New Haven, 1996-1998

<table>
<thead>
<tr>
<th>Race / Ethnic Grouping</th>
<th>% Live Births after &lt;37 weeks gestation</th>
<th>% Live Births &lt;2500 grams</th>
<th>% Live Births &lt;1500 grams</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>9</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>African American</td>
<td>15</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>12.3</td>
<td>11</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: New Haven Department of Health

15 City of New Haven Health Department.
16 Title V, page 81.
In both prematurity and low birth weight, Hispanic infants were at a higher risk than White infants, but the disparity between these two was not nearly as dramatic as the disparity between births to African American and White women. African American infants were consistently at higher risk (1.5 to 2 times higher risk) for infant mortality than infants of White mothers.

These findings again reflected the trends seen on the statewide level, where African Americans had a higher prevalence for risk factors (i.e., birth rates among teenage women, lack of prenatal care, and low birth weight). The Title V Needs Assessment reported that perinatal care could have a profound effect on lowering the incidence of infant mortality. It reported that with the elimination of non-adequate care in Connecticut, the infant mortality could be reduced by an estimated 15% overall. Among African/Black American infants, where non-adequate care was more common, the elimination of non-adequate perinatal care could result in an estimated 24% infant mortality reduction.

**Teen Mothers**

Number of teen births is also an important indicator for infant mortality. Women ages 15-19 have the highest likelihood of giving birth to children that are premature and low birth weight, and in Connecticut, teen mothers were 1.5 times more likely to deliver low birth weight children than women 20 years or older. The Fetal Infant Mortality Review concurs, reporting that, “the younger the woman, the less likely she is to receive adequate prenatal care, and the more likely she is to deliver a baby weighing less than 2500 grams.”

In New Haven, there are on average of 152 children born to women age 18 years or younger each year (8% of all live births). This figure marked an improvement from past years (in 1991-1993, 12.9% of live births were to teenage mothers and 1994-1996 revealed 13.9%); however, there was a substantial disparity between groups of the New Haven population that still remained.

Table 6 presents the percentages of births to teens 18 and younger for the 1994-1996 and 1996-1998 reporting brackets. Of live births to white mothers, 3% were to teenage mothers. In contrast, the number of live births to teenage Hispanic mothers was more than triple this figure (10%) and the number for births to teenage African American mothers almost quadrupled the white

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>African American</td>
<td>23%</td>
<td>11%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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17 Title V.
18 Title V Needs Assessment, page 80.
21 Fetal Infant Mortality Review.
figure (11%). The comparison between the two time increments showed that although the figures consistently improve, the percentages for non-white races remained at levels that were above the White levels six years ago.

Although teen pregnancy typically refers to women ages 13-18, the numbers of pregnancies to women who were 18 and 19 years old should not be omitted from study due to the large number of births to women who are 18 and 19 years of age.

Table 7 presents the number of births to women ages 13-17 and 18-29. The table illustrates that while women ages 13-17 accounted for 8.4% of all live births in New Haven (1996-1998), women below the age of 20 accounted for 18.1% of births in New Haven. That means that in 1996-1998, 1 out of every 5.5 children was born to a woman under 20 years of age in New Haven.

Additionally, the high rate of homelessness among pregnant and parenting teenagers in New Haven reflects the poor social and economic situation of teen mothers in New Haven. A 1999 survey of five New Haven agencies identified 39 pregnant or parenting teenagers that did not have a stable and safe residence. The study also identified that of the 330 births to adolescents in each year, 158 pregnant or parenting teenagers (47.9%) had resided in three or more living situations in the previous six months.22

The Title V Needs Assessment, the Fetal Infant Mortality Review, and Department of Public Health publications concurred that high numbers of teenage pregnancies were startling because of the clear association with high risk of substance abuse and precariousness of housing situations, and because of the highly correlated risk factor of low birth weight infants. All indicated potential poor health outcomes for infants.

**Prenatal Care**

Quality prenatal care is a critical component of infant mortality and morbidity prevention. Absence of prenatal care is known to triple the incidence of low birth weight, a known indicator of infant mortality risk. Nationally, Connecticut was well-ranked for its achievement of 88% of women receiving prenatal care (12% women not receiving prenatal care). In contrast, New Haven was well below the Connecticut figure with 19% of live births occurring without prenatal care in 1996-1998.

In New Haven, there was a strong disparity between the receipt of prenatal care among racial and ethnic groups. Table 8 details the number of

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22 FIMR.
live births and percentage of live births with no prenatal care by race and ethnicity. While African American mothers were responsible for 41% of the live births, 48% of the births without prenatal care were to African American mothers. In contrast, 21% of the live births were to White mothers, whereas only 11% of the live births without prenatal care were to White mothers.

The figures depict two key findings: 1) New Haven had a lower percentage of women receiving prenatal care than the state, and 2) Non-White women were much less likely to have prenatal care than White women in New Haven.

These findings were directly consistent with the Title V Statewide findings that non-adequate prenatal care was more common in cities, African/Black American and Hispanic women achieved adequate prenatal care less often than other race/ethnic groups, and that non-adequate care was more common among the African/Black American racial group.23

Table 8: Number of Live Births and Percentage of Live Births with no Prenatal Care by Race and Ethnicity, New Haven, 1996-1998

<table>
<thead>
<tr>
<th>Race/Ethnicity of Mother</th>
<th>Number of Live Births</th>
<th>% Live Births with no Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>380</td>
<td>11%</td>
</tr>
<tr>
<td>African American</td>
<td>738</td>
<td>23%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>507</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>62</td>
<td>18%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,814</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: New Haven Department of Public Health

Other Health Indicators

Other health indicators in New Haven showed that New Haven was improving, but still remained well below the health status of Connecticut, as a whole.

Immunization Trend: The percentage of full-immunized New Haven children under the age of 2 increased from 69% to 79% from 1996-1998.24 However, this remained well below the 90% target rate for the Healthy People 2000 immunization goal.25

AIDS Cases Trend: Number of AIDS cases in New Haven decreased between 1996 and 2000 (from 183 to 80 cases). The percentage of AIDS cases in males decreased (from 71.0% to 62.5% from 1996 to 2000). Conversely, the percentage of AIDS cases in females increased from 1996-2000 (from 29.0% to 37.5%). The number of cases that were caused by perinatal transmission decreased from 28 to 2 from 1996-2000.26 However, New Haven retained the second highest number of adults living with AIDS in the State of Connecticut (as determined by residence at the time of diagnosis).27

23 Title V, page 80.
24 New Haven Health Department.
25 FIMR.
26 All AIDS data is from the State Department of Public Health web site (http://www.state.ct.us/dph/).
Trend in Crime Levels: For the 7th year in a row, the crime statistics for the City of New Haven decreased, and the Mayor claimed that crime dropped more than 50% since 1990. In 2000, rape, robbery, assault, burglary, larceny, and car theft each decreased in New Haven. The category that increased between 1999 and 2000, however, was the murder rate, which rose from 12 murders to 18 murders, an increase of 50%.  

Crime statistics are found in “Crime rate beats national average: City police report shows declines in 7 categories” in the New Haven Register.

Trend in Environmental Conditions: New Haven had the highest number of permitted air polluters in the State of Connecticut and the City was ranked as having the eighth highest number of hazardous waste sites in the State of Connecticut.

II. Project Implementation

Using as a framework the five Healthy Start Core Services (Outreach and Client Recruitment; Case Management; Health Education and Training; Interconceptional Care; and Depression Screening and Referral) and the four Core Systems-building Efforts (Local Health System Action Plan; Consortium; Collaboration and Coordination with State Title V and Other Agencies; and Sustainability) identify how your Healthy Start Project implemented each service and system intervention. For each one, answer sequentially the following:

Outreach and Client Recruitment

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.

Context for the implementation strategy

In 2000, data from the Consumer Price Index Report stated that an inflationary impact of the economic climate would be reflected in higher costs for food, transportation and healthcare. This would have a direct effect on the fixed income population; increasing stress factors, i.e., depression, alienation, and economic status of family or individual. The risk client population would undoubtedly increase as companies continued to scale back employees. Job loss and retention continued to be a major concern. Another factor that could influence the potential swelling of the client population was the increased numbers of Latino families entering the New Haven area (see Census data 2000).

During 1997 to 2001, New Haven Healthy Start used federal Healthy Start funds to establish and train an indigenous and culturally competent case finding team to conduct specialized outreach and recruitment activities within targeted geographic areas of New Haven.

Toxins Action Center, West Hartford, CT. Toxics in Connecticut: Top Ten Lists.
The case finding approach proved to be effective. For example, during the 1997-2001 project period, over 700 women were identified and referred to care. The case finding model, however, required additional refinements to make services more customer friendly and more relevant to the changing external environment.

The revised model of outreach and recruitment restructured the location and the working hours of the outreach workers. It more closely aligned the outreach function with outreach activities of the New Haven Health Department’s Maternal and Child Health Division, and community health education activities occurring in the community at public events or within programs that served high risk women (and their children) as well as programs that sought to increase involvement of men in family life.

The outreach and recruitment model continued its tradition of community building dimension that relies on the eyes, ears and individual networks of our community’s most valuable assets: its citizens. This community building tactic turns the tables, moves citizens out of the “client” role, and allows them to take personal responsibility in improving the health and overall well-being of their neighborhood communities.

### Improve on the Healthy Start Case Finder Model (1997-2001)

- Build upon the Healthy Start ‘case finder’ model, that matched 1,300 women with services over the 4 years
- Develop and use a uniform database to track cases and manage the program. Full integration into the MCH data tracking system to avoid duplication
- Use a team of indigenous outreach workers and provide them with adequate professional development, supervision, and training
- Target strategic areas in the community for case finding and outreach
- Link to strategic services in the community:
  - New Haven Home Recovery – Teen Housing Initiative
  - Criminal Justice/Juvenile
  - Teen Truancy Prevention Program
  - Hospital of St. Raphael Project Mothercare Van
  - Christian Community Action Homeless Shelter – Life Haven
  - Health Department’s , HUSKY/Healthy Start Client Identification and MANOS – an outreach support, home visiting program for pregnant women
- Link closely with health education and special events. Case finders help to staff the community events/health fairs in neighborhoods. Also coordinate and participate in their respective institutions.
- Use non-traditional approaches such as seeking out clients at Laundromats, churches, homeless shelters.
- Use non-traditional approaches to identify and connect with services individuals of hard-to-reach populations (e.g., recent immigrants, homeless, substance abusers).
intervention where the outreach workers and case managers had more frequent contact.

Description of specific activities

Project funds were to be used for continuation funding of 4.0 full-time equivalent Community Outreach Workers stationed in the New Haven Health Department’s Maternal and Child Health Division. However, due to union regulations and the contract for workers, increases in city worker salaries increased beyond the capacity of the grant funding. After one outreach worker left the city to pursue other employment, the MCH Division Director and NHHS leadership decided to streamline services by freezing the position and utilizing the remaining three outreach workers more efficiently. The Care Coordinator Manager refocused and helped to provide guidance on data, cross institutional collaboration, community issues and was a liaison to the Community Foundation. The Care Coordinator Manager worked with outreach workers and care coordinators to make certain that women didn’t fall out of care and were provided a seamless system of care.

At that time, Healthy Start maintained three Outreach Workers/Case Finders, who were stationed at a primary health care institution (Saint Raphael’s Hospital, Yale-New Haven Hospital, Hill Health Center, and Fair Haven Health Center). The 2001-2005 model centralizes the stationing of the Community Outreach Workers at the New Haven Health Department to ensure better coordination of maternal and child health outreach, case management services that included HUSKY/Healthy Start Outreach, which is an initiative that identifies uninsured pregnant women and children in the community and links them to prenatal and pediatric care. Also, MANOS an outreach, home visiting support program for pregnant women and the Pediatric Immunization project, that identifies children less than 24 months that are under-immunized and connects them back to primary care. (NOTE: the Immunization project has a bilingual outreach component, which focuses on recent immigrants).

Community Outreach Workers are now fully integrated into the Health Department’s Maternal and Child Health Division and have the added benefit of peer support/motivation, and to create new

<table>
<thead>
<tr>
<th>Outreach Workers at a Glance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0 FTE Community Outreach Workers stationed at the New Haven Health Department and integrated with outreach workers from additional Health Department programs (e.g. HUSKY, MANOS).</td>
</tr>
<tr>
<td>2.0 PTE Community Health Advocates stationed at New Haven Family Alliance.</td>
</tr>
<tr>
<td>Indigenous (i.e., residents) to project catchments area.</td>
</tr>
<tr>
<td>Trained in MCH issues including outreach, recruitment, assessing risk, education, local MCH resources, client engagement, and how to navigate the managed care system (via DSS informational sessions)</td>
</tr>
<tr>
<td>Work closely with liaisons from local primary healthcare providers as well as the existing City Department of Health Medicaid/Healthy Start case managers and staff from the Maternal and Newborn Outreach Services are supervised by the Case Manager Coordinator.</td>
</tr>
<tr>
<td>Canvas target areas using a variety of strategies e.g. meeting with neighborhood associations, community-based police officers, block watches, leaders from the faith and business community, among others to establish contact.</td>
</tr>
<tr>
<td>Identify healthcare practitioners who live in the target neighborhoods and develop a neighborhood-based healthcare assets inventory</td>
</tr>
<tr>
<td>Connect with human service agencies such as emergency homeless shelters, day-time drop-in centers, soup kitchens, and drug treatment centers, among others</td>
</tr>
<tr>
<td>Link and/or refer women to other human service providers (to diminish the impact of other MCH risk factors)</td>
</tr>
</tbody>
</table>
opportunities to implement alternative outreach and recruitment strategies (e.g., non-traditional business hours of service) as well as take advantage (added value) of the outreach/case finding strategies in place through the Health Department’s HUSKY/Healthy Start Initiative. Centralizing the outreach/client recruitment strategy at the Health Department creates an “army” of outreach workers, maximizes the outreach resources by leveraging outreach initiatives within the Health Department and provides vital linkages to external outreach programs. Centralized outreach affords the opportunity to consolidate the supervision of the outreach activities resulting in increased capacity to serve. This enables follow-up and direct interchange with MANOS; increased timeliness in exchange of information and referral, and less likelihood of duplication (service and data) concomitantly providing a direct conduit to the Perinatal Partnership the staff of whom NHHS and NHHD are members.

Each Outreach Worker was assigned a target population and goal for outreach and recruitment. These individual goals corresponded to the annual team goal (i.e., project objective). During the first 12 months of implementation, for example, the team goal was to reach the number of women recruited internally by Care Coordinators + the number of women identified by the Community Outreach Workers: these numbers are calculated for “women of childbearing-age” and “pregnant women”.

In September of 2002, Community Health Advocates (CHA) became an essential part of the outreach team. Community Health Advocates reside in the targeted communities and public housing developments. The goal is to provide support to NHHS outreach workers, identify and enroll women eligible for NHHS services, expand NHHS Consortium related activities and to create and sustain health literacy in the community. Two CHA were hired who live at Farnam Courts and Eastview Terrace housing developments in New Haven. They were trained in the same fashion as the care coordinators and outreach workers. The CHA are supervised by the Consortium Development Director with additional support from the Care Coordinator Manager and outreach workers. The CHA have engaged the communities they live in, participated in the Consortium and its related activities, enrolled new participants in NHHS and reconnected others.

Outreach Workers employ the following tactics to connect pregnant women with services:

- **Locate and recruit pregnant and parenting women and their infants** (aged 0-2). Using non traditional strategies case finders locate high-risk pregnant and interconceptional women and engage them in dialogue about MCH-related issues. Strategies:

  1) Polly McCabe (school for pregnant teens – approximately 30 students/year), pregnant teens are identified/assessed and referred to the Health Department’s MANOS program for outreach support, case management and home visiting;

  2) Utilize the number of pregnant women identified/assessed and referred by CCHI – HUSKY/Healthy Start staff at the YNHH, HSR women’s clinics and NHHD (approximate number of
uninsured pregnant women completing HUSKY applications for health insurance is 300;

3) Utilize the number of undocumented pregnant women identified/assessed and referred by CCHI – HUSKY/Healthy Start staff at YNHH, HSR and NHHD, approximate number 140 undocumented pregnant women;

4) Utilize relationship with the Cellotto Day Care at Wilbur Cross High School to provide MCH information and workshops to teen parents – 30 approximate students/year – Interconceptional Care;

5) Teen Housing Initiative – New Haven Home Recovery operates a model care coordination and housing program.

6) Two Community Outreach Workers at the Health Department provide outreach during non-traditional hours including weekends, identifying pregnant women and women of child bearing age who engage in risky behaviors – develop a trusting relationship with them and refer them to support services so that they are more likely to enter prenatal care30.

7) Maintain flow referral with the Mothercare Van of Hospital of St. Raphael which makes regular visits to the neighborhoods in targeted areas.

- **Connect women with care coordinators and healthcare services.** After gaining her confidence, the Outreach Worker encourages the pregnant woman to visit her local primary healthcare center where she is connected with a care coordinator. The Outreach Worker accompanies the woman to the first visit if necessary. Through outreach/client identification, the Community Outreach Worker will a) identify client through outreach (see above); b) complete a needs assessment, the New Haven Healthy Start Participation Information Form (15); c) refer high risk pregnant women, identified by the needs assessment to MANOS for home visiting and support services; d) follow-up to determine that the referred client is engaged in services e) periodically re-assess pregnant clients as to the high risk status, (including depression – ESPD and PRIME depression assessment forms). NOTE: those who may not have been identified as high risk in the 1st trimester, may become high risk in the third.

- **Work in partnership with Care Coordinator Manager** the Community Outreach Workers work closely with the case managers/care coordinators who are located at the YNHH, HSR, FHC, HHC to ensure consistency of service to individuals and a seamless delivery of health services. Outreach Workers provide input as to the common difficulties, gaps and barriers

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experienced by clients and offer solutions to remedy the identified issues. Monthly case conferences occur in the Health Department, with participation by the COW’s and MANOS outreach Workers. This model expands and strengthens the “army” of outreach workers, care coordinators, all of which is coordinated by the Case Manager Coordinator who will in turn act as the liaison to the Hospital and Clinic institutions.

- **Participate in monthly Care Coordination meetings** at which coordination of the client needs are discussed and referrals made. The monthly Care Coordination meetings are the vehicle by which Community Outreach Workers and the Care Coordinators are able to discuss difficulties, gaps in service delivery, barriers and client loads. The Care Coordinator Manager holds joint monthly meetings with the Community Outreach Workers and the Care Coordinators.

**Identification of non-traditional Strategies**

Outreach Workers employ a variety of tactics to identify clients in need of Healthy Start services. These tactics include best practices and lessons learned from the existing and effective Healthy Start implementation in New Haven (and other sites throughout the nation). Outreach Workers conduct:

- Door-to-door recruitment and information sharing campaigns in areas identified that contain a high concentration of women of child-bearing age in conjunction with many referrals to health and service agencies; or in areas identified as high priority by analysis of Federal Infant Mortality Review or Perinatal Periods of Risk. PPOR and FIMR identify Infant deaths geographically

- Targeted community location recruitment in programs that serve as a nexus for women of child-bearing age such as administration centers for the Women Infant and Children program, Temporary Family Assistance, and Section 8 Housing Vouchers. HUSKY/Healthy Start – MCH Division, and the Foundation’s Neighborhood Program (a small grants program directed at revitalization and social development in neighborhoods)

- Targeted community location recruitment at civic/citizen involvement programs such as Neighborhood Improvement Committees of the Empowerment Zone, Enterprise Communities, Neighborhood Blockwatches, education events in Family Resource Centers and on-site social services at HUD projects where Social Services are provide on premises.

- Targeted community outreach through programs that serve eligible individuals including many that are existing Healthy Start partners some of which are fiscally supported by the Community Foundation for Greater New Haven (e.g., New Haven Home Recovery, Christian Community Action – Mothers For Justice, Housing Shelter, Parent Leadership Institute, Community College System, child care centers and early
stimulation programs, Planned Parenthood, STD Clinics, Bright Beginnings, Women’s Center, New Haven Family Alliance Male Involvement Network, Life Haven, INFOLINE –youth outreach), Criminal and Juvenile Justice Systems, the Male Involvement Network at New Haven Family Alliance and teen transitional housing programs.

- Hosting and/or staffing community health and education events such as neighborhood and community health fairs, and neighborhood block parties in collaboration with CT Consortium for Women


- Connections with multi-disciplinary organizations such as Churches, peer support programs, community health clinics, School Based Health Clinics, and Family Resource Centers, MAAS, Catholic Family Services.

- Venues of informal learning for families such as the public library, museums, and community celebrations e.g., International Festival of Arts and Ideas, conferences and public information sessions sponsored by the Community Foundation, Children’s Advocacy Groups, and Yale University.

- Collaborations with the Yale School of Medicine Pediatrics Department (contracted under the Bright Beginnings program to work with 12-15 families annually) work closely with NHHS case finders (note: Bright Beginnings was funded in part by the Community Foundation).

Outreach activities occur during traditional business hours as well as during evenings and weekends – particularly as it relates to neighborhood and community meetings. Collateral materials are printed in English and Spanish. Effort is made to print all prenatal and postnatal materials in languages according to country of origin. Outreach staff is reflective of the community demographics.

C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.

The Community Foundation embraces a community investment approach to grant making. The Foundation invested over $2 million in the areas of Education, Health, Civic Engagement & Community Development, and Regional and Community Development - a total of 140 programs. Through leveraged, matching and individual funds the Foundation provided a continuum of fiscal support that enhanced and facilitated programs that were directly or in some way linked to the Healthy Start Initiative.

Programs having an indirect impact while influencing the Community in which the Healthy Start Initiative operates build capacity and provide for an environment conducive to
integrated service, e.g., Community Fuel Bank, Regional Workforce Development, Citizen’s Television, AIDS Interfaith Network, Community Mediation, Connecticut Association of Human Services, ACCT Association, Male Youth Responsibility, Yale Conference on Women’s Health.

The Community Foundation, in its convening and funding capacity, supports traditional, (i.e., research, advocacy, treatment and rehabilitation) and necessary maternal and child health strategies, concomitantly combining them with other “community” building strategies ranging from the creation of strong social networks in neighborhoods through the Neighborhoods Small Grants Program to investing in broader change. The Community Foundation has supported efforts that increase access to services for underserved populations emphasizing comprehensive approaches to critical public health issues through increased prevention education, intervention and innovative collaborative efforts.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Christian Community Action</td>
<td>$105,000</td>
</tr>
<tr>
<td>Clifford Beers (Behavioral Health)</td>
<td>$27,798</td>
</tr>
<tr>
<td>Fair Haven Community Health Center</td>
<td>$3,000</td>
</tr>
<tr>
<td>INFOLINE (including Youth Outreach program)</td>
<td>$60,000</td>
</tr>
<tr>
<td>Yale New Haven Hospital (Bright Beginnings)</td>
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<tr>
<td>Planned Parenthood</td>
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<td>Community Consultation Board</td>
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<td>Hill Health Center</td>
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<td>Downtown Evening Soup Kitchen</td>
<td>$66,000</td>
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<tr>
<td>New Haven Home Recovery</td>
<td>$40,000</td>
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<tr>
<td>New Haven Family Alliance</td>
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<tr>
<td>Life Haven</td>
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<tr>
<td>Hospital of St. Raphael</td>
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<tr>
<td>Domestic Violence Services</td>
<td>$15,000</td>
</tr>
<tr>
<td>CT AIDS Action Council</td>
<td>$47,500</td>
</tr>
</tbody>
</table>

The Foundation led a basic needs campaign in 2003 in response to state cuts with the intention of replacing the loss of resources for the cities’ most vulnerable population. The Foundation challenged community philanthropists to invest to help sustain the safety net for the homeless and food supply for the needy, raising more than $400,000. Many of NHHS program participants were beneficiaries of this effort.

During the 2001-2005 period, Medicaid policy changes around children’s behavioral health and prescriptions caused extreme concern. However, as a result of discussions between the health centers, our partner the Hill Health Center opened a pharmacy to accommodate its patients and Fairhaven Health Center worked out a deal with Hill Health Center for its patients to utilize the new pharmacy. This also prompted advocacy action from our consumers as they went to the state capitol to testify to the state legislature.

**Case Management / Care Coordination**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.


Context for the implementation strategy

The New Haven Healthy Start Consortium successfully implemented a City-wide system of partnership, referral and outreach around Maternal and Child Health and Family Centered Health Care. However, the restructuring of vital cross institutional links after the difficult implementation of a new and unwieldy managed care system, the inflationary impact of increased basic needs expenses and the economic downturn had a devastating effect and influenced the health of New Haven’s families, in particular the at-risk population. In response to the identified objectives, the Consortium determined that in conjunction with the four Care Coordinators, two more Interconceptional Care Coordinators should be hired and funded through the Interconceptional Grant. These two ICC’s were to be stationed at each of the Hospitals, i.e., Yale New Haven Hospital and Hospital of St. Raphael. Each would perform risk screening, define needs, identify services, and coordinate care. The ICC would also work interactively with the Perinatal Partnership, the Obstetricians and Pediatricians at their respective institutions. They would provide assistance to clients in navigating the system, work collaboratively with the Care Coordinator Manager, Supervisors and other institutions.

However, the project was unable to fulfill the request for two Interconceptional Care Coordinators because of the reduced award from the requested $7.6 million to $5.2 million. The project had to scale back and the leadership decided to devote the time of one outreach worker to focus on interconceptional women and the Community Foundation for Greater New Haven made a significant commitment to support one care coordinator to focus on interconceptional care and housed at Yale New Haven Hospital over the life of the grant.

Successful implementation of Healthy Start case finding resulted in a significant increase of women connecting with perinatal services. The additional demand for services, however, exposed quite clearly the limitations of the maternal child healthcare delivery system. Specifically: A need to enhance the services of Case Management at the hospitals by enlarging the scope of their work to include case management and coordination, to develop protocols across Managed Care Providers and a universal intake form, to create a vehicle for data and information exchange and integration to avoid duplication, for client risk assessment, referral to appropriate services, to monitor, facilitate and follow-up on utilization of needed services.

Identified Gaps in service necessitating the need for enhanced care coordination:

- The Perinatal subcommittee of the Consortium determined that a connection had never been made between Healthy Start and the obstetricians and pediatricians at Yale New Haven Hospital and Hospital of St. Raphael to identify and refer high-risk clients. They suggested the need for a Perinatal Partnership and two Interconceptional Coordinators who would work interactively to develop a set of risk protocols and referral link to ensure a continuum of care from birth through postpartum to year two of the infant.

- No system existed to provide bereavement services and referral in New Haven.
• New Haven lacked an adequate screening system for depression, even though depressive disorders were common among pregnant and recently delivered women\textsuperscript{31}.

• Unstable housing and homelessness in pregnant or parenting teens. A 1999 survey of five New Haven agencies identified 39 pregnant or parenting teenagers who did not have stable or safe residences. Of approximately the 330 births to adolescents in New Haven each year, 138 were not living with their parents or guardian; 158 resided in three or more living situations within the previous six months and 82 experienced substance abuse in their families. (findings consistent with FIMR data)

• An ongoing need existed for an education and awareness campaign to publicize prenatal and pediatric services; continued training and education for consumers, paraprofessionals, professionals, outreach workers and care coordinators.

• Need for improved data collection. The data collected from the Participant Information Form was collected by the Care Coordinator and compiled by the Data Technician at the Community Foundation. Risk Assessment form was also administered by the four Care Coordinators and compiled at CFGNH. Data was then merged with MANOS and the NHHD. The database program red flagged duplicates to ensure integrity of data. Information was evaluated on a monthly basis.

• The implementation of Managed Care and the subsequent upheaval caused by the change from a fee for service system to managed care created problems for consumers, health care providers and MCH community based workers. The outreach and case management capacity of the Health Care Institutions was seriously compromised.

• Inflation and job loss were increasing. Individuals classified as working poor may have found themselves in economic crisis with no health insurance, and limited resources to pay for increasing costs of transportation, home heating oil, and food. The numbers of individuals and families needing health coverage rose substantially.

• The influx of immigrant families and the increase of the Hispanic population who did not have family support and were in need of prenatal screening, and access to healthcare for their children began to swell the client base.

• Healthy Start (including both Disparities grants and Interconceptional care funding) provided case management and care coordination services to the

\textsuperscript{31} “Mental Health is fundamental to a person’s overall health, indispensable to personal well-being, and instrumental to leading a balanced and productive life. While there is no single solution to any mental disorder, most people with mental disorders have treatment options—including medications and short term psychotherapy and community-based supportive services.” Surgeon General’s Report on Mental Health, 1999.
highest-risk women and children. Case management was a natural extension of existing case finder services and established a seamless continuum of care for women in need of perinatal and interconceptional care services. The case management function was designed to retain patients in the healthcare system, and to provide counseling / coaching related to navigating the system of care. Case finding included depression assessment and referral. This approach demonstrated through cost-benefit analysis and health outcome studies that a care management approach produced a return on investment that warranted ‘system’ change both in terms of staff deployment and best practices related to care coordination.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.

**Description of specific activities**

This section describes the specific activities for case management / care coordination. Included in this description are the staffing patterns and professional development; the number of clients and referrals; and how outreach fits into the bigger picture of the Healthy Start model.

Healthy Start created an opportunity for the health providers to create a model approach for maternal and child health services. Healthy Start initially focused on these areas of care coordination:

- **Disparity Funding** - Maintain a team of indigenous workers - 4 Care Coordinators one each at YNH, HSR, HHC,FHC who perform risk screening, define needs, identify services, and coordinate care across multiple providers to assure that each pregnant woman’s needs are met to the extent resources are available and the client agrees with the scope of planned services (client driven). The activities of the Care Coordinators are managed by the Care Coordinator Manager who also facilitate integration of services with the Health Department/MCH “army” of outreach workers

- **Interconceptional Care Funding** - One additional care coordinator stationed at YNHH and one outreach worker stationed at the NHHD provide care coordination to the highest risk post partum women and their children. Women identified during hospitalization and at delivery, who are at increased risk for low birth weight, short gestation, pre existing medical problem fetal loss and neo-natal death. The activities of the Care Coordinator are essential in assuring that the children at highest risk receive their timely well-child visits, developmental screening and
immunizations.

The ICC (in conjunction with Depression Grant) administers not only the Risk Assessment Form but the EPSD and PRIME forms for depression. Referrals for pediatric assessment and development are made to Birth to Three, Yale Child Study Center, Early Childhood Education for example; Depression referrals made to the Dept. of Psychiatry at Yale Premenstrual/Postpartum Program, APT Foundation Treatment and Prevention clinics, la Clinica Hispana, Post Traumatic Stress Disorder Clinic and Yale Psychiatric Hospital, CT Mental Health Hospital, Catholic Family Services, Dixwell Newhallville Mental Health Center, Multicultural Ambulatory Addiction Services (MAAS) and APT’s Mothers Project.

- The Care Coordinator receives bereavement referrals from delivery and helps facilitate the coordination of the postpartum team that includes MANOS and VNA and appropriate behavioral and social services.
  - Coordination and integration of care and identification of women at highest risk of poor birth outcome for outreach support and home visiting (MANOS)
  - The populations served are pregnant and parenting women and their infants (0-2 years old).
  - The goal of care coordination is to fully integrate services available to pregnant women and their children, including assessment, referral and follow-up. The goal is to ensure that children less than two years of age receive their well child care, immunizations, developmental screenings and are linked to birth-to-three and school readiness initiatives at the appropriate age
  - Development of a bereavement program, that was lacking in the project area, by providing women with culturally and linguistically appropriate bereavement services including access to mental health services (depression), insurance coverage, substance abuse treatment, and housing.
  - Establish a care coordination management team that includes representatives from hospital and clinic supervisors, MANOS, HUSKY, Pediatric Immunization Unit, and outreach services. This team focuses on the efficient and effective management of services to avoid duplication of efforts and ensure consistency. The team also works to identify and address barriers that women and their infants face as they move through various services from conception through the second year.
  - Integrate the activities of the Healthy Start Care Coordinators with those of Community Outreach Workers and existing case finders within the New Haven Health Department’s Maternal and Child Health Division (e.g., HUSKY immunization and MANOS).
• Care Coordinators:
  • Stationed at each of four healthcare facilities (Hill Health Center, Fairhaven Health Center, Hospital of Saint Raphael, Yale-New Haven Hospital).
  • Work within the hospital/clinic system at which they are stationed and report directly to the hospital/clinic system supervisor.
  • Integrate activities with other HS/MCH services through a Care Coordinator Manager who will provide oversight and care coordination for all Healthy Start clients.
  • Participate in monthly Care Coordination meetings at which coordination of the client needs will be discussed and referrals made.
  • Ensure each client receives a risk assessment, needed referrals, continuous monitoring, assistance in navigating service systems, and coordinated services, providing the client is in agreement with the scope of planned services.
  • Partner with available human and other service agencies in the community to ensure that all community resources are available to the client depending on need.
  • Administer client assessments pregnant and post-partum women to identify service needs and risk factors and work with the client to design a service plan that is culturally appropriate, matches the intensity of care required by the client, and is acceptable to the client. This is targeted through the needs assessment which should be done at a minimum 2–3 times during the pregnancy.
  • Receive professional development services according to an annual schedule. Training subjects are geared towards assisting case managers to provide excellent services and include the following topic areas: smoking cessation; prevention and early identification and treatment for HIV and STDs.
  • Share information and network across disciplines.

- Maintain up to date data on women involved in the Healthy Start program to gauge program success and for purposes of continuous improvement and integrate MCH data as it pertains to pregnant women and women with children less than 2 years of age, utilizing HUSKY and MANOS data

• Depression Funding –Healthy Start Care Coordinators ask each patient to complete the Edinburgh Postnatal Depression Scale (EPDS) and Primary Care Evaluation of Mental Health Disorders Patient Health Questionnaire (PRIME-MD PHQ) and, if necessary, contact the MOMSLINE/MOMs Unit for treatment and referral. One advantage of initiating depression screening as part of the Healthy Start Program was that women at high risk for poor perinatal outcomes and for depression remain associated with the program even while their healthcare visits occur less frequently.

Once case managers / care coordinators receive a client referral through the outreach workers, the following activities occur:

1. **Administration of a Risk Assessment.** Care coordinators administer risk assessments to all women who are seeking prenatal care, pregnancy testing and/or counseling related to family planning or interconceptional care. The risk assessment instruments (prenatal and interconceptional) was developed jointly
by the four participating local primary healthcare providers with assistance from the evaluator, the New Haven Health Department and other local medical and MCH research experts and consortium. The purpose of the risk assessments are to survey needs, identify risk factors associated with women who are currently not receiving care e.g. smoking, drug abuse, inadequate housing, spousal abuse, and trauma (domestic, child abuse, and violent episode). In addition the care coordinators distribute and check self report screening forms for depression (EPDS and PRIME). This does not duplicate data collected by Medicaid enrollment processes or by the managed care organizations or their agents. Case Finders/outreach workers were trained to administer the risk assessment. The risk assessments are used to identify women of highest risk for case management support, home visiting and follow up.

2. **Develop an individualized plan for services that meets the needs of the client.** Using the results of the risk assessment, the Care Coordinator works with the client to identify service needs and priorities. Plan development is driven by the client to ensure it is acceptable. Service intensity matches the level of risk. If necessary and appropriate, service delivery is designed to occur at sites in the client’s community, Mothercare Van, Yale Healthcare Van, FQHC’s – HHC (Dixwell Avenue and Columbus Avenue Sites) and FHC as well as the VNA, linking to hospital based transportation services, including homes. In addition to providing a comfortable environment for services for the client, this allows case managers to receive first hand knowledge of each family’s environment, behaviors and needs.

3. **Connect women with healthcare services.** In the event the woman is uninsured, the Care Coordinator informs her of existing plans and how to choose a primary care physician. As well, she will be provided with basic knowledge about navigating services. The Care Coordinator troubleshoots any problems encountered throughout this process. Should the woman refuse healthcare at a clinic setting, the Care Coordinator conducts the risk assessment and arrange a home-visit, refer to the Health Department’s MCH MANOS program, to existing programs or agencies located in their neighborhood or through other methods such as the Hospital of Saint Raphael’s Mother Care Van. For patients with severe depression, the Care Coordinator enlists the assistance the MOMs line and unit worker to assist in evaluation and treatment. The Care Coordinator links the woman with Connecticut’s HUSKY program for pregnant women, or if she is Medicaid eligible but not enrolled, the worker refers her to the HUSKY program at the Health Department for assistance.

4. **Connect women with Healthy Start educational services.** Care coordinators refer clients to health education workshops (SIDS, nutritional, parenting, stress reduction), support groups associated with participating agencies and provide materials. They then encourage and direct clients to read the materials in order to increase their knowledge and awareness of the importance of early access into prenatal care and well child care and to improve individual health behavior and birth outcomes. In this grant period a new effort was started where each client was given a pamphlet on depression – how to recognize it and what to do if she thinks she is depressed.
5. **Connect women with additional social services.** When appropriate to a client’s circumstances, the Care Coordinators also explore the strategy of strengthening the woman’s natural support networks. They link them with INFOLINE for information on rental assistance, legal aid etc. Research suggests that natural support systems are an effective means of reaching urban women. This includes relatives, partners, friends and neighbors. New Haven Family Alliance has developed a program, funded by the Community Foundation and directly partnered with the NHHS initiative, MALE Involvement Network that works with male partners of pregnant women, and fathers to encourage interaction and responsibility. In so doing, the case finder strengthens the individual’s support network as well as the neighborhood community. Care Coordinators refer to outreach support programs such as (MANOS). The Care Coordinators should provide the coordination to these services, not provide the services. Through risk assessment and follow up, clients are referred and supported throughout their pregnancy and beyond, as allowed for in the Interconceptional Care component. Through home visiting, case management support (MANOS) a trusting relationship is developed and referrals to family mediation and social work support are made.

6. **Serve as a resource and ongoing support for pregnant and parenting women as they maneuver within health and service systems.** The goal for case management was to make services and systems work to meet each family’s needs, as the family defines them. The Healthy Start system was designed to empower and educate women and families through their pregnancy and early motherhood. The Care coordinator monitors the client as she moves through her service delivery plan to check for follow through and effectiveness of services.

*Care Coordination Management Team*

Healthy Start developed a care coordination team, made up of representatives from HUSKY, MANOS, PIU and Outreach and NHHS Care Coordinators, to provide overall management and care coordination. This team meets to review cases, identify barriers and develop solutions. Information and recommendations from the Care Coordination Management team are reported to the Consortium and the Perinatal Partnership for action if necessary. The Care Coordinator Manager holds monthly care coordination meetings with the 4 Care Coordinators (plus the additional Care Coordinator supported by the Foundation) and the 3 Community Outreach Workers, including the MANOS Field Supervisor, with the goal of identifying barriers to care, pregnant women outside of care, non-compliance and to discuss tough cases (women who are homeless, substance abuse, domestic violence, or depressed).

In addition to the monthly Care Coordination Meetings, the Care Coordinator Manager conducts monthly meetings with the MANOS Outreach Workers to discuss difficult cases, share information between and among institutions. As well, the two groups meet together as needed. Serving as a conduit to the Management team, they facilitate communication between institutional systems (intra communication system) and reduce duplication of service/information collection. The Care Coordination Management Team ensures all case finding, outreach and education activities are integrated and remain consistent with the Consortium Prime objectives.
The Care Coordination Management Team assists in monitoring interagency activity, participates in Consortium meetings maintains contact with the Managed Care Providers, and ensures information is shared intra and inter-institutionally.

Healthy Start funds supported 4.0 full-time equivalent Care Coordinators, one for interconceptional care. The Foundation supported an additional Care Coordinator at Yale New Haven Hospital. The primary function of the Care Coordinators is to coordinate the total care for pregnant and parenting women and their infants (0-2 years old).

A Program Monitor was hired to manage the New Haven Healthy Start Data Tracking System, an ACCESS database designed by NHHS that tracks enrollment, service and clinical data of program participants. This position was responsible for ensuring quality management regarding data collection and monitoring. Healthy Start funds supported a 1.0 full-time equivalent in years 1 and 2 but in year 3 transitioned to a .50 full-time equivalent. The time was reduced consistent with efficiencies in data collection and monitoring procedures. The NHHS Program Monitor resigned in the fall (11/03) to pursue a different opportunity. Her primary responsibility was to monitor the NHHS database and verify data entry. Those responsibilities were folded into the responsibilities of the Project Director and the Care Coordinator Manager. These changes are one of the best indications of how the healthy start data collection system has enabled NHHS to gain efficiencies in staffing as well as better management and analysis of data.

NHHS funds also supported the Care Coordinator Manager who was responsible for overseeing the outreach component and the care coordinators that are hired at each of the health care institutions. She also helped to coordinate training for the outreach workers and the care coordinators. In the absence of the program monitor, her responsibilities increased as a natural outgrowth of her position. The Care Coordinator Manager’s job responsibilities always included NHHS data verification and database management but a formal expansion into this area occurred when the part time program monitor resigned.

As a result of the NHHS Program Monitor resignation during CY03, project administration decided against refilling the position. Because of the new networked data system, the project data management had become more efficient and streamlined. Given the length of time that remained in the project period, management decided to utilize current staff to fill the gap. The Care Coordinator Manager’s job responsibilities increased to include the day to day operation of the database management and verification of data. As she was significant in the planning and implementation of the database, she was fully capable of handling this expansion of duties. Additionally, as a result this change the Care Coordinator Manager was relocated to the Foundation offices in order to be close to the database, server and MIS Director. The Project Director oversees the Care Coordinator Manager and the overall data system management. She also fills in for the Care Coordinator Manager when absent.

C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.

See answer on page #23
Health Education and Training

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.

Context for the implementation strategy

The overarching goal of the Case Management/Care Coordination strategy is the coordination and integration of services from multiple providers to assure the total care of pregnant and parenting women and their infants up to two years of age. The NHHS strategy was to broaden the scope to include the male partner and the community support network in an effort to ensure ongoing, culturally sensitive relations between outreach workers, care coordinators, health care and social service providers, and families. Survey instruments developed and conducted by consumers help to determine problem areas such as housing, substance abuse, trauma, fear for safety, transportation issues, barriers to care, behavioral health needs, adolescent pregnancies, domestic violence, smoking, alcohol and drug addiction, and child care problems. However, the need for ongoing information exchange, up to date education and training sessions on health care and its financing, instruction on availability of services and how to access them was a major component to the provision of services and a healthy community.

Needs assessment information, consumer input from the Consortium, outreach and the Perinatal Partnership membership provide direction for Education and Training. Much of the needed training focuses on risk behaviors: Smoking cessation, STDs, trauma, housing, substance abuse, mental illness, depression, prenatal and postnatal care, birthing and parenting, domestic violence, cultural sensitivity, working with at-risk families, accessing services, male involvement, and self harm.

The Health and Education strategy implemented by Healthy Start New Haven 1997-2001 focused its effort in two areas: a) organizing training for front-line workers such as outreach workers and case managers; b) developing activities and products to reach out directly to women of child-bearing age; and c) increasing awareness of available resources in the community. (Refer to sidebar for example of accomplishments.)

New Haven offers several innovative training and professional development programs for outreach workers and human service providers. Healthy Start has worked within this framework to incorporate maternal and child health content. The demand for these training programs continues to exceed the supply.

No methodology exists to measure the knowledge base of the general community on topics such as the prenatal care visit schedule, proper nutrition, warning signs for complications in pregnancy, signs of depression, and preventive and primary pediatric care. Only 66% of women in the project area receive adequate prenatal care. Healthcare providers confirm that in the majority of cases, the absence of knowledge and awareness of maternal and child healthcare result in lack of appropriate engagement in the healthcare system. This is
particularly true for younger women, who are less likely than older women to access prenatal care in the critical first trimester. According to INFOLINE Prenatal Care Data, the most significant factors influencing engagement in prenatal care include a lack of financial coverage, lack of access, did not feel prenatal care was important, afraid to reveal pregnancy, lack of transportation, inability to take time off from work or school. Other factors identified by the Outreach Subcommittee include denial and the increased numbers of undocumented recent immigrants who are ineligible for prenatal care. A universal targeted message that can be accepted and understood across cultural groups is necessary.

Healthy Start 1997-2001 created the basic infrastructure to conduct a community-driven MCH awareness campaign. Through its outcomes (e.g., recruiting 700 people into care during the past 12 months), Healthy Start has established strong relationships and credibility with civic, grassroots, and community-based groups. It used this infrastructure in the 2001-2005 model to expand its social marketing and health promotion reach into the community.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.

**Description of specific activities**

NHHS Health Education model was developed by Healthy Start New Haven in 1997-2001 and focused on three areas: training program staff (front-line workers, administration and professional service providers); developing activities and products to reach out directly to women of childbearing age; and increasing awareness of available resources in the community. NHHS refined and enhanced the focus areas based upon the satisfaction of clients and frontline workers, and the number of clients accessing services. Methods to conduct program and community participant health education include: group instruction, one-on-one instruction, educational workshops, written materials, referral to another provider, video presentations and media campaigns.

Our model utilizes four sectors, each of which is described in detail in the following section:

1. **Social Marketing.** The target audience is the community at large to increase the community’s knowledge, attitudes, behaviors and practices regarding pregnancy and early parenting by utilizing a multi-media approach to social marketing that would include the same public health messages (e.g. healthy moms, beautiful babies, information about depression, smoking cessation, HIV/AIDS, STDS, alcohol and drug abuse and domestic violence) in a variety of mediums including: billboards, buses, pamphlets, brochures, workshops, health fairs, cable, print, video, radio PSA’s, and CTV. Public

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32 Source: INFOLINE Prenatal Care Data Base 10/95 - 9/96.
service messages based on the Healthy Moms Beautiful Babies campaign, charge the greater community to partner in taking action to ensure the health and well-being of New Haven’s children and families.

2. **Healthy Start Participant Training.** Targeted training was designed and implemented for Healthy Start clients to provide education on maternal and child health including pyscho-socio issues. Through workshops, targeted in neighborhoods, as well as existing groups (e.g. Polly McCabe, Celotto Day Care at Wilbur Cross High School, Teen Housing Initiative). Hill Health Center and Yale New Haven Hospital offered smoking cessation programs that are available to NHHS participants. The Hospital of Saint Raphael recently introduced a free smoking cessation program that is also available for NHHS participants. Caseworkers follow up on the progress of the client. NHHS works with clinicians and caseworkers to provide educational programs on reducing infections among infants. Participants are referred to birthing and parenting classes held at the healthcare institutions.

3. **Professional Education and Development.** The strategy targets the professional and technical service provider who interacts with pregnant and recent parents to increase their knowledge and understanding of pregnancy and early parenting issues as well as recent trends in the delivery of birth outcome research, FIMR, Perinatal Periods of Risk, Disparity in birth outcomes, CDC research, research to support home visiting and support services and their impact on birth outcomes, infant mortality and low birth weight. There was an “in-kind” professional development series from the City of New Haven focusing on “Women and Trauma” and also conducted Perinatal Periods of Risk (PPOR) training. In-service education workshops were conducted at the hospitals for MD, RN, SW, paraprofessionals that included a specific program to educate providers about maternal depression and accompanying guidance.

4. **Healthy Start Program Staff Training.** Targeted training was designed and implemented for Healthy Start project staff, Consortium members and other committee members. Training included: Monthly Social Work Intervention and Support for Community Outreach Workers and Care Coordination and monthly Social Work Intervention and Support of MCH Division staff. CT Consortium for Women provided Behavioral Health Needs Education touching upon such topics as: Problems associated with trauma, Post Traumatic Stress Disorder, Depression, Self-harm and Substance Abuse; Treatment and skills needed for Recovery; Outreach Worker Casefinder role with traumatized client; Domestic Violence as a critical women’s issue (including substance abuse); Addressing psycho-social issues. Curricula were developed in conjunction with First Thursdays specific to the roles of the Case Manager/Care Coordinator and Outreach Worker.

*Social Marketing*

In the last two program years of the prior grant we estimated that 30,000 individuals were
The Consortium developed a new Teen Subcommittee (a membership of 17) in 2004 to bring educational information to their peers on school grounds in the following topic areas; pregnancy, sexually transmitted diseases, HIV/AIDS, chronic diseases, smoking, substance abuse, among other topics. Based upon initial feedback, the program will serve a major purpose in raising the knowledge level of teens about risky health and sexual behavior, and the importance of accessing health care.

The Project used a combination of traditional and innovative public education strategies to broadcast positive, practical messages:

- Participation in **Public Health fairs** at the neighborhood and community level. Since 2001, HS has been represented at more than 40 health fairs and community events.

- **Videotape** A video about the Male Involvement Network in collaboration with NHHS is regarded as an education tool about male engagement and fatherhood. The video has been presented at philanthropic conferences and peer learning institutes.

- **Informational presentations** to neighborhood and civic groups on maternal and child health information, how to get involved in Healthy Start activities, and services available.

- **Produced and released Newsletter inserts** and News briefs (produced quarterly) which are widely distributed through the New Haven Housing Authority Public Housing Developments and address topics such as program updates, upcoming events, emerging data trends, information on maternal health issues (e.g., child safety, pregnancy tips, etc.), highlights of clients and information on other social services. Please see attachments for an example of the New Haven Healthy Start’s Newsletter insert that reaches 5,400 residents and approximately 30 service providers.

- **Media / Public Information Campaign**, which included Public access television spots and mass print media such as bus placards, billboards and Op Eds placed in the local paper and human interest stories framed for

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34 City of New Haven Health Department.
local news station and newspaper. WYBC aired Public Service Announcements. The PSA was aired 43 times per month. Two full page ads were placed in the New Haven Register in 2004 focusing on NHHS and MIN respectively. They were published two times per week for four weeks.

- **Resource Guides.** Produced and regularly updated user-friendly, neighborhood-specific resource guides with practical information regarding prenatal care, depression, substance abuse treatment, insurance advocacy, counseling and support resources for women and families. The guides are a key tool of New Haven’s Healthy Start outreach workers and care coordinators, and were also disseminated widely through the MCH community.

- **Expansion of Resource Library:** Housed at the Community Foundation, the Resource Library provides training materials, charts, videos and a directory. Subcontracted sites use this library for clients during evening clinics. Workshops and training sessions are organized by the Education and Training Coordinator (subcommittee of the Consortium) and held on site as well as in various locations such as hospital waiting rooms and community agencies.

- **Awareness Month forums.** New Haven's vast non-profit sector frequently organizes “awareness-month” initiatives to highlight a single issue, such as domestic violence and AIDS. Building on their existing relationships with these groups. The Health Department offers activities during October for Breast Cancer Awareness and AIDS Awareness month. In April it is National Immunization Week with daily activities occurring throughout the city to focus on Immunizations for children. CDC – Division of Reproductive Health (DRH) is sponsored a National Summit on Safe Motherhood Preventing Pregnancy Related Illness and Death, September 5-7, 2001.

- Information updated on [Healthy Start Web Site](#) and publicized in community newspapers.

- **Bilingual Information:** NHHS materials and most publications are translated into Spanish. NHHS advertised in the Hispanic community newspapers. Messages are broadcast on local Spanish Radio programs.

- The Consortium Development Coordinator schedules workshops in the Hispanic facilitated in Spanish.

- **Host Male Involvement Summit.** In June 2001, New Haven Healthy Start partnered with the New Haven Family Alliance and the Male Involvement Network to host a conference to address the importance of the role of the father in improving child and maternal health, *Portraits of Reality II: Real Men, Real Fathers.* The success of this summit, as in the 1999 summit proved a need for attention to male involvement in Healthy Start activities.
INFOLINE provided information and referral for the Youth Outreach Program, Birth to Three, Pregnancy Healthline, Children’s Health Line, and convened an MCH Advisory Council. INFOLINE played an important role in referral, public information dissemination, and outreach and data collection.

**Examples of successful training and education events during 2001-2005 include:**

- NHHS staff facilitated 22 health education workshops for community participants that addressed topics such as: lead safety, environment and asthma, pediatric immunizations, changes in state benefits, HIV & AIDS, and post-partum depression among other topics.

- NHHS successfully trained paraprofessionals on identifying signs of depression. That is evident by the 450 women who have been successfully referred by paraprofessionals to receive a full mental health assessment by a licensed clinician (MOMsline).

- NHHS held a community workshop on sexually transmitted diseases that was attended by 15 community participants. This workshop resulted in 12 out of 15 community participants seeking risk-reduction services at the New Haven Health Department.

- A video about the Male Involvement Network in collaboration with NHHS is regarded as an education tool about male engagement and fatherhood. The video has been presented at philanthropic conferences and peer learning institutes.

**Healthy Start Participant Training**

Specific training plans for individuals directly involved with Healthy Start activities were designed to increase consumer understanding of maternal and child health issues. Activities included:

- Hosted monthly preview sessions (education packages) for Healthy Start participants on subjects including smoking cessation, SIDS, childbirth education, and parenting classes, identifying depression, connect with Polly McCabe, Cellotto Day care to reach teen parents, job corp, regional workforce development, adult education programs at area colleges, Youth programs funded and/or partnered by the Community Foundation.

- Connected program participants with classes, workshops and programs offered by hospitals and community health centers. Hill Health Center and Yale New Haven Hospital both hold smoking cessation classes open to NHHS participants. Birthing and Parenting classes are also available to clients.

- Developed brief ‘learning modules’ that can be communicated verbally by Outreach Workers and Care Coordinators – with reference to collateral materials printed in English and Spanish.
• Hosted Consortium Orientations for consumers interested in participating on the Consortium.

• Consumers who participated on the consortium received formal training in effectively participating in group strategy, consensus building, and empowerment. Consumers need to be reassured that their input is of equal value to the professionals sitting around the table. Survey instruments developed and conducted by consumers help to determine problem areas.

• Fair Haven Health Center provided workshops on stress reduction during pregnancy.

• Continued to hold forums and community presentations on topics such as Male Involvement. Empower New Haven partnered with NHHS to continue training programs.

Professional Education and Development

New Haven Healthy Start continued to educate professional staff who came into contact with pregnant women and new moms to increase their understanding of health and social issues unique to this population.

Training for New Haven’s professional population was designed for three sectors: 1) Project Staff; 2) Providers; and 3) Clinicians/Professionals.

We identified the following tactics:

• Host annual Disparity Conferences. On January 8, 2001, Healthy Start produced a conference, “Racial and Ethnic Disparities and Birth Outcomes; A select Forum on the State of Maternal and Child Health In New Haven.” The goal for this conference was to convene a forum to educate a diverse group of health professionals, policy leaders, administrators and community stakeholders on maternal and child health issues. The conference was a major success, attended by 160 participants and resulting in a committed partnership with CDC to monitor and interact with the NHHS Initiative and Infant Mortality Studies. New Haven built on the success of this conference and continued to host high level dialogues on the state of maternal and child health and existing disparities by hosting a conference on eliminating disparities with for NMA President, Rodney Hood, M.D. in October 2003. Over 300 community participants were in attendance.

• Developed and hosted Agency Training for organizations on maternal and health topics and related in-services conducted for staff at agencies who

Racial & Ethnic Disparities and Birth Outcomes Conference

January 8, 2001

• 160 people in attendance
• Keynote speakers included
  - Dr. Vijaya Hogan, CDC
  - Congresswoman Rosa DeLauro
  - Mayor John DeStefano
• Launched Perinatal Partnership
serve the target population (e.g., Public Housing, childcare centers, Family Resource Centers). Agencies involved with this training include: Christian Community Action, Life Haven Shelter, New Haven Family Alliance - Male Involvement Network, Teen Truancy, Legal Office for Teens (LOFT) housed at New Haven Home Recovery, Pregnancy, Parent and Prevention Network.

- **Briefing sessions** and presentations related to FIMR, PPOR, Depression research, and Healthy Start Project Evaluation.

- Host **Grand Rounds** at health clinics and hospitals. NHHS developed a professional training / development series for clinical staff at hospitals where experts presented on the latest health information.

- **National speakers** secured by Community Foundation to increase knowledge of the philanthropic community on issues related to maternal and child health and male involvement.

- Establish **partnerships** with other training programs that are focused specifically on empowering individuals, e.g., Parent Training Leadership Institute, Legal Office For Teens and advocacy and free legal service, Connecticut Consortium for Women provides technical assistance for MCH outreach workers.

- **First Thursdays**, Cornerstone/ALSO supported in part by CFGNH. A system wide program developed to educate, train and inform individuals who work with children and families. The workshops served as a vehicle for information dissemination and sharing, consensus building, and as a venue for education on current Maternal and Child Health topics. Note: 80% of Case finders attended the 11 sessions provided by First Thursdays.

- **Pursue the Development of Training Curricula**, i.e., a perinatal health and a cultural competency course at a local community college. A specific curriculum for paraprofessionals addresses MCH issues such as self-care, dealing with stress and building relationships with your doctor. Efforts are still underway.

**Healthy Start Program Staff and Participant Training**

Professional development training plans for individuals directly involved with Healthy Start activities were designed to increase knowledge, skill and ability around maternal and child health issues including how to identify signs of depression. Activities were designed for the specific target audience (e.g., case coordinator, Consortium Developer,
etc.). Develop a quarterly Case Management Workshop that targets citywide case managers to improve networking, communication and enhanced care coordination skills and provides a forum for exchange of ideas and information that will foster inter and intra institutional collaboration to reduce disparities in care and data collection.

Send key staff to national training, March of Dimes Healthy Mothers, Healthy Babies Annual Meetings and Summits provided by CDC, MCHB with the intention of utilizing their newly acquired skills for training sessions organized by and for the benefit of the Consortium.

Activities include hosting and / or providing funding for professional development activities for project staff, such as:

- Monthly in-service sessions on a specific health topic such as depression screening, SIDS, cultural sensitivity, etc.

- Attendance at national Healthy Start annual meetings and conferences, relevant Summits

- Attendance at maternal and child health trainings offered through the Title V office. New England Maternal and Child Health Outreach (NEMO) conference addresses all aspects of MCH outreach, e.g., conducting home visits, cultural diversity forum – influence on pregnancy; role of outreach in managed care; empowering men to claim fathering potential; parenting tips.

- Connect with Children’s Defense Fund and their training opportunities for professional staff and grassroots organizations

Connecticut Consortium for Women provides Behavioral Health needs education.

**Integration with Existing Case Finding / Outreach / Health Education**

All activities described in our Education and Training model serve to enhance the activities of case finding, case management, interconceptional care, and depression and to provide a forum for information and data exchange. Gaps in care, referral, assessment, and access are substantially reduced with the inter-relational partnerships and information sharing. The establishment of linked services, i.e., through professional training, grand rounds, education and training for healthcare workers, care coordinators, outreach workers and consumers effectively increases the overall capacity of prenatal, family planning and mental health providers. This leads to earlier access to quality care, early identification of potential problems and the ability to screen, assess and engage pregnant and postpartum women

**Maintaining Up-to-Date Data**

Effectiveness of training programs is gauged through a process evaluation that collects information on quality, comprehension, utilization, satisfaction and effectiveness. Process evaluations consist of two parts:
1. Establish baseline understanding around topic to be covered before the training occurs, i.e., how does the information presented help in the provision of services to the target population?

2. After the training session occurs, a feedback process will occur that solicits specific responses to check for understanding of content, effectiveness of presentation, comfort within the session, and overall satisfaction.

This data, currently compiled by many of the partnering agencies, is collected, compiled, and used for continuous improvement of training and education activities. Effectiveness at meeting our targeted number of individual and agency involvement will be measured through attendance, further requests for education and training sessions/forums and the impact training sessions have on the effectiveness of interagency communication and information sharing, referrals, and client recruitment and care.

Participants are served by the depression team, have received referrals to other providers and/or have received health education through the community health workshops. NHHS sub-grantees provide health education to program participants on topics such as substance abuse, smoking cessation, family planning, nutrition, oral health and depression to name a few. The Care Coordinators and Outreach Workers provide health education information to program participants along with other NHHS staff. The outreach staff continues to build on the relationships with local agencies and organizations. They will spend time at specific agencies providing education, health insurance application assistance, as well as enrollment into NHHS. The NHHS budget supports education efforts through Life Haven Shelter providing education and training to homeless women, and New Haven Family Alliance for the Male Involvement Network.35

NHHS program participants who receive care at Fair Haven Community Health Center have access to a group prenatal care program where they can receive educational information and connect with peers who are encountering a similar experience. The Me and My Baby program provides a series of baby showers hosted by a nurse who provides educational information on health, pregnancy, infant care, labor, and financial services. This program also provides referrals to needed medical and social services within the hospital. Husky workers from the Health Department provide participants at low risk (as identified through the risk assessment process) some health education and information and insurance application assistance. NHHS provides guidance on all health education, fills gaps in services, and coordinates all health education among provider sites, however supervision and oversight will be provided by the individual sites.

Community participant health education activities for the purpose of disseminating health education messages to NHHS staff, consortium members, health care providers, and to the general population will be conducted through health education workshops. Topics covered will include: lead safety, environment and asthma, pediatric immunizations, changes in state benefits, bereavement, nutrition and healthy eating habits, breast cancer, oral health, HIV/AIDS, and post-partum depression, among others.

35 The Health Advocates program was formerly supported by the NHHS budget, but due to the elimination of the interconceptional grant, NHHS will recruit 5-10 volunteer health advocates from the Consortium.
The Consortium Development Coordinator plans and coordinates educational workshops in the community, attends community meetings, and attends local health fairs. The workshops are conducted on a monthly basis and include subcontractors, volunteer speakers who go into public housing developments. Often the Consortium members and health advocates assist with the workshops and conferences. This includes presentations on Healthy Start Orientation to staff and participants. The dissemination of health education material is integrated into all of the core service components of the program, therefore all NHHS funded staff is responsible for providing some level of education. Supervision of the health education core service is the responsibility of the NHHS Project Director.

C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.

See answer on page #23

**Interconceptional Care**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.

**Context for the implementation strategy**

Interconceptional participants receive care coordination, which includes a comprehensive assessment, referral, outreach, immunization and well child visit tracking, depression assessment and referral for treatment, oral health screening, as well as education and training opportunities provided by the NHHS Consortium.

NHHS provides interconceptional care services through six subgrantees. Care Coordination funded through NHHS for interconceptional women is provided through Yale New Haven Hospital, the Hospital of Saint Raphael, Hill Health Center, and Fair Haven Community Health Center. The New Haven Health Department Division of Maternal and Child Health is subcontracted to provide outreach and case management to interconceptional women. Through a subcontract with New Haven Family Alliance, Community Health Advocates provide outreach services to interconceptional women residing in isolated neighborhoods and public housing.
NHHS has contact with a typical interconceptional participant at the first post-partum visit. The level of need indicated by the interconceptional risk assessment determines the frequency of contact. If the participant is not compliant with the recommended referrals, post-partum care or the well child care for her infant then the frequency of contact is increased, an Outreach Worker may become involved to help the participant navigate additional services within the community. NHHS has developed and implemented a follow up protocol for each level of risk. The protocol is specific as to the level of contact recommended for participants with different risk levels and aid NHHS staff management.

NHHS serves two different groups of program participants during the interconceptional period. One group is women who were enrolled into the program when they were pregnant, have since delivered and are still at a moderate to high-risk level. The second group is women who are first encountered by the program during their interconceptional period. These are women who are identified through community outreach and by care coordinators during well baby visits.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.

Description of specific activities

All NHHS participants are asked to identify a medical home during the intake process. If the participant cannot identify a medical home, a referral is made to a provider that is convenient for them. Once a medical home is identified the Care Coordinator at that medical home is notified and confirms the information. The Care Coordinator at the designated medical home then monitors compliance with post-partum and well child visits. NHHS locates Care Coordinators in each of the four medical homes most commonly used by program participants.

The following steps are taken to track whether a woman made a post-partum visit within six weeks of delivery, has a medical home and needs follow up: 1) If the participant misses

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56 It is also possible that the first encounter with an interconceptional participant may be in the community through outreach efforts given that some women do not make it to their post-partum visit.

37 The highest risk interconceptional care participants will be assigned to a Case Manager funded to focus only on interconceptional women and their children. A high-risk woman and her child/ren may have contact with their case manager on a weekly basis. A moderate risk interconceptional care participant will have contact with a care coordinator at well child visits and may have contact with an outreach worker if she needs assistance navigating additional services in the community. Interconceptional participants that are determined by the risk assessment to be low risk will receive minimal follow up if needed.
the appointment, the Care Coordinator calls and then reschedules the appointment for her or refers her to a medical home that is more convenient geographically. The Care Coordinator can also assist the participant in getting appropriate transportation to her appointment; 2) If the participant cannot be reached by telephone then the Care Coordinator will check the NHHS networked database to see if the woman has engaged in care at a different location; 3) If the participant still cannot be located, a referral is made to NHHS and an outreach worker is dispatched to go into the community to locate the participant; 4) Once the participant is located, the outreach staff assesses the potential barriers to care being experienced by the participant and tries to help her overcome these barriers; 5) The outreach staff is responsible for connecting the woman back to the appropriate medical home; 6) If the woman cannot be located by outreach, her file is coded as ‘lost to follow up.’ Her electronic record will be retained in the database in the event she reengages in care, is located by staff, or becomes pregnant.

NHHS staff asks about contraception choices and use during the intake process as part of the assessment. The Care Coordinator discusses family planning options with the participant and/or refers them to the appropriate family planning specialist within the medical home. The Care Coordinator follows up with women who appear to be at a higher risk for a repeat or unwanted pregnancy (i.e. women with a previous repeat pregnancy within one year after birth, women who are reluctant to choose a family planning method, women who have not been using family planning methods consistently, and teens). If a participant is determined to be at risk for a repeat or unwanted pregnancy then the care coordinator connects her to the appropriate clinician to discuss and receive family planning options. It is typically the clinician’s primary responsibility to follow up with the patient regarding family planning. If the woman is a high-risk interconceptional participant then her case manager follows up with her weekly regarding all of her needs. If she is a moderate risk client then the care coordinator follows up at her well child visits.

NHHS identifies and enrolls infants and toddlers whose mothers were not enrolled into the program when they were pregnant. These infants and toddlers are infants who have not been to well child care or are behind on immunizations. Once staff identifies the infant or toddler, the mother is enrolled into the program as an interconceptional participant. Infants or toddlers cannot participate in the program unless their mother or guardian is enrolled and has signed a NHHS consent form. The infant or toddler is automatically enrolled as part of the intake process for the mother. Once the mother or guardian is enrolled both the mother and infant are formally assessed for risk and monitored accordingly.

NHHS provides care coordination and outreach services to all interconceptional participants including infants and toddlers. All NHHS funded staff is required to provide services to both interconceptional participants and prenatal participants. One Care Coordinator focuses only on interconceptional participants and working out of the pediatric clinic at one of the subcontracted sites. There is a case manager working out of the New Haven Health Department Maternal and Child Health Division. The case manager works with the highest risk interconceptional families. The level of care coordination and/or case management needed for each participant is determined by the risk assessment (e.g., low, moderate, or high risk).
NHHS continues to locate Care Coordinators in each of the four medical homes most commonly used by participants and their infants. The Care Coordinators monitor well child visits within four weeks of being discharged. This monitoring is made efficient by use of the NHHS database, which can be used to alert the worker that a participant is scheduled to have a well child visit. If the infant misses the appointment, the Care Coordinator contacts the mother or guardian to reschedule the appointment or make a referral to a medical home that is more convenient geographically, or to assist in getting appropriate transportation to the appointments. If the interconceptional participant cannot be reached by telephone, the Care Coordinator checks the NHHS networked database to see if the infant has received care at a different location. If an infant visit still cannot be verified then a referral is made to NHHS outreach to go into the community and try and locate the participant. Once the participant is located then she is connected back to an appropriate medical home. The participant may also receive a referral to the New Haven Health Department’s Maternal and Child Health Division Immunization program. This program has a designated worker who makes home visits to women who have difficulty getting their children to medical appointments. This program is funded through the Connecticut State Department of Public Health and is responsible for monitoring all infant immunizations in the New Haven area. The immunization worker will work closely with the care coordinator at the medical home to ensure that the infant is receiving age appropriate immunizations and well child visits. This process is used to monitor well child visits and infant immunizations through the first two years of life.

C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.

See answer on page #23

**Depression Screening and Referral**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.

**Context for the implementation strategy**

During the 2001- 2005 project period, NHHS was awarded the Maternal Depression Grant (93.926L). This enabled NHHS to partner with the Yale University School of Medicine, Department of Psychiatry. When the depression component of NHHS was implemented no activities were in place at the state or local level that screened for perinatal depression. Depression screening is now a part of the NHHS enrollment

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38 Because of its work with NHHS, Yale University School of Medicine Department of Psychiatry was able to win a grant for over $2 million dollars from NIH to do similar work.
protocol adopted by the MCH Division of the Health Department and as part of the Collaboration Agreement with the State Department of Public Health Maternal and Child Health Division to look at the NHHS model of care coordination, consortium development and database as a model for MCH state funded programs. This partnership was instrumental in making that change.

All NHHS staff is trained to screen prenatal and interconceptional program participants for depression. The staff person that completes the initial screening is responsible for making a referral for treatment, following up with the participant and treating clinician to determine compliance with recommended treatment and any potential barriers to care. NHHS no longer has the capacity to fund a treatment component under 2005-2009 grant. However, the network of providers that offer treatment is integrally linked with NHHS. The NHHS enrollment protocols include depression screening and have been adopted by the Health Department among others. NHHS participants are linked to local mental health providers and managed care networks.

All program participants receive the initial screen for depression. Over 2,600 were screened during the 2001-2005 project period. The Healthy Start workers initially screen both pregnant and interconceptional women using the Primary Care Evaluation of Mental Disorders Brief Patient Health Questionnaire (PRIME-MD PHQ) to diagnose major depressive disorder or minor depressive disorder. The PRIME-MD PHQ is a self-report questionnaire that is available in English and Spanish and probes depression and panic disorder and is used for both pregnant and interconceptional participants.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.

Description of specific activities

Program participants are screened for depression during their initial contact with their NHHS worker. The screening tool is integrated into the comprehensive risk assessment that is administered during the intake process. All staff is encouraged to screen women again for depression at least once during the post partum period. Women who screen positive for depression during their initial assessment are referred to an appropriate

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39 In addition to the staff funded by NHHS, other staff employed by the subcontractors will also assess women for depression. This includes the HUSKY liaisons and MANOS workers employed by the New Haven Health Department, the nurse midwives employed by Fair Haven Community Health Center, and the Perinatal Case Managers employed by Hill Health Center.

40 Standard NHHS enrollment protocols include; 1) demographic profile; 2) comprehensive psycho-social assessment; 3) perinatal depression screen; 4) referral to needed health and community-based services; 5) follow-up to determine if services have been engaged; 6) program monitoring (data entry) and 7) evaluation (reports), adopted by the Maternal and Child Health Division of the New Haven Health Department.
provider given consideration to insurance status, primary language, and availability of provider.

The tools that are used to screen for depression have been validated for use in both English and Spanish speaking populations. These instruments have proven validity in populations of similar socioeconomic status as clients enrolled in NHHS. NHHS continues to employ bi-lingual/bi-cultural staff to account for the cultural diversity among participants. NHHS funds at least 4 FTE staff who are bilingual.41

During the 2001-2005 project period, NHHS was awarded a Healthy Start Maternal Depression grant. One of the outcomes of this grant was the creation of a mental health service resource guide. The guide contains information on: a) all providers in the local area that will treat pregnant and interconceptional women; b) the insurance accepted by the provider; and c) bilingual capacity. The guide will continually be updated and used by NHHS staff as a referral tool.

NHHS staff distributes depression information packets to every client enrolled in the program. The team of professionals that worked under the maternal depression grant prepared materials that will be distributed during the 2005-2009 project period as part of their transition.42 The materials detail signs, symptoms, and screening forms for depression, as well as information on depression treatment. NHHS staff participates in training workshops on how to educate clients. Workshops have also been held for consortium members and the public on how to identify symptoms of depression, and information on providers and treatment.

After a positive screen for depression, further clinical assessment is provided by clinical social workers on staff at the provider sites or by the clinician at the agency to which the participant is being referred. Available treatment options for program participants diagnosed with perinatal depression in this community include approximately 12 Spanish-speaking providers ranging from psychiatrists to social workers who treat Spanish-speaking women with insurance. Spanish speaking clients without insurance have one treatment option: La Clinica Hispana. Over 20 psychologists and social workers in the community treat English-speaking women with perinatal depression covered by insurance. English speaking women without insurance have two options for treatment: Connecticut Mental Health Center or Catholic Family Services. The table below summarizes referral agencies in New Haven.

<table>
<thead>
<tr>
<th>Referral Service Need</th>
<th>Referral Agency</th>
</tr>
</thead>
</table>
| Emergency Psychiatric Care                                 | • Yale New Haven Hospital Emergency Room Crisis Intake Unit  
• Hospital of St. Raphael Emergency Room                    
• Connecticut Mental Health Center walk-in care              |
| Outpatient prenatal and postpartum depression treatment    | • Catholic Family Services  
• La Clinica Hispana  
• Dixwell Newhallville Mental Health Center                  |

41 These positions include the two care coordinators at the community health clinics, one of the care coordinators at Yale New Haven Hospital Women’s Center, and one of the community outreach positions.  
42 The NHHS Project Director is managing a transition related to the close out of the Healthy Start maternal depression grant.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Provider(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient substance abuse treatment for women with comorbid substance abuse and depression</td>
<td>- Yale School of Medicine PMS and Perinatal Research Group</td>
</tr>
<tr>
<td></td>
<td>- Hill Health Center Adult Behavioral Health (on a limited basis)</td>
</tr>
<tr>
<td></td>
<td>- MAAS</td>
</tr>
<tr>
<td></td>
<td>- Central Treatment Unit</td>
</tr>
</tbody>
</table>

NHHS tracks the status and outcome of referrals made to mental health providers the same way all other referrals are tracked through the NHHS database, which is designed to track the completion of referrals. Each referral entered into the database has an accompanying “link to treatment” field that must be completed. Priority is given to tracking women who have mental health referrals, because they are considered high risk and therefore require more intense follow up. The worker who makes the referral is responsible for following up with the participant and the referral agency to determine the outcome of the referral. If a woman does not follow through with a mental health referral, the worker who made the referral contacts her and tries to assess the barriers to treatment and provide assistance in overcoming those barriers. If a participant cannot be reached by telephone or at her medical appointments, a referral is made to NHHS outreach. An outreach worker goes to the home to assess barriers to care and connects the woman to the mental health provider.

Through the Maternal Depression grant, a depression screening tool was implemented across the perinatal service delivery system. Various levels of workers were trained to administer the depression screening, which is a tool that NHHS will continue to use even in the absence of funding through the depression grant. In addition, Yale University School of Medicine, Department of Psychiatry implemented the MOMs (Mental Health Outreach for Moms) Hotline. This hotline offered a comprehensive psychiatric assessment for women who screened positive for depression during an initial screening administered by a NHHS worker. The MOMs Hotline staff consisted of two clinical Social workers, a psychologist, and a program coordinator. The MOMs hotline staff provided depression assessment, referral, follow up, and treatment.

C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.

See answer on page #23

**Local Health System Action Plan (LHSAP)**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based

43 Due to the elimination of the Maternal Depression Grant, NHHS will not have the capacity to continue to fund the MOMs hotline component in the 2005-2009 project period. NHHS will continue to use the depression screening tool that has been integrated into the full risk assessment and will provide referral and follow up via outreach staff and care coordinators. In CY 2003 25% of identified depressed women followed through with a behavioral health referral.
upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.

**Context for the implementation strategy**

The Local Health System Action Plan has been implemented and the project continues to work with the State Title V agency to coordinate its activities. The State looks to NHHS to provide leadership, information and guidance to other State-funded MCH programs. The NHHS project has also experienced considerable success with its local health department, Maternal and Child Health Division who administers the SCHIP and Immunization Program (CDC). NHHS uses a systems approach to enhance services for pregnant and parenting women and their families that incorporates social, emotional, and medical needs that are crucial to assure the provision of quality services to women and children in the New Haven Project Area. The overall goal of the action plan is to integrate service delivery systems to better serve NHHS program participants.

Considerable challenges exist in implementing the LHSAP including lack of sufficient/consistent staff support; lack of resources, limited stakeholder investment and finally, the political environment often threatens the continued advancement of the plan. The Foundation has been instrumental in pushing the LHSAP forward by providing support to organizations and agencies that are important to the plan. The LHSAP has been evolving into its current efficient form over the last seven years. The New Haven community has proved to be fertile ground for a health system that would, over the years, become a supportive health environment. The LHSAP faces one remaining challenge: to sustain the system and the changed behavior of providers, the institutionalized programs within each organization, and the ongoing network of established linkages.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.

**Description of specific activities**

Project staff developed a plan to overcome these challenges by maintaining and supporting existing partnerships, and through a memorandum of agreement with the State Department of Public Health that will be fostering NHHS as a statewide model. NHHS no longer requests federal funding for the Health Advocates program, the model was tested 03 and 04 years, and has been proven successful. The Community Foundation committed to fundraising activities to ensure the continuation of the Health Advocates initiative; the Life Haven Shelter Education and Training Program for homeless women,
and supplemental support for the periodontal disease screening program. The Foundation also continues to fund a second Care Coordinator at Yale New Haven Hospital.

The Stakeholders involved in the development of the LHSAP include Healthy Start staff, City of New Haven Health Department MCH Division, consumers, Consortium members, New Haven Family Alliance, Members of the NHHS Consortium; Title V; key public and private agency partners that sat on the Commission on Infant and Child Health established in 1985 as a public/private partnership with the City of New Haven; community partners; consumers; and were involved in the development of the LHSAP and continue to work together as a team to foster the continuation of the system.

The priorities for the LHSAP were based on the NHHS needs assessment conducted in the final year of the previous funding cycle of Healthy Start, and on the lessons-learned from the implementation of the same grant. The NHHS Consortium contributed to the setting of priorities by letting NHHS staff know what has worked well and has not worked so well through input, feedback and written surveys. The Consortium is provided with administrative updates and program updates at every meeting. As well, they are given documents to review and also participate in various meetings where program and system changes are discussed. Other information considered included information from the Fetal Infant Mortality Review (FIMR) and Perinatal Periods of Risk Practice Collaborative and input from consumers and participants who benefited directly from the implemented services. The NHHS program also uses information from the State Title V action plan to refine and strengthen its implementation locally.\(^44\) This planning leads to identification of priority areas to be accomplished each year that are based on the needs presented by the women, children and families that participate in the program. The timelines for each activity and accomplishment are set by the NHHS Consortium and integrated into the overall work-plan of the project.

The LHSAP guides funding priorities for NHHS; provide Consortium and Perinatal Partnership with priorities and direction; is the basis for the local MCH Division at the Health Department; strengthens the advocacy agenda for consumer participants by focusing attention on specific systems; and it provides a framework for identifying, developing and establishing collaborative relationships, and communicates useful information about the status of healthcare locally and statewide and gaps in service that can be integrated into respective work-plans of those who have a role in the LHSAP. Priorities identified in the LHSAP featured in the 2001-2005 funding cycle indicated a need to centralize outreach workers at the New Haven Health Department. The NHHS staff and the NHHD used the information to secure three outreach workers, house them at the NHHD, and coordinate outreach activities across funding streams. Performance based objectives are utilized to monitor progress.

The Healthy Start grantee/staff; Consortium, subcommittees and ad hoc committees; local Title V agency, MCH Division of the New Haven Health Department; Community Health Centers; Yale New Haven Hospital; Hospital of St. Raphael; State Title V agency; and NHHS subgrantees are responsible for achieving and monitoring the goals of the

\(^{44}\) The State Title V and NHHS have worked diligently to develop a signed collaborative agreement to work on various mutual priorities. (See attached agreement in Appendix).
LHSAP. NHHS staff is involved in the following local health community organizations and activities:

<table>
<thead>
<tr>
<th>Role</th>
<th>Organizations/Initiatives</th>
</tr>
</thead>
</table>
| Principal Investigator, Amos L. Smith | • CT Health Funders Group  
• CT Fatherhood Advisory Committee (Legislative Appointment)  
• The Community Compass Partnership  
• Advisory Committee for Mothers for Justice  
• Chair, Male Involvement Network Management Team  
• National Association of Social Workers  
• Greater New Haven Partnership for a Healthy Community  
• Planned Parenthood  
• CT Public Health Association  
• CT H.E.A.T.  
• CT Dept. of Public Health Asthma Initiative  
• CT Dept. of Public Health Childhood Obesity Initiative |
| Project Director, Delores Greenlee | • New Haven Oral Health Initiative  
• New Haven Mayor’s Task Force on AIDS  
• Title V Women’s Health Week Planning Committee  
• Grant Reviewer for Ryan White Title I  
• Grant Reviewer for Housing Opportunities for Persons with AIDS  
• CT Perinatal Health Advisory Committee  
• American Public Health Association  
• CT Public Health Association Board of Directors  
• Title V Community Phase of five year needs assessment  
• CT Perinatal Depression Workgroup |
| Care Coordinator Manager, Christina Ciociola | • Fetal Infant Mortality Review (FIMR)  
• National Association of Social Workers  
• CT Public Health Association |
| Coordinator of Consortium Development Natasha Ray | • Commissioner on New Haven’s Homeless Advisory Commission  
• Advisory Board of Yale New Haven Hospital’s Adopt-A-Doc Pgm  
• Council member of the City of New Haven’s School Readiness Council  
• Liaison to Empower New Haven Management Teams  
• One Connecticut  
• CT Public Health Association  
• CT Dept. of Public Health Asthma Initiative |

Challenges to achieving the goals of the LHSAP have been workloads and time commitment on the part of staff. Scheduling meetings with stakeholders continues to be a challenge due to difficult work schedules and proximity, making it hard to formalize plans to implement activities in the plan. Finally, administrative bureaucracy and the political climate have impeded productivity for implementation, for example the significant reductions in state budgets supporting local Title V programs, MCH Divisions, partner agencies and Medicaid. Cuts in Healthy Start funding for the 2005-2009 funding cycle provide a significant challenge for continued implementation plans as local and state resources decrease. To address these challenges, the NHHS staff will look at alternative meeting times and locations and current technology (e.g., e-mail, webcasts).

NHHS project has maintained ongoing collaboration with existing community services within the medical and social services communities to implement an integrated approach to improve the perinatal health system. The plan is based on the federal resources that are received under this grant, which are also maximized by resources from the
Foundation. The NHHS program and Consortium work with the State Title V Office by reviewing the state’s action plan and collaborating on feasible opportunities.

Building sustainable systems requires time, and a commitment of stakeholders who will collaboratively continue building and working within a “changed” and “linked” environment to provide a comprehensive perinatal system of care. Sound management of resources to ensure ongoing services, and a system that is capable of obtaining and using data to improve care and evaluate impact is essential to a comprehensive system of care.

The Healthy Start Plan is a comprehensive system of care that builds upon the City of New Haven Department of Health’s local maternal and child health system action plan.45 As a primary partner since 1997, the City MCH division has adopted the New Haven Healthy Start enrollment protocols for all women seeking MCH services, and integrated and coordinated its service delivery system across funding streams.46 The plan was designed in partnership with community residents, community-based organizations, state agencies, the local hospitals, community health centers and other institutions. The priority areas for the maternal child health system that have been accomplished to date include:

<table>
<thead>
<tr>
<th>MCH System Priority Area Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centralization of all existing Healthy Start outreach and recruitment workers</strong> at the NHHD. Coordinated outreach activities across funding streams and use performance based objectives to monitor progress.</td>
</tr>
<tr>
<td><strong>Developed a layered approach to intensive health education and professional development training</strong> for: a) Healthy Start consumers; b) community-based organizations; and c) professionals and para-professionals integral to system change efforts (e.g., physicians through grand rounds).</td>
</tr>
<tr>
<td><strong>Structured, standardized risk assessments were developed</strong> to be completed by high-risk consumers: a) at the time of entry into the pre-natal care system; and b) after delivery during the interconceptional period. The risk assessment process is integrated with local evaluation efforts (e.g., depression assessment).</td>
</tr>
<tr>
<td><strong>Developed an improved method of assessing signs of depression, and the need for more bereavement services and support.</strong> The method has been integrated into the risk assessment. Addressing the need for more bereavement services and support continues as a focus. The Also/Cornerstone agency continues to provide support to women experiencing a fetal loss and/or who need counseling.</td>
</tr>
<tr>
<td><strong>Established a Perinatal Partnership</strong> that provides a forum for maternal and child health professionals to solve systemic issues. Information used to inform their decision-making are data provided from the care coordination implementation, data used in the Healthy Start Evaluation and the findings from the Fetal Infant Mortality Review. Of particular note is: a) the creation of a risk assessment protocol that is implemented uniformly across all providers; and b) improvement of care coordination services for women who deliver with no exposure to pre-natal healthcare.47 The group is currently trying to resolve a problem of inconsistent reporting of birth weights on the local level as compared to EVRS state database.</td>
</tr>
<tr>
<td><strong>Developed a care coordination protocol for high-risk women.</strong> This included securing funding to field test a care coordination / case management approach both for women who: a) enter the prenatal care system but are at risk to drop out of care; and b) deliver with no history of pre-natal healthcare. This level of</td>
</tr>
</tbody>
</table>

45 The Community Foundation/NHHS continue to explore all of the linkages by and between the CT Department of Health and City of New Haven programs to maximize resources and eliminate potential duplication.

46 Standard NHHS enrollment protocols include: 1) demographic profile; 2) comprehensive psycho-social assessment; 3) perinatal depression screen; 4) referral to needed health and community-based services; 5) follow-up to determine if services have been engaged; 6) program monitoring (data entry) and 7) evaluation (reports).

47 The current model used by NHHS is a care coordination model that is a direct result of the work of the perinatal partnership.
coordination involves improving linkages with fathers and other significant male partners.

The City of New Haven Department of Health updated in 1999-2000 its strategic vision and plan (i.e., local health system action plan). The Strategic Plan set forth by the City of New Haven Department of Health recognized formally that the existing 1997-2001 Healthy Start Plan embraced the City’s philosophical and practical approach to identifying, prioritizing, and addressing the community’s maternal and child health issues. This conclusion is logical given that the City of New Haven Department of Health serves as the primary implementation partner in the Healthy Start Initiative (1997-2001 and 2001-2005).

C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.

See answer on page #23

**Consortium**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.

**Context for the implementation strategy**

The 1997-2001 consortium model consisted of a Joint Project Advisory Committee (JPAC) comprised of approximately 50 members, of whom about 12 (46%) were consumers. The JPAC provided guidance and oversight of Healthy Start during the 1997-2001 years. However, the Consortium model required further refinement. Specifically:

- **A need existed for broader community involvement.** New Haven Healthy Start recognized that creating a comprehensive system of care for mothers and their children involved a community wide effort, including representatives from social service agencies, neighborhood management teams, community leaders and local, state, and federal politicians. While the 1997-2001 Consortium at a Glance

  - Consumer driven with a goal of over 200 consumers participating.
  - Provides training and support to consumers.
  - Uses data to guide program refinements and system change.
  - Links health professionals and policy leaders.
  - Shares information from evaluation and research-related activities.
  - Provides oversight for the direction of the Healthy Start Program.

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48 The Joint Project Advisory Committee was created by merging two existing efforts affiliated with the Consortium for Substance Abusing Women and Their Children and the Commission on Infant and Child Health. Professionals were over represented on the JPAC. The proposed application will continue to increase consumer involvement.
2001 model supported consumer involvement, the 2001-2005 model expanded participation to include consumer representation from a variety of community players. The target goal for the Consortium was 200 community participants (including 100 consumers) by 2005. And expand to include a more culturally diverse consumer group, which would include recent immigrants from Mexico, South and Central America, and Puerto Rico.

- A need existed to refine the forum used by health professionals and policy leaders. Therefore, Healthy Start supported the emerging Perinatal Partnership, a specialized group of medical professionals, clinicians, social workers and community based organizations who targeted women living in shelters and teen parents who could react to emerging themes around healthcare delivery. The fully developed Perinatal Partnership informs the Consortium on health matters and enacts necessary system change within their own institutions. The goal of the Perinatal Partnership is to enhance communication between and among health care institutions to reduce infant mortality, improve birth outcomes and provide referral for needed services. Long-term strategies included creating a legislative agenda targeting the needs of recent undocumented pregnant women as well as the implementation of a universal risk assessment to be used by the health care institutions. The partnership was able to implement the latter within the 2001-2005 grant cycle.

- Creating a viable community and consumer-driven Consortium was challenging. Consumers and professionals valued different meeting styles and communicated on different levels. It took time for consumers to change their skill sets, and time for professionals to understand the value of consumer input. During the initial year of involving consumers, many professionals dropped away from the process. These professionals have re-engaged once again as Healthy Start continued to increase its commitment to consumer training and orientation.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.

_Description of specific activities_
Healthy Start upgraded its Joint Project Advisory Committee (JPAC) to a 200+ member Consortium by 2005, comprised of more than 51% consumers. New Haven Healthy Start developed a diverse and effective consortium infrastructure that is consumer driven, is guided by data to impact system change, and supports each of the activities of the project. The Consortium convenes every stakeholder involved in New Haven's efforts to improve the health and welfare of women and infants. Agency representatives typically have the authority to make decisions for the entity they represent.

The Consortium will set the meeting agendas and ensure consistency across all subcommittees. Other meetings will be convened to provide guidance on each of the project’s core services: Outreach; Case Management; Health Education and Training; Interconceptional Care; and Perinatal Depression.

Committee Support and Staffing

The Healthy Start Project Director is responsible for oversight of the entire Healthy Start Program Infrastructure. A full-time Consortium Development Coordinator was hired in 2002 and was responsible to recruit and orient/train Consortium members who represent and reflect all stakeholders of maternal and child health in New Haven - including our goal of 200+ consumers by 2005.49 Today, 63% (137 of 219) of our Consortium Members are consumers, and consumer-driven groups are common-place and well-managed in the region.

- Funds were made available to remove for consumer participants any barriers associated with childcare and transportation.
- Consumers were encouraged to participate in ongoing professional development and training activities organized through Healthy Start.
- The Consortium Development Coordinator also established a peer mentor system to create a supportive environment for consumer participants.
- The Consortium Development Coordinator is responsible for ensuring that Consortium meeting standards are met (see sidebar).

The activities described above have proved extremely successful in similar consortium-lead initiatives in and around New Haven, such as the Ryan White Title I Planning Council for New Haven and Fairfield Counties.

Identification of non-traditional Strategies

49 The Consortium Developer in his/her role as trainer will also assist in implementing activities associated with the Health Education and Training plan.
The Consortium’s work focused on the following three broad areas:

1. **Service delivery.** The Consortium’s primary focus was on the delivery of perinatal services in New Haven to identify gaps in / barriers to service, develop solutions to address disparities, and identify and recommend changes to the system of care.

2. **Strategic planning.** The Consortium plans strategically, by a data-driven process, to ensure a comprehensive network of services exists for pregnant and recently delivered women and their infants. A group called the Perinatal Partnership, comprised of professionals and medical technicians (see above), informs the consortium on health matters and enacts necessary system change within their own institutions. The Perinatal Partnership (as a subcommittee) was established in early 2000 as a means of bringing together high-level professionals and administrators, perinatologists, OB/GYN’s from health institutions throughout New Haven, key staff of the City’s Health and Vital Statistics division and FIMR under the assumption that these organizational leaders could enact change in the health system through their respective institutions. The FIMR and the Perinatal Period of Risk research played an important role in informing the planning process.

3. **Internal operations.** The Consortium paid close attention to meeting and committee structure, membership levels, member development, and ways to improve its internal operations. The Consortium Development Coordinator was responsible for monitoring internal operations, and working with the Healthy Start Project Director to assist the Executive Committee in refining the program structure. In addition, the Consortium Development Coordinator was responsible for ensuring that conflicts of interest were managed appropriately (e.g., develop conflict of interest policies).

### Integration with Existing Case Finding / Outreach / Health Education / depression

As described above, each of the core services in the New Haven Healthy Start project reported its activities to the Consortium, which allowed targeted guidance and support for each activity. Information is shared through the Executive Committee or Consortium Chair to ensure that information is shared across all groups.

### Maintaining Up-to-Date Data

Data on membership (e.g., participation, reflectiveness, conflicts of interest) are maintained. Process evaluations around meeting effectiveness are conducted at each Consortium meeting to gauge participant comfort, sense of accomplishment, understanding, and overall satisfaction.

C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.

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50 Initially funded by the Healthy Start Grant, NHHS conducted ongoing Fetal Infant Mortality Review and compiled socio-demographic indicators as underscored by the Connecticut Department of Public Health Title V Needs Assessment report, to better understand factors that contributed to morbidity and mortality risks. The perinatal Partnership and CDC provided guidance and assistance.
D. For consortium, please address the following additional elements:

1) Highlight how the Consortium was established and identify any barriers that emerged in its establishment and how they were addressed.

The NHHS Consortium emerged in 1997 when two community collaborative groups that focused on women of child-bearing age (and their children) merged as a result of the planning process associated with New Haven’s first Healthy Start application (1997 – 2001). The merger reflects the impact of NHHS on the local environment, and the commitment by our community leaders – including the Foundation - to develop collaborative approaches that address the communities changing needs and opportunities.

Prior to 1997, the Foundation supported The Commission on Infant Child Health. The Commission was comprised primarily of community leaders, medical professionals and para-professionals concerned with unconscionable levels of adverse maternal and child health outcomes. The Commission’s agenda emphasized more heavily the policy and systemic aspects related to maternal and child health outcomes. The Connecticut Women’s Consortium (formerly known as the Consortium for Substance Abusing Women and Their Children) developed in response to a community-level intervention around the issue of substance abuse. In 1989, the City of New Haven received a coveted Robert Wood Johnson Foundation “Fighting Back” planning grant to reduce the demand for alcohol and other substances. The City of New Haven received an additional 10-years of Robert Wood Johnson Foundation project funding to implement its community-level plan (e.g., education, prevention, intervention, treatment, relapse prevention). The Consortium for Substance Abusing Women and Their Children formed to solidify the efforts targeting women of child bearing age and their children. The Consortium for Substance Abusing Women and Their Children involved more residents as the Fighting Back Initiative focused on neighborhood-level interventions as well as systemic interventions.

In 1997, the Community Foundation announced its interest in submitting on behalf of the community a Healthy Start grant application. The federal funding would put legs under the work of the Commission on Infant Child Health, particularly in strengthening a community-driven (v. professionally driven) response. Rather than create a new community Consortium, the Community Foundation asked leaders from the Commission and the Consortium to develop a solution that would be both practical for community leaders and satisfy the federal Healthy Start requirements for a Consortium. The leaders and members of the Commission on Infant Child Health and the Connecticut Consortium for Women agreed to merge and form an entity called the Healthy Start Joint Project Advisory Committee. Both groups addressed health issues of women of child bearing age (and their children). The combined membership of the group created a better balance of professionals and residents.

The newly formed entity – which soon after changed its name to the Healthy Start Consortium, soon began to exercise significant influence in the shaping of the community’s
plan to reduce adverse maternal and child health outcomes. Equally important, the Community Foundation reinforced the importance of involving consumers and residents in the Consortium – a value embraced in all of the Foundation’s work. Today, 60% (137 of 219) of our Consortium Members are consumers, and consumer-driven groups are commonplace and well-managed in the region.51

2) Briefly describe the working structure of the Consortium which was in place for the majority of the implementation, its composition by race, gender and types of representation (consumer, provider, government, or other). Also, please describe the size of the consortium, listing the percent of active participants.

The Consortium meets six (6) times a year. The Consortium meets in the early evening – a recommendation made by the consumer membership. NHHS grant funds support quality on-site daycare, transportation, and nutritional supplements to support consumer participation on the Consortium. The Consortium serves as the entity responsible to set strategic direction for the project as well as to provide general oversight of the project. At the close of the 2001-2005 grant period, the Consortium was comprised of 219 members representing consumers, service providers, government representatives, program participants, etc. (See attached Consortium Membership List). 86% (188 of 219) of Consortium Members maintained an attendance level at or above 50% (3 or more meetings out of 6 meetings per year). Most of the other members participate in 1-3 meetings per year. The Consortium is organized into five committees:

- The Perinatal Partnership is charged with providing clinical oversight and program integration across healthcare institutions that are involved with the project. The Perinatal Partnership is also responsible for assisting with the identification of medical and other technical issues of importance to providers and consumers of Healthy Start services.

- The Sustainability Committee is responsible for integrating program components into the healthcare system – including integrating third party payers (HMO’s) with local health care providers to ensure sustainability of Maternal and Child Health programs. The Sustainability Committee is also charged with working with the Philanthropic Services Area of the Community Foundation for Greater New Haven to identify donors interested in supporting maternal & child health issues that we hope will culminate in the development of an endowment.

- The Neighborhood Committees are responsible for recruiting and engaging other community residents in health education workshops that are held monthly in New Haven’s empowerment zones, so that we may begin to create a family health dialogue across communities. These committees serve as eyes and ears for identifying women in need of care or those who have fallen through the cracks and are not able to be reached by the medical institutions.

51 Another example of consumer-driven planning occurs in the public health area of HIV/AIDS. The Ryan White Title I Planning Council established to set service priorities and allocation amounts for emergency HIV/AIDS care services maintains a membership in which 56% of Council Members are HIV positive and 50% of the Council or Committee leadership positions are held by individuals who are HIV positive or members of high risk populations. This local group is recognized by HRSA as one of the best performing Planning Councils in the nation.
• The FIMR Committee is the nucleus for a regional FIMR Community Action Team whose function is to translate the opinions and recommendations of the FIMR Case Review Team into real culturally competent interventions aimed at directly impacting problems within our communities. It is expected that this working relationship between FIMR and NHHS can only help to facilitate the work of each program and create real synergy to effectively address important issues related to the health of women, children and families in the Greater New Haven area.

• The Teen Committee is charged with participating in a Peer Education model implemented in partnership with the City of New Haven Health Departments AIDS Division. This committee was developed with the purpose of teens educating other teens on topics including, but not limited to Maternal & Child health issues with the intent of preventing early unplanned pregnancies and raising awareness around health risks that are associated with risky behaviors.

3) Describe the activities this collaborative has utilized to assess ongoing needs; identify resources; establish priorities for allocation of resources; and monitor implementation. Describe your relationship with other consortia/collaborative serving the same population.

Most of the “work” occurs at the Committee level. Project management delivers presentations, provides reports, data analysis and project concerns to the committees. Committee level discussions are then shared as informational items at the Consortium level or as recommendations for approval (via consensus) at the Consortium level. Surveys and open discussion are also used to identify priority areas and resources. Administrative updates, progress reports, evaluation presentations and reports are all used to monitor implementation.

4) Describe the community’s major strengths which have enhanced consortium development.

Healthy Start program infrastructure has created connections among and between residents, community-based organizations and institutions all working toward improving maternal and child health outcomes. NHHS has integrated the work of the consortium into the existing infrastructure and has created an environment for consumers and professionals to develop common language.

The community has embraced the concept of a consumer driven consortium and seeks the expertise and assistance of NHHS in helping other organizations to develop their own consumer driven consortiums. Our Consortium Development Coordinator has offered technical assistance in the area of consortium development to Boothill Healthy Start, the Connecticut Department of Public Health and the New Haven School Readiness Council. She also participated on a panel about consortium development at the National Healthy Start Association Annual Meeting in March 2005.

NHHS also created an employment component where consortium members and consumers
serve as advocates and ambassadors for NHHS. Consortium members have provided childcare during consortium meetings and activities, worked at health fairs and other public venues. New in the 2005-2009 grant period is a program to recruit ten members of the consortium to become health advocates. Members will enroll new clients into healthy start and reconnect others. They will also work in the neighborhoods by assisting with health education workshops and activities.

5) Describe any weaknesses and/or barriers which had to be addressed in order for the consortium to be moved forward.

At the beginning of the 2001-2005 project period, NHHS had a consortium that was predominantly made up of service providers. The focus during this period was to increase consumer participation but there were some barriers to getting consumers to attend. The leadership of NHHS surveyed consumers and found out that barriers for consumers included childcare, transportation and the time scheduled for the meetings was not suitable for them. Healthy Start funds were made available during this period to remove those barriers and consumer participation increased.

6) Discuss what activities/strategies were employed to increase resident and consumer participation. How did these change over time?

One of the most visible forms of commitment to supporting consumer voices relates to the Consortium Development Coordinator who was hired on a full time basis. She was a former Healthy Start Consortium Chair who expressed high levels of motivation on the Consortium level and was soon hired to develop the Consortium and protect the integrity of the consumer voice across all levels of the project. She established relationships with the New Haven Housing Authority and its Tenant Residents Council in order to access some of our most vulnerable and at risk residents. She attended Empowerment Zone Management Team meetings in the targeted areas. She became an “Ambassador” for the Consortium and continued to develop relationships with service providers, community leaders, and residents and others.

7) How did you obtain consumer input in the decision-making process?

Consumers participate in all aspects of the Healthy Start Project. Consumer voices drive NHHS strategic planning. Service utilization data (representing consumer encounters) and consumer satisfaction data. Consumer satisfaction surveys are generated annually at the Consortium meetings and they consistently show 95-100% consumer satisfaction. Surveys are distributed to Consortium Members on a monthly basis that guide in the development of discussion topics and meeting agendas. The surveys also guide strategic planning, and consumers participate directly in the strategy formation and strategy approval processes. The Consortium Development Coordinator also takes into consideration consumer input when determining the “goodness” of fit (e.g., track record, cultural diversity) for NHHS subgrantees as well as the scope of service to address the needs of the consumers.
8) How did you utilize the suggestions made by the consumers?

The Consortium Chair (a NHHS participant) provides input in the hiring processes related to Healthy Start staff and/or consultants. The most recent example resulted in the hiring of the project evaluators. All marketing, promotional, and health education-related Healthy Start efforts reflect the voices of consumers. The Consortium Chair works with the Consortium Development Coordinator to design Member recruitment, orientation, and training materials. The Chair is also participates in the Sustainability Committee by making certain the consumer is represented at the table.

The Consortium was not satisfied with the depression services offered by NHHS and felt that we could and should do more. This prompted NHHS leadership to include a treatment component to Yale School of Medicine Department of Psychiatry contract that offered support groups and walk-in hours. As a direct result of consortium membership and consumer requests, NHHS leadership appealed to the Community Foundation to support a contract offering bereavement services for NHHS clients. In 2004, the Foundation awarded ALSO/Cornerstone a multi-year grant offering bereavement counseling, education and informational workshops for NHHS program and community participants.

More importantly, the impact of valuing consumer involvement has created a shift in the norms of the community – far beyond at the Consortium level. All Healthy Start program participants (male or female) understand better the basics of prenatal care and interconceptional care. They understand better the resources available within the community and the level of quality. Valuing the voice of consumers has unleashed more than 5,000 “voices” in the community – mothers, fathers, advocates, professionals, elected officials – who can share their knowledge and experiences with their friends and communities, and who can reinforce a higher level of expectations for maternal and child healthcare.

**Collaboration and Coordination with Title V MCH**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.

**Context for the implementation strategy**

The Connecticut Bureau of Maternal and Child Health has been a closely aligned partner since 1997 when it was involved in the initial planning process of Healthy Start. The New Haven Healthy Start Program has been linked directly with the State’s Title V Plan. The State continues active involvement in the implementation activities and NHHS staff
and partners provided direct input into the development of the State’s Title V Needs Assessment and Plan. The following are primary examples of NHHS 2001-2005 linkages across funding sources:

- The City of New Haven Health Department, a NHHS primary partner oversees FIMR, and receives Title V funding from the Connecticut Department of Public Health.

- Early and Periodic Screening and Developmental Testing (EPSDT) continues to be a priority. According to a 2001 report from the Connecticut Health Policy Project, Investigators from the federal General Accounting Office visiting Connecticut and four other states found inconsistent EPSDT data reporting, inadequate oversight mechanisms and a significant need for consumer education about the value of preventive care. While EPSDT is a critical component of care, it is only a beginning. Screens that identify problems must lead to productive referrals for treatment and eventually to improvements in health. Overall, much work remains to improve services to children in Connecticut's Medicaid program.

- Immunization: A function of the Pediatric Immunization Unit three components: 1) outreach support to families with children who are identified as being behind on their immunizations; focus on recent immigrants 2) CIRTS Registry (CT. Immunization Registry and Tracking) database with the immunization records of children born after January 1996 and 3) support of the Tuesday Afternoon Preschool Immunization clinic, which provides health assessments and immunizations to children 3 & 4 yrs of age who are entering preschool or Head Start.

- Coordinated and integrated service delivery system across funding streams through City of New Haven MCH centralized outreach funded through New Haven Healthy Start and the Department of Social Services. CCHI HUSKY receives a small portion of Title V funding.

- Data Sharing: The Title V Needs Assessment, the Fetal Infant Mortality Review, and Department of Public Health, INFOLINE, the four major Health Care Providers, the Pediatric Immunization Unit, (PIU) and MCH division of the New Haven Health Department, Healthy Start workers, and NHHS care coordinators, the New Haven Family Alliance and Christian Community Action Agency share information and compile data for ongoing reports about the status of New Haven’s Infants, Children and Families. The new NHHS Networked Data System allows all NHHS sub-grantee sites to sign onto the Foundation’s server and access the database which houses information about NHHS participants. The design of the database has been informed through collaboration with the community stakeholders. The database serves three major functions: 1) it allows the front line workers to manage their day-to-day work more efficiently; 2) it allows subcontracted sites to monitor their own performance around various health indicators; and 3) allows the Foundation to monitor subcontractor performance. In CY 03 NHHS had the opportunity to share the data management system with the HRSA Healthy Start Federal Project Officer as well as with HRSA Federal Performance Reviewers from Boston, MA in June 2004.

**Systems Impact** - linkages with statewide Title V planning and program activities.
The City is involved directly with any Maternal and Child Health-related bonding applications (and often serves as fiscal manager). A Maternal and Child Health Bond funding released resulted in the creation of a new facility for r’Kids, a family preservation, reunification, and foster care program designed to serve children who are involved in child protective services through Connecticut’s Department of Children and Families. r’Kids maintains collaborative relationships with the adolescent behavioral and primary healthcare providers, and the Male Involvement Network, once again demonstrating the value of the close partnership between the Foundation and the City of New Haven.

The Foundation provides grantmaking resources to the Connecticut Department of Public Health, Maternal and Child Health (Title V) for professional staff development in the area of cultural diversity training.

The Foundation’s Director of Health, Amos Smith maintains relationships across the statewide healthcare infrastructure at both the public and private level. The Foundation’s grantmaking portfolio in the area of healthcare requires Mr. Smith to identify grantmaking opportunities that leverage public and private funding. Examples relevant to Healthy Start include the State’s ongoing investment in INFOLINE and the State’s focus on the issues of Asthma and Obesity. The Foundation is playing an instrumental role in convening the major healthcare concerns throughout the region to achieve better healthcare outcomes.

Statewide Funders Collaborative for Health: The Foundation’s Chief Executive Officer and its Director of Health use the Funders Collaborative as a vehicle to organize healthcare changes using the philanthropic sector. Through Healthy Start, the Philanthropic and Government Agencies have benefited from public forums such as Health Disparities Forum in October 2003.

NHHS provides information through presentations to organizations such as STRIVE New Haven, JUNTA for Progressive Action, Stepping Stones, and Anthem Blue Cross Blue Shield for staff and participants on the NHHS services and Care Coordination model.

The partnership between the Foundation and the City of New Haven Department of Health creates multiple opportunities to interact with and influence the planning and program activities associated with the Title V plan. The NHHS project has also experienced considerable success with its local health department, Maternal and Child Health Division who administers the SCHIP and Immunization Program.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.

**Description of specific activities**
The NHHS major healthcare partners New Haven Health Department, Hill Health Center, Fair Haven Community Health Center, Yale-New Haven Hospital (and its affiliated programs), and the Hospital of St. Raphael all serve clients that enroll in and receive publicly subsidized healthcare benefits. These providers maintain close affiliations with the Connecticut Department of Social Services, the Connecticut Department of Children and Families, the Connecticut Department of Mental Health and Addiction Services, the Connecticut Department of Labor and affiliations with all major managed care organizations and health maintenance organizations serving Connecticut residents. Both of the hospitals are members with the Connecticut Hospital Association – the statewide trade organization for hospitals, and monitor closely the regulatory, healthcare financing, and insurance environment.

- **The Department of Social Services** is the source for Medicaid Management. DSS is an integral partner serving on the Consortium and committees in an advisory and directing capacity including the training sessions on Medicaid and Social Service referral. The partnership has made significant changes in the way non-traditional caretakers and the working poor acquire health coverage for pregnant women and their children. The Foundation has provided matched funding to local agencies receiving dollars from DSS who are part of the network.

- **The Department of Children and Families** investigates claims of abuse and neglect, and provides protective and foster care services in cases that warrant removing the child from his/her family. TCF provides core operating and capacity building grants to providers of child and adolescent behavioral health (e.g., Clifford Beers Guidance Clinic) in the community who are part of the NHHS network. DCF staff serves on the NHHS Consortium.

- **The Department of Mental Health and Addiction Services** provides substance abuse prevention and treatment funding for high-risk populations. The Foundation established the South Central Connecticut Regional Substance Abuse Prevention Action Council and has provided financial support to a multi-agency collaborative designed to transition children from psychiatric hospitals back into the community. The NHHS Project Director also works on the collaborative efforts with New Haven Fighting Back – a Robert Wood Johnson Foundation funded initiative to reduce the demand for and use of alcohol and drugs.

- **The Department of Labor** enacts the Workforce Investment Act the case management portion of low-income clients. New Haven Family Alliance receives funding from DOL to provide case management. New Haven Family Alliance is a member of the Consortium, receives funding from TCF and provides services through its Male Involvement Network.

- **The Department of Education** funds major local initiatives such as the School Readiness Council that targets children who are 3-5 years old. The City of New Haven recently finalized a citywide planning process for its “Educare” Initiative that targets the well-being of children ages 0-8. NHHS Care Coordinator participates as an active member of the Council. The Foundation staff participated in the planning process. More importantly, however, the Foundation is developing a community building initiative in the area of early childhood. Although the Foundation will measure impact in terms of educational improvement, the Foundation’s health
grantmaking, in addition to NHHS, will represent a major leverage point in the City’s Educare and the Foundation’s early childhood initiative.

- The **Department of Community and Economic Development** provides resources to promote economic development. The Foundation recognizes the importance of economic sustainability as it relates to health outcomes. The Foundation’s Chief Executive Officer serves on the Board of Directors of a number of regional economic development-related initiatives (e.g., Empower New Haven – the City’s Empowerment Zone, Regional Cultural Plan) in which the Department of Community and Economic Development invests heavily. The State is interested in maximizing its investments in economic development, and the Community Foundation participates directly in these conversations.

NHHS is now recognized as a statewide model for replication. The State Department of Public Health has entered into a formal agreement with NHHS to collaboratively achieve the following goals: to improve access to perinatal healthcare; to increase awareness of maternal and child health related issues; to improve access to women’s healthcare and to enhance and strengthen the perinatal health system in New Haven. The NHHS model is recognized as a replicable model for all MCH funded programs in the state. Title V developed a Statewide Consortia on Maternal and Child Health and invited NHHS to contribute to its development and to participate as a member; included NHHS in the Community Phase of the Title V five-year needs assessment; agreed to collaborate with NHHS to initiate discussions with managed care organizations for prevention and outreach dollars and sustainability; look at the NHHS model of care coordination, consortium development, depression screening and database and co-convene with NHHS to establish a model for statewide replication. Title V will also identify state MCH programs that would benefit from NHHS staff technical assistance. NHHS staff will share information on the program model and provide web-based data system orientation to critical Title V staff.

Various meetings and discussions were held to address issues of access to appropriate insurance, lack of Spanish speaking providers and not enough providers with appropriate levels of expertise, which resulted in the production of a referral list for mental health services and a list of resources available to undocumented clients. NHHS has begun to discuss specific barriers related to the lack of available and affordable mental health treatment and the lack of available services for undocumented immigrants to adequate care in regular meetings with the Title V Director. NHHS staff and partners continue to enroll as many clients as possible into the CT HUSKY program and attempt to identify other means of insuring clients. Other examples of planned coordination and information dissemination of lessons learned include:

- The MCH Director maintains information sharing with her MCH colleagues across the state and through the statewide network of HUSKY subcontractors.
- Lessons learned from programmatic experiences are shared at the Perinatal Partnership and Consortium meetings.
- Best practices are documented through collaborative publishing in appropriate journals and other written materials.
The NHHS Project Director and the local MCH Director both sit on Perinatal Advisory Committee coordinated by the Title V Director, which can serve as a forum to disseminate information to colleagues from across the state.

The NHHS program uses information from the State Title V action plan to refine and strengthen its implementation locally. This planning leads to identification of priority areas to be accomplished each year that are based on the needs presented by the women, children and families that participate in the program. The LHSAP is based on the federal resources that are received under this grant, which are also maximized by resources from the Foundation. The Foundation, the NHHS program and Consortium work with the State Title V Office by reviewing the state’s action plan and collaborating on feasible opportunities.

NHHS increases the alliances and services provided between and among community-based organizations that serve high-risk women of child-bearing age (and their children) allowing for broader systems change and an environment in which services are provided through a seamless system of care. The table below depicts the breadth of services provided through the NHHS network. NHHS Outreach Workers received leads or referrals through and made connections to the organizations below.

<table>
<thead>
<tr>
<th>Agencies using NHHS Outreach and Recruitment Services</th>
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<tbody>
<tr>
<td>Hill Heath Center</td>
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<tr>
<td>Columbus House</td>
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<td>INFOLINE</td>
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<td>Job Corps</td>
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<td>Domestic Violence</td>
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<td>Birthright</td>
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<td>UConn Extension</td>
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<td>Fair Haven Health Center</td>
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NHHS contributes to and benefits from other major citywide initiatives that use a community coalition and/or community building approach to stimulate resident involvement, create alliances between community-based organizations, and/or build the capacity of community-based organizations to deliver services more effectively to their constituent groups. The following are some examples of community-wide initiatives (i.e., multi-agency collaborations) that have a community focus and are linked to NHHS.

- **Empower New Haven:** The US Department of Housing and Urban Development designated New Haven as an Empowerment Zone. New Haven’s plan focuses on creating healthy families and bringing sustainable, measurable improvement and economic status and quality of life of individuals, families and businesses in the Empowerment Zone. Empowerment Zone funding supports activities to promote positive health outcomes, and has leveraged its program funding to support healthy start education and intervention activities. The CDC for NHHS works closely with the Director of Marketing and Communications of empower New Haven on various neighborhood events i.e., health fairs, safe nights, resource networking activities.
Empower New Haven has been responsible for creating videos for Healthy Start events, such as the Male Involvement Summits, Racial & Ethnic Disparities Forums and Consortium meetings. Further collaboration is planned for video-taping and airing community health education workshops on Connecticut Public Television.

- **New Haven Fighting Back**: Robert Wood Johnson Foundation funds New Haven Fighting Back, a community-wide initiative to reduce the demand for and use of alcohol and other illicit drugs. NHHS incorporates some of Fighting Back’s successful strategies such as follow-up completion by Health Advocates to ensure individuals get into treatment in its interconceptional care coordination process when women ‘show up to deliver’ and have no previous history of prenatal care.

- **School Readiness Council**: In 2001, the New Haven School Readiness Council expanded its role to focus on providing high-quality early care and education for all children in New Haven ages 0 – 5. This broader focus for the Council was an outgrowth of the data collected by the Mayor’s Task Force on Early Care and Education and the Task Force’s recommendations. New Haven’s strategies have focused on improving quality in all childcare settings: licensed family day care providers, unlicensed providers (kith and kin), and center-based early childhood programs. As a council member, the NHHS Consortium Development Coordinator has the opportunity to participate in discussions that involve setting standards for high quality early care for Connecticut’s children ages 0-5. This forum also allows the NHHS CDC an opportunity to share some of the early care issues that participants of New Haven Healthy Start are experiencing.

- **Housing Authority of New Haven**: The Housing Authority, with its central office located adjacent to the Foundation, has recently moved itself off the US HUD troubled list. The Foundation supports through its grants and by linking NHHS to the social services designed to promote health and economic self-sufficiency for Housing Authority Residents.

- **Yale University**: Yale has partnerships with community groups in the Dwight and Hill neighborhoods to increase homeownership and economic development. Yale secured $2.4 million from HUD for Dwight leveraging matching funds and in-kind contributions of $2.8 million from Yale and $3.2 million from other funding sources.

The following Table depicts how NHHS partners participate:

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Health Educ.&amp; Training</th>
<th>Outreach &amp; Recruitment</th>
<th>Care Coordination</th>
<th>Evaluation, FIMR&amp;PPOR</th>
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<tr>
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<td>ALSO / Cornerstone</td>
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<td>Legal Organization for Teens</td>
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<td>Life Haven Shelter</td>
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<td>New Haven Family Alliance</td>
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<tr>
<td>Organization Name</td>
<td>Health Educ.&amp; Training</td>
<td>Outreach &amp; Recruitment</td>
<td>Care Coordination</td>
<td>Evaluation, FIMR&amp;PPOR</td>
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<tr>
<td>New Haven Home Recovery</td>
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<td>Fair Haven Health Center</td>
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<td>Hill Health Corporation, Inc.</td>
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<td>Hospital of St. Raphael</td>
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<td>Yale – New Haven Hospital</td>
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<td>CT Dept. of Social Services</td>
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<td>Planned Parenthood</td>
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<td>Dixwell Chain of Faith</td>
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<td>Immanuel Baptist Church</td>
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<td>Channel 8 / WHTD</td>
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<td>Empower New Haven</td>
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<td>New Haven Head Start</td>
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<td>St. Rose of Lima Church</td>
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<td>State Latino / Puerto Rican Affairs Com.</td>
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<td>New Haven Board of Education</td>
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<td>Southern CT State University</td>
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<td>Yale School of Nursing</td>
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<td>Yale School of Public Health</td>
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<td>March of Dimes</td>
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<td>Hygeia Foundation, Inc.</td>
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<td>Connecticut Health Foundation</td>
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C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.

See answer on page #23

**Sustainability**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the
quality of available services was more crucial than increasing their number, and
so you focused on quality improvement in your Local Health System Action Plan.

**Context for the implementation strategy**

The State of Connecticut Department of Public Health endorses fully the Healthy Start
project, and participates on the Healthy Start Consortium. During the 2001-2005 cycle,
the State’s Title V Coordinator met with Healthy Start staff to develop a plan for
addressing racial and ethnic disparities as they relate to birth outcomes, and to identify
and support common goals. In January 2005, the Title V staff visited our project and
learned more about best practices and lessons learned that can subsequently be
incorporated as the standard for all State Title V funded projects. Other areas of common
interest include: increasing male involvement in maternal and child health services
(which the Male Involvement Network represents the premier effort in the State);
engaging Managed Care Organizations more substantively in preventive care services;
enhancing consumer involvement; and more effectively utilizing data to shape service
and policy refinements.

These discussions among Healthy Start leaders and State Agency officials have led to
exploratory discussions about securing General Funds from the State for implementation
support of NHHS as well as other communities in the State. The discussions have also
addressed critical policy issues such as the limitations of healthcare coverage for
undocumented mothers subsequent to the birth of their child. The long history of the
Foundation’s involvement in state and community-level policy and funding issues creates
a solid platform for the project to address healthcare system-related issues.

NHHS benefits from the relationships of Mr. Amos Smith. Mr. Smith serves as the
Director of Program for the Foundation. In his capacity, Mr. Smith serves as the
Foundation’s liaison for all health-related efforts nationally and statewide. Mr. Smith’s
extensive relationships – including those with three fortune 500 managed care
organizations with which he worked formerly, creates connections and opportunities for
the project that range from linking other child-centered grant-making of the Foundation
to paving the way for State Agencies to pilot projects originated in New Haven (e.g., the
Healthy Start data system, the Male Involvement Network). Over the last two years of
the project he helped to forge a relationship between NHHS and two substantial
foundations; The CT Health Foundation, which is focusing on health disparities; and The
Coalition of Community Foundations for Youth (CCFY), which helped to fund male
involvement activities in CY03.

The Foundation maintains strong relationships with community institutions responsible
for implementing major state and federal funding streams (e.g., Early Head Start,
Empowerment Zone). The respect for the role of federal funding originates with the
Foundation’s Chief Executive Officer who served as Assistant Secretary of Commerce
under the late Secretary Ron Brown. Consequently, the Foundation leadership embraces
opportunities to leverage simultaneously philanthropic and public sector funding. For

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52 Our Healthy Start project has also offered assistance to the Cities of Hartford and Bridgeport in the development of their 2005-2009 applications – to incorporate lessons learned during New Haven’s implementation, and to take advantage of the existing resources (e.g., assessment tool, electronic database, project evaluators).
example, the Foundation played an instrumental role in securing New Haven’s Empowerment Zone designation. The Foundation maintains a strong working relationship with the Public Housing Authority – in which Healthy Start targets outreach, education, and support programs such as its Male Involvement Network. Additionally, the Foundation supports a wide array of efforts related to improving the health and well-being of children and families. One such example is the Foundation’s First Years First Initiative – a 10-year effort to raise $20 million to support the emotional, physical, social, and educational development of children ages 0 – 8 years of age. This work focuses on family literacy, family self-sufficiency, medical homes for families, and quality and affordable early care opportunities for children.

NHHS engages all of the community’s major healthcare institutions: New Haven Health Department, Hill Health Center, Fair Haven Community Health Center, Yale-New Haven Hospital, and the Hospital of St. Raphael. These healthcare institutions all serve clients that enroll in and receive publicly subsidized healthcare benefits. The core healthcare providers maintain affiliations with all major managed care organizations and health maintenance organizations serving Connecticut residents. Both of the hospitals are members with the Connecticut Hospital Association which is the statewide trade organization for hospitals.

All of these organizations conduct individual fundraising campaigns that involve securing state and federal grants as well as individual donations. The Foundation has awarded grants to all of these institutions for a variety of purposes ranging from research to organizational capacity building (e.g., improving third party reimbursement mechanisms). The hospitals maintain stronger networks with the business community. Any time a maternal and child health-related funding opportunity arises, the Healthy Start partners strategize and determine what approach and service configuration would serve the best interests of the client and produce the most competitive grant award. Additionally, these community healthcare institutions are often at the planning table for a wide variety of interests (e.g., substance use prevention, asthma prevention, obesity prevention). The representatives at the planning tables are more likely to connect community health-related efforts to the widely recognized Healthy Start project. Healthy Start affiliated community healthcare institutions all secure third party reimbursement at maximum levels for healthcare related services and other services to access healthcare (e.g., transportation). The Healthy Start project budget fills the “gaps” related primarily to care coordination. The most relevant example of leveraging other payers relates to the enrollment into HUSKY of undocumented pregnant women. During the course of the pregnancy, HUSKY pays for prenatal care and the birthing process. The child is then enrolled (as a US Citizen) into HUSKY. Unfortunately, the healthcare insurance coverage for the (undocumented) mother ceases after a post-partum check-up with the OB-GYN.

53 Studies show that children whose fathers are an active part of their lives are more likely to stay healthy, stay in school, and avoid drugs, alcohol, and early pregnancy. A partnership of more than 30 local and state social service agencies and health care providers, the Male Involvement Network offers outreach and engagement, counseling, job assessment, placement assistance, as well as strategies for navigating both the legal and financial aspects of their support responsibilities.

54 The Connecticut Hospital Association closely monitors the regulatory, healthcare financing, and insurance environment.
Healthy Start works closely with the State Title V programs to coordinate training and professional development activities (e.g., care coordination, consortium development). The Healthy Start Project Director serves on the State Perinatal Advisory Committee and representatives from the Department of Public Health serve on Healthy Start’s Perinatal Partnership Committee. These working relationships as well as the feedback from Healthy Start participants and community healthcare providers allow the Healthy Start project funding to support critical activities that are not paid for by other federal, state, or local resources.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.

Description of specific activities

Sustainability planning occurs at three levels of the project. First, the Healthy Start Consortium operates a Sustainability Committee. Third party reimbursement and government funding for certain healthcare services play a role in building a strong healthcare delivery system. But these resources alone are rarely enough to respond to all of the challenges being experienced in our communities. NHHS leadership together with the Foundation convened representatives from key stakeholder and subcontractor organizations to design longer term strategies to sustain core elements of the Healthy Start program. Among the participating organizations are the Hospital of St. Raphael, Yale New Haven Hospital, Hill Health Center, the New Haven Health Department and Fair Haven Community Health Center. Each of these organizations agreed to work in concert with Foundation staff to establish an endowed fund to be held at The Foundation. The group had several meetings and established its fund at the Foundation in December of 2004. To guide us in this effort we used resources available at The Foundation, as well as, those available through The Finance Project.55

The fund serves to institutionalize a foundation of support for non-reimbursable and core social supports that are necessary to sustain a well functioning perinatal healthcare delivery system. The establishment of the fund gives way to the realization that government resources (local and national) must work in partnership with private, third party, and philanthropic resources for NHHS programs to succeed. At its maturity, the fund will ensure the presence of community-based efforts that are broad in scope, inclusive, comprehensive, culturally competent, and well coordinated with medical services.

At a more operational level, the Healthy Start Perinatal Partnership Committee examines

Harnessing the Power of Philanthropy
The creation of an endowment fund will mark the beginning of a new era for maternal and child health in New Haven, and for Healthy Start programs nationally.

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55 The Finance Project provides materials to help program developers and community leaders identify basic issues in sustaining promising initiatives; address the strategic details; and develop a comprehensive sustainability plan.
on an ongoing basis how to improve access to and maintenance in the healthcare system, particularly for high-risk populations. Discussions relate to improving the responsiveness of the system (e.g., cultural diversity, friendly environment), the efficiency of the system (i.e., data collection systems, training), and examining the impact of healthcare policy and financing considerations as it relates to the populations most at risk for adverse maternal and child health outcomes. Each of these areas of focus relate to project sustainability.

Finally, the Foundation – as fiscal agent and managing partner – maintains a high level of institutional commitment to supporting community-driven approaches that achieve positive maternal and child health outcomes. This institutional commitment resulted in the Foundation’s support of the Commission on Infant and Child Health (during the 1980s – mid-1990s) and continued from 1997 to the present with two (3) federally funded Healthy Start applications. The 2005-2009 Healthy Start funded application is intended to reduce the remaining health disparities (i.e., African American population) and to implement a transition out of federal Healthy Start funding – which presumably our community will no longer meet the eligibility criteria!

As a strategic (and institutionally driven) transition plan, the Foundation has recently launched a 10-year initiative called “First Years First.” The initiative is designed to facilitate the development of children (ages 0 – 8) who meet physical, emotional, social, and educational benchmarks. Four program strands drive the initiative (and complement other institutional efforts to support children and families): family literacy, medical homes (i.e., Healthy Start), early child care, and changing public policy. The Foundation has set a goal to raise $20 million over a 10-year period to sustain these approaches – each of which was selected as a result of a community dialogue and a focus on “evidence-based” approaches.56

Given the positive (and measurable) outcomes produced by our community’s Healthy Start approach, the Foundation is in a solid position to make our case for policy and funding changes at the State level (general funds) as well as to other sources of financing (e.g., managed care organizations, health foundations, individual philanthropy). During the 2005-2009 implementation period, sustainability strategies will receive high priority status from the Healthy Start Consortium as well as from the Community Foundation. Our community has come to expect better integration of services, stronger collaborations, and comprehensive approaches to service delivery. Healthy Start is approaching perhaps its most difficult period. In an environment of declining resources, we have a unique opportunity to create linkages to early care, education and school entry for Healthy Start children. Efforts are underway currently at the Foundation to infuse health into early care and education, particularly during the interconceptional period. This opportunity is in part the result of having a large, vibrant, and assertive Consortium, as well as, the

56 The Connecticut Voices for Children is the managing partner of Ready, Set Grow – CT Kids!, a public awareness campaign that is rallying support for reinvestment to meet the needs of young children and their families. [See www.readysetgrowctkids.org]. Seventy eight (78%) of infants and toddlers are cared for in someone’s home. The Foundation supports the Family Child Care Network – designed to turn home-based child care into a powerful tool for school readiness (including proper health). The Yale Child Study Center evaluates the Family Child Care Network effort to track quality and impact. The Connecticut Humanities Council is the lead partner to implement the Mothered/Fatheread program – which builds on the passionate desire of parents to be the best first teacher for their child.
community’s belief that NHHS has helped to create conditions for success in these areas.

We have created an infrastructure in New Haven that supports MCH collaborations as evidenced by a high functioning networked data base, a system of care coordination, targeted outreach, and consortium development. As a result, we have created opportunities for additional leverage of state programs through our collaborations with the Connecticut Departments of Public Health and Social Services. We anticipate that these relationships will assist us with leveraging and deepening our work. The hardest part of our work has been coming to the realization that MCH is intricately connected to important outcomes for children in other areas. We have demonstrated with a high degree of clarity our ability to work within multiple, complex, and integrated systems of care that includes consumers. As our confidence has grown, so has confidence of external groups in us, including state and local governments. As a result, our efforts might provide the best leverage of government resources (MCHB, Medicaid, Philanthropy, and Individual Donors) to date. We are at a critical point of institutionalization of federal funded Healthy Start services that maximizes earlier investments into this community across a number of other systems for children and families.

B. For sustainability, please address the following additional elements:

9) Describe your efforts with managed care organizations and third party billing.

Healthy Start affiliated community healthcare institutions all secure third party reimbursement at maximum levels for healthcare related services and other services to access healthcare (e.g., transportation). The Healthy Start project budget fills the “gaps” related primarily to care coordination. The most relevant example of leveraging other payers relates to the enrollment into HUSKY of undocumented pregnant women. During the course of the pregnancy, HUSKY pays for prenatal care and the birthing process. The child is then enrolled (as a US Citizen) into HUSKY. Unfortunately, the healthcare insurance coverage for the (undocumented) mother ceases after a post-partum check-up with the OB-GYN.

Third party reimbursement and government funding for certain healthcare services play a role in building a strong healthcare delivery system. But these resources alone are rarely enough to respond to all of the challenges being experienced in our communities.

10) Describe major factors associated with the identification and development of resources to continue key components of your interventions without HS funding.

NHHS leadership together with the Foundation has convened representatives from key stakeholder and subcontractor organizations to design longer term strategies to sustain core elements of the Healthy Start program. Among the participating organizations are the Hospital of St. Raphael, Yale New Haven Hospital, Hill Health Center, the New Haven Health Department and Fair Haven Community Health Center and the Male Involvement Network. Each of these organizations has agreed to work with Foundation
staff to establish an endowed fund to be held at The Foundation. In December 2004 an
Endowment Fund was established at The Community Foundation of Greater New Haven
for the purposes of sustaining key components of the New Haven Healthy Start Program
and The Male Involvement Network beyond federal dollars. To guide us in this effort we
used resources available at The Foundation, as well as, those available through The
Finance Project.\textsuperscript{57}

Upon its maturity, the fund will institutionalize a foundation of support for non-
reimbursable and core social supports that are necessary to sustain a well functioning
perinatal healthcare delivery system. The establishment of the fund gives way to the
realization that government resources (local and national) must work in partnership with
private, third party, and philanthropic resources for NHHS programs to succeed. At its
maturity, the fund will ensure the presence of community-based efforts that are broad in
scope, inclusive, comprehensive, culturally competent, and well coordinated with
medical services.

The database provides compelling, quantitative evidence that can also be used to advance
project sustainability.

11) Describe whether or not you were able to overcome any barriers or
to decrease their negative impact.

There is still skepticism in the community that we can sustain NHHS and MIN services
because of the large amount of money we need to raise. What we have done is inspire
people to believe that we could create the possibility of leaving a legacy after federal
dollars disappear and emphasizing the importance of these services. The inspiration
comes from seeing NHHS related programs within the context of a comprehensive
program approach that builds on positive aspects of community life including fatherhood
involvement, grand parents as care takers, policy and advocacy and systemic issues. It is
the inclusion of a more comprehensive approach to community change that is broader
than maternal and child health.

When change occurs, leaders have to be willing to take on the change and systems that
serve them.

C. Identify any resources or events (your State experienced a budget
shortfall) that either facilitated or detracted from successful
initiation and implementation of each intervention.

See answer on page #23

III. Project Management and Governance

A. Briefly describe the structure of the project management which was in
place for the majority of the project’s implementation.

\textsuperscript{57} The Finance Project provides materials to help program developers and community leaders identify basic issues in
sustaining promising initiatives; address the strategic details; and develop a comprehensive sustainability plan.
The Community Foundation (TCF), established in 1928, is one of the largest and oldest community foundations in the country. The Foundation employs a community building approach to grant-making investments and program development through partnering with the community to identify needs and create solutions that develop the human, social, economic and physical assets of a community for the benefit of all. The Foundation is led by an active, diverse, and committed Board of Trustees who set policy and approve all new initiatives and grants. The Board members are appointed by the Mayor of New Haven, Yale University, the Greater New Haven Chamber of Commerce, as well as by each of the four Trustee banks that manage the endowment funds. The ongoing work of the Board is carried out through both standing sub-committees (Long Range Planning and Program Committee, Finance and Audit Committees, and Development Committee) and work groups established on an ad-hoc basis. Mr. Will Ginsberg, President and Chief Executive Officer, provides leadership and direction to the Foundation Board and its staff.

The Chief Financial and Operating Officer, Mr. A.F. Drew Alden, is responsible for maintaining the financial integrity of the Foundation by working closely with Board members in overseeing all fiscal and management operations, including contract management, managing the fiscal assets of the foundation, and development and donor relations. Those who work in Development and Donor Relations attend to the needs of prospective and current donors. Under Mr. Alden’s guidance, The Community Foundation (TCF) leads the nation in return on investment for its class (mid-size foundation) of assets under management. A Controller reports directly to Mr. Alden. The Controller supervises the bookkeepers and financial analysts assigned to the Healthy Start Initiative.

Senior Vice President of Philanthropic Services, Ms. Laura Berry, replaced Vice President of Programs, Ms. Etha Henry. Ms. Berry assists in establishing and updating programs and procedures for all Foundation activities and supervises the Director of Programs and the Program Officers who serve as the front line contacts with the community. The Program Officers meet with members of the community to discuss their programs and the needs they are attempting to address through programming. Program Officers also serve as liaisons for projects such as this that depend on the Foundation for its ability to convene diverse collaborators within a neutral, yet highly productive space.

Mr. Amos Smith, Director of Programs for TCF, is the primary point person for the Healthy Start Initiative. Mr. Smith has been instrumental in convening partnerships and aligning the Foundation’s health grant-making activities to leverage community partnerships, to promote system change, to build organizational capacity for healthcare providers, and to increase involvement of consumers and community residents. Mr. Smith is the Principal Investigator on the Eliminating Disparities and Interconceptional Care grants. He provides oversight and supervision to the entire Healthy Start staff. As the Director of Programs, Mr. Smith ensures that the Healthy Start program is fully integrated into the Foundation focus areas and that appropriate linkages are made through responsive grant-making around issues that affect maternal and child health.

The following identifies personnel that play an integral role in managing and
administering the Healthy Start Initiative:

Ms. Delores Greenlee was recruited and hired by the Foundation as the new Project Director in July 2003. Ms. Greenlee has a strong background in Human Services, HIV/AIDS, substance abuse and other public health concerns. She replaced Mr. Kenn Harris who served on the project in the 1997-2001 and 2001-2005 project periods. The Project Director provides day-to-day management of the entire project.

Ms. Mary Sliwinski served as the NHHS Program Monitor. Her primary responsibility was to monitor the NHHS database and verify data entry. Ms. Sliwinski resigned in November of 2003.

Christina Ciociola, Care Coordinator Manager, continued in her role. She is responsible for overseeing the outreach component and the care coordinators that are hired at each of the health care institutions. She also helps to coordinate training for the outreach workers and the care coordinators. She has taken on more responsibility in the absence of the program monitor. Her job has always included NHHS data verification and database management but a formal expansion into this area occurred when the part time program monitor resigned.

Caren Lang, Senior Program Assistant hired 6/02 continues to provide administrative support to the project. Ms. Lang is also assigned special projects for the program.

Natasha Ray continues as the NHHS Consortium Development Coordinator. Her role with NHHS began over 6 years ago when she became involved as a consumer participating in a support group called Mothers for Justice. “Mothers for Justice” is a program of Christian Community Action, Inc. an agency working with women transitioning from welfare to work. Ms. Ray then served as the Chair of the NHHS Consortium until she was hired as the Consortium Development Coordinator for the project. She now works with the current Consortium Chair, Ms. Patricia Burruss. They continue working together to identify and engage and train consumers interested in participating in the Consortium. Ms. Ray also provides support and guidance to NHHS health advocates.

B. Describe any resources available to the project which proved to be essential for fiscal and program management.

The Foundation leadership decision to continue as the project lead and fiscal agent was made in close consultation with the City of New Haven and the Consortium. The leadership role is a natural outgrowth of the Foundation’s long-standing commitment to issues of maternal and child health, and a recognition that the Foundation’s leadership plays an instrumental role in achieving objectives – including leveraging funding, changing statewide policies, involving community residents, and convening program partners.

The Foundation operates highly efficient administrative and fiscal management protocols. Finance and management-related Foundation staff assigned to the Healthy Start project include but are not limited to:
C. What changes in management and governance occurred over time and what prompted these changes?

Vice President for Programs, Ms. Etha Henry, left the Foundation in October 2004 and Ms. Laura Berry, Sr. Vice President of Philanthropic Services took over Ms. Henry’s responsibilities to the NHHS project.

Mr. Smith’s role grew substantially over the ’02-’03 year requiring him to assume more responsibility in the administration and implementation of the grant. Based on his contributions and involvement with the program, a portion of his salary is charged to the grant. During the time when the position of project director was vacant, Mr. Smith assumed complete responsibility for the project. He continues to work closely with the project by providing strategic and analytical support. Additionally, he is charged with the task for ensuring sustainability and integration with other initiatives funded outside of the federal Healthy Start. Mr. Smith also provides guidance to the Male Involvement Initiative that is supported by both TCF and NHHS. Finally, in the absence of the Director of healthy start, Smith acted in the role of liaison to the federal government and other local constituencies involved with healthy start.

In May of 2003 Mr. Kenn Harris resigned as the Project Director in order to pursue fulltime pastorate. Ms. Delores Greenlee was recruited and hired by the Foundation as the new Project Director in July 2003. Ms. Greenlee has a strong background in Human Services, HIV/AIDS, substance abuse and other public health concerns. Mr. Smith coordinated the recruitment process for the Project Director. Advertisements for the vacant position were placed in local media publications as well as an internal distribution of the job posting. A group of candidates were selected to be interviewed by staff, Consortium Chair and members of both the Consortium and Perinatal Partnership and a list of the three finalists along with resumes were provided to the federal project officer at the time, Jane Martin Heppel. The process was completed in only three months. Ms.
Greenlee was hired in July 2003.

Ms. Sliwinski’s position started as a full-time staff person and her time was reduced consistent with efficiencies in data collection and monitoring procedures. Mary Sliwinski resigned as the NHHS Program Monitor in the fall (11/03) to pursue a different opportunity. Her primary responsibility was to monitor the NHHS database and verify data entry. Those responsibilities have been folded into the responsibilities of the Project Director and the Care Coordinator Manager. These changes are one of the best indications of how the healthy start data collection system has enabled us to gain efficiencies in staffing as well as better management and analysis of data.

Christina Ciociola, Care Coordinator Manager, continued in her role but gained some new responsibilities. She is responsible for overseeing the outreach component and the care coordinators that are hired at each of the health care institutions as well as a combined responsibility of oversight with Consortium Development Coordinator for the health advocates. She also helps to coordinate training for the outreach workers, care coordinators and health advocates. She has taken on more responsibility in the absence of the program monitor. Her job has always included NHHS data verification and database management but a formal expansion into this area occurred when the part time program monitor resigned.

As a result of the NHHS Program Monitor resignation during CY03, project administration decided against refilling the position. Because of the new networked data system, the project data management had become more efficient and streamlined. Given the length of time that was remaining in the project period (15 months), management decided to utilize current staff to fill the gap. The Care Coordinator Manager maintains the day to day operation of the database management and verification of data. As she was significant in the planning and implementation of the data base, she proved to be fully capable of handling this expansion of duties. The Project Director oversees the Care Coordinator Manager and the overall data system management. She also fills in for the Care Coordinator Manager when she is absent.

Two new care coordinators were hired in CY03, they are as follows:

The Community Foundation (TCF) for Greater New Haven provided a grant to Yale New Haven Hospital to hire a second Care Coordinator since this institution handles the higher volume of pregnant women. Tracy Cusack, MSW was hired 11/03.

Hill Health Center – Miriam Serrano was hired 01/03 as the Care Coordinator for that institution. She is Latina and has a BA and knows the community and its population.

The biggest challenge impacting the NHHS program was finding that our evaluators were conducting double blind research studies that were involving our clients or their data without the knowledge of healthy start administration. In order to address this matter, we consulted with a variety of professionals including our federal officers about this matter. It has been the practice of the NHHS to work very closely in building trust with its consumers and the Consortium. In doing so, we believe that implementation of a research protocol without prior discussion and consent with our subcontractors and
consortium members constituted a breach of their contract. As a result the evaluators resigned with short notice. We engaged our constituencies more fully in instituting reconciliation and involved them in the hiring of new evaluators, Nia Solutions Limited, Inc. Nia Solutions contracted with us in March of 2004 and have met with all of the NHHS staff, stakeholders, consortium and administrators and front line staff. They quickly familiarized themselves with the healthy start programs, subcontractors and consumer advisory councils. They have completed a draft evaluation report (attached) and have designed the evaluation for the 2005-2009 project period. We have established a good relationship with our evaluators and are very pleased with their work so we expect to continue with Nia Solutions Limited, Inc. over the next four years.

D. Describe what process had to be developed to assure the appropriate distribution of funds and what happened with the process over time.

The Foundation maintains excellent internal financial controls for managing federal grant funds. Specifically, Finance Director Richard Collins with the assistance of a bookkeeper: a) processes on a bi-weekly basis payments to Healthy Start vendors and/or subgrantees; b) produces monthly financial reports on each of the three Healthy Start program models58; c) meets monthly with the Foundation’s Healthy Start Project Director to review the validity and meaning of the financial information as well as to receive authorization to pay Healthy Start invoices from vendors or subgrantees based on benchmarks defined in performance-based contracts59; and d) submits quarterly to the federal government from PSC 272 that tracks cumulatively expenditure of money over the entire (i.e., 4-year) grant period.

The Finance Director also assists the Foundation’s Healthy Start staff in developing budgets and performance-based contracts (i.e., measurable outcomes, payment schedules). The Foundation requires its subgrantees (i.e., hospitals, health centers) to negotiate the scope of service and execute contracts prior to the receipt of any federal Healthy Start payments. Mr. Smith (Director of Programs) and Ms. Greenlee (NHHS Project Director) communicate financial and program-related information to the Consortium and to subgrantees on a regular basis.

Mr. A. F. Drew Alden reviews quarterly with the Director of Finance all NHHS financial information. Mr. Alden manages the Foundation’s independent audit process and staffs the Audit Committee (i.e., Trustees). Two months subsequent to the end of the Foundation’s fiscal year, an external accounting firm (i.e., PriceWaterhouse Coopers, LLP) audits the compliance of the Foundation with the types of compliance requirements described in the US Office of Management and Budget Circular A-133 Compliance

58 Monthly reports are produced by the 15th of the subsequent month based on the closing statements of the prior month.
59 Subgrantee contract language includes stipulations that relate to: a) obligations imposed on the Foundation by the federal government pursuant to 45 CFR Section 74.163, e.g., OMB Circular A-110, Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-profit Organizations, in establishing procedures for procurement of supplies, equipment, construction and other services purchased with monies paid to the Subcontractor hereunder, and OMB Circular A-133 which pertains to the annual audit of all federally funded grants and subcontracts and b) all applicable regulations and guidelines of the U.S. Department of Health and Human Services, including without limitation those contained in 45 CFR 74 (as amended and in effect from time to time) pertaining to, among other matters, record retention and access; grant-related income; standards for financial management systems and audits; financial reporting requirements; monitoring and reporting of program performance; and payment requirements.
Supplement, as well as the Government Auditing Standards. The 2003 independent audit confirmed the non-existence of any material weaknesses, reportable conditions or noncompliance in financial statements for three federal programs (Healthy Start Health Disparities, Interconceptional Care, Maternal Depression). The external auditors stated, “In our opinion, the Foundation complied, in all material respects, with the requirements referred to above that are applicable to major federal programs for the year ended December 31, 2003.”

E. As the project moved forward with implementation, what additional (non-HS) resources obtained for quality assurance, program monitoring, service utilization, and technical assistance became important especially as contractors were funded or additional staff members were hired?

We began to align program monitoring and contracting with that of the Foundation. We also incorporated program practices with those of our grantmaking efforts e.g. Impact Manager, etc.

The Foundation supports an ACCESS database developed exclusively for the Healthy Start project and available via internet access to all Healthy Start subgrantees. The 2001-2005 project budget supported (partial) implementation and further development of the database.

The database parameters were developed jointly by all NHHS subgrantees. The functionality of the database meets multiple maternal and child health reporting requirements (e.g., federal Healthy Start, SCHIP, immunization), protects patient privacy and confidentiality of records (i.e., HIPAA), and aligns with subgrantee’s information technology security protocols. The database allows online (i.e., real time) entry and storage of intake forms, assessment forms, pregnancy outcome forms, infant care tracking, and contact/referral logs.

The database generates reports designed to help the Foundation and subgrantees to monitor progress and performance as frequently as desired. Additional tools are available to front-line staff to increase efficiency of their day-to-day work (e.g., list of follow-up appointments; calculation of low, moderate, or high risk) and to improve the quality of care (i.e., no more subjective risk assessments). Presently all NHHS subgrantees use the online database. All NHHS and subgrantee staff receive training on how to use the database and to produce reports. The NHHS Project Director, Care Coordinator Manager, and the Foundation’s Director of Management Information Services oversee the implementation of the database. The database provides compelling, quantitative evidence that can be used to advance project sustainability.

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60 Page 16 of the December 2003 audit memo from Pricewaterhouse Coopers, LLP to the Trustees’ Committee and the Board of Directors of the Community Foundation for Greater New Haven.
61 The prior database relied upon subgrantees loading information onto laptops and then uploading data into a centralized database. Healthy Start staff was required to upload and merge the files (once every 30 days). The process provided for overall management of the project but did not benefit the care coordination function of front-line staff.
62 The security concerns were addressed by ensuring that the network use a128 bit encryption software to ensure information remained protected.
The State Department of Public Health Title V Director is examining the feasibility of using the database for all Title V funded projects in Connecticut. Locally, NHHS launched a parallel database for service providers affiliated with the Male Involvement Network. Also, the Foundation is conducting due diligence activities related to obtaining licensing or copyright protection for the database, and sharing the database approach with federal Healthy Start affiliates (e.g., program officer, Worcester, MA Healthy Start).

NHHS subgrantees provide direct care services to NHHS participants. The Foundation does not require a separate client satisfaction process for Healthy Start participants. Client satisfaction for NHHS program participants falls under the subgrantee’s regular quality assurance processes as determined by national and state accreditation and licensing entities. The community health centers and hospitals: a) remain in good standing through JACHO accreditation processes; b) comply with State of Connecticut Department of Public Health licensing and regulatory requirements; and c) in some instances hold other accreditations (e.g., federally qualified community health center). The health care providers apply Public Health Standards (for primary care—among others) and operate Continuous Quality Improvement Committees.

F. To what extent was cultural competency of contractors and of project staff an issue? If cultural competency was an issue, how was it addressed, and were any noticeable benefits realized?

Each contractor is required to complete a cultural competency self assessment as part of the contract process and before a contract is fully executed. The assessment tool in accordance with the Health and Human Services Administration (HRSA) is used to measure institutional policy and procedures on cultural competence. If a score falls between 0-14 (indicates the objective is not met), NHHS leadership is not inclined to enter into a contract with the contractor but will meet with the contractor to discuss in person. If the score falls within 15-28 (indicates the objective is partially met), NHHS leadership is cautious about entering into a contract and will meet with the contractor in person to discuss and encourage better performance. A score of 29-44 (indicates the objective is met), means NHHS leadership is comfortable with entering into a contract but will still encourage better performance.

The staff of NHHS is diverse with 60% being persons of color. All staff receives cultural competency training. Two members of the Healthy Start staff serve on the Community Foundation’s Diversity Council while the remaining members of the staff participate in Diversity Council activities. Healthy Start Outreach Workers, Care Coordinators and Health Advocates are also a diverse group with 90% representing persons of color.

Approximately 45% of the Healthy Start prenatal participants are Latino and 28% are African American. According to 2000 Census data, over half (51%) of the women of childbearing age in New Haven are either Latino (21%) or African American (30%).

63 The Foundation does, however, conduct a participant satisfaction survey among its Consortium Members, the majority of whom are Healthy Start program participants. The Consortium’s satisfaction survey, however, does not speak towards quality of care for services provided by Foundation subgrantees.
Clearly, the diversity of the community necessitates a culturally competent health care system. New Haven, one of Connecticut’s most diverse communities, prides itself on resident-driven initiatives. The New Haven community also believes strongly in an empowerment philosophy, and NHHS programs educate and train patients to understand the medical system as well as to be informed healthcare consumers.

Since 1997, NHHS has broken down traditional and cultural barriers in an attempt to reach populations that may be underserved due to various factors that often predict whether or not a woman will postpone or forgo prenatal care (e.g., income, race, education levels). NHHS has encompassed five basic principles within its system reflected in attitudes, structures, policies, and services: 1) valuing diversity, achieved by having a Consortium that is representative of the population served; 2) conducting cultural self assessment, setting goals for race / ethnicity representation on the Consortium; 3) conducting cultural sensitivity training to produce awareness of cultural differences and dynamics; 4) institutionalizing cultural knowledge by conducting ongoing training and education for providers; and 5) being adaptive, by creating new ways to engage and provide service delivery for persons of different cultures.

NHHS care coordinators and outreach workers have distributed baby items, culturally sensitive and appropriate educational materials, attended baby showers for participants, engaged women at grocery stores, churches, homeless shelters and through home visits (e.g., grassroots outreach to Public Housing Authority residents).

The NHHS Consortium strives to achieve a membership that is reflective of the community it serves. Although NHHS has exceeded its targets for the previous two calendar years in terms of the overall size of the Consortium, the graph below shows how the Consortium membership overall is not yet reflective of the racial and ethnic composition of the Healthy Start participants. Latinos appear to be underrepresented on the Consortium (9%) as compared to their percentage (45%) among Healthy Start prenatal participants.

The Consortium has been examining the feasibility of creating a committee charged with increasing Latino membership. The Committee would request technical assistance from another successful Healthy Start grantee and adopt best practices to improve recruitment of Latino Consortium membership, and to explore ways to increase the Consortium’s cultural awareness of NHHS program participants.

Activities include four training workshops for Consortium members yearly, two training retreats yearly for staff and sub-contractors, and a yearly forum with more than 300 in attendance including providers, government officials, consumers, consortium members, Foundation staff, NHHS staff, NHHS subcontractors and direct service workers, physicians, and researchers, among others.
Some activities already implemented are the coordination of a recruiting and enrollment activity with our Hispanic Health Advocate in the predominantly Hispanic Fairhaven Community at C-Town, the largest grocery store serving this population; analyzing NHHS data more closely to look at ethnicity, language and mobility to better understand this population; the project’s evaluators conducted focus groups with program and community participants that include questions about the lack of Hispanic participation on the Consortium; development of a collaborative relationship with Junta for Progressive Action, the largest Hispanic agency in New Haven.

The NHHS Care Coordination model has a significant number of bi-lingual and bi-cultural staff, which increases the accessibility of services to consumers. The networked database minimizes duplication of enrollment and allows for regular updates on participant progress through the care system. Using the data system to analyze data on low birth weight babies by race, ethnicity, age, insurance status, alien status, residency, and neighborhood allows providers to target services more efficiently. Improved communication among stakeholders through the networked database and strengthening relationships with providers increases the likelihood of community residents’ access.

The free care program at Yale New Haven Hospital increases the ability to reach undocumented women yet, cultural issues, which include distrust of institutions and fear of deportation still impede access. Although better coordination and deployment of health advocates and other community based resources exists, an issue of cultural stigma and the need for more Spanish speaking providers remains.

Finally, the “convening” role played by the Community Foundation in NHHS guarantees that resident’s voices will be heard by partners responsible for program services.

IV. Project Accomplishments

A. Describe each major strategy implemented, with its goals and objectives and accomplishments for this project period. Within the narrative describe in quantitative and qualitative terms the degree of success in achieving the goals and objectives. Describe any barriers that had to be dealt with during implementation and how they were addressed. Summarize all lessons learned. Strategies and goals and objectives that were commonly used across services can be cross-referenced. You may wish to use the Suggested Format, in Attachment A for this part of your report.

See Attached

B. For those projects that received mentoring or technical assistance from another site, please discuss any activities/lessons learned from those projects that you utilized in your project. If you provided technical assistance, describe your activities, feedback received on them, and any other lessons learned.

New Haven Healthy Start received mentoring from Boston, Philadelphia and Mobile Healthy Start projects. Each one gave us valuable information and
learning, specifically:

- Boston – helped us to organize our program and showed us how to fit within a community structure
- Philadelphia – gave substantial guidance around consortium development and outreach
- Mobile - gave us a good understanding of service delivery and a clearer indication of what was needed in galvanizing strong relationships with sub-contractors

We also received visits from Worcester and Brooklyn Healthy Starts for technical assistance, specifically:

- Worcester – was interested in the NHHS database and was referred to us by our Federal Project Officer, Jane Martin Heppel. They were interest in developing a database of their own and wanted more assistance on the reporting we do as a result of our database. After a demonstration of the NHHS database, they were interested in replicating but were waiting on a grant award from their competitive application.

- Brooklyn – The Project Director and Coordinator of Depression Services visited NHHS for technical assistance on depression service delivery, particularly the MOMs hotline. We received positive feedback from the visit and learned that the coordinator was interested in incorporating the NHHS referral and evaluation process and tool in the Brooklyn Healthy Start Depression Program.

V. Project Impact

Based on a review of all of your project HS grant submissions during the project period, and the services and strategies implemented, describe the impact of Healthy Start on your Project Area and community. Please organize your description using the outline below.

A. Systems of Care: Describe how the project has enhanced collaborative interaction among community organizations and services involved in promoting maternal and infant health and social support services.

1. Describe the approaches utilized to enhance collaboration.

Building collaborations and sustainable systems requires time, and a commitment of stakeholders who will collaboratively continue building and working within a “changed” and “linked” environment to provide a comprehensive perinatal system of care. Sound management of resources to ensure ongoing services, and a system that is capable of obtaining and using data to improve care and evaluate impact is essential to a comprehensive system of care.
NHHS has had a profound impact on quality interaction between the major healthcare centers. We have created interactions, coordination, linkages and a spirit of cooperation among those healthcare centers that does not exist at any other table in the city. It is the one table where people from neighborhoods, to policy leaders to program administrators all come together. NHHS has taken on a substantial role of leader in this community and we have created a galvanized force for other prominent community issues from early school failure for children to lack of integration between health and early education for young children. This is particularly significant since one of the greatest barriers for access to school is health related concerns. The Foundation’s two largest investments are driven because of the success of NHHS, they are First Years First and the Child Outcomes and Tracking Project.

2. Identify the extent to which structured changes, such as procedures or policies, have been established for the purpose of system integration.

As a primary partner since 1997, the City MCH division has adopted the New Haven Healthy Start enrollment protocols for all women seeking MCH services, and integrated and coordinated its service delivery system across funding streams.\(^{65}\) The plan was designed in partnership with community residents, community-based organizations, state agencies, the local hospitals, community health centers and other institutions.

<table>
<thead>
<tr>
<th>MCH System Accomplishments</th>
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<tr>
<td><strong>Centralization of all existing Healthy Start outreach and recruitment workers</strong> at the NHHD. Coordinated outreach activities across funding streams and use performance based objectives to monitor progress.</td>
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<tr>
<td><strong>Developed a layered approach to intensive health education and professional development training</strong> for: a) Healthy Start consumers; b) community-based organizations; and c) professionals and para-professionals integral to system change efforts (e.g., physicians through grand rounds).</td>
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<tr>
<td><strong>Structured, standardized risk assessments were developed</strong> to be completed by high-risk consumers: a) at the time of entry into the pre-natal care system; and b) after delivery during the interconceptional period. The risk assessment process is integrated with local evaluation efforts (e.g., depression assessment).</td>
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<tr>
<td><strong>Developed an improved method of assessing signs of depression, and the need for more bereavement services and support.</strong> The method has been integrated into the risk assessment. Addressing the need for more bereavement services and support continues as a focus. The Also/ Cornerstone agency continues to provide support to women experiencing a fetal loss and/or who need counseling.</td>
</tr>
<tr>
<td><strong>Established a Perinatal Partnership</strong> that provides a forum for maternal and child health professionals to solve systemic issues. Information used to inform their decision-making are data provided from the care coordination implementation, data used in the Healthy Start Evaluation and the findings from the Fetal Infant Mortality Review. Of particular note is: a) the creation of a risk assessment protocol that is implemented uniformly across all providers; and b) improvement of care coordination services for women who deliver with no exposure to pre-natal healthcare.(^{66}) The group is currently trying to resolve a problem of inconsistent reporting of birth weights on the local level as compared to EVRS state database.</td>
</tr>
<tr>
<td><strong>Developed a care coordination protocol for high-risk women.</strong> This included securing funding to field test a care coordination / case management approach both for women who: a) enter the prenatal care system</td>
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\(^{65}\) Standard NHHS enrollment protocols include; 1) demographic profile; 2) comprehensive psycho-social assessment; 3) perinatal depression screen; 4) referral to needed health and community-based services; 5) follow-up to determine if services have been engaged; 6) program monitoring (data entry) and 7) evaluation (reports).

\(^{66}\) The current model used by NHHS is a care coordination model that is a direct result of the work of the perinatal partnership.
3. Describe key relationships that have developed as a result of Healthy Start efforts covering the following areas:

a. Relationships among health service agencies; between health and social service agencies; and with community-based organizations;

NHHS increases the alliances and services provided between and among community-based organizations that serve high-risk women of child-bearing age (and their children) allowing for broader systems change and an environment in which services are provided through a seamless system of care. The table below depicts the breadth of services provided through the NHHS network. NHHS workers received leads or referrals through and made connections to the organizations below.

<table>
<thead>
<tr>
<th>Agencies using NHHS Outreach and Recruitment Services</th>
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<tbody>
<tr>
<td>• Hill Heath Center</td>
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<tr>
<td>• Columbus House</td>
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<tr>
<td>• INFOLINE</td>
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<tr>
<td>• Job Corps</td>
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<td>• Domestic Violence</td>
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<td>• Birthright</td>
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<td>• UConn Extension</td>
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<td>• Fair Haven Health Center</td>
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<td>• Yale Consultation Center</td>
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<td>• New Haven Family Alliance</td>
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<td>• Hospital of Saint Raphael</td>
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<td>• Christian Community Action</td>
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<td>• Board of Education</td>
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<td>• Planned Parenthood</td>
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<td>• 3PN</td>
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<tr>
<td>• Yale New Haven Primary Care Center</td>
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<tr>
<td>• Dixwell Newhallville Mental Health Center</td>
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<tr>
<td>• Healthy Families, Yale New Haven Hospital</td>
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<tr>
<td>• Yale Child Study Center – Family Support</td>
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<tr>
<td>• Department of Children and Families</td>
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<tr>
<td>• Department of Social Services</td>
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<td>• Department of Labor</td>
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b. Relationships that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.

NHHS has developed relationships with All Our Kin, who provide training and assistance in certification and licensing of quality daycare. One of our consortium members became certified through this process and opened a daycare in her home in 2004. The School Readiness Council has sought technical assistance from NHHS on developing a consumer driven consortium. This relationship has given us a stronger connection to the education system. Finally, NHHS helped to inform the neighborhood work of the Foundation through its small grants program and Hill project where both seek consumer input and involvement. Several of our consumers and consortium members have participated in the activities of these two programs.

4. Describe the impact that your HS project has had on the comprehensiveness of services particularly in the following areas:

a. Eligibility and/or intake requirements for health or social services;
The intake process is one of four components of the Care Coordination Model implemented by NHHS during the 2001-2005 project period. The intake procedure includes an explanation of the program and obtaining signed consent, the completion electronically of a Patient Information Form (PIF), a comprehensive risk assessment, and the referral/contact log. The PIF records traditional demographic data (e.g., name, address, secondary contact, race).

The comprehensive risk assessment assesses the psychosocial risk of pregnant and postpartum women. Separate risk assessments are used for prenatal and interconceptional participants. The risk assessment was created by a group of providers in the community, NHHS partners, consortium and perinatal partnership and is implemented universally across the perinatal service delivery system. An new infant risk assessment was introduced in August 2005.

The referral/contact log is started upon completion of the assessment. This tool facilitates appropriate client referrals are made by staff and streamlines monitoring a participant’s compliance with referrals and appointments. The worker can document client contact and progress toward established goals in the client’s electronic record.

b. Barriers to access and service utilization and community awareness of services;

The two most significant barriers are the lack of available and affordable mental health treatment and the lack of available services for undocumented immigrants. Other barriers to note are access to appropriate insurance, lack of Spanish speaking providers and not enough providers with appropriate levels of expertise. NHHS will overcome these barriers by continuing to develop collaborations with providers who will meet the needs of NHHS participants. As a result of community collaborations, now available to NHHS providers is a referral list for mental health services and a list of resources available to undocumented clients. NHHS has begun to discuss these specific barriers in regular meetings with the Title V Director. NHHS holds a seat on the statewide Perinatal Advisory Committee and Perinatal Depression Work Group, which is charged with the task of addressing specific barriers to adequate care.

c. Care coordination including descriptions of mechanisms implemented to assure continuity of care, quality improvement and follow up system(s) for client referrals;

NHHS has designed and implemented a Care Coordination Model that will continue to evolve during the 2005-2009 project period. This model is a framework that works within a complex system of community providers, which includes hospitals, community health clinics, social service agencies, municipal agencies, private medical practices and faith-based organizations. Care Coordination is a core service that is on the continuum of

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The above text includes references to Community Outreach Workers, Care Coordinators, Community Health Advocates and other direct service providers not funded through the project can complete the intake process.
services delivery. This core service is different from intensive case management and outreach. Care Coordination tracks the health and social service interventions of a woman and her child through an otherwise fragmented system. This service helps women navigate the system, reduces duplicative services, and allows NHHS to identify and reduce some of the barriers to engagement in services.

**Client Identification:** The primary populations targeted for enrollment in the client identification phase are pregnant women and women of child bearing age with a child between the ages of birth and two. Some preconception women are also identified and enrolled as well as some women (usually grandparents) who are guardians of children under the age of two. During the client identification phase NHHS gives special consideration to women who present with the following risk factors: teens, homeless, undocumented, previous poor birth outcome, history of dropping out of care, limited prenatal care, late entry into prenatal care, lack of insurance coverage, depression, limited social support, history of substance abuse, history of interpersonal violence, and DCF involvement. Women are identified for enrollment by the NHHS Care Coordinators (5 FTE) working out of four medical homes. Four Care Coordinators focus on providing services to pregnant women, the fifth Care Coordinator focuses on interconceptional women and their children.

The Care Coordinators on staff at Yale New Hospital Women’s Center and the Hospital of Saint Raphael predominantly identify women. They review the prenatal and postpartum appointment schedules to identify women who meet the criteria for the program. At the Women’s Center the volume of appointments is so heavy that women usually have to wait for their appointment. During the waiting time, the Care Coordinator meets the potential participant and completes the enrollment process. In the event that the Care Coordinator is unable to meet with the potential participant while waiting for their appointment, the person is called and a separate appointment is set up for enrollment. The volume at the hospital clinics prevent Care Coordinators from seeing 100% of the women they identify for enrollment.

At the two healthcare center sites (Fair Haven Health Clinic and

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**NHHS Care Coordination Database and Tools**

1. **Participant Information Form (PIF)** — collects detailed demographic data and data on prenatal/pregnancy status;
2. **Prenatal Risk Assessment (PRA)** — collects in-depth data on pregnancy history; STD history; drug, alcohol, and tobacco use; interpersonal violence; mental illness; traumatic events; depression; anxiety; problems and concerns; and strengths;
3. **Pregnancy Outcome Form (POF)** — collects data on the outcome of the pregnancy and infant outcome data;
4. **Infant Well-Visits and Immunization Form (IWVI)** — collects data on well visits and the infant’s vaccination schedule;
5. **Interconceptional Risk Assessment (IRA)** — similar to the Prenatal Risk Assessment but collected during interconceptional periods;
6. **Risk Assessment Follow-Up Form (RAFF)** — similar to the Prenatal and Interconceptional Risk Assessments to track progress on current risk situations; and
7. **NHHS Care Coordination Database** tracks participants’ medical homes and service use.

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**Translating Risk Factors into Care Coordination Decisions**

**Category A**
- History of low birth weight, pre-term delivery or fetal loss
- Current use of drugs other than marijuana
- Late entry into prenatal care
- Experiences interpersonal violence
- Age 15 years old or under
- Homeless or marginally housed

**Category B**
- Age 16-19 years old
- Undocumented immigrant
- Current use of alcohol
- Current use of marijuana
- Current use of cigarettes
- History of interpersonal violence
- Sexual risk (STD)
- Mental health risk
- Stress/low social support

**High Risk** = One Category A risk factor or 3 Category B risk factors
**Moderate Risk** = One or two Category B risk factors
**Low Risk** = Lack of health insurance only or requires only brief services & assistance with health education
Matching Service Intensity to Participant Risk

Weekly contact is maintained with the highest risk program participants. Moderate risk clients will receive ongoing care coordination from the care coordinator at their medical home with follow up support from the NHHS outreach team when necessary.

Moderate to high-risk program participants receive follow up support at each prenatal appointment. This may involve a direct meeting with the care coordinator or review of the medical record by the care coordinator after each visit to monitor and document progress.

Low risk participants will receive health education and insurance application assistance. A typical low risk participant may only have one or two interactions with their NHHS Worker.

Intake: Intake by a Care Coordinator is the second component in the NHHS care coordination framework. The following documents are completed during the intake process: a NHHS consent form; patient information form; and a comprehensive risk assessment. The risk assessment is the most critical piece of the intake process. The risk assessment directs what referrals will be made and how much follow up will be needed. Once the risk assessment is complete a determination is made regarding the risk intensity (low, moderate, high) of the participant. The risk intensity designation becomes part of the client record and helps determine the level of follow up needed. NHHS has created a follow up protocol for each risk category. Once the risk assessment is complete the worker makes the appropriate referrals.

Referral: The third component of the care coordination framework is referral. The most immediate needs are addressed first. Examples of the issues that take precedence include but are not limited to mental health/depression, homelessness, current substance abuse, and current domestic violence, late entry into prenatal care, prior low birth weight infant, history of preterm delivery, and history of fetal or infant loss. A woman who presents with any one of these issues is automatically deemed as high risk. The Care Coordinator makes all of the referrals indicated by the assessment. The participant may refuse any of the referrals. Refusal of referrals does not affect their status in the program. In some cases, the participant may already be in treatment for a risk factor indicated on the assessment.

Follow-up: Follow up is the fourth component of the care coordination model. The Care Coordinators’ take responsibility to follow up with the referral agencies and the participants to determine if the recommended services have been initiated. The highest risk clients require a more intense level of follow up and are usually referred to the case management service available at the New Haven Health Department’s Maternal and Child Health Division. The moderate risk participants receive ongoing care coordination and the low risk participants may receive some health education and information and insurance application assistance.

NHHS implemented the care coordination model on April 15, 2002. This model has proved to be extremely successful, creating a foundation for care coordination within the perinatal service delivery system in New Haven.

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68 All risk assessment, intake, referral and tracking forms are available through the NHHS Project Director.
69 This determination will be made electronically. The NHHS database is programmed to calculate the risk intensity of a program participant automatically once the intake forms and risk assessment are completed.
Positive outcomes resulting from Care Coordination include:

- Over 2,658 women and 1,600 infants have received care coordination services as a result of NHHS since 2002.
- Care Coordination has played a role in connecting the provider institutions. Women experience a seamless continuum of care as opposed to a fragmented system. Providers are now connected to each other and communicating in ways that were not possible prior to NHHS. The service delivery system for women and children is starting to operate as a whole instead of in isolated pieces.
- NHHS care coordination model has been fully integrated into the New Haven Health Department’s Maternal and Child Health Division programs
- NHHS care coordination model received a positive Federal Performance Review in June of 2004
- The innovative NHHS networked database has strengthened the model and aids in the efficiency of services being delivered across the system
- A universal comprehensive risk assessment has been implemented across the perinatal health delivery system
- During the summer of 2004, NHHS piloted a successful periodontal screening and treatment project via the Hospital of Saint Raphael Mobile Dental Van.\(^70\)

\(\quad\)
d. Efficiency of agency records systems and sharing of data across providers (within the confines of confidentiality rules) to reduce the need for repetition.

NHHS implemented a centralized networked database in 2003 that provides “real time” information on clients. All of NHHS contracted sites utilize the data system to conduct the intake process and monitor clients. The data system has proven to be an effective and efficient tool that streamlines the work of care coordinators and outreach workers as well as their supervisors. Each site can see the information on all clients in the database in real time which helps to eliminate duplication of services. They are also able to produce reports for their site only. All of the information collected during the intake process is entered into the networked database. The database reduces duplication of service delivery between sites, enhances communication between the providers, provides day-to-day

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\(^70\) Since current research suggests a direct link to periodontal disease and poor birth outcomes, the purpose of this project was to screen clients for periodontal disease and treat or refer for treatment to improve the birth outcome. In two and a half months, 32 referrals were made to the dental van with 2 walk-ins. Of those, 13 were screened and 1 was found to have active periodontal disease. While all had some kind of decay, 9 had active decay and (if left untreated could turn into periodontal disease) were referred to the Hill Health Center Dental Clinic.
management tools for staff, and offers a mechanism to assess performance and conduct evaluation activities. Because of HIPAA guidelines, NHHS administration is only able to access and produce reports on aggregate data.

Also during this period NHHS supported and implemented a networked database for the Male Involvement Network that is accessed through the NHHS database and server housed at the Foundation. The database collects the same demographic and health data that NHHS collects as well as data specific to men and men’s health and the Male Involvement Network needed information. The database is one of the most comprehensive data collection tools on men in the state.

The NHHS database is being reviewed by the Connecticut Department of Public Health and the Title V office for replication across the state.

5. Describe the impact on enhancing client participation in evaluation of service provision in the following areas:

a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender (especially male) needs of the community;

The goal of care coordination is to secure a connection to a medical home. All program participants get assigned to a medical home when they enroll into the program. The Care Coordinators and Outreach Workers are responsible to help participants stay connected to their medical home. Childcare, transportation assistance, and translation services are all available at the provider sites to assist in ensuring compliance with medical appointments. Care Coordinators on site at the medical homes monitor compliance with medical appointments, meet with participants when they come in for appointments, and address any other needs that may surface. Outreach services are dispatched if a participant misses a scheduled appointment.

A barrier to compliance with appointments is waiting times. Previous experience with clients not showing for appointments has led some of the larger providers to schedule several appointments in one block of time. However, this has resulted in waiting time and frustrated patients who do not show up for their appointments. Lack of insurance, transportation, and trust, language and cultural barriers are all obstacles to clients staying connected to a medical home. NHHS staff and partners continue to enroll as many clients as possible into the CT HUSKY program and attempt to identify other means of insuring clients. All medical home sites provide transportation assistance. All subcontractors are encouraged to hire staff that is representative of the populations served.

NHHS is committed to connecting fathers to their children and this is evidenced by the collaboration with the Male Involvement Network. NHHS referred more than 45 male partners of women who were enrolled in NHHS to MIN for support services in the 2001-2005 project period. Because of the integrated databases, we will be able to refer more males and tell a better story about connecting families in the 2005-2009 project.
b. Consumer participation in developing assessment and intervention mechanisms and tools to serve perinatal women and/or infants, and the extent of implementation and utilization of these tools or mechanisms.

NHHS consumers and consortium members participated in the development of the universal risk assessment tools for prenatal and interconceptional women noted elsewhere in this document. The risk assessments for prenatal and interconceptional women have been fully implemented and utilized by outreach workers, care coordinators and health advocates. The tool has been implemented electronically so that workers can easily plan a course of care for their clients. Consumers also provided input to the new infant risk assessment that will be implemented in the 2005-2009 project period.

B. Impact to the Community: Describe the impact the project has had on developing and empowering the community, at a minimum in the following areas:

1. Residents’ knowledge of resource/service availability, location and how to access these resources;

All Healthy Start program participants (male or female) understand better the basics of prenatal care and interconceptional care. They understand better the resources available within the community and the level of quality. Valuing the voice of consumers has unleashed more than 5,000 “voices” in the community – mothers, fathers, advocates, professionals, elected officials – who can share their knowledge and experiences with their friends and communities, and who can reinforce a higher level of expectations for maternal and child healthcare.

As shown by a steady downward shift in our infant mortality rates and an upward shift among other measures such as engagement in early prenatal care (i.e., first trimester), our community is beginning to reach the “tipping point” of a societal change in maternal and child healthcare. However, our community remains in a pitched battle to overcome the most challenging obstacles at both the policy and cultural levels.

2. Consumer participation in establishing or changing standards and/or policies of participating service providers and local governments, that affect the health or welfare of the community, and have an impact on infant mortality reduction;

The voice of consumers has created significant impact in shifting from a case management to a care coordination model. The voice of consumers has made a difference in allowing Healthy Start leaders to understand the unintended consequences of existing policies such as covering undocumented women during pregnancy and dropping them from coverage immediately upon discharge after delivery and one Ob-Gyn follow-up visit. When the mother drops out of the healthcare system, the child often follows.
3. Community experience in working with divergent opinions, resolving conflicts, and team building activities;

Working with divergent opinions is a difficult process that must align language between professionals, lay people, grass roots advocates and consumers. The way to do that is through the presence of leadership, vision and commitment. We were willing to have people walk away from the table because we were responding to a need that people wanted to address. Leadership has to be able to anticipate some of the needs of the community. We found that we needed to move people to an environment off-site where they can focus. By moving off-site, people couldn’t go about their daily work like coming back late from breaks because they had to answer e-mails, return phone calls, make copies, etc., etc. By removing these distractions, we found that people focused on the work and began to talk to each other.

4. Creation of jobs within the community.

At different times over the 2001-2005 grant period, NHHS has directly created and supported four care coordinator positions, four outreach positions, four health advocate positions, two MIN case management positions, four mental health counselors and six administrative positions. Additionally, NHHS leveraged one care coordinator position and two mental health counselors (supported by the Foundation).

C. Impact on the State: Over the past four years Healthy Start has supported activities to strengthen and develop relationships with the State Title V program. In some states where there was more than one HS project, the Division of Healthy Start and Perinatal Services (DHSPS) encouraged coordinated activities across these sites. Describe the activities and impact that this approach has had on your relationship to the State Title V Agency, State Children with Special Health Care Needs Program(s), your state Medicaid and SCHIP programs, your State Early Intervention Program and other state programs. Highlight any benefits and lessons learned from these relationships.

NHHS is now recognized as a statewide model for replication. The State Department of Public Health has entered into a formal agreement with NHHS to collaboratively achieve the following goals: to improve access to perinatal healthcare; to increase awareness of maternal and child health related issues; to improve access to women’s healthcare and to enhance and strengthen the perinatal health system in New Haven. The memorandum of agreement with Title V initiated through NHHS will also be made with Hartford if funded in 2005-2009 funding cycle, who has adopted the NHHS model. The NHHS model is recognized as a replicable model for all MCH funded programs in the state. Title V has developed a Statewide Consortia on Maternal and Child Health and invited NHHS to contribute to its development and to participate as a member; includes NHHS in the Community Phase of the Title V five-year needs assessment; collaborates with NHHS to initiate discussions with managed care organizations for prevention and outreach dollars and sustainability; looks at the NHHS model of care coordination, consortium development, depression screening and database and co-convene with NHHS
to establish a model for statewide replication. Title V will also identify state MCH programs that would benefit from NHHS staff technical assistance.

NHHS has begun to discuss specific barriers related to the lack of available and affordable mental health treatment and the lack of available services for undocumented immigrants to adequate care in regular meetings with the Title V Director. NHHS staff and partners continue to enroll as many clients as possible into the CT HUSKY program and attempt to identify other means of insuring clients. Other examples of planned coordination and information dissemination of lessons that will be learned include:

- The MCH Director maintains information sharing with her MCH colleagues across the state and through the statewide network of HUSKY subcontractors.
- Lessons learned from programmatic experiences will be shared at the Perinatal Partnership and Consortium meetings.
- Best practices will be documented through collaborative publishing in appropriate journals and other written materials.
- The NHHS Project Director and the local MCH Director both sit on Perinatal Advisory Committee coordinated by the Title V Director, which can serve as a forum to disseminate information to colleagues from across the state.
- The NHHS program uses information from the State Title V action plan to refine and strengthen its implementation locally. This planning leads to identification of priority areas to be accomplished each year that are based on the needs presented by the women, children and families that participate in the program. The LHSAP is based on the federal resources that are received under this grant, which are also maximized by resources from the Foundation. The Foundation, the NHHS program and Consortium work with the State Title V Office by reviewing the state’s action plan and collaborating on feasible opportunities.

D. Local Government Role: Highlight activities/relationships at the state and local level that facilitate project development. Briefly describe barriers at the state and local level, and the lessons learned in dealing with these barriers.

The following are primary examples of NHHS 2001-2005 linkages across funding sources:

- The City of New Haven Health Department, a NHHS primary partner oversees FIMR, and receives Title V funding from the Connecticut Department of Public Health.
- Early and Periodic Screening and Developmental Testing (EPSDT) continues to be a priority. According to a 2001 report from the Connecticut Health Policy Project, Investigators from the federal General Accounting Office visiting Connecticut and four other states found inconsistent EPSDT data reporting, inadequate oversight mechanisms and a significant need for consumer education about the value of preventive care. While EPSDT is a critical component of care, it is only a beginning.
Screens that identify problems must lead to productive referrals for treatment and eventually to improvements in health. Overall, much work remains to improve services to children in Connecticut's Medicaid program.

- **Immunization:** A function of the Pediatric Immunization Unit three components: 1) outreach support to families with children who are identified as being behind on their immunizations; focus on recent immigrants 2) CIRTS Registry (CT. Immunization Registry and Tracking) database with the immunization records of children born after January 1996 and 3) support of the Tuesday Afternoon Preschool Immunization clinic, which provides health assessments and immunizations to children 3 & 4 yrs of age who are entering preschool or Head Start.

- **Coordinated and integrated service delivery system** across funding streams through City of New Haven MCH centralized outreach funded through New Haven Healthy Start and the Department of Social Services. CCHI HUSKY receives a small portion of Title V funding.

- **Data Sharing:** The Title V Needs Assessment, the Fetal Infant Mortality Review, and Department of Public Health, INFOLINE, the four major Health Care Providers, the Pediatric Immunization Unit, (PIU) and MCH division of the New Haven Health Department, Healthy Start workers, and NHHS care coordinators, the New Haven Family Alliance and Christian Community Action Agency share information and compile data for ongoing reports about the status of New Haven’s Infants, Children and Families. The new NHHS Networked Data System allows all NHHS subgrantee sites to sign onto the Foundation’s server and access the database which houses information about NHHS participants. The design of the database has been informed through collaboration with the community stakeholders. The database serves three major functions: 1) it allows the front line workers to manage their day-to-day work more efficiently; 2) it allows subcontracted sites to monitor their own performance around various health indicators; and 3) allows the Foundation to monitor subcontractor performance. In CY 03 NHHS had the opportunity to share the data management system with the HRSA Healthy Start Federal Project Officer as well as with HRSA Federal Performance Reviewers from Boston, MA in June 2004.

**Systems Impact** - linkages with statewide Title V planning and program activities.

- The City is involved directly with any Maternal and Child Health-related bonding applications (and often serves as fiscal manager). A Maternal and Child Health Bond funding released resulted in the creation of a new facility for r’Kids, a family preservation, reunification, and foster care program designed to serve children who are involved in child protective services through Connecticut’s Department of Children and Families. r’Kids maintains collaborative relationships with the adolescent behavioral and primary healthcare providers, and the Male Involvement Network, once again demonstrating the value of the close partnership between the Foundation and the City of New Haven.

- The Foundation provides grantmaking resources to the Connecticut Department of Public Health, Maternal and Child Health (Title V) for professional staff development in the area of cultural diversity training.
• The Foundation’s Director of Health, Amos Smith maintains relationships across the statewide healthcare infrastructure at both the public and private level. The Foundation’s grantmaking portfolio in the area of healthcare requires Mr. Smith to identify grantmaking opportunities that leverage public and private funding. Examples relevant to Healthy Start include the State’s ongoing investment in INFOLINE and the State’s focus on the issues of Asthma and Obesity. The Foundation is playing an instrumental role in convening the major healthcare concerns throughout the region to achieve better healthcare outcomes.

• Statewide Funders Collaborative for Health: The Foundation’s Chief Executive Officer and its Director of Health use the Funders Collaborative as a vehicle to organize healthcare changes using the philanthropic sector. Through Healthy Start, the Philanthropic and Government Agencies have benefited from public forums such as Health Disparities Forum in October 2003.

• NHHS provides information through presentations to organizations such as STRIVE New Haven, JUNTA for Progressive Action, Stepping Stones, and Anthem Blue Cross Blue Shield for staff and participants on the NHHS services and Care Coordination model.

The partnership between the Foundation and the City of New Haven Department of Health creates multiple opportunities to interact with and influence the planning and program activities associated with the Title V plan. The NHHS project has also experienced considerable success with its local health department, Maternal and Child Health Division who administers the SCHIP and Immunization Program (CDC).

E. Lessons Learned: If not discussed in any sections above, please describe other lessons learned that you feel would be helpful to others.

VI. Local Evaluation

Using the suggested format in Attachment C, submit a copy of the Healthy Start Local Evaluation Report for each local evaluation conducted. Instructions pertaining to this report are provided in Attachment B.

See Attached
VII. Fetal and Infant Mortality Review (FIMR)

For those programs that developed or participated in a FIMR, please identify the length of time you have had a FIMR process; whether it includes an emphasis on maternal and child mortality as well; the components of the process (including whether it has a home visitation component) and funding sources. Indicate whether you use a two-tiered approach [e.g., Community Review Team (CRT) and Community Action Team (CAT)] and what challenges and changes have occurred over time. Describe major accomplishments on implementing recommendations arising from the FIMR process and any other lessons learned.

Fetal and Infant Mortality Review (FIMR) is a system wide examination of infant and fetal death.

New Haven initiated a Fetal and Infant Mortality Review (FIMR) in May 1999 to identify the ways in which social, economic, health, educational, environmental and safely issues relate to infant loss and low birth weight in New Haven.

The City participated in a Fetal Infant Mortality Review project and Center for Disease Control (CDC) Perinatal Periods of Risk study. This process provided the Consortium and its subcommittees with critical data for use in directing their program agenda and action plans, through the identification of barriers to care, health risk factors, and co-morbidities associated with depression. Based on the City of New Haven Department of Public Health’s Fetal Infant Mortality Review (FIMR) report dated 7/24/00 recommendations were made to address disparities or community and/or health system factors identified in case reviews which may be related to infant/fetal mortality (see sidebar).

A team of examiners reviews confidential, de-identified cases of fetal and infant death in order to identify the reasons for the death. This knowledge fuels the design and implementation of interventions to improve service delivery systems and resources. The FIMR continues to build upon the Health Department’s MCH data collection and analytical expertise (PPOR/FIMR) to promote regional services, influence policy, and improve the health and well being of women, children and families. In addition, FIMR strengthens regional services by increasing the referrals made to the New Haven Health Department’s regional

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71 The City of New Haven’s Department of Health has partnered with the City of West Haven and the Town of East Haven to implement a regional Fetal and Infant Mortality Review (FIMR) project.

72 New Haven initiated a Fetal and Infant Mortality Review in May 1999 to identify the ways in which social, economic, health, educational, environmental and safely issues relate to infant loss and low birth weight in New Haven.
integrated MCH programs (Client Identification/Community Outreach, Care Coordination, and Case Management).

During this grant period, the Consortium established a FIMR Committee. The FIMR Committee is the nucleus for a regional FIMR Community Action Team whose function is to translate the opinions and recommendations of the FIMR Case Review Team into real culturally competent interventions aimed at directly impacting problems within our communities. It is expected that this working relationship between FIMR and NHHS can only help to facilitate the work of each program and create real synergy to effectively address important issues related to the health of women, children and families in the Greater New Haven area.

- **Perinatal Periods of Risk (PPOR) Collaborative.**

  In December 2000, the New Haven Health Department was selected as one of 16 cities in the nation to participate in an 18-month, community driven research project that examined fetal and infant mortality, the Perinatal Periods of Risk (PPOR) Collaborative. Supported and funded by CityMatCH, the March of Dimes, and the Center for Disease Control, the project’s overall goal was to capture the best maternal and child health practices and lessons learned, to develop and enhance supporting materials, to develop local practice expertise, and to capture the experience for use by other cities.

  PPOR links with New Haven’s FIMR program to describe in greater depth the risk factors, events and services that contribute to the City’s high and disparate feral and infant mortality rates. New Haven’s plan consists of 5 goals:

  1. Engage community partners.
  3. Target further investigations and prevention efforts.
  4. Examine potential opportunity gaps.
  5. Reduce the overall feto-infant mortality rate.

PPOR is an evidence-based methodology that maps fetal and infant mortality. The PPOR mobilizes a community to improve racial disparity and birth outcomes by: 1) prioritizing preventive efforts; 2) developing policies and legislation; and 3) targeting the allocation limited resources. The New Haven Health Department has developed a clear understanding of the added value of PPOR to a variety of other MCH and Women’s Health programs. Demonstrating the value of PPOR at the local, regional and state level, resulted in a Regional FIMR grant. That led to the establishment of a broad-based team.

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73 First funded in December 2000 as one of 16 cities in the nation, the New Haven Health Department created a community driven research project to examine fetal and infant mortality. Supported and funded by CityMatCH, the March of Dimes, and the CDC, the project’s overall goal is to capture the best maternal and child health practices and lessons learned, to develop and enhance supporting materials, to develop local practice expertise, and to capture this experience for use by other cities.
of providers committed to developing policy using an evidence-based approach that improves service delivery across disparate populations.

VIII. Products

A copy of any materials that were produced under the Healthy Start grant funding must accompany this report. Examples of products include but are not limited to the following: brochures, booklets, posters, videotapes, audiotapes, diskettes, and CDs. These items will go to the Maternal and Child Health Library, Resource and Reference Collection that is housed at Georgetown University.

See Attached

IX. Project Data

The Healthy Start Data Reporting Requirements (HSDRR) consisted of variables that described Healthy Start Participants, major services provided by Healthy Start Programs and common project-specific performance measures. Combined the aggregated data from these variables is used to:

1. measure utilization
2. measure penetration,
3. assess program outcomes
4. assess the communities= progress in meeting their objectives,
5. identify potential performance problems, and
6. assess compliance with the requirements of the Government Performance and Results Act.

See Attached