

**Camden Healthy Start Project -
Second Replication Phase Period**

Final Report

September 1997- June 2001

PROJECT IDENTIFICATION

Project Title: Camden Healthy Start Project

Project Number: STH34C055

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Grantee Organization: Southern New Jersey Perinatal Cooperative (SNJPC)

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Project Period: 9/1/97-6/30/01

Total Amount of Grant Awarded: \$6.8 million (original four-year award)

Narrative:

I PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH PROGRAMS

The Camden Healthy Start Project during the past four (4) years was a “Replication Phase” Healthy Start site which served the residents of Camden City, New Jersey. The purpose of the project was to utilize models from the national pilot phase of Healthy Start by adapting these models to the unique needs of Camden City. The Healthy Start Models that were implemented were: Adolescent Services, Outreach and Client Recruitment, Risk Prevention and Reduction and Consortium Building. The Healthy Mothers, Healthy Babies Coalition of Camden City (HMHBC), a program of the Southern New Jersey Perinatal Cooperative (SNJPC), the grantee agency, further developed as the Healthy Start consortium.

The ultimate goals of Camden Healthy Start are to reduce the high infant mortality rate and incidence of low birth weight babies in the city; as well as increase access and utilization of health and social services related to maternal and child health. The Camden Healthy Start Project is a coordinated, collaborative effort of health and social service providers, city agencies, community-based organizations, other voluntary agencies, community leaders and consumers. Camden Healthy Start addressed the problems of teen pregnancy, substance abusing pregnant/postpartum women and their families, and the lack of adequate perinatal and pediatric care due to social, cultural and system barriers.

Camden Healthy Start is integrally linked and coordinated with State and local maternal and child health programs. SNJPC is a licensed maternal and child health consortium and recipient of New Jersey Department of Health & Senior Services (NJDHSS) administered grant funds. This formal relationship has enabled close ties to be fostered between the HMHBC and the NJDHSS including the Divisions of Regional Maternal and Child Health Services and Community Health Services, AIDS and Addictions. Other state agencies have been engaged in the Healthy Start project, such as the Departments of Human Services, Education and Community Affairs. Communication with State agencies regarding Healthy Start activity is accomplished by staff/member participation in State forums and by State staff representation on Consortium committees. The following describes some of the state, regional and local relationships between SNJPC (the grantee) and HMHBC (the Consortium).

Title V MCH Collaboration:

The HMHBC has been a recipient of MCH Title V funds for Healthy Mothers, Healthy Babies since 1985. And involvement of SNJPC and HMHBC in statewide MCH activities has insured that the perinatal and childhood service needs identified in MCH Title V - Five Year Comprehensive Needs Assessment and Block Grant Plan reflect information compiled in the SNJPC Perinatal and Pediatric Plan and the HMHBC annual work plans. Block grant

objectives proposed by NJDHSS Divisions of Maternal and Child Health Planning and Regional Services, and Community Services addressed include:

- Coordination by SNJPC of regional MCH surveillance and needs assessment; analysis of vital data and identification of perinatal health trends. Utilize data to plan for services to improve the health status of pregnant women, infants and children in New Jersey and evaluate outcomes associated with grant funded services.
- Assure access to quality perinatal health care services for all mothers, statewide, especially low income, medically underserved, and high risk pregnant women.
- Coordinate prenatal services including perinatal addiction, medical high risk and FAS prevention services.
- Support the development or expansion of quality prenatal care services, with emphasis on areas of greatest need.

Staff of the NJDHSS participate in consortium activities, contribute data and have reviewed its congruence with the statewide MCH goals and objectives. The Commissioner of Health and Senior Services has committed the support of NJDHSS to the successful implementation of this project. As a result of the National Healthy Start program's support to build and strengthen regional perinatal systems, beginning with the BY 98/99 Partnership Funds, the Healthy Start programs in New Jersey have facilitated such statewide programs as the "Addressing the Gaps" state summit of stakeholders which reviewed current perinatal systems' issues. This process included consumer empowerment sessions, and subsequent follow-up meetings, as well as consumer and provider trainings relevant to the summit recommendations at both the local level and state levels.

Also the following activities have been and will continue as in-kind contributions to the Camden Healthy Start project and are incorporated in Camden Healthy Start services to maximize resources and avoid duplication of effort. They include:

- Fetal and Infant Mortality Review (FIMR) 1994-present;
Funding Source - NJDHSS: Recommendations are forwarded to the SNJPC's Clinical Committee or to the HMMBC, which functions as the community review panel for the Camden FIMR process, for the development of strategies to improve care. FIMR has been operational in Camden since 1995.

- Fetal Alcohol Syndrome (FAS) Prevention Project 1989-present;
Funding Source - NJDHSS: Provides for the early identification and intervention/referral of pregnant women in the southern New Jersey region considered high risk because of substance abuse. SNJPC staff provide counseling and referral services at prenatal care facilities in the region; assist in the development, implementation and monitoring of an identification/referral system for the region; advocate for patients and professionals; and provide consumer and professional education on FAS. Funded staff participate in the Healthy Start Substance Abuse Committee and model activities.

- Baby Your Baby Hotline (BYB) 1992-present;
SNJPC contributed \$25,000 to Project: A multimedia, public awareness campaign to reduce infant mortality by encouraging early and continuous prenatal care. The SNJPC is a member of the Delaware Valley Partnership for Healthy Babies, a coalition of MCH organizations in New Jersey, Delaware and Pennsylvania, which is responsible for the project. The Cooperative staffs a consumer hotline, which complements the media campaign.

SNJPC has been and or continues to be active with:

- The New Jersey State Health Planning Board (SHPB)(NJDHSS)
This group prepares an annual State Health Plan that identifies current health care needs in New Jersey. The SHPB also reviews Certificate of Need applications and makes recommendations to the Commissioner of Health and Senior Services concerning the approval of these applications.

- Maternal Mortality Review/Medical Society of New Jersey
Annual review of maternal deaths in New Jersey. Recommended professional education topics are forwarded to SNJPC Clinical/QA Committee.

- Governor's Council for the Prevention of Mental Retardation and Developmental Disabilities (OPMRDD)
31-member council appointed by the Governor. The Council oversees and monitors the Statewide Prevention Plan for Developmental Disabilities; develops mechanisms to facilitate early detection of developmental disabilities; and fosters cooperative working relationships among responsible agencies.

- Black Infant Mortality Reduction Council Advisory Committee
A Blue Ribbon Panel appointed by the Commissioner of Health and Senior Services in 1996 to develop policies and strategies aimed at reducing the state's unacceptably high rate of black infant deaths. This council was appointed to oversee the implementation of new initiatives. Four of the 31 members of the Council were SNJPC or HMMBC members.

- NJ Child Health Regional Network (NJDHSS)
Regional and county public health nurse representatives who provide child health services. This group serves as a forum for professional education, networking and the dissemination of NJDHSS regulatory information.

- Healthy Families Consortium/New Jersey (HFNJ)

Healthy Families programs provide the prevention component of New Jersey's Family Preservation and Support Services (FPSS) Initiative, Title IV-B of the Social Security Act; administered by New Jersey Dept. of Human Services. The HFNJ Consortium is a statewide network of health and human service professionals and consumers dedicated to the expansion of this lay home visiting program which provides intensive parenting support and education for at risk families. The Camden Healthy Families project, was expanded in the Healthy Start Adolescent Model during this past four-year period.

The following are some of the major initiatives that have also included the participation of the SNJPC as a provider, and SNJPC/HMHBC members:

Title V. Maternal and Infant Health Services and Special Child Health Services

- 1) Quality prenatal care for low income women in high need areas. Expand prenatal care through CHC's and Family Planning Agencies.
- 2) High Risk Infant Follow-up Project: Developmental screening of high risk newborns.
- 3) Genetic Counseling
- 4) Tertiary Pediatric Services
- 5) Regional Pediatric HIV Center

Title V - IX Coordination: Medicaid Managed Care

Comprehensive care for Medicaid eligible women and children to improve access and use of pediatric and prenatal care services.

Participants: Primary care providers in city; State approved MMCOs participate in HMHBC.

Title X and Title XX: Family Planning.

Access to family planning services for women in low income areas.

Participants: Planned Parenthood of Southern New Jersey; Women's Care Center/Cooper Hospital/UMC; CAMcare Health Corp. (FQHC) – participants of HMHBC.

Title XXI State Child Health Insurance Program (KIDCARE)

Increase access to primary care for children: 200% of poverty
Participants: HMHB Outreach workers: case-finding;
Primary care providers in city; State approved MMCOs.

USDA: WIC

HMHB staff promotes and links residents to WIC and breastfeeding services, and are based at WIC sites on a regular schedule. Breastfeeding Initiative: Lactation consultant and peer counseling.

Participants: SNJPC/ Camden Co. Division of Health

Office of Substance Abuse Prevention: Pregnant/Postpartum Women and Infants

Substance abuse prevention, education, treatment: community-based inpatient, outpatient, residential settings.

Participants: SNJPC - FAS Program; Cooper House-Intensive OP Program; Alcove-West Jersey Health System; Segaloff Substance Abuse Treatment Ctr.; Sikora Center for Child Development.

NJDHSS Electronic Birth Certificate Implementation

Comprehensive birth certificate and perinatal data system. Simplifies assembly of birth certificate and perinatal data. Reduces expensive, redundant data collection and paperwork.

Participants: SNJPC staff provides technical assistance to all 15 maternity hospitals in region who are now "on-line".

NJDHSS Comprehensive Immunization Project (NJCIP) New Jersey Immunization Information System (NJIIS)

1) Electronic patient record with follow-up and outreach application; links to Electronic Birth Certificate (EBC).

2)

Participants: CAMcare; Osborn Family Health Center; West Jersey Family Health Center; Cooper Pediatrics; Immunization clinics located at WIC and AFDC sites. 20 private physicians. SNJPC is a Service Bureau for Camden City private providers for NJIIS.

School-Based Youth Services

Preventive health care, screening and counseling for teens on-site in high schools in target areas. Healthy Start expands service to middle school and provides child care/parenting at one high school.

Participant: Camden Co Department of Health receives funding. Sites: Woodrow Wilson High School; Camden High School.

Social Services Block Grant

Counseling, financial assistance, shelter, medical assistance, general support services for income eligible families, individuals.

Participants: Funds distributed to social service and mental health agencies by Camden County Community Planning & Advocacy Council (CPAC) through an RFP process in which SNJPC and HMMHC members participate.

II. GOALS AND OBJECTIVES:

The goal of the Camden Healthy Start Project is to reduce infant mortality in the city and reduce the incidence of low birth weight infants through an enhanced, comprehensive and coordinated system of perinatal, pediatric and support services that are collaborative efforts of the entire community. The Camden Healthy Start Project's key objectives during the Replication Phase Funding period were: 1) the development of a coordinated system of care for substance abusing pregnant and postpartum women, 2) the expansion of both teen pregnancy prevention programs and services available to pregnant and parenting teens in Camden, 3) the expansion of the maternal/child outreach program initiated by the NJDHSS funding to the HMMHC, with improvement of its data collection and report capabilities and 4) the expansion of the HMMHC as the Healthy Start Consortium to include all stakeholders who have a shared vision that supports ongoing community empowerment in addressing maternal and child health issues.

III. METHODOLOGY:

The Camden Healthy Start Project had a focus on easier access to and increased utilization of services for childbearing families. It replicated three service models, Outreach and Client Recruitment, Risk Prevention and Reduction and Adolescent Services, and the Consortium Building Model. The Adolescent Services Model received the most funding (nearly \$535,000 per year). Funds were used for four service programs (Healthy Families, Partners in Parenting, Teens on Track and the Lion's Den School-based Clinic) and included cost of construction and maintenance of a school-based clinic and child care facilities for teen mothers. Partial support of a Male Reproductive Health Clinic was also a component. The Outreach and Client Recruitment Model was second in the amount of Healthy Start funds received (about \$483,000 per year). Funds supported staff expansion, training, new satellite program offices co-located with another community consortium, van lease, data forms, client education/incentive and supplies among other types of expenses. The Risk Prevention and Reduction Model supported initially four programs (Alcove Risk Reduction Specialists, Sikora Outpatient Substance Abuse Treatment and Enhanced Services for Pregnant/Parenting Women, the Woodland Community Substance Abuse Prevention Program and the Teratology Information Service Phone Line or TIS) with an average cost per year of \$367,000. The TIS program was dropped from Healthy Start funding by Year 03 due to low utilization by Camden

City residents and providers. However, TIS is utilized by other areas of the region and continues with other funding sources. The remainder of Healthy Start funds supported consortium building and administrative expenses.

The Healthy Mothers, Healthy Babies Coalition (HMHBC) has been in existence since 1985. Its expansion has been significant under Healthy Start as further described under the *Consortium Building Section*. The major emphasis undertaken by HMHBC as the consortium involved the encouragement of the community as a major stakeholder active in the planning, implementation and monitoring of an effective maternal-infant health care delivery system. One of the strategies used to enhance the consortium was that HMHBC revised its policies and procedures to reflect a more consumer-friendly organization. To further accommodate consumer needs HMHBC developed four Neighborhood Advisory Boards (NABs) which work in partnership with the HMHB Outreach Teams and the HMHBC Community Network Committee.

The Outreach and Client Recruitment Model was able to better serve pregnant and parenting Camden City residents with an expanded staff organized into four outreach teams, each deployed to one of four major sections of the city with a NAB. Outreach teams educated residents about maternal and child health issues, and provided peer advocacy, support and referral. Program visibility was also enhanced with the use of the outreach van, “the Baby Cruiser”, and a consortium mascot, “Storky Stork”. The Baby Cruiser and mascot were used during neighborhood canvassing, outreach visits, and at events. Outreach staff also worked at scheduled times out of provider sites and WIC offices to receive referrals for follow-up of clients who missed appointments. The outreach teams worked closely with providers through regular case conferencing to problem solve around barriers to care. This was also addressed through monthly meetings of the HMHBC’s Community Network Committee. The Committee identified strategies, resources and projects that support improved access to care. One project was the development of *Keeping A Roof Over My Head*, a user-friendly guide on tenants’ rights for clients since housing is a major barrier to care.

The Risk Prevention and Reduction Model funded the development of a comprehensive collaboration of all relevant entities who both serve and have interest in substance abusing families, including consumers. Services within this model target substance abusing pregnant and parenting women through the provision of outpatient intensive treatment, transportation, child care, community-based prevention services, professional education and sensitivity training, case management, assessment and planning. Additionally, a teratology information hotline service (TIS), standard case finding, standardized substance abuse screening and risk reduction counseling at prenatal clinics were other model components. Two Risk Reduction Specialists traveled between prenatal clinics, conducted home visits when necessary, assured coordination and linkage to services and tracked client participation. The model through its HMHBC Substance Abuse Committee, which includes key stakeholders such as NJ Work First and the Division of Youth and Family Services (DYFS), looked at how to impact system-wide changes to care in order to provide sustained needed changes. A Committee task force

has ongoing assessment of current treatment programs to identify gaps and encourage improved understanding of existing treatment resources.

The Adolescent Model encompassed a neighborhood-based approach to reduce first and subsequent teen pregnancies, improve parenting/life skills and encourage healthy behaviors. Specifically the model concentrated on the expansion of services within East Camden by extending The School Based Youth Services Program at Woodrow Wilson High School into the East Camden Middle School (Lion's Den). This allowed for the provision of primary health care, including reproductive health, counseling and health education for the middle school-age student, a group at the initial experimental stages for risky health behaviors. The model then has the potential to track these students from the feeder middle school into Woodrow Wilson High with a continuity that strengthens the intervention. The Adolescent Model included after school programs, the Teens On Track Adolescent Males Outreach and Preventive Health Care and Education Program, and the Healthy Families Intensive Home Visiting Teen Parent Support and Education Program. The innovative Reach Out and Read Program incorporates literacy development within parenting education and is part of Healthy Families. The Healthy Mothers, Healthy Babies outreach team for East Camden assisted with client recruitment into model services, assisted Healthy Families case managers with locating teen mothers who may have dropped out of service and conducted presentations to teens around such topics as: the importance of childhood immunizations, lead poisoning prevention and reproductive health.

IV. EVALUATION:

To determine the impact and effectiveness of the Camden Healthy Start Project, Health Visions Inc., the subcontracted evaluator, had primary responsibility and continues to work under the oversight of the Project Director for Camden Healthy Start, in assessing both access to services and health outcomes for Healthy Start clients in Camden City. The evaluation involved an ongoing assessment of the program's impact on infant mortality as well as an evaluation of the project itself to determine whether stated goals and objectives were achieved. Health Visions worked with Coalition leadership and its Evaluation Committee to do an evaluation of each model that involved two steps: 1) a process evaluation which identified, described and assessed the implementation steps of the various programs; and 2) an outcome evaluation which determined the effectiveness of those implementation efforts. The process assessment identified problems or obstacles encountered in implementing interventions, and assessed the grantees' ability to implement partnership relationships. The outcome evaluation was based on a three-tiered data collection approach. This involved 1) collection of vital statistics which also included linkage with the Electronic Birth Certificate (EBC) data, 2) client-specific case management data from all participating case management agencies, and 3) clinical data and results of referrals through record abstractions. In addition, program monitoring was completed on a regular basis with client satisfaction measured through surveys and focus groups of program participants.

Tasks by service model were varied. For the Adolescent Model, analysis of data using existing tools from the Healthy Families and School Based Youth Services programs was performed. Assessment tools determined repeat pregnancy rates and the percentage of adolescents remaining in school or seeking a GED as a result of the child care programs. Pre- and post tests for the Teens on Track program and the Lion's Den School-based Clinic were implemented. An annual satisfaction survey of Consortium members was also conducted, along with using an attendance tracking sheet for Consortium meetings to look at participation levels of consumers and providers (as discussed under the *Consortium Building Section* of this report, and as cited in annual reports). Annual satisfaction surveys of participants and analysis of the data as previously presented in annual reports were administered for the Outreach and Client Recruitment Model and the Risk Reduction Model. Monthly HMHB Evaluation Committee meetings included reviews of the Logic Models, problem solving data collection issues and monitoring process issues of Healthy Start services. Reports were prepared by each Healthy Start service provider on a monthly basis, and quarterly reports were developed for local review. Data tables appear in the appendices.

V. RESULTS/OUTCOMES:

Results and outcomes for the Camden Healthy Start – Replication Phase Period are presented by model, and includes the input of consortium members who participate on model-specific standing committees. An *EBC Outcomes Report* was forwarded to HRSA and also appears in the appendices. EBC has certain limitations. Data from EBC is provided voluntarily by the birth facilities in South Jersey. Therefore, outcome data for all Healthy Start prenatal clients was not available at the time of this report. Limitations also exist when matching variables from the Healthy Start Data with the EBC variables. Name changes, errors in documentation, and deliveries occurring outside of the region limit the capabilities of matching all participants with birth outcomes. Healthy Start case managers will be required to do medical record abstractions for data in the future to compensate for these limitations. However, of the Healthy Start participants that could be tracked for this phase funding period, the majority delivered live births, weighing more than 2500 grams, with greater than 38 weeks gestational age, whose infants were discharged home with them.

(A) The Adolescent Model

The Adolescent Model consisted of three distinct strategies which were targeted toward teens in the East Camden area: (i) provision of education and service linkages to adolescent mothers under the Healthy Families Program, (ii) school based services, including education programs, medical and mental health, child care and parenting education to students at a high school and middle school in East Camden, and (iii) health and medical services as well as after-school recreational and cultural activities provided to adolescent males through Planned Parenthood's Teens on Track Program. It should be noted that all of these subcontractors were actively involved in the Adolescent Committee; the Director of the School Based Youth Services Program was the Chair of the Committee.

The Adolescent Committee

The Adolescent Committee reviewed the Logic Model for Adolescent Programs and the Project Period Objectives for the Camden Healthy Start Project during its June 2001 meeting. The review considered the first four-year funding cycle, September 1997 through June 2001. The following is a synopsis of this committee review. Overall, the committee noted changes in the original performance objectives for each of the Healthy Start funded services for adolescents and identified reasons for these changes. Generally speaking, the Adolescent Committee felt that some of the original objectives in the Logic Model were unrealistic. For example, reducing the school dropout rate by 90%, and reducing the teen birthrate by 50% were unrealistic goals given the complexity of psychosocial factors and the short time frame of the project. Further, several of the subcontractors experienced changes in the scope of their programs and thus in their period objectives. For example, Partners in Parenting changed their objectives of targeting school and community teen mothers to dealing only with school based mothers, which was different than their original objective. Also, Partners in Parenting cited the objective of enrolling forty-five (45) teens in MELD and sixty (60) teens to be case managed for city-wide sites, instead of just East Camden sites, which became the adolescent services project area. Overall, objectives in the Adolescent Logic Model were often inconsistent and did not capture the true scope of work that the Adolescent Model has performed over the past four years.

The Adolescent Committee identified several model strengths. The use of social contracting which delineates both client and staff responsibilities and “deliverables” is cited as a strong strategy in empowerment of adolescent clients. Results of social contracting indicated a shifting of responsibility to the teen mothers, with social support networks becoming stronger. Partners in Parenting nurtured this process through group support sessions. Healthy Families have long term case management and has greater ability to document changes over time. This program cited that the average length of time for client growth in terms of life skills is two years. And a major model success was the level of collaboration between Partners in Parenting, Healthy Families and the HMHB Outreach Program. The future challenge is to expand this collaboration to all key adolescent health and social services providers. Another challenge is the involvement of parents or guardians to foster family support. Partners in Parenting enhanced its client intake process by requiring that parents and guardians attend program orientation and are involved in the social contracting process.

Model gaps and barriers were also cited by the Committee. The “highest risk” adolescent clients are very mobile due to unstable home environments. Healthy Families’ clients move an average of five times and often live with various relatives. System gaps and barriers often related to Work First NJ and welfare reform. There is no centralized intake system. Adolescent clients and their case managers must go to different locations for such items as school enrollment forms and alternative education documents, welfare determination and childcare services. In Partners in Parenting, teen mothers must navigate this process by themselves first to help them learn how to be independent, with the case managers assisting when problems surface. Another barrier is that NJ Family Care has many access issues. A client may wait an average of three (3) or more months to

receive their insurance card. A major gap is the lack of affordable, quality daycare services. Adolescent mothers are not given priority for the NJ Cares for Kids Voucher Program, a daycare subsidy. And there needs to be more funded daycare slots for infants. The average wait for NJ Cares for Kids Voucher Program is nine (9) months. If the teen mother is not on welfare due to the family's income level (i.e. working poor, moderate-income group) then funding affordable childcare is a major obstacle.

Adolescent Committee members felt that to address the gaps/barriers and improve the adolescent service system that a multi-agency, multi-disciplinary case management system with regular case conferencing for difficult situations and system issue collaborative problem solving are necessary. The Adolescent Committee will implement such a process during the "Eliminating Disparities in Perinatal Health" phase funding.

Over the past four years, the Adolescent Committee has planned and taken part in several exciting events sponsored by Healthy Start. In Year 02, a Youth Summit took place at Rutgers University, Camden. The topics covered included gangs, drugs, youth violence, domestic abuse, community improvement, teen pregnancy, self-defense strategies, and anger management. The Youth Summit reached approximately two hundred fifty (250) youth. During Year 03, the Adolescent Committee sponsored Teen Pregnancy Prevention Month with a Teen Pregnancy Prevention Forum in October 2000. The purpose of this forum was to provide the opportunity for school district staff to network with Healthy Start care providers and other service providers in support of teen pregnancy prevention efforts and begin the process for improved coordination of adolescent health and social services. The target population was school nurses, guidance counselors, and health and physical education teachers. Additionally, in Year 03, a Teen Pregnancy Prevention Public Service Announcement Contest for the city youth took place. Youth in middle through high schools, and who also participated in community based programs in Camden City, were eligible to submit a public service announcement with a prevention message. The youth developed PSA's are shown periodically on cable television station channel 18.

The following sections highlight each subcontractor's achievements of period objectives.

Model Period Objectives:

- The percentage of births to mothers aged 15-19 is greater than the County percentage, with the City being 28.2% compared to 12.2% for the County in 1997 as a baseline measure. Project period objective was to decrease incidence of teen pregnancies.
- Healthy Families had a child abuse objective to reduce by 90%. In Camden County the number of substantiated cases of child abuse was 1,091, with 596 of these abuse cases being in Camden City. (State DYFS – Child Abuse and Neglect 1997-1998). Both domestic violence and child abuse are known to be significantly under-reported problems.
- All programs met 95% immunization level objective

Healthy Families

The goal of the Healthy Families program is to provide support and case management to adolescent mothers to prevent child abuse and subsequent teen pregnancies. Information about parenting skills, job opportunities, applying for housing, job training, obtaining public assistance and health education was provided to all clients. Additionally, clients were provided with transportation as well as clothing, food, diapers, and other necessary baby items such as cribs, formula, and baby clothing. A great number of home visits have taken place by the Family Support Workers, who work very closely with each client, in order to insure that both mother and baby are thriving. The program has also managed to include several male partners in various activities and has helped to stabilize these families. Healthy Families has also helped clients obtain secure housing, re-enroll in school, obtain medical care for mother and child, and receive job training and career development.

- During the course of the four-year funding cycle, Healthy Families has served a total of eighteen (18) adolescent mothers and their families. Of these eighteen (18) teens, seven (7) were African-American, four (4) were White, and the race of seven (7) clients was unknown. Twelve (12) clients reported their ethnicity as Hispanic/Latino. One (1) client was under the age of fifteen (15), eight (8) were between the ages of fifteen (15) and seventeen (17), three (3) were between the ages of eighteen (18) and nineteen (19), and six (6) were over the age of nineteen (19), at the time of enrollment. At the conclusion of the funding cycle, six (6) clients (or 33%) were pregnant for at least the second time during the course of their enrollment. As of December 2000, four (4) teen mothers are in high school, and (1) was working on her GED. One (1) teen mother was enrolled in Camden County College for the fall semester, but due to financial difficulties, had to discontinue her education. Further, seven (7) teen mothers were working full time, and three (3) were working part time. Seven (7) teen mothers were living in their own apartment or home, while seven (7) more were living in a stable housing situation with other family members, and only one (1) reported living in a stable housing situation with someone other than family. Only two (2) clients were living in unstable housing conditions, with one (1) in foster care. Healthy Families work with very high risk adolescent clients who live in unstable families. There is a need to incorporate a stronger secondary teen pregnancy prevention intervention for these clients. However, Healthy Families as part of a national program has shown positive outcomes for the prevention of child abuse, which is its major goal. During these past four years there were no reported child abuse cases with Healthy Families clients. However, there were six (6) clients lost to follow-up and it is unknown whether or not these clients had reported child abuse cases with their children.

During the funding cycle, the program has undergone many changes and revised many of the goals and objectives set forth in the Original Logic Models developed at the start of the grant cycle. However, the program has been able to review prenatal records for identified high-risk first time mothers in East Camden and enroll qualifying teens in

the program. The vast majority of these clients had remained in the program for at least one year. The program's Logic Model objective was that 90% of clients will remain in program by 9/98. In October 1998, Healthy Families had eight (8) Healthy Start clients, and four of these eight (4/8) remain in program as of 6/30/01. In 1999 there were 12 more clients enrolled in Healthy Families, and ten of these twelve (10/12 or 83%) are still in the program as of 6/30/01. In 2000, three (3) new clients were enrolled and all three (100%) remain in the program as of 6/30/01.

Another Healthy Families objective was that the Kempe Family Stress Checklist would be used for referral to Healthy Families as stated within the Logic Model. At baseline, 25% of clients were referred by this tool. As of 6/30/01, 100% of clients were referred by this instrument.

The Family Support Workers have also engaged in many creative outreach attempts in order to reach identified families who are at risk, but who refuse services. Additionally, these creative outreach attempts are also made to clients who have lost touch with the program, but who reportedly are in need of the services provided by Healthy Families.

The objective to incorporate the Reach Out and Read component (a literacy promotion and parenting program) was reached with this component being continued without Healthy Start funds beyond the four-year period. The program component is now funded by the State Department of Human Services. An anecdotal evaluation has noted that there is an increase of children's books in clients' homes. There was no formal evaluation conducted on Reach Out and Read.

Further, weekly training sessions were conducted for all clients on parenting skills. Several teen fathers also participated in these training sessions, as they were anxious to learn about their newborn child and how to properly care for a baby. Support for parents, and support for positive parent-child interaction and child development were provided to all clients, as well. All clients were also linked with a health care provider for preventive and primary care services. Prenatal clients in the program were also encouraged to attend prenatal care medical visits and were linked with the appropriate care.

Healthy Families reported on significant numbers of school dropouts, and originally had an expected change of 90% of clients either remaining in school or seeking GED. This may have been an unrealistic goal as during the 1998-99 school year, of the 18,536 students in the City, a total of 621 dropped out of school, with the highest number (209) dropping out in the 9th grade. In addition, 158 special education students dropped out of school that year. The Camden School District, with the involvement of the state, is currently looking at system wide school reform in dealing with the dropout and fiscal crisis of the district.

Healthy Families reports a high percent of immunization of infants in the program, and increased knowledge and skills for parenting occurred as noted in expected

change within the logic model. There also seems to have been increased utilization by teen clients of needed resources due to case management as reflected through record abstractions.

Several problems were encountered by this program during the four years of the project. First, the strategy to recruit clients through partnership with Osborne/Our Lady of Lourdes Medical Center changed during the first year of the project, as Osborne opted out of the partnership which entailed that they provide in hospital screenings. However, screening was expanded to other providers such as Planned Parenthood and the Visiting Nurses Association. Further, recruitment of clients proved to be difficult. However, this problem was solved as other subcontractors and the HMHB Outreach Team encouraged teen mothers to enroll in the program despite the three-year long follow-up period. In spite of the delay in getting referrals while new provider partners were identified, Healthy Families went over their original goal of maintaining fifteen (15) families, and case managed seventeen (17) Healthy Start families.

Over the course of the 4-year funding cycle, several tests have been administered to the Healthy Families clients. The Adult/Adolescent Parenting Inventory (AAPI), the Denver Prescreening, Baseline Data Forms, and Support Functions Scale are some of the tools that have been used to measure different facets of a client's life. Results of these tests can be found in the *Adolescent Program Evaluation Report*, found in the appendices. Sixty-seven percent (67%) improved their overall AAPI scores

School Based Youth Services

(a) Lion's Den

The purpose of the Lion's Den was to address infant mortality and low birth weight through Teen Pregnancy Prevention, health education, and healthcare services. The Lion's Den provided both convenience and confidentiality to all clients, which has been shown to be of great importance to adolescents as they seek health-related services. The main goals of the Lion's Den were to promote abstinence, provide reproductive health education in classrooms and through health classes, provide healthcare services including pregnancy testing, provide after school programming with academic support, recreation, and self esteem building activities, and provide clients with an enriched summer camp experience.

The Lion's Den program was very successful over the four-year funding cycle and met every single one of their goals proposed in the Original Logic Model. They reached their goal of enrolling 85% of the student population at East Camden Middle School. Specifically, approximately eight hundred fifty (850) students received services through the Lion's Den over the past four years. The school population of East Camden Middle School averages between seven hundred fifty (750) and eight hundred (800) from which a student advisory board was formed and met monthly. [Please note that in the Original Logic Model, the student population at East Camden Middle was estimated at one thousand one hundred (1,100) students, but due to the closing of several housing

projects, the student population decreased to around eight hundred (800)]. A total of eighty-three (83) student health educators were trained, and did fifty-four (54) presentations to their peers on health related issues such as good nutrition, anti-tobacco use, and teen pregnancy prevention. An after-school program was formed, and a Homework Center was available to students who needed help with homework. Students were treated to cultural field trips including several trips to area theaters and a trip to Washington, D.C. to meet Congressman Ronald Payne. Students were also rewarded for good behavior and attendance with pizza parties, holiday parties and skating parties. Further, the Lion's Den provided pregnancy prevention strategies to all health classes.

The use of pre and posttests validated an increase in participants' knowledge on all prevention strategies. See *Adolescent Program Evaluation* (appendices) for more detailed descriptions of tests and outcomes. Additionally, the Lion's Den provided teen pregnancy prevention counseling and programming during and after school. Activities included peer education presentations, public service announcement contests, poster contests, and reproductive health education. Overall, healthcare services, counseling and mental health services were provided to over 50% of the students enrolled in the program by the nurse practitioner. Collaborations were formed with other community agencies including Planned Parenthood, Sikora Center, Camden County 4-H, Rutgers University and University of Medicine and Dentistry of New Jersey to name a few.

Some of the activities that the Lion's Den participated in during Phase I of the Camden Healthy Start Project include participation in "Safe Night USA" in which safe places were provided to youth to have fun and learn about alcohol and drug abuse and how to resolve conflict peacefully. In May 2000, the Lion's Den participated in Teen Pregnancy Prevention Month by sponsoring several activities including a letter writing campaign to local, state, and federal officials to make them aware of Teen Pregnancy Prevention Month. In November 2000, the Lion's Den observed Tobacco Free Week at East Camden Middle School. Part of this week was spent educating the students about the dangers of tobacco use and abuse. An innovative drama program was instituted at East Camden Middle where the students would write and perform skits detailing the dangers of tobacco use and abuse. Student anti-tobacco ambassadors taught about the dangers of smoking and coordinated a student/parent smoking cessation pledge campaign.

(b) Partners in Parenting

The goal of Partners in Parenting was to provide education and social service supports to adolescent parents attending Woodrow Wilson High School in order to enhance their capacity for academic progress and positive parenting and prevention of additional pregnancies during adolescence. An "Early Care and Education Center" was available for twelve (12) student parents. Weekly support groups highlighting parenting and life skills were offered to participants. Monthly individual counseling sessions were available for each student and a three-day retreat focusing on self-growth and development was also part of the program. The Parent Infant Care Program (PICC) which was proposed in the Original Logic Model, was not used during the intervention.

However, a coordinated adolescent parenting program was established and included parenting skills, pregnancy prevention and life skills, employment and career development, with an on-site childcare center and is detailed below.

Each year, twelve (12) slots were available for parenting students to participate in the program. However, on several occasions, a student may have been enrolled in the program for more than one year. Therefore, over the course of the past four years, twenty-six (26) student parents participated in the program, and ten (10) students were enrolled for more than one academic year. Data is available for seventeen (17) clients regarding race. Of these seventeen (17) students, ten (10) were African-American, and five (5) were Hispanic. The race of two (2) clients was unknown. Additionally, a total of twenty-six (26) infants and toddlers were served, and all of their immunizations were up to date.

During the 1997-1998 school year, the center was being constructed and students were beginning to participate in group sessions and receive referrals to various social service agencies. During the 1998-1999 school year, the Child Development Center was licensed and opened with a staff of five (5) including a Center Coordinator, Group Teacher, and three (3) assistant teachers. At the conclusion of the 1998-1999 school year, seven (7) parenting students graduated from high school. Five (5) attended college, one (1) attended a training program, and one (1) obtained employment. All of the underclassmen in the program, passed on to the next grade level. Participants maintained an average rate of attendance at group sessions of 81%, and the attendance rate in the Child Development Center was 80%. The following year, class attendance for participating students at school was recorded at 89%. Attendance at group sessions averaged at 83%, and the average attendance rate in the Center was 81%. At the conclusion of the 1999-2000 school year, seven (7) parenting students graduated from high school. Four (4) of these students made the honor roll, five (5) went on to college, and two (2) enrolled in vocational training programs. During the 2000-2001 school year, class attendance averaged 85% for participating students. Attendance in group sessions averaged 78%, and attendance in the center averaged 78%. In June 2001, eight (8) seniors graduated. Two (2) Partners in Parenting participants ranked within the top ten students in the graduating class. Further, one (1) participating student was the President of the Senior Class. Seven (7) graduates are planning to attend college in the Fall 2001, while one (1) has obtained employment. Overall, twenty-two (22) participants graduated from Partners in Parenting, which is 85% of all participants. This is extremely close to meeting the goal of 90% of participants graduating high school.

In order to enroll in Partners in Parenting, student parents filled out applications throughout the school year. Recruitment was on a first come, first serve basis, however, priority was given to seniors. Each summer, individual family orientation was held, where each family met with the Partners in Parenting Coordinators and/or the Partners in Parenting Case Manager/Counselor to review the participation guidelines and to gather baseline information on the student parent and her child. At this time, the student parent signed a Family Planning Agreement and a Partners in Parenting Participation Agreement. At the time of enrollment, baseline information was gathered about each

child including Social Security number, birth certification, and documentation from a recent physical exam including immunization records.

The Child Development Center is staffed by teachers and assistant teachers who have been trained in Infant/Toddler Development. It is open from 8:30AM through 4:30 PM Monday through Friday to allow for student participation in extracurricular activities. The curriculum resource used is the Creative Curriculum for Infants and Toddlers. Student parents were encouraged to visit their children during lunch or at any free period during the school day. Additionally, students participated in parent support groups meetings weekly, which are facilitated by the Child Development Center Coordinators and monitored by the Case Managers/Counselor. The MELD curriculum was used to guide discussions and group activities related to child development, positive mother/child relationships and appropriate parenting. Student parents also participated in a weekly life skills group which is facilitated by the Case Manager/Counselor and volunteer facilitators who have been trained in MELD facilitation. Subject matter for this group experience included reproductive and sexual health, positive relationships, stress management, budgeting and other life skill development. The Case Manager/Counselor had individual sessions with each participant monthly as well as family sessions and in home visits as needed. Students who were not maintaining appropriate attendance and grades were provided with options for improvement, such as tutoring, and placed on probation within the program. Communication with other School Based Youth Services, Guidance Counselors, the Attendance Office, and other Healthy Start Collaborators was maintained to assure comprehensive service delivery to adolescent parents.

Evaluation of the program is through use of the AAPI which is completed by each participant at orientation as a pretest and again at the end of the school year (or when participant is terminated) as a posttest. The inventory measures parental attitudes needed for positive parenting and parent/child bonding. Further monitoring of participants was performed through report card review and monthly attendance monitoring. Healthy growth and development of the infants and toddlers in the program was measured through the Creative Curriculum Developmental Checklist. All of the children were assessed in September and again in June of each school year. For specific evaluation outcomes and data analysis, please see the *Adolescent Program Evaluation* in the appendices. The vast majority of clients improved their AAPI and scored above average on the posttest.

Teens on Track

The purpose of the Teens on Track Program (TNT), through Planned Parenthood of Southern New Jersey is to prevent teen pregnancy and to connect males ages ten (10) through nineteen (19) with medical care through their male reproductive health clinic, and to health education, recreation and cultural events. Over the course of the four -year grant cycle, TNT clients have participated in monthly Teen Nites at the Camden City YMCA where they were able to engage in recreational activities and received health education. Some topics covered at these Teen Nites included self-esteem, school performance, teamwork, male issues, goal setting and coping skills. Overall, a total of

thirty-one (31) Teen Nites were conducted with one thousand two hundred twenty-four (1,224) male clients. Swim leagues were also available to participants. Several TNT youth also participated in the Youth Summit held at Rutgers University in Camden in November 1999. Through TNT, four thousand seven hundred ninety-six (4,796) teen males attended six hundred two (602) education sessions and one thousand eighty-five (1,085) males received medical services. Cultural trips and recreational activities were also conducted.

TNT Community Education

Overall, a total of six hundred two (602) education sessions were held, serving four thousand seven hundred ninety-six (4,796) clients. Details regarding the education sessions at the various sites where they were conducted follows.

During the past four years, a total of one hundred five (105) outreach education sessions were conducted at the Roberto Clemente Community Center in North Camden and a total of one hundred two (102) sessions were conducted at Lanning Square School. Session topics at both locations included violence prevention, puberty education, drug abuse and reproductive health. To the surprise of the program coordinator and the TNT health educator, many of the young teens were very comfortable discussing issues of sexuality and had a wide range of information which was obtained from their peers or older family members. The majority of work involved providing accurate information and allowing the teens to address their concerns and teaching responsible decision making skills.

With regards to the Original Logic Models, the output of thirty (30) programs in year one was exceeded by two (2) programs, for a total of thirty-two (32) being conducted in 1998 at Roberto Clemente Community Center. Twenty-five (25) programs were conducted in 1999 and thirty (30) programs were conducted in 2000. Thirty-eight (38) programs were conducted January- June of 2001. At Lanning Square School, twenty-five (25) programs were conducted in 1998, thirty -one (31) programs were conducted in 1999 and thirty-one (31) programs were conducted in 2000. Fifteen (15) programs were conducted January-June of 2001.

Westfield Acres

The Westfield Acres Program offered many challenges. The location, by any measure, could only be considered substandard. The housing units were below par, the grounds were poorly maintained and drug dealers operated in plain view. Working in very stressful circumstances, the TNT outreach educator gained the support of the housing administrators, the tenants' association and the parents of the participants. A total of two hundred thirty-five (235) sessions were conducted at this site with one thousand three hundred eighty-two (1,382) teens participating in the program. In 1999, Westfield Acres was demolished due to mismanagement. Some families were relocated to other housing projects in the city, other families moved out of the state and many of the teens never reconnected with TNT.

The Westfield Acres' component was relocated to Ablett Village and Maguire Gardens. Session topics continued to include self-esteem, puberty, school performance, peer relationships and violence prevention. A total of twenty-eight (28) sessions with two hundred seventy-eight (278) participants were conducted at Ablett Village and fourteen (14) sessions with thirty-seven (37) participants were conducted at Maguire Gardens.

Providing programs at the community centers was a continued challenge. The teens were anxious to participate, but the space needed to provide programming was limited or in a constant state of disrepair. Due to the pressures of their day to day assignments, the community center staff did not respond to the needs of Teens on Track in a timely manner. TNT continued to provide programming at Ablett Village, while Maguire Gardens has been closed for renovation.

East Camden Middle School

In collaboration with the School Based Youth Services Program at East Camden Middle School, Teens On Track provided educational sessions, recreational activities, and assisted in the coordination of the homework center. Education topics addressed issues of self-esteem, substance abuse, abstinence, decision making, and violence prevention. During the grant period, ninety-eight (98) sessions were conducted and one thousand three hundred twenty-nine (1,329) teens attended the sessions.

The participants' knowledge was monitored by use of pre- and posttests which were administered at each education session, Teen Night, and event. One issue which was encountered was that the pre/post test instruments had problems in design and implementation. The tests were too easy for the participants and it often proved difficult to get an adequate number of the same participants when administering the posttest. However, many sets of pre and posttests, as well as the School Bonding Scale, Sexuality Survey, and Client Satisfaction Surveys were administered. Many of these measures were self-report and thus may not accurately depict increases or changes in knowledge and/or behavior. More details are in the *Adolescent Program Evaluation Report* (see appendices). On the Sexuality Knowledge test, the mean score increased by seven points on the posttest. And ninety-eight percent (98%) would refer a friend to this program.

Male Clinic

Statistics reveal that the need for adolescent male medical services in the reproductive health area remains high. In 1998, three hundred ninety-seven (397) clients used the male clinic for some form of medical care, which ranged from obtaining condoms, to STI testing, and physical exams. One hundred ninety-one (191) of these clients came into the clinic for condoms, and two hundred six (206) were seen by the doctor. In 1999, two hundred ninety-three (293) clients used the male clinic, which is a 29% increase. Ninety-seven (97) clients used the clinic to obtain condoms. Further, one hundred eighty (180) clients were seen by the doctor. In 2000, two hundred sixty-three

(263) clients, of which one hundred thirty-three (133) were for condoms, used the male clinic, which is a 10% decrease. One hundred five (105) clients were seen by the doctor in 2000. Finally, from January through June of 2001, one hundred thirty-two (132) clients used the male clinic, of which eighty-seven (87) were dispensed condoms, and sixty-one (61) clients were seen by the doctor. The utilization fluctuations during the project period was directly attributable to staff changes. Improved outreach, marketing and staff training has shown marked results during the current year manifested by a significant rise in male users for medical care. Planned Parenthood anticipates continued positive growth in this area. From 1998 through 2001, only sixteen (16) clients reported having fathered a child. Additionally, from 1998 through 2001, forty-one (41) clients reported contracting a Sexually Transmitted Infection. [The CCDHHS data for 1999 show that Camden City had 75% of the reported late and latent syphilis cases \(49/65\) and 72% of gonorrhea cases \(751/1039\)](#)

Cultural Events

The output of two (2) cultural trips per year was met in 1998 and 2000. Two (2) trips were planned for 1999 but one (1) was cancelled due to rain. Two (2) trips were also taken in 2001. A total of seventy-one (71) clients participated in TNT Cultural Events. These events included trips to: the Pennsylvania Academy of Fine Arts, Franklin Institute Science Museum and African-American Museum

Home Visits

Home visits have been an integral component of the Teens on Track Program. The visits broaden the TNT staff's understanding of the lives of a group of teens who have been identified as high risk and in need of additional attention. These visits were not formal family therapy sessions, but were offered to assist the teens and their families in negotiating the difficult task of coping in an urban environment. The output of two (2) home visits a year for identified high-risk young teens was accomplished in 1998, 1999 and 2000. Home visits have not been conducted in 2001 due to the hiring of a new TNT Coordinator in January.

(B) The Outreach and Client Recruitment Model

Healthy Mothers, Healthy Babies is the major service program under the Camden Healthy Start Initiative Outreach and Client Recruitment Model. Another initiative under this model was the OB Incentive Program, based on an original pilot program of Our Lady of Lourdes/Osborne Family Health Center.

Healthy Mothers, Healthy Babies (HMHB) Outreach Program

Healthy Mothers, Healthy Babies connects women of child bearing age and young children to necessary healthcare and supportive services. HMHB provides supportive in home education concerning family healthcare, pregnancy related health issues, WIC and Kid Care (CHIP) enrollment and healthy choices; as well as provides referrals to medical facilities for family planning services. HMHB follows through on service requests on

outreach for difficult to reach individuals from other Healthy Start subcontractors as well as project area perinatal/pediatric providers and social service agencies.

In addition to providing education and connection with healthcare, the HMHB Outreach Program has participated in and hosted many community activities over the four-year grant cycle to promote maternal and child health. The Outreach Staff has also assisted clients in enrolling in Medicaid, Medicaid Managed Care, or NJ Family Care in an effort to increase the number of clients with health insurance.

Data has been being compiled since January 1999. During this year, data was not being separated according to pregnancy status. Therefore, statistics are not specifically available for age and race of prenatal, postpartum, and pediatric clients for this year only. The numbers of clients served also reflect the number of signed consent forms to join the HMHB Outreach Program. In 1999, HMHB served a total of one hundred thirty-three (133) clients, of which ninety-one (91) were prenatal, thirty (30) were postpartum, and twelve (12) were pediatric. Overall, two (2) clients were under the age of fifteen (15), twenty-seven (27) were between fifteen (15) and seventeen (17), twenty-seven (27) were between eighteen (18) and nineteen (19), and seventy (70) were nineteen (19) or older. With respect to race, one hundred eight (108) were African-American, seven (7) were White, one (1) was Asian, and the race of the remainder were not known or reported. Fifty-four (54) reported their ethnicity as Hispanic/Latino. Twelve (12) pediatric clients were served during 1999. Of the ninety-one (91) prenatal clients, ten (10) entered care in their first trimester, thirty-eight (38) entered care in their second trimester, twenty-eight (28) entered care in their third trimester, and fifteen (15) did not report when, during the course of their pregnancy, they entered prenatal care.

During Year 03 data reporting became much more detailed. This year, a total of one hundred forty-four (144) clients were served through HMHB. Eighty-five (85) of these clients were prenatal clients. Of these eighty-five (85) clients, two (2) were under the age of fifteen (15), thirteen (13) were between the ages of fifteen (15) and seventeen (17), eleven (11) were between the ages of eighteen (18) and nineteen (19), and fifty-nine (59) were over the age of nineteen (19). Fifty (50) reported their race as African-American, five (5) were White, two (2) were Asian, and the race of twenty-eight (28) clients was not known. Thirty (30) reported their ethnicity as Hispanic/Latino. Further, of these eighty-five (85) prenatal clients, forty-three (43) entered prenatal care during their first trimester, twenty-three (23) during their second trimester, five (5) during their third trimester, and fourteen (14) did not report when, during the course of their pregnancy, they entered prenatal care. Additionally, twenty-one (21) postpartum clients were served during this year. Of these twenty-one (21), two (2) were between the ages of fifteen (15) and seventeen (17), one (1) was between the ages of eighteen (18) and nineteen (19), and eighteen (18) were over age nineteen (19). Fourteen (14) reported their race as African-American, two (2) were White, and the race of five (5) was not known or reported. Five (5) postpartum clients reported their ethnicity as Hispanic/Latino. Thirty-eight (38) pediatric clients were also seen by HMHB during Year 03. Nineteen (19) of these pediatric clients were African-American, three (3) were

White, and the race of sixteen (16) was not known or reported. Fourteen (14) pediatric clients were Hispanic/Latino.

From January through June of 2001, Year 04, eighty-eight (88) clients were served, of which thirty-one (31) were prenatal clients. Of these thirty-one (31) prenatal clients, four (4) were between the ages of fifteen (15) and seventeen (17), two (2) were between the ages of eighteen (18) and nineteen (19), while the remaining twenty-five (25) clients were over the age of nineteen (19). Twenty-two (22) reported their race as African-American, one (1) was White, while the race of eight (8) clients was unknown or not reported. Eight (8) clients reported their ethnicity as Hispanic/Latino. Further, fourteen (14) prenatal clients entered care during their first trimester, seven (7) during their second trimester, while ten (10) did not report when, during the course of their pregnancy, they entered prenatal care. Further, thirty-one (31) postpartum clients were served during year 04. One (1) client was under the age of fifteen (15), eight (8) were between the ages of fifteen (15) and seventeen (17), seven (7) were between the ages of eighteen (18) and nineteen (19), while the remaining fifteen (15) were over the age of nineteen (19). Eighteen (18) postpartum clients reported their race as African-American, three (3) were White, while the race of ten (10) postpartum clients was unknown or not reported. Eleven (11) postpartum clients reported their ethnicity as Hispanic/Latino. Finally, twenty-six (26) pediatric clients were served. Twenty-one (21) were African-American, one (1) was White, and the race of the remaining four (4) pediatric clients was unknown or not reported. Six (6) pediatric clients were Hispanic/Latino.

Below is a synopsis of the goals and objectives the HMHB Outreach Program proposed at the beginning of the four-year grant cycle. Also, outcomes are highlighted below.

Project period (9/1/97 – 8/31/01) goals set by HMHB Outreach were as follows:

- 1) Provide door to door canvassing to two thousand five hundred (2,500) doors in the project area each year.
- 2) Educate and refer women and children who have missed appointments or dropped out of care programs.
- 3) Implement the use of a uniform registration instrument at all HMHB outreach sites.
- 4) Follow-up and document care plans for prenatal women.
- 5) Identify prenatal and postpartum women ages twenty (20) to thirty-five (35) and over thirty-five (35) who are in need of more intensive followup based on initial assessment each year.
- 6) Participate in twenty (20) health fairs each year.
- 7) Open three (3) additional outreach sites in the project area.
- 8) Hire and train 12 new outreach staff (year one, supervisors and outreach workers).
- 9) Recruit a core group of residents for Neighborhoods Advisory Boards (NABs).
- 10) Educate and follow up on teen mothers to assure compliance with a method of contraception.
- 11) Provide educational presentations on immunizations and the importance of prenatal care to groups as well as individual contacts each year.

- 12) Register seven hundred fifty (750) pregnant women with the program by 8/31/01.
- 13) Conduct street canvassing for 24 hours each week.
- 14) Refer 100% of registered clients to appropriate services and intensive follow up programs where clients match program criteria by 8/31/01.
- 15) Increase by 50% the number of women receiving prenatal care in the first trimester of pregnancy in the project area by 8/31/01.

Healthy Mothers Healthy Babies proposed to implement some of the following strategies in order to achieve the above outlined goals:

- Case finding through door to door neighborhood canvassing and the outreach van.
- Referrals from providers and social service organizations around prenatal and pediatric care issues.
- Home visits to locate women and children who have missed medical appointments.
- Conduct group presentations on maternal and child health.
- Secure three additional neighborhood outreach sites.
- Staff the three additional outreach sites once they are secured
- Individual follow up, assessment and referral.
- Recruitment of NABs as part of Coalition (consortium).

Outcomes for the Project Period (9/1/97 – 6/30/01)

Outcome data for HMHB Outreach was not submitted for data collection until 4/99. High staff turnover, which included the hiring of a new program coordinator, delayed this data process. Currently, there is a stable staff which has been aboard since 1999. All data reported in this section covers 4/99 through 6/30/01, unless otherwise noted.

- 1) HMHB provided door to door canvassing to five thousand four hundred nineteen (5,419) doors in the project area (9/1/97 – 7/31/01).
- 2) Upon receipt of a clinic request for follow up, HMHB educates and refers women and children for necessary healthcare; the average time between the receipt of a request for follow up and an attempted home visit was one day.
- 3) All HMHB outreach sites use a uniform registration instrument to enroll clients.
- 4) HMHB has documented care plans for two hundred fifteen (215) prenatal women.
- 5) HMHB identified three hundred one (301) prenatal and postpartum women ages twenty (20) to thirty-five (35) and thirty-five (35) and over who were in need of more intensive follow up.
- 6) HMHB participated in sixty-eight (68) health fairs.

- 7) HMHB had three (3) additional neighborhood outreach sites. However, the North Camden site was relocated to the main HMHB program office due to facility problems, leaving two additional program sites.
- 8) During Year 01 HMHB hired and trained four (4) outreach supervisors and twelve (12) outreach workers.
- 9) HMHB began recruiting a core group of residents for NABs in February 2000.
- 10) HMHB educated and followed-up on teen mothers to assure compliance with a method of contraception.
- 11) HMHB provided monthly presentations on immunizations and the importance of prenatal care.
- 12) HMHB registered three hundred seventy-nine (379) pregnant women with the outreach program.
- 13) HMHB conducted street canvassing for thirty-two (32) hours each week; 4 sites for 8 hours each.
- 14) HMHB referred 100% of registered clients to appropriate services and intensive follow-up programs where clients matched program criteria.
- 15) Out of three hundred seventy-nine (379) registered HMHB participants, seventy-two (72 or 19%) pregnant women began receiving prenatal care in the first trimester. A baseline measure is in 1997, 60.7% of Camden City births received prenatal care in the first trimester. This may show that highest risk women are being reached.
- 16) HMHB completed three hundred seventy-eight (378) successful home visits.

Community Network Committee

The Community Network Committee is charged with overseeing the work of the HMHB Outreach Program. The Committee continues to meet monthly at area locations throughout Camden. Service providers, the County Health Department, prenatal sites, non-profit agencies, and HMOs in the City, as well as Outreach staff are represented on the committee.

As a result of the work of the Community Network Committee, HMHB discovered that receiving referrals for pregnant women after the third missed appointment usually meant that by the time a pregnant woman was located and enrolled in services, she was either close to delivery or was already postpartum. In January 2000, HMHB began receiving referrals from prenatal providers at the first missed appointment which led to an increase in the number of pregnant women beginning to receive prenatal care in the first trimester of pregnancy.

The Network Committee reviewed the original logic model to compare the program achievements during the past four years with original expected outcomes. The

logic model identified one of the expected changes in the project area as a result of the HMHB Outreach Program to be a reduced rate of teen pregnancy, including a reduced rate of repeat pregnancies for teens. However, the majority of HMHB Outreach clients fell within the age range of twenty (20) to thirty-five (35) years of age; teen parents were not the primary target population of the outreach program since there were Healthy Start funded adolescent services for both primary and secondary teen pregnancy prevention. The small number of pregnant teens receiving services through HMHB were initially followed to insure a reconnection to healthcare and then discharged from service. In January 2000, HMHB began following all clients for at least one year. This strategy was implemented to assure the promotion of healthy lifestyles including compliance with a method of contraception. For the general outreach population, this strategy was effective in developing a more productive working relationship with clients.

HMHB was able to expand to three (3) more neighborhood outreach sites (an original objective, Parkside, East Camden and North Camden). Its Central Office site was already in existence before Healthy Start funding, and is supported with a state HMHB grant. The North Camden office was closed due to poor building conditions. There are limited options for office space in the North Camden area. At this time HMHB still provides service to the residents of North Camden and the Community Network Committee hosts monthly meetings in one North Camden community center.

Establishing NABs, another original objective, has been an ongoing process for HMHB. Monthly meeting times for each NAB were established. Maintaining a core group of Camden City residents to serve on the NABs is a labor intensive endeavor. HMHB employed various strategies to recruit residents such as: hosting NAB Kick-off events, doing presentations, contacting neighborhood organizations and leaders, as well as networking with the Camden Learning Collaborative's Living Rooms (neighborhood councils). The HMHB neighborhood offices co-locate with the Learning Collaborative's Living Rooms. The Community Network Committee felt that barriers for NAB development related to transportation and the misperception that children are not allowed to be present at meetings. The HMHB "Baby Cruiser" van is not used for client or consumer transportation due to insurance liability restrictions. In other Healthy Start programs, clients are transported to appointments and meetings with agency vans. Consumers may bring their children to NAB and general consortium meetings. HMHB began promoting this on meeting notices. Further discussion on NABs appears under the *Consortium Building Section* of this report.

OB Incentive Program

In addition to the HMHB Outreach Program, the other service within this model is the Healthy Start OB Incentive Program. Significant improvements were noted in gestational age and birth weight when women with inadequate prenatal care in a previous pregnancy were given grocery store coupons to seek prenatal care in their current pregnancy, as reported by a OB Incentive pilot program developed by the Osborne Prenatal Clinic. The Healthy Start OB Incentive Program, modeled after this pilot program, was designed to increase the number of at-risk pregnant women who are

receiving and completing prenatal care in the city of Camden. Pregnant women who experience a previous poor birth outcome and/or have missed prenatal appointments were eligible for the incentive program. Three (3) out of five (5) prenatal clinics in Camden City participated in this prenatal incentive program. Funding, in the Year I budget, was available to purchase a supply of grocery store (Pathmark) coupons as incentives. Prenatal clinics were not compensated for staff time required to enroll clients, or to collect and report data to Healthy Start. Incentives purchased with Year 01 funds were utilized throughout the four-year term of the project. After Year 02, the Women's Care Center was not able to implement the program to full capacity because of significant staff reductions. In the subsequent year, the Women's Care Center ceased participation. All programs followed standardized criteria for enrolling clients, gathered data on standardized data collection tools and were to submit data reports regularly. Women's Care Center was not able to gather outcome data. Also outcome data on some clients was available from EBC files.

Outcome data from the two prenatal sites that participated throughout the four years is not complete due to difficulties in reporting and obtaining correct data. In Year 02, one hundred eighty-five (185) clients were served through the OB Incentive Program. Outcome data shows that for a sample of ninety-two (92) clients that ninety percent (90%) delivered babies over 2500 grams. In Year 03, seventeen (17) clients received incentive coupons. Six (6) of these clients were between the ages of fifteen (15) and seventeen (17), three (3) were between the ages of eighteen (18) and nineteen (19), and eight (8) were over the age of nineteen (19). Eight (8) were African-American, one (1) was White, and the race of eight (8) clients was unknown. Seven (7) clients reported their ethnicity as Hispanic/Latino. All seventeen (17) clients delivered live births; one (1) client delivered twins. Sixteen (16) clients delivered babies weighing over 2500 grams. All eighteen (18) babies were discharged from the hospital.

A surplus of Pathmark coupons was available in Year 04, and at the request of the Healthy Start Risk Reduction Specialists in the prenatal sites, were made available to encourage clients enrolled in substance abuse treatment programs to attend treatment sessions. Criteria for participation were developed and forty-five (45) clients enrolled. The Pathmark coupons had positive impact on client behavior. All "incentive" clients kept prenatal, WIC, AA and substance abuse treatment appointments. Also the majority abstained from substance use as indicated by negative urine tests.

Lessons Learned:

1) Prenatal care providers are interested in participating in Healthy Start activities, however they have diminished staff, a result of the implementation of Medicaid Managed Care in the project area. Therefore they are limited in their ability to take on activities requiring in-kind staff time for data collection and reporting.

2) Client participation levels in this program indicate that, for some women, a tangible incentive encourages compliance with prescribed care during pregnancy. Incentives should be considered for high risk clients who have difficulty prioritizing preventive care and other necessary health care visits.

(C) Risk Reduction Model

The Risk Reduction Model has a well organized Substance Abuse Committee which met once every month to discuss issues that affect all substance abuse providers within the project. This committee has representation from Healthy Start funded Risk Reduction Model services, as well as from others such as substance abuse treatment providers in the city of Camden, Division of Youth and Family Services (DYFS) management, Camden County Department of Health, the school district, prenatal providers, among other key stakeholders. The Committee also reviewed the original logic model to examine whether or not these goals, objectives and expected outcomes for the period were met. Below are the findings that were identified during this review.

An original objective was to establish inpatient detoxification services for pregnant women. Inpatient detoxification services for pregnant women enrolled in Healthy Start were not feasible because of Medicare and Medicaid reimbursement issues, also discussed further on under this section.

Another objective was implementing uniform substance abuse screening of pregnant women. A uniform screening tool was successfully adopted in all prenatal sites to identify all pregnant women at risk of poor birth outcomes due to use of drugs, alcohol or tobacco. It is important to note that, in order to achieve the best possible outcomes, this tool must also be introduced and used in the offices of private physicians. Further, an audit is necessary to insure continued and appropriate use of the tool, during the implementation phase.

Risk Reduction Counseling was also implemented in all prenatal sites. This original goal was achieved and because of the number of clients identified, an additional Risk Reduction Specialist was hired. More specifically, case management in prenatal sites was successful, but home visits and community-based interventions were also necessary to meet the needs of clients. Risk reduction specialists are now available to meet with clients in the community and are available by beeper and cell phone. Services are comprehensive and are not limited to prenatal clinic visits.

Overall, improvements in continuity of treatment, treatment success and positive birth outcomes were experienced over the past four (4) years. However, several lessons were learned. More improvements could be seen with increased attention to: gender-specific treatment services, expanded community-based case management by Risk

Reduction Specialists, increased coordination of cases through multidisciplinary case review, greater availability of transportation to treatment services, greater availability of childcare for clients with infants and children over age two (2), services developed for MICA (Mentally Ill/Chemically Abusing) clients, and expansion of residential treatment services.

Further, the Healthy Start funded community education and prevention program conducted by the Woodland Avenue Presbyterian Church had limited success in recruiting adults. This may be related to the fact that this church has a relatively small congregation which may have affected its ability to recruit adult residents into the intervention. Some lessons learned here are that a coordinated effort with treatment services would improve education and prevention efforts city-wide. Parents and providers must be included in curriculum development in order to make sure that the curriculum is age appropriate as well as informative, specific to the target population's needs and effective. The measurement of the impact of these efforts was limited to pre/post knowledge tests on a relatively small sample size. The overall results showed gains in knowledge by participants.

The education of physicians was most effective when conducted on a "physician-to-physician" basis. Additionally, provider education was necessary on an ongoing basis due to staff reductions and changes related to the implementation of Medicaid Managed Care. It also became clear that the case management system for very high-risk clients is necessary due to limited prenatal staff. A major concern is the overall lack of treatment services for Hispanic clients. There exists limited numbers of bilingual/bicultural substance abuse treatment professionals. However, both the Healthy Start Risk Reduction Specialists are bilingual/bicultural Latino professionals. Also the inclusion of male partners in treatment is necessary for success as it deals with issues of codependency and offers a more holistic approach to improving parenting and family structure

More universal use of the American Society of Addictions Medicine (ASAM) criteria for identification of the appropriate level of treatment necessary would lead to more consistent communication and diagnosis among providers. Also, the development of case management plans by DYFS and all providers should prioritize the mother's need to bond with the baby, as well as the importance of her sobriety.

There were three (3) subcontractors under the Risk Reduction Model: Sikora Center, Inc., Woodland Community Substance Abuse Initiative, and the Alcove Risk Reduction Specialists. In addition to these subcontractors, the Teratology Information Service (TIS) Phone Line was operational, as well as the Fetal Infant Mortality Review (FIMR).

1) Sikora Center, Inc.

The Sikora Center, Inc. provides intensive outpatient drug treatment and facilitative services for substance abusing prenatal and postpartum women and their children. They provide drug treatment, as well as individual and group sessions for all

participants which highlight areas such as anger management, peer support, relapse prevention, personal recovery issues, parenting education, social skills, self-esteem and career development. Sikora also provides transportation and childcare for women who are enrolled in their program.

At the beginning of the funding cycle, Sikora identified an expected output of up to fifteen (15) women in treatment during the first year of the grant will continue in outpatient treatment. During the first budget year, Sikora provided services to twelve (12) women. While Sikora was ready to provide drug treatment, the Risk Reduction referral component was slow due to start-up activity. During the second year, Sikora increased the number of women being served and provided services to twenty-three (23) women, which is eight (8) more than they originally proposed. During the third year, thirty-one (31) women were served, and during the fourth year, eighteen (18) women were served in a ten-month time period.

As part of Healthy Start, treatment was expanded to nontraditional hours, which were determined by polling clients and selecting the hours of operation that they indicated were most needed. The Healthy Start project through the Sikora Center was the only program offering non-traditional, gender specific drug treatment and facilitative services in Camden City. Transportation to and from drug treatment was provided by the Sikora Center through a subcontract with the Woodland Community Substance Abuse Initiative. All women were offered transportation for themselves and their children up to age two (2) who attended Sikora. Drop-in childcare was offered for all women who had custody of children, up to age two (2). Childcare for older children became problematic as Sikora did not have age appropriate space for older children. Sikora staff worked with women to identify off-site childcare for older children.

During Year 01, seventeen (17) women received drug treatment and support services at Sikora. Six (6) of these clients were prenatal, and eleven (11) were postpartum. Of these seventeen (17) women, two (2) completed treatment and graduated from the program. Five (5) continued in treatment, and ten (10) were discharged from the program. Information regarding age and race is not available.

During Year 02, fifteen (15) new clients received drug treatment and support services at Sikora. Seven (7) were prenatal clients, and the remaining eight (8) were postpartum clients. Overall, nine (9) were African-American, four (4) were Hispanic, and two (2) are of an unknown race. All fifteen (15) clients had Medicaid. One (1) client was nineteen (19) years old, while the remaining fourteen (14) clients were over the age of nineteen (19). Four (4) women were poly addicted, two (2) were addicted to cocaine and tobacco, one (1) was addicted to tobacco, cocaine, and alcohol, and one (1) was addicted to alcohol and cocaine. No data regarding entry into prenatal care is available.

During Year 03, twenty-four (24) new clients were admitted to the Sikora Center. Twelve (12) were prenatal clients, and twelve (12) were postpartum at the time of intake. Of the prenatal clients, one (1) was between the ages of fifteen (15) and seventeen (17), while the remaining eleven (11) clients were over the age of nineteen (19). Nine (9)

prenatal clients reported their race as African-American, and three (3) did not report their race. Three (3) reported their ethnicity as Hispanic/Latino. Further, one (1) prenatal client reports entering care in the first trimester, while the remaining eleven (11) clients did not report when, during the course of their pregnancy they entered prenatal care. Of the twelve (12) postpartum clients, two (2) were between the ages of eighteen (18) and nineteen (19), and the remaining ten (10) clients were over the age of nineteen (19). Six (6) were African-American, one (1) was White, and five (5) did not report their race. Five (5) of the postpartum clients reported their ethnicity as Hispanic/Latino.

During January through June 2001, Year 04 of the project, four (4) new clients were enrolled in Sikora. One (1) of these clients was prenatal, while the remaining three (3) clients were postpartum. The one (1) prenatal client was over the age of nineteen (19), African-American, and entered prenatal care in the first trimester of her pregnancy. Of the three (3) postpartum clients, one (1) was between the ages of eighteen (18) and nineteen (19), while the remaining two (2) were over the age of nineteen. Two (2) were African-American, while the race of the other postpartum client was not known or reported. One (1) postpartum client reported her ethnicity as Hispanic.

Through the funding cycle, Sikora Center experienced great success. There was zero infant mortality for pregnant substance abusing women who came to drug treatment at Sikora. Seventeen (17) babies, including one set of twins, were born to Healthy Start clients. All babies appeared healthy, well nourished, and well cared for. Well baby care and immunizations were up to date for all participating infants and children. Childcare and transportation were positive additions to the program and enabled women who may not have been able to attend drug treatment, to obtain the ways and means of staying clean.

Pre and posttests were administered to clients regarding health issues, substance abuse and other important issues related to recovery. However, due to the transient nature of clients, collecting posttest data was virtually impossible. Therefore, data is not available for report. In an effort to combat this deficit, a monthly attendance sheet and drug use status sheet has been kept. Since records have been kept, only four (4) women increased their drug use for at least one (1) month. One (1) of these clients dropped out of treatment after being in for three (3) months, and another client continued in the program, completed treatment, and graduated. The remaining clients have either decreased their drug use, abstained, remained the same, or began a methadone regiment. However, please note that data for at least one (1) month during this time frame is unavailable.

Several challenges were also faced within this model. Referrals were often outside of the Risk Reduction Model and were mainly postpartum women. Childcare also became an issue for women who did not have custody of their children, but who did have day to day responsibility for their children, as facilities can not provide childcare for a child not in the custody of the client. Getting a letter from DYFS authorizing childcare for the non-custodial parent was problematic. Additionally, Sikora only provides childcare for children up to age two (2), so childcare for clients with older children was problematic. Referrals were made to outside childcare centers when available for older

children. Clients were given pre and posttests to measure changes in knowledge and behaviors regarding substance abuse issues. Posttesting was impossible when clients disappeared from the program. Therefore, an attendance and behavior grid was instituted for which Sikora Center would observe clients for signs of substance use. Housing was a major issue for clients. The Sikora Center did provide information and emotional support regarding housing situations. Inadequate reading and writing skills posed a problem for clients. Clients were urged to get their Graduate Equivalency Degree (GED) and obtain literacy training.

2) Woodland Community Substance Abuse Initiative

The mission of the Woodland Community Substance Abuse Initiative was to provide a drug prevention program. The program was to improve knowledge of health and risk behaviors. Classes regarding parenting issues, health issues, and a 12 Step class, which was developed as being the spiritual side of Alcoholics Anonymous, were conducted. The class curriculum was derived from *Serenity: A Companion for Twelve Step Recovery* by Hemfelt and Fowler. Additionally, Woodland provided transportation to Sikora's clients, as well as transportation to Planned Parenthood's Teens on Track Teen Nights.

Overall, two hundred seventy-one (271) clients were served, including students enrolled in non-Healthy Start funded Summer Day Camp and Homework Centers. During Year 01, twenty clients were served and participated in the various classes offered by Woodland. In Year 02, fifteen (15) clients participated in the 12 Step and Health Issues Classes. One (1) client was between the ages of sixteen (16) and twenty-five (25), eight (8) were between twenty-six (26) and thirty-five (35), two (2) were between thirty-six (36) and forty-five (45), and four (4) between forty-six (46) and fifty-five (55). Twelve (12) clients were female, one (1) client was male, and two (2) did not report their gender. Eleven (11) clients were African-American, and two (2) did not report their race. Two (2) reported their ethnicity as Hispanic/Latino. Four (4) were married, two (2) were divorced, and six (6) were single. During Year 03, sixteen (16) clients were served and participated in the various classes. However, data is known for twelve (12) participants. Two (2) clients were between the ages of sixteen (16) and twenty-five (25), three (3) were between twenty-six (26) and thirty-five (35), five (5) were between forty-six (46) and fifty-five (55), and two (2) were between fifty-six (56) and sixty-five (65). Nine (9) clients were female, one (1) clients was male, and the gender of two (2) is unknown. Nine (9) clients reported their race as African-American, one (1) client was White, and two (2) reported their ethnicity as Hispanic/Latino. Further, one hundred three (103) school aged children were served as part of the Anna B. Clark Summer Day Camp. One hundred seventeen (117) school aged children were also served with Mary Esther Williams Homework Centers, which operated in four (4) Camden City schools. There were no classes held during Year 04 as funds were given to only support transportation..

Pre and posttests are given to participants of the health issues and 12 Step Classes to measure increases in knowledge regarding these topics. Data from the first year is not available. However, 100% of the twenty-four (24) graduates from parenting issues, and

health issues classes in Year 01 reported that they or their families learned something from the program. In Year 02, thirteen (13) clients participated in health issues and 12 Step classes. Overall, 72% increased their knowledge about health issues and substance abuse. Two (2) additional clients graduated from the fall health issues class, however no data is available regarding pre and posttest scores. During Year 03, a total of sixteen (16) clients participated in classes. In March 2000, five (5) clients graduated from the 12 Step class. Four (4) participants took both pre and posttest and 100% improved their scores on the posttest. The remaining one (1) participant did not take the posttest. In June 2000, four (4) clients participated in the health issues class, and two (2) graduated. One (1) participant increased their score on the posttest, while the other client received a perfect score on both pre and posttest. In October 2000, seven (7) participants enrolled in the fall health issues class, where six (6) graduated. Data is available for five (5) participants. Two (2) participants improved their score on the posttest, while the remaining three (3) participants received a perfect score on both pre and posttest.

One non-Healthy Start funded program that the Woodland Community Substance Abuse Initiative offered during Year 03 was the Anna B. Clark Summer Day Camp. A total of one hundred three (103) school age children participated; eighty-four (84) participants were campers, while nineteen (19) were camp counselors. Topics at camp included good hygiene, nutrition, and substance abuse prevention. Thirty-three (33) campers took pre and posttests regarding substance abuse. Sixty-seven percent (67%) improved their scores on the posttest. Thirty-eight (38) campers took pre and posttests regarding health issues. Eighty-four percent (84%) improved their score on the posttest. Further, in October 2000, the Mary Esther Williams Homework Centers began operating in four (4) area schools. Approximately, one hundred seventeen (117) students were enrolled in the Homework Centers.

Several challenges became evident during the funding cycle and many lessons were learned. For example, recruitment of adult clients for the various classes proved to be very difficult. Woodland noticed that recruitment was a major issue, and had a serious effect on continuity of services. One way this problem was handled was to target children and integrate Substance Abuse Education and Prevention into existing non-Healthy Start funded programs that were conducted through the Woodland Development Corporation and its Woodland Avenue Presbyterian Church.

3) **Alcove Risk Reduction Specialists**

The Alcove Risk Reduction Specialist Program through Virtua/West Jersey Hospital has been a very successful part of the Camden Healthy Start Project. They have provided case management including support and advocacy through the legal system, employment and vocational training programs, and health and family services to their clients. The twenty-four (24) hour, seven (7) day a week case management was provided for crisis intervention for substance abusing women. The Alcove program provided bus vouchers from the HMHB Outreach Program to clients which resulted in a higher rate of follow through with recommended prenatal care services and other treatment for addressing substance abuse concerns. Medical transportation was also provided for

women to receive inpatient substance abuse treatment in Northern New Jersey, which would have otherwise been impossible for them to receive. Alcove also had a high degree of collaboration with other Healthy Start subcontractors, such as the Outreach program, which was instrumental in assuring that client needs, other than substance abuse treatment, were being met, such as providing car seats, cribs, and other miscellaneous items which assure good infant care, as well as the previous cited bus vouchers. The Risk Reduction Specialists referred clients to Sikora when appropriate. For example, if a client spoke little or no English she could not be referred to Sikora, which has no bilingual staff. The Risk Reduction Specialists were also available to the Healthy Start funded adolescent services and are now active on the Adolescent Committee. The Risk Reduction Specialists are on site at the city's prenatal clinics on a regular basis, and visit various community locations. This strong collaboration with other Healthy Start services, substance abuse treatment centers and other health and social services providers resulted in a process through which women experienced a seamless transition throughout the case management and treatment process. Further, clients were also given the option of meeting the Risk Reduction Specialists at public places in order to increase the effectiveness of the engagement process into the program. This also served to educate community agencies and resource centers to the nature of the Healthy Start and Risk Reduction Programs. Alcove also frequently participated in health fairs in order to increase the community's knowledge of the availability of services to pregnant and postpartum substance abusing women and their families. Education was a large component of the Risk Reduction program, as community and client education increased the awareness of consequences of substance abuse on pregnant women. This education also provided information on how to decrease or eliminate the usage of substances harmful to the client, infant, and family. Community networking by the Risk Reduction Specialists was instrumental in decreasing stress related barriers resulting in higher utilization of network resources available to help meet client specific needs such as emergency housing, food, medical care, clothing, and state entitlements. As part of the program, contact with the clients was continuous, which allowed for individuals to receive services and maintain contact with a support network allowing the opportunity for re-engagement into the recovery process.

During Year 01, the Alcove Risk Reduction Specialists began the process of establishing relationships with the local substance abuse treatment centers, local hospitals, and other Healthy Start service providers. In Year 02, services were implemented and sixty-six (66) women received services at Alcove. Fifty-eight (58) of these clients were prenatal, while five (5) were postpartum clients. Of the fifty-eight (58) prenatal clients, twenty-two (22) entered prenatal care in their first trimester, seventeen (17) in their second trimester, three (3) in their third trimester, and the remaining sixteen (16) did not report when, during the course of their pregnancy, they entered prenatal care. Information regarding pregnancy status for the remaining three (3) clients is not available. Overall, three (3) clients were between the ages of fifteen (15) and seventeen (17), three (3) were between the ages of eighteen (18) and nineteen (19), and fifty-four (54) were over age nineteen (19). The remaining six (6) clients did not report their age. Thirty-three (33) clients were African-American, seven (7) were White, and twenty-six

(26) were of an unknown or other race. Twenty-four (24) clients reported their ethnicity as Hispanic/Latino.

During Year 03, fifty-five (55) women received services from Alcove. Forty-eight (48) were prenatal clients, while seven (7) were postpartum clients. Of the forty-eight (48) prenatal clients, four (4) were between the ages of fifteen (15) and seventeen (17), five (5) were between the ages of eighteen (18) and nineteen (19), while thirty-nine (39) were over the age of nineteen (19). Thirty-three (33) reported their race as African-American, eleven (11) were White, and the race of four (4) is unknown. Fifteen (15) prenatal clients reported their ethnicity as Hispanic/Latino. Twenty-six (26) prenatal clients entered prenatal care in their first trimester, fourteen (14) in their second trimester, five (5) in their third trimester, and three (3) did not report when, during the course of their pregnancy, they entered prenatal care. All seven (7) postpartum clients were over the age of nineteen (19). Further, three (3) were African-American, three (3) were White, and one (1) reported her ethnicity as Hispanic/Latino. The race of one (1) postpartum client was not known.

During January through June 2001, Year 04, Alcove served seven new (7) clients. Six (6) were prenatal clients, and one (1) was postpartum. Of the six (6) prenatal clients, one (1) was between eighteen (18) and nineteen (19), while the remaining five (5) were over age nineteen (19). Three (3) were African-American, and three (3) were White. Three (3) reported their ethnicity as Hispanic/Latino. Five (5) entered prenatal care in the first trimester, and one (1) entered care during the second trimester of her pregnancy. The one (1) postpartum client was over age nineteen (19), and White.

Further, twenty-seven (27) clients have had previous DYFS involvement at the time of enrollment in Alcove, thirty-four (34) had received prior drug treatment and twenty-one (21) had previous children born drug exposed. The majority of clients are polyaddicted. Eleven (11) clients reported having had psychological problems, eight (8) report being victims of sexual abuse and nine (9) report being victims of domestic abuse. And fourteen (14) clients were on a methadone regiment to manage their heroin addiction.

Some additional outcomes from the Alcove Risk Reduction Specialists -

In order to investigate the success of the smoking cessation and health issues education offered to clients, pre and posttests were administered. Data from these posttests is available from Years 03 and 04 (January – December 2000, January- June 2001). All pre and posttests are scored by counting the number of wrong answers given by the client. Twenty (20) clients took both pre and posttests on addiction. The mean number of wrong answers on the pretest was 2.40, while the mean number of wrong answers on the posttest was 1.25, an improvement of 1.15 points. A total of eighteen (18) clients have taken both pre and posttests regarding smoking cessation and the effect of smoking on health. The mean number of wrong answers given on the pretest was 1.44, while the mean number of wrong answers given on the posttest was 1.67, which is 0.23 more wrong answers on the posttest. This test and curriculum need to be reviewed to revise the learning objectives as clients seem to already know the information being

taught. Additionally, a drug use measure has been used since May 2000. Since that time, nineteen (19) women have showed evidence of increased drug use for at least one (1) month. The remaining clients have either completely abstained, decreased, remained the same, or began a methadone regiment. However, data for over twenty-five (25) clients is not known, which makes it difficult to ascertain their drug use status for the time that drug use records have been kept. A new way of keeping this drug use data is being developed.

Many barriers and changes to the original Logic Models and project period objectives were encountered by Alcove. First, the inability to provide detoxification due to reimbursement issues by Medicare and Medicaid seriously affected the efficacy of the Alcove program. The number of pregnant women in the program was affected by the program's inability to provide inpatient detoxification. Also, some clients were engaged in two separate treatment programs at one time, which did not work. Clients experienced a high level of stress which increased the potential for relapse and the development of resistance towards following the recommended treatment plan. Philosophical differences between providers interfered with the delivery of services. Also, a system to meet the federal confidentiality regulations was not available through the local hospital system. Throughout the county, there is a general lack of treatment slots available. A high demand exists for gender specific treatment and the availability of those treatment slots are insufficient resulting in the client being placed on a waiting list, which often results in the loss of interest in the level of care recommendations and in recovery as a whole. There is a limited amount of childcare available to clients, which resulted in women not following through with recommended treatment plans. This lack of childcare caused an interruption in the clients' focus on the counseling and group dynamics sessions due to the constant interruptions as a result of responding to their child's needs. The lack of transportation also created problems for clients, especially if they needed to access services outside the city. The lack of funding for necessary infant care items resulted in the direct loss of client service time due to time spent by Risk Reduction Specialists on acquiring the necessary items to have custody of an infant. As previously mentioned when discussing limitations encountered by the Sikora Center, housing continues to be a problem, which was often discussed by the Substance Abuse Committee (and Community Network). This lack of housing increased the amount of stress these already vulnerable women were under. Emergency housing services were also a barrier encountered by Alcove. There was a lack of space in which to confidentially interview clients in shelters. The process for accessing emergency housing did not allow for effective crisis intervention.

Additionally, servicing women in the County Jail proved to be difficult as clearance was required during each visit and thus, limited direct time spent with the client. One major barrier facing the Alcove program was the lack of an inpatient treatment facility within the project area. The lack of a local facility often resulted in women losing their motivation to follow through with the needed recommended level of care. Also, there were few available slots for women, and often long waiting lists for admission into one of these non-local centers. There was also a lack of residential services for Mentally Ill Chemically Abusing (MICA) Clients, and pregnant and

postpartum clients. A lack of funding slots for treatment also adversely affected the clients. Another problem was that overall, there seemed to be a lack of understanding by other subcontractors and community agencies regarding the American Society of Addictions Medicine (ASAM) criteria. Inconsistent diagnoses within the provider network resulted in clients being placed in an inappropriate level of care. Alcove was unable to provide ASAM training due to personnel changes. Other issues include the inability for treatment providers to work together in the development of a comprehensive treatment plan that specifically addressed the needs of the mother and her newborn, to assist in the bonding process. There was also the inability of providers to work with the client's family, which may increase the chances of relapse, domestic violence, loss of family and treatment drop out. Further, language barriers existed and increased the Latino clients' level of anxiety, as they experienced the inability to communicate with treatment staff. Finally, some of the various treatment centers in the local area did not offer individual counseling sessions which increased the client's difficulty in addressing personal life issues that were felt to be too emotional or too risky in a group setting.

As a result of these many challenges and revisions, the Alcove program was able to identify some lessons learned. First, the need to review the interview process. The interview process needs to include representation from other aspects of the Risk Reduction Program. The client interview process also needs to be shortened, as clients are unable to maintain focus for long periods of time. One major lesson learned is the importance of confidentiality to the client. The stigma of being a substance-abusing mother is very harsh and has been cited as a significant reason for forgoing treatment. It is vital that confidentiality be maintained in order to treat the addiction disease. Further, the collaboration with the Outreach staff proved to be invaluable in identifying and engaging substance abusing clients in the Risk Reduction programs. Additionally, working with the Adolescent model, especially the Lion's Den and Teens on Track was quite successful in capturing the teenage population which might not be captured by the Outreach staff. As a whole, the Risk Reduction program offered the opportunity to engage the client's significant other or family members in the treatment process. The need for a multidisciplinary treatment center allowing for a holistic approach to addressing women's health issues and needs became evident. This would allow for a "one stop shop" for women to obtain the care and services they need to take care of themselves and their families.

4) **Teratology Information Services (TIS)**

The SNJPC's TIS is a telephone information service, developed in 1996, to provide clinicians and pregnant women in the seven (7) county southern New Jersey region with research-based advice regarding teratogenic effects of medications and other substances. Healthy Start funds were dedicated in Year 01 to support this program with the expectation that pregnant women and providers in Camden could use the telephone hotline to anonymously discuss concerns about exposure to substances, including use of illicit drugs and get referral to prenatal care and substance abuse counseling.

In order to publicize the hotline, staff conducted inservice sessions with Camden prenatal providers and conducted presentations at HMHBC forums in Year 01. Brochures

and wallet cards were distributed in prenatal care sites and in the community. Because few calls were received in Year 01, a brochure was redesigned for Camden consumers in Year 02 by the Substance Abuse Committee. This process took several months and included client focus group review and revision. Brochures were again widely distributed. Despite these efforts, minimal numbers of clients were documented in the TIS hotline database as Camden residents. Therefore, Healthy Start funding for this initiative was discontinued in Year 03. The TIS hotline continues to serve as a resource for Camden residents and promotional efforts continue as well, despite the discontinuation of Healthy Start funding. TIS is utilized by both providers and consumers in other areas of the region.

Outcomes (Camden city residents use of TIS):

1998 ... no data available due to start-up activity.

1999 ... 5 callers referred to prenatal care and substance abuse counseling

2000 ... 4 callers referred to prenatal care and substance abuse counseling

2001 ... 4 callers referred to prenatal care and substance abuse counseling

Data on gestational age and weight is known for eight (8) callers from 1999 and 2000. Four (4) callers who have utilized TIS in 2001 have yet to deliver. The average gestational age for TIS clients was thirty-seven (37) weeks, and the average gestational weight was 2967 grams. This includes one very low birth weight baby who was born under 1500 grams. This baby was also premature and was born at the 25th week.

5) Fetal Infant Mortality Review (FIMR)

Although Healthy Start funds were not dedicated to the FIMR process until the end of the project, seventy-six (76) cases were reviewed over four years. The FIMR case review process resulted in the documentation of case-specific issues as well as the discussion of potential system barriers and improvements that occurred during the networking opportunity offered at the bimonthly meetings.

During Year 04, funds were dedicated to home visits for the purpose of maternal interviews. Many home visit attempts have been made in order to secure four (4) maternal interviews. Information gathered during these interviews will be reported at the case review team meeting in September, 2001.

Listed below are some of the case-specific issues that were identified in FIMR case review sessions. These issues were discussed at a case review team meeting and recommendations were made regarding issues that required action and what action should be taken. The recommendations were, when appropriate, reported to relevant HMHBC committees and members for the development of strategies to improve the system of health and social services care for Camden families. HMHBC committees are responsible for the development and implementation of those community-based strategies. Some issues were:

1. Referrals to WIC and nutritional counseling were not done on eligible, anemic pregnant woman.
2. A patient with a 26-week gestation fetal loss was managed in the emergency room. No drug screen was done. She returned to the emergency room having delivered the placenta at home.
3. DYFS should be notified even in cases of a stillbirth with substance use because of the implications for other children in the home. The best phone number for providers to use after work hours or on weekends for notifying DYFS is the 1-800 number.
4. Three (3) cases with a history of substance abuse in the current or past pregnancy, combined with an unstable home situation resulted in an unexplained infant death. These cases should be referred to the Risk Reduction Specialist Team for intensive case management. This case management should be community-based with risk reduction specialists available by beeper to meet clients at home or where they are comfortable.
5. The team discussed the importance of reporting prenatal information to Labor & Delivery prior to 34 weeks. In light of opportunities and plans for electronic transfer of information, they suggested that 28 weeks be considered the initial reporting period, with at least bi-weekly updates.

(D) Consortium Building

Introduction - The Healthy Mothers, Healthy Babies Coalition of Camden City as the Healthy Start Consortium

The SNJPC, the grantee agency for the Camden Healthy Start Project, is a state recognized Maternal and Child Health Consortium which oversees the Healthy Mothers, Healthy Babies Coalitions within the seven-counties of South Jersey. The Healthy Mothers, Healthy Babies Coalition of Camden City (HMHBC), historically and presently, is one of the strongest HMHB coalitions in the region. HMHBC has been in existence since 1985. Healthy Mothers, Healthy Babies is a national program that is licensed out to different communities. Until the Replication Phase funding for Healthy Start, the HMHBC was funded solely by the NJDHSS as a program of the SNJPC. The HMHBC has involved Camden area healthcare providers and social service workers, along with community based organization representatives and leaders since its inception in working together around maternal and child health issues. It was well positioned to become the Healthy Start consortium in 1997 and embarked on an ongoing effort to expand to include other stakeholders, including clients of Healthy Start services.

The HMHB Outreach Program had been the major service component of the HMHBC, and continues to be well connected with the City's perinatal and pediatric providers. The HMHBC serves as a vehicle for mobilizing community members when

issues related to health and or social services delivery require advocacy. An example was HMMHBC involvement in educating both providers and the community about transition issues related to Medicaid managed care, and its helping the State to anticipate barriers.

The HMMHBC's major challenge under Healthy Start was to assure the involvement on the consortium of more clients as consumers, to support consumers as equal partners and to reframe the providers' perspective that their primary role is to be a community resource while sharing power with clients of services and other consumers.

Original Project Period Objectives and Performance Measures for Consortium Building

Within the original grant proposal for the Camden Healthy Start Project there were four Consortium Model specific project period objectives and performance measures. HRSA labeled performance measures related to consortium building C1, CM4 and CM6. Original objectives were as follows:

- 1) Increase the number of consumers in the HMMHBC and involve as equal partners (CM4).
- 2) Provide an environment and method by which providers, consumers and other stakeholders can meet together in overseeing the Camden Healthy Start Project.
- 3) Establish a process for a common vision for HMMHBC members, a strategic plan and ongoing monitoring for Healthy Start (C1).
- 4) Conduct ongoing training and support to enable the HMMHBC to successfully implement the Camden Healthy Start Project (C1).

Another national performance measure (CM6) related to the percentage of consortium members who speak English as a second language. In 1997 there were four (4) Latino providers and 0 Latino consumers on the HMMHBC.

The HMMHBC utilized a Logic Model in establishing a strategic plan for consortium building as it did with the service related Healthy Start models. Expected Outputs were as follows:

- Community/provider membership is representative of program services to be delivered, with an increase in community/consumer participation in the HMMHBC.
- Two to four focus groups of community/consumers and providers are conducted to assess needs and solicit input to market the HMMHBC and its Healthy Start Project.
- Implement consortium trainings around Cooperation, Team Building, Conflict Resolution, Cultural Sensitivity, among other topics of membership interest and needs.
- Conduct a consortium retreat utilizing the Future Search methodology to assure a shared vision among stakeholders.
- Identify barriers to working as a partnership and problem solve.
- Finalize consortium operating procedures.

- Hold regular consortium meetings that relate to oversight of Healthy Start and services.

An analysis was conducted on the membership of the HMMHBC to determine a baseline measure and to track the impact of Healthy Start funds in the support of consortium building and the further development of the HMMHBC. In 1997, the baseline year when HMMHBC/SNJPC received Healthy Start Replication Phase funding, there were 171 HMMHBC members. The HMMHBC definition of “providers” is: anyone who either works within the healthcare field and or has a medical or health related degree. Therefore, social service workers without such degrees are considered to be a type of “consumer”. This is a much broader view of “consumer” than HRSA’s definition, which is a client of Healthy Start services. The HMMHBC identifies 5 types of consumers. They are: 1) Camden City residents, who may be clients or relatives of clients of Healthy Start services, 2) Non residents of Camden City who also don’t work in the healthcare field, 3) Church representatives/religious leaders, 4) legislators/legislative aides and 5) social services representatives. Camden City residents are viewed by the HMMHBC as “primary consumers”. A Camden City resident who works in the healthcare field is still considered a “provider”. In 1997 only 14 HMMHBC members were classified as “primary consumers” (Camden city residents). Only four of these “consumers” were former HMMHBC Outreach Program clients or relatives of clients.

During this past 4-year period, the HMMHBC achieved all of its original consortium building performance measures and expected outputs to some degree. The following sections will summarize levels of achievement, discuss gaps, barriers and issues relevant to consortium building, and discuss ongoing efforts in problem solving.

Enablers and Achievements

The HMMHBC first adopted a definition of consumer types to help strategize recruitment methods. The HMMHBC membership assessment was completed during the first quarter of 1998. Identified stakeholder gaps included: management level HMO representatives, more Latino and Asian representatives, representatives from law enforcement, Work First New Jersey Program for Welfare reform, day care representation and parent coordinators from the school district, among others.

There has been tremendous development of the HMMHBC as the Healthy Start consortium during the initial grant period under the National Healthy Start Replication Phase. As of 6/30/01, there was a total HMMHBC membership of 470, with 332/470 (or 71%) being classified as a type of consumer. There are 77 Latino members (16%) of whom the majority are a type of consumer. Under the consumer category, membership is further delineated as follows. There are 213 primary consumers or Camden City residents, 48 non-resident consumers, six (6) legislators/legislative aides, five (5) church representatives/church leaders and 60 social services representatives. The HMMHBC has 138 provider members.

A large percentage of the primary consumers are school district parents and parent coordinators. The HMMHBC chairperson for two years was a Community School Coordinator, a strong enabling influence, who recruited parents for the HMMHBC. The non-resident consumers often live right outside of Camden City and many grew up in Camden. They still have strong allegiance to the city because their relatives and friends still live in Camden and or they themselves work or go to church in the city. The current city council president has been an active member of HMMHBC and also serves on the Executive Committee.

Currently, within the categories of consumers is representation of a wide range of stakeholders, including ethnic diversity, school district parents, community based organizations/community leaders, representatives of court system, juvenile justice, police department and other city employees, DYFS, daycare, United Way, the Empowerment Zone, homeless programs, YWCA, and city council to cite a few. As stated previously the vast majority of HMMHBC members were healthcare providers and social service workers who had a history of partnership. This is an enabling factor. Camden City providers know when to put their differences and competitiveness aside to partner for the good of the community. However, there was a challenge to overcome. They had viewed the paraprofessional HMMHBC Outreach staff as the “consumer voice”. Indeed, the Outreach staff were residents of Camden City and key informants about consumer needs based also on their client advocacy role. But they had become part of the provider team based on training and such outreach services as linkage to care and health education. Both HMMHBC members and staff had to reorient their perspective of “consumer”.

Other enabling factors that supported consortium building include the following. The HMMHBC Executive Committee identified necessary changes in how HMMHBC Coalition meetings were conducted, and submitted revisions to the HMMHBC Rules of Procedures that would support more meaningful consumer participation. For example, Coalition meeting time and location were changed to evenings and held at varied community-based sites like churches and community centers to accommodate working consumers and be more consumer-friendly. Previously, the Coalition meetings had been from 10:00 am to 12:00 noon at a hospital site. The structure of Coalition meetings also was revised. Business and reports were primarily agenda items at standing committee meetings and the Executive Committee. Coalition meetings became more of a town meeting, with presentations and discussion around topics suggested by consumers and less time spent on Coalition business. Revised *Rules of Procedures* also incorporated expanded slots for consumer representation on the Executive Committee. At the 1998 Annual meeting of HMMHBC, eight (8) new Executive Committee members were elected, with five (5) being consumers. Equal partnership for consumers and providers was now reflected even within the officers of the Executive Committee. There were now two Vice Chairpersons, with one being a consumer, and one a provider. The Chairperson role now alternates terms between a consumer and a provider. All HMMHBC standing committees began brainstorming ways to get consumer participation and tried various strategies which included rescheduling meetings, conducting consumer (client) focus groups and implementing surveys.

There were two lead “consortium building” agencies who conceptionally partnered to implement relevant strategies and oversee progress towards the performance objectives. The SNJPC, as grantee agency, along with the subcontracted “technical advisor”, the Camden Area Health Education Center (AHEC).

During Year 01 a HMMHBC initial promotional brochure was designed to help recruitment efforts. Its drafted version was used during a total of eleven (11) consumer focus groups to determine the target communities’ knowledge of the HMMHBC and Healthy Start. A total of 123 primary consumers participated in these focus groups. AHEC conducted a Focus Group Facilitators Training for 24 HMMHBC members. AHEC also conducted three community meetings during the first year to collect preliminary information on community perception of infant mortality and knowledge of the HMMHBC, as well as to introduce the Camden Healthy Start Initiative. The HMMHBC hosted its Healthy Start Kick-off Event, “ Growing Healthy Families”, in August 1998, which included the Name-that-Van Contest for the new outreach program van. This kick-off had over 500 Camden City residents in attendance.

HMMHBC Standing Committees were further developed during the first year. Each Healthy Start Service Model had a HMMHBC standing committee to oversee development and implementation of Healthy Start funded services. Furthermore there are the Evaluation Committee, Communications Committee, Nominations and Rules of Procedures Committee. An Awards Committee and Consortium Building Committee were ad hoc. AHEC organized a peer mentors group for consumers called “The Navigators” to recruit and mentor other consumers. Standing Committees meet either monthly or bimonthly. The service related standing committees often have subcommittees or task forces. For example, the Substance Abuse Committee has several subcommittees such as the Leadership Team that received training at the Chicago Research Triangle with Dr. Chasnoff , and the Substance Abuse Treatment Task Force. This Task Force conducts site visits to treatment programs to assess similarities and differences, and identify gaps and needs.

During Year 01 a total of 295 HMMHBC members received AHEC training regarding the HMMHBC, of whom 230 were consumers and 65 were providers. Of the consumers, seven (7) were youth clients of Healthy Start adolescent programs who participated on the Adolescent Committee.

During the second year a total of 81 HMMHBC members received AHEC training around such topics as: “The Art of Advocacy”, “Organizational Skills” and “Career Development”. The HMMHBC sponsored an Open Space Retreat with 23 HMMHBC members who participated in strategic planning and development of a shared vision for membership. A very successful Consumer Empowerment Session with 50 primary consumers was held as part of the HMMHBC’s state partnership grant activity in October 1999. This training prepared for the participation of consumers in the State Maternal and Child Health Summit, “Addressing the Gaps Through Partnerships” which was held for 170 participants on November 5, 1999 in collaboration with the Essex County Healthy Start and the NJDHSS–MCH Title V Section. The 50 Camden consumers gave input

about needs and new ideas while expanding their perspectives of maternal and child health issues by interacting with consumers from Newark, statewide providers and state health department professionals. HMMHBC's Communications Committee coordinated the development of the Camden Healthy Start multi-media public awareness campaign. This included the selection process for an advertising agency, input on community surveys and focus groups and the actual production of literature, video and PSA's for radio and television. The public awareness campaign began the latter part of 1999. As cited within annual reports, subsequent campaign surveys of residents showed the effectiveness of this campaign, with the majority of survey participants remembering the television PSA's (cable), radio spots and billboards.

During the third year and as follow-up to the state partnership initiative, the HMMHBC sponsored a two-day program for the 50 primary consumers who had participated in the previous empowerment session and state summit. AHEC conducted on June 15, 2000 a half-day training on "How To Be A Self-Advocate", a need identified during both the empowerment session and state summit. On the second day of this program, the 50 consumers visited Washington DC and Baltimore. The Blacks in Wax Historical Museum highlighted individual and group advocacy, struggle and achievements from ancient Africa through modern times. Participants also visited the Smithsonian Museum's "From Fields to Factories" which focused on the Civil Rights Movement. And Camden consumers visited Capital Hill and discussed maternal and child health related legislation, including that related to Healthy Start. Consumers initiated a petition in support of this legislation and forwarded post cards to their congressmen.

Also during Year 03 a total of 257 HMMHBC members received training from AHEC on team building, partnership building and NAB training. The HMMHB field staff coordinated the development of NABs, which provide input to the HMMHBC about services and needs. Each of the four HMMHB Outreach Teams has a respective NAB. As of 6/30/01 the membership of NABs are as follows: I) Central Site NAB has 37 members, II) East Camden NAB has 15 members, III) the North Camden NAB has 47 members and IV) the Parkside NAB has 35 members. NAB members are mainly primary consumers or neighborhood residents. The North Camden NAB however, had been primarily providers. NAB members are automatically placed on the HMMHBC and are counted within its membership. NAB members receive all HMMHBC mailings, including newsletter, quarterly calendar and notices about the HMMHBC bimonthly consortium wide meetings. AHEC conducted special NAB trainings and other guest speakers covered topics of interest to NAB members. A team building session was part of the HMMHBC Annual Meeting in the third year, with 86 members present, of whom 48 were consumers. Another training conducted by AHEC was "Building Community-Provider Partnerships" with 11 members participating, of whom 5 were consumers.

The HMMHBC sponsored a very successful 2-day retreat on August 23-24, 2000, "Precious Gems Of The Community...Sustaining The Healthy Start Initiative", with 120 HMMHBC members participating, of whom 39% (47) were primary consumers. There were 10 youth who participated and the age range of all attendees was 11 to 70 years old.

The report from this retreat, which outlined a shared vision for future HMMHBC programs and activities, is a road map for the Executive Committee, Fund Development Committee and other standing committees. For example, the Fund Development Committee incorporated the priorities from this HMMHBC retreat within its Fund Development Strategic Plan. The retreat report, previously sent to HRSA, appears in the appendices.

Barriers and Challenges

Consortium building is an ongoing process. Volunteer membership levels of involvement change as individuals experience life changes, such as new employment opportunities, relocation or family dynamics. There are gaps in stakeholder representation which are opportunities for further development. The HMMHBC does not have any Asian members. The HMHB outreach staff had an Asian worker for a very brief time. Although Camden City still has a relatively small Asian population, it is growing and may have greater representation among the client population in the future. The Community Network Committee has had great fluctuation in the participation of prenatal providers and HMO representatives. This ranges from the Community Network Committee being primarily prenatal providers, HMO representatives and HMHB field staff to current low participation due to significant staff layoffs experienced by prenatal clinics and HMO's. Past representatives are either no longer employed or due to staff shortages can't attend meetings. However, prenatal providers are integrally involved within Healthy Start substance abuse services and HMHB outreach services. Risk Reduction Specialists and HMHB field staff are based at these sites on a regular basis, and prenatal providers refer clients to these staff for outreach and linkage to services. The HMMHBC plan to recruit prenatal providers to its Evaluation Committee and will also involve them within the care coordination subcommittees that have begun and will be part of all the service related standing committees. HMO representation is active on the Substance Abuse Leadership Team, with the nurse director for utilization review from Horizon Mercy as a member. Also another Horizon Mercy manager is active on the Evaluation Committee, Executive Committee and has begun participating with Community Network. Horizon Mercy is the largest Medicaid managed care organization in Camden City. The Adolescent Committee has also fluctuated in participation of non-Healthy Start funded adolescent services providers. This committee made a strong recruitment effort during its Adolescent Services Networking Forum held October 2000. This forum brought together school district staff (i.e. nurses, health teachers, guidance counselors) with community adolescent service providers, including Healthy Start funded programs. This increased interest in the committee and the committee expanded its focus to begin addressing system wide issues that impact adolescent services. This will continue within the new grant period for the Camden Healthy Start program.

A major challenge for the HMMHBC is the involvement of Healthy Start clients. Strategies such as hosting meetings in the evenings at community-based sites, providing dinner, welcoming children during meetings and offering door prizes have attracted community residents. However, actual client participation remains low. The Leadership Team has a former client, the immediate past chairperson and current vice-chairperson of Community Network is a mother of a former client, and clients have participated in focus

groups. The Adolescent Committee found that it was more productive for the youth to have a separate advisory group that sent a representative periodically to meetings. Therefore, standing committees sought client input through special interviews, surveys and focus groups while trying to identify those who would attend meetings. Many clients have major life issues to address and also must adjust to the requirements of Welfare-to-Work. Clients involved in education and training or employment have varied schedules. Some standing committees varied their regular meeting times and have tried breakfast, lunch, late afternoons and evening dinner meetings to accommodate client schedules. However, this has not met with much success. The HMHBC is embarking on a pilot “Coalition Meeting Attendance Incentive Program” which will give extra points to HMHBC leadership and staff for client involvement in meetings in hope that new creative strategies will surface. A special gift certificate will be presented at the end of each month to the member who involves the most consumers in HMHBC meetings.

Another major challenge was the development of Neighborhood Advisory Boards (NABs). HMHB outreach supervisors had the primary responsibility of organizing respective NABs with the assistance of a HMHB Community Development Specialist. Although supervisors received an initial orientation on volunteer recruitment and community development, their expertise was not in these areas. Team issues with a former Community Development Specialist also served as a barrier to NAB development. Field staff turnover further slowed the process. In the original Camden Healthy Start proposal it was planned to have NABs as part of the Camden Learning Collaborative’s “Living Rooms”. The Learning Collaborative and the HMHBC participate on each other’s consortia. Living Rooms are the neighborhood based groups for the Learning Collaborative. It was originally thought that since these two consortia had health related missions, albeit the HMHBC was more focused on maternal and child health, that the Living Rooms would have subgroups or HMHB neighborhood advisory boards to work with the HMHB field staff. HMHBC did co-locate its outreach teams at Learning Collaborative Living Rooms where appropriate. However, the structure, by-laws, developmental processes, politics and operations of the Learning Collaborative and the HMHBC were too complex to have one organization be a “subgroup” of the other. Therefore, HMHB NABs were organized separately, as entities of the HMHBC.

A significant challenge surfaced in having two different agencies taking a leadership role in consortium building, that of AHEC and SNJPC. AHEC created the consortium’s consumer peer mentoring group, the Navigators. Navigators were to recruit consumers to HMHBC, facilitate some consumer training and mentor consumers about their role on the HMHBC. However, many community residents and other stakeholders were confused about what they were being recruited for, the HMHBC or AHEC. And understanding the relationship between AHEC, SNJPC and the HMHBC was a challenge for some stakeholders. SNJPC later addressed this by decreasing AHEC’s role to training, and by Year 04 involved AHEC as only a consortium member rather than a Healthy Start subcontractor. Many “navigators” stayed involved with AHEC as an agency, while a few opted to be incorporated onto the HMHB NABs. SNJPC as the Healthy Start grantee with the leadership role for consortium building now had more quality control over consortium related orientation, training and reports. It should be

noted that AHEC's reporting system met its agency's needs, but was difficult to understand and incorporate within the centralized Camden Healthy Start database and evaluation system.

The HMMHBC began implementation of a consortium member satisfaction survey starting October 1999. The survey was administered during consortium related meetings and a survey mailing was conducted. An incentive was not used because it was initially believed that this would not allow anonymity, which would decrease response rate. However, only 17.5% of the HMMHBC membership completed and returned the survey. Survey results were reported within the Year 03 Annual Report. Of the respondents, 45% were primary consumers. No youth members were represented in this sample. The ethnicity of the respondents were 49% African Americans, 27% Caucasian, 15% Latino and one respondent cited being Asian. Respondents reported a high level of consortium participation, with the majority being satisfied with their orientation. The vast majority rated meeting purposes, logistics, and outcomes as good or very good. The 2000 consortium member satisfaction survey included an incentive drawing for a \$50 American Express Check. The survey mailing to all membership was conducted in October 2000. Response rate was still low and the survey was also conducted at the Annual Meeting held March 2001. Eighty-four (84 or 18.5%) surveys were completed and returned. The majority of this sample was primary consumers (52.4%). The sample also included youth (3%) with the youngest being 10 years old. Additionally 64.3% were African American, 26.2% Caucasian and 7.1% Latino while the remainder were other and unidentified. The survey report appears in the appendices. Results indicated that the majority of respondents were satisfied with the work of the consortium, their orientation and training and their own level of participation. The future challenge is to increase the consortium member satisfaction survey return rate in order to have a more accurate depiction of member satisfaction. The incentive did not significantly impact the response rate, nor did combining mailings and distribution at consortium meetings. Anonymity was continued with the incentive as the survey drawing form was returned separately from the completed instrument.

There is a continued need to increase Latino membership to reflect the percentage of Latinos within the Camden City population (31.2%). Bilingual and Spanish marketing materials will continue to be used and developed, as well as outreach to Latino organizations. There is also a need to increase participation of religious leaders and male consumers in general. The HMMHBC has a challenge to assure that the community is aware of the importance of male input and that male support services are a component of Healthy Mothers, Healthy Babies in spite of the fact that this "national" name and logo excludes the fathers. The HMMHBC is prevented from altering its name and the HMMHB logo because it is part of the National Healthy Mothers, Healthy Babies program. However marketing materials must creatively include the importance of fathers.

Consortium Related Lessons Learned and Recommendations

The HMMBC's experience to date has resulted in the following lessons learned and recommendations:

- Only one agency should have the primary leadership role in consortium building to prevent stakeholder confusion and for quality control in orientation, training and consortium reporting. It makes most sense that this would be the grantee agency.
- Consortium building, like community development, is an ongoing process which needs adequate staffing, resources, time and involvement of the volunteer consortium leadership.
- Client involvement in meetings will take creative strategies that vary depending upon types of clients (i.e. youth vs. adults, substance abusers, teen parents).
- There are many ways to involve clients other than just meetings (i.e. focus groups, surveys, special task forces, mentorships).
- Consumer involvement in general involves rethinking the way a consortium does business, including the structure and purpose of meetings, use of attendance facilitative services, types of by-laws, orientation, training and methods of leadership opportunities for consumers.
- Changing consortium operations to be more consumer-friendly sends a strong message of the desire for equal partnership between providers and consumers.
- Responsibility for consortium building should be given to staff with community organization and community development skills, and who have this as their primary responsibility as this is a labor intensive endeavor.
- Recruit some stakeholders to the consortium who have the ability to attract others, and who also have good skills in community development to support staff in ongoing consortium building.
- Networking with other organizations is important, but it is unrealistic to combine organizations with complex structures. However, collaboration can still take place and be beneficial to both organizations (i.e. sharing sites, co-sponsoring events).

VI. PUBLICATIONS/PRODUCTS

A listing of the publications and other materials developed during the first four-year phase of Camden Healthy Start appears in the appendices with sample copies. Intended audiences are also included within this listing.

VII. DISSEMINATION/UTILIZATION OF RESULTS:

There are plans to share results of the initial phase of the Camden Healthy Start Project with many stakeholders, including the NJDHSS, SNJPC Board of Directors, HMMBC membership, local, state and federal legislators, corporate sectors and other potential funding sources. Outcome data and program successes will be incorporated into a fund development marketing piece to support sustainability efforts. The Camden Healthy Start Marketing Campaign materials have already been shared at national and

regional Healthy Start meetings. The National Healthy Start Resource Center has received materials during this period. And program experience is shared at state Healthy Mothers, Healthy Babies Coordinators meetings, as well as at various planning and community advisory groups at the local and county levels. Examples include the Camden County Department of Health & Human Services (CCDHHS). A presentation on Camden Healthy Start was given at a CCDHHS staff inservice sponsored by its Black Infant Mortality Committee. Information has also been shared during meetings of the Rowan University Urban & Public Policy Institute's Community Outreach Partnership Center, the Community Health Workers Advisory Committee and the Planning Committee of the Building Sustainable Healthcare Collaborative Networks and its Camden City Healthy Futures Committee.

VIII FUTURE PLANS/FOLLOW-UP:

The HMHBC is planning to implement the recommendations cited throughout this document. Many of these recommendations and lessons learned were incorporated within the "Eliminating Disparities in Perinatal Health" phase funding for Camden Healthy Start. Multi-agency, multi-disciplinary case conferencing had already begun by the HMHB Substance Abuse Committee during Year 04, and identified system issues are being addressed in its strategic plan developed under the consultancy of Dr. Ira Chasnoff and associates. The HMHB Adolescent Committee is planning a subsequent networking forum, "Being A Better Bridge for Adolescents and The Services They Need", to further problem solve system issues and recruit more stakeholders. Previous interventions that were not as successful as others were not incorporated within the Camden proposal for Eliminating Disparities phase. The HMHB Outreach Program has expanded into inclusion of case management with an upgrade in staff qualifications and job descriptions. SNJPC continues agency wide standardization of the HMHB Outreach and Case Management Program, with staff strategic planning sessions with Camden and Atlantic City Healthy Start sites. And consortium building continues under the leadership of the grantee agency with the implementation of new strategies. For example, the NABs are now recruiting members through church-based feeding programs where presentations about HMHB and discussion of residents' interests and needs are part of these gatherings. The Evaluation Committee is planning local evaluation components up front and has identified a minimum data set for all subcontractors to guide the development of data collection instruments, rather than depend on HRSA defined performance objectives only, a lesson learned during the first phase experience.

IX SUPPORT AND RESOURCES NEEDED:

Camden Healthy Start Project activities were easily adapted in response to community needs throughout the four year project. Factors related to the grantee agency's organizational structure and the HMHBC governance structure made this possible:

- The grantee agency is a non-governmental, non-profit, regional maternal and child health consortium that is licensed by the state of New Jersey. Fiscal procedures and

decisions are, therefore, not rooted in a bureaucratic structure. The agency has a decade of grant management experience with the state and large foundations.

- Subcontractors carried out more than half of the Camden Healthy Start Project activities. The project director was responsible for assuring that subcontractors were accountable by matching monthly invoices to monthly narrative reports. When planned activities were not possible or successful because of unforeseen obstacles, budget and program changes were made easily and in a timely fashion.
- The governance structure of the Camden Healthy Start Project was designed to assure HMMHBC oversight of project activities. Committees of the HMMHBC were kept informed of progress and problems. Changes in project activities were recommended by the committees and reported to the HMMHBC. As a result of this process, revised activities were implemented under the direction of the project director in a timely manner and in response to community input and needs.

A new phase of the Camden Healthy Start Project began in July 2001 with an emphasis on eliminating racial disparities, improving interconceptional care, and treating perinatal depression through intensive case management and risk reduction services. Case management and care coordination has been expanded, with emphasis on the integration of Healthy Start funded services and close linkage to the clinical and mental health care systems. Successful elements from the first phase funding for Camden Healthy Start remain; such as the Risk Reduction Specialists, standardized routine screening for substance abuse at all city prenatal clinics, expanded outreach and case management services, and comprehensive services for pregnant and parenting adolescents. All of these components can be adapted to other communities, and exist among other Healthy Start sites. These are labor intensive interventions which require adequate staff and administrative resources. The partnership of public entities including state and local health departments, non-profit and corporate sectors, with consumer stakeholders is essential to the replication of Healthy Start models. It is expected that over the next several years, Camden Healthy Start will make great strides in reducing infant mortality and the number of low birth weight infants born in Camden City, as well as providing a more holistic system of care for childbearing families.