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in Review:
Analysis and
Findings of a
Descriptive Survey***

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Executive Summary

In 1989, the Healthy Tomorrows Partnership for Children Program (HTPCP) was initiated to engage communities in working to improve children's health through prevention and better access to health care. The program is funded by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). It is administered by MCHB in partnership with the American Academy of Pediatrics (AAP).

HTPCP was designed to provide communities with seed money to identify and address pressing local problems. A unique aspect of HTPCP, and one that distinguishes it from other MCHB programs, is the partnership that was developed with the AAP. The concerted effort to blend public health resources with the knowledge and skills of the pediatric professional community is the hallmark of HTPCP. To date, 107 projects nationwide have been awarded 5-year grants, of which 54 have completed the federal funding cycle.

The HTPCP evaluation is part of MCHB's larger effort to document the impact of its investment in Title V Block Grant programs and its discretionary grant programs. In particular, MCHB is interested in measuring the impact of the Special Projects of Regional and National Significance (SPRANS), which comprise an array of demonstration, research, and training grants.

Findings

HTPCP Goal Number 1: Use innovative and cost-effective approaches to promote preventive health care among vulnerable children and their families, especially those with limited access to quality health services. The clients of the HTPCP are women and children, 96 percent of whom either have no insurance or are Medicaid recipients. HTPCP grantees represented in this survey initiated a broad range of activities to meet the health needs of the children and families they served. New case management services were the single most common component added: Fully half of grantees reported that they initiated case management as part of their HTPCP project. Projects used a variety of settings to reach their clients: homeless shelters, clients' homes, elementary and high schools, and recreational centers, as well as community clinics and hospitals; all projects stressed coordination and linkage.

To capture insights about the impact of HTPCP projects in their communities, the questionnaire solicited open-ended responses on the perceptions of the project directors, who reported a wide range of successful outcomes.

One noteworthy aspect of the HTPCP projects is the attention devoted to “cultural competency.” Cultural competence is especially important to the HTPCP program since the projects serve a racially and ethnically diverse population.

HTPCP Goal Number 2: Foster cooperation among community organizations, individuals, agencies, and families. HTPCP projects generally attempted to work collaboratively in three venues: (a) developing partnerships with a core of direct service partners; (b) establishing a community network; and (c) selecting influential persons to serve on an advisory committee. Projects involved a broad array of partners—in fact, half the grantees had five or more partners with whom they worked toward local program goals. Many grantees found this aspect of program development challenging and at times



frustrating, and yet most grantees ultimately concluded that it was extremely important to their project's success.

HTPCP Goal Number 3: Involve pediatricians and other pediatric health professionals. The majority of projects reported that they had pediatricians on staff; about half of the project directors were individuals with medical degrees. Other types of providers were also utilized, including nurses, social

workers, psychologists, health educators, and nutritionists. This survey suggests that HTPCP projects are successful in integrating a variety of health professionals into the program and that leadership positions are held primarily by pediatric-trained providers.

HTPCP Goal Number 4: Build community and statewide partnerships among professionals in health, education, social services, government, and business to achieve self-sustaining programs. Goal number 4 stresses partnership building in the context of project sustainability. In fact, these projects were quite successful in leveraging funds during the period of the grant and in achieving a permanent service in the community. During the period FY 1990 to FY 1997, MCHB invested \$15.95 million in these projects, which in turn leveraged a total of \$67 million. Questionnaire data from projects that had either completed their grant or were in the last 2 years of funding

found that most had secured long-term funding. Those projects directed by nurses or Ph.D.s were much more likely than those directed by M.D.s to use state or other federal sources of reimbursement to sustain their projects, while the M.D. group tended to solicit contributions from local sources, to contract with managed care organizations, and to merge with the local system of care. In sum, HTPCP grantees appear to be successful in forging partnerships that lead to additional support for children's health and the long-term sustainability of services, but their approaches to doing so vary.

Project Evaluations. HTPCP grantees are required to evaluate their projects. Few grantees attempted an outcome evaluation, but most did undertake a process evaluation and monitored their own progress toward meeting project goals. A few grantees noted that the evaluation process had a positive, transforming impact on their agencies, but most found that their evaluation resources were very limited and that technical assistance was not easily available in this area. In short, grantees indicated considerable frustration with this aspect of their grants.

Program Oversight and Technical Assistance. A single federal staff member is responsible for implementing and monitoring the HTPCP. The creative MCHB/HRSA/AAP partnership has served both to enhance the support of and technical assistance for the HTPCP projects and to secure additional resources. Grantees gave high ratings to the technical assistance they received from MCHB and the AAP.

Conclusions

The HTPCP appears to be an effective strategy for promoting children's access to health services at the community level. The HTPCP has clearly enhanced community-based service programs by creating new services and adding components to existing programs.

Modest funding provided to community organizations, with a matching fund requirement, can leverage significant amounts of money for children's health care. HTPCP grants are quite small by federal program standards. Yet, this amount appears to be adequate both to provide a valuable service and to attract additional funding.

The HTPCP includes elements that successfully foster the long-term sustainability of services. The match requirement forces grantees to begin searching for additional funds immediately. At the same time, grants are funded for a long enough period (5 years) to both demonstrate success and value locally and enable grantees to develop the relationships with other groups that are needed to secure the resources that can sustain the program.

Small, community-based projects do not have the expertise or resources to conduct outcome evaluations. Valid outcome evaluations are challenging and expensive to conduct. Expertise in evaluation design is costly and may be difficult to acquire.

Meaningful multiagency partnerships and collaborations can greatly improve the delivery of services for children, but they are challenging to develop and attempts to do so frequently fail. Most HTPCP projects ultimately developed what they considered to be effective and productive partnerships that project directors believed critical to the success of their projects. However, many difficulties were encountered in developing these relationships.

Pediatricians and other pediatric health professionals, when provided with support through a mechanism such as a grant, can serve as leaders and advocates in improving children's access to services. Advocacy efforts on the part of HTPCP grantees—primarily pediatric health professionals—led to improved service components, permanent changes in local services, and new dollars for children's health.

The activities of staff at the federal level and at the AAP provide important guidance and leadership to HTPCP projects and contribute to the program's success. Projects received "care and feeding" from a variety of both public

and private sources. The overwhelmingly positive response of projects to the technical assistance they received points to the effectiveness of this approach.

Recommendations

Continue the programmatic focus on cultural competence.

Continue to emphasize different types of partnerships with multiple groups.

Consider the provision of intensive training in coalition building and partnership development for project staff within the first 6 months of the grant award.

Continue to require outcome evaluations and provide training and/or special technical assistance materials within the first 6 months of the grant award.

Consider adding community performance monitoring requirements for some projects to assess the usefulness of this approach to improving children's health care.

Continue the partnership with AAP.

Increase the technical assistance capacity.

Increase staff at the federal level.

Consider linking with State Children's Health Insurance Programs (CHIP).



Introduction

Naomi Eisen, M.P.H.,¹ Jerome Evans, Ph.D.,² Laura Kavanagh, M.P.P.,³ Jean Athey, Ph.D.,⁴ and Jennifer Schwab⁵

Changes in certain health indicators for women and children in the United States over the past decade document the positive impact of concerted efforts by health professionals to improve access to care and to prevent serious health problems. For example, infant mortality and low birthweight are at all-time lows (CDC, National Vital Statistics System, 1998). More children are entering school with completed immunizations (CDC, National Immunization Program, 1998), and fewer teens are having babies (CDC, National Vital Statistics System, 1998).

However, troubling problems remain. Among African Americans, the frequency of low birthweight and infant mortality is still greater than in any other racial/ethnic group (CDC, Vital Statistics, 1998). Nearly one out of every four Hispanic children and one out of every five African-American children have no health insurance coverage (Weigers et al., Medical Expenditure Survey Chartbook, 1998). Large numbers of children are born every year to women who are substance abusers

¹At the time of the survey, Naomi Eisen was a Senior Project Associate in the Office of Policy Analysis at the National Center for Education in Maternal and Child Health (NCEMCH), part of Georgetown University.

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³Laura Kavanagh is the Director of the Office of Policy Analysis at NCEMCH.

⁴Jean Athey of Health Policy Resources, Inc., worked as a consultant to NCEMCH on this project.

⁵Jennifer Schwab is a graduate research assistant at NCEMCH.

*Improving the
health of
women and
children
requires a
broad focus
and a
community-
wide approach*



(National Institute on Drug Abuse, 1996). The frequency of reported child abuse and neglect is unacceptable (National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services, 1997). Violence and suicide claim the lives of thousands of young people every year (U.S. Department of Justice, Bureau of Justice Statistics, 1998).

While the recently launched State Children's Health Insurance Program (CHIP) may make health services more available to many socioeconomically disadvantaged children, nonfinancial barriers exist that limit children's access to care (Millman, 1993; Margolis et al., 1995; Riportella-Muller et al., 1996; Meyer and Bagby, 1998). Uncoordinated services, overcrowded or inconveniently located clinics, and inadequate attention to cultural issues all serve to limit the health care that is available to impoverished children and families. In addition, improving the health of women and children requires a focus that is broader than health services. Prevention, in particular, demands a communitywide approach. Homelessness, family violence, substance abuse, and sexually transmitted diseases are examples of problems that cannot be successfully tackled by the medical community alone.

In 1989, the Healthy Tomorrows Partnership for Children Program (HTPCP) was initiated to engage communities in problem solving to promote access to health care for mothers and children through community-based prevention programs. The HTPCP is funded by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). It is administered in partnership with the American Academy of Pediatrics (AAP).



History of HTPCP

*HTPCP
provides
communities
with seed
money to
address
pressing local
problems*



The HTPCP grew out of a movement in the late 1980s to promote access to health care for low-income children. At the time, Medicaid expansions had made health care more financially accessible to low-income families, but nonfinancial barriers were still a source of great concern. Uncoordinated services, lack of transportation, difficulties in securing child care for siblings, and other problems made it difficult for many Medicaid-covered women and children to obtain the care they needed (U.S. General Accounting Office, 1987; Short et al., 1992). The HTPCP was designed to provide communities with seed money to identify and address pressing local problems that remained unsolved.

At about the same time, MCHB also launched other programs expected to yield improvements in health outcomes for children. In 1991, millions of federal dollars were allocated for Healthy Start, a multifaceted, community-based program aimed at reducing infant mortality. The following year, the Community Integrated Service Systems (CISS) program was initiated, designed to foster more coordinated systems of care.

All three programs had the common goal of building community-based systems of care that are “family centered” and “culturally competent.” Barriers to care would be reduced and services enhanced and linked. It was recognized that this would be a slow process, and that grantees would have varying degrees of success,

*HTPCP's
hallmark is
blending
public health
resources with
pediatric
professionals'
knowledge
and skills*



depending on the local political environment, the degree of involvement of local pediatric providers, and the availability of local resources.

A unique aspect of HTPCP that distinguishes it from the other programs is the partnership that was developed with the AAP, a professional membership association of pediatricians. Private practitioners joined with local, public programs in a new collaboration—just as MCHB and the AAP modeled a public-private partnership at the national level. The concerted effort to blend public health resources with the knowledge and skills of the pediatric professional community is the hallmark of HTPCP.



The HTPCP Grant Program

An HTPCP project must be either a new community initiative or a new component to an established program



To qualify for a grant, an HTPCP project must consist of either a new community initiative or the addition of a new component to an established program. Projects must incorporate the following elements, which correspond to the goals of the HTPCP :

- Innovative and cost-effective approaches for promoting preventive health care among vulnerable children and their families, especially those with limited access to quality health services;
- Cooperation among community organizations, individuals, agencies, and families, to improve care and services;
- Involvement of pediatricians and other health care professionals; and
- Development of partnerships among professionals in health, education, social services, government, and business to achieve self-sustaining programs.

HTPCP grants support a wide range of services for children and their families. For example, programs have been funded to address issues such as the following:

- Primary care for uninsured children and children covered through Medicaid;
- Care coordination for children with special health care needs;

HTPCP grant awards are capped at \$50,000 annually, with a 5-year funding period



- Health promotion through risk reduction in families;
- Adolescent health promotion, including reproductive health, prenatal care, and education services;
- Expanded perinatal care and parent education services; and
- Services for special child and family populations, such as children in foster care and homeless children.

The HTPCP is administered by MCHB in partnership with the AAP. Both organizations provide technical assistance to grantees. MCHB, with assistance from the AAP, organizes an annual project directors' meeting to facilitate networking among project directors and MCHB and AAP staff, and it provides technical assistance and consultation to support ongoing project implementation and grant administration. The AAP organizes technical assistance site visits to each project, helps link projects with local pediatricians, and fosters partnerships with an array of private-sector groups.

HTPCP grant awards are capped at \$50,000 annually, with a 5-year funding period. Starting in year 2, projects must meet a two-thirds matching funds requirement by securing a minimum of \$100,000 from nonfederal partners. Programs are also required to form a project advisory committee (PAC) that includes diverse representation from the community, including parents. Programs are encouraged to develop partnerships with community organizations, including foundations, local government, schools, businesses, and nonprofit organizations. The PAC partners raise community awareness about child health issues and help resolve problems related to these issues. They also participate in the planning, implementation, and evaluation of the project and contribute resources to ensure long-term sustainability of the programs.

To date, 107 projects nationwide have been awarded 5-year grants, and 54 have completed the federal

funding. Grants have been awarded to a wide variety of organizations, including medical centers and schools, local foundations and nonprofit agencies, community-based clinics, community health centers, hospitals, local and state health departments, and schools. (See Figure 1, Appendix A.)



Study Goals and Methodology

The HTPCP evaluation is part of MCHB's larger effort to document the impact of its investment in Title V Block Grant programs and its discretionary grant programs. In particular, MCHB is interested in measuring the impact of the Special Projects of Regional and National Significance (SPRANS), which comprise an array of demonstration, research, and training grants. The National Center for Education in Maternal and Child Health (NCEMCH) at Georgetown University was awarded a grant that included, as one of its objectives, the development of a model for evaluating SPRANS programs, beginning with the HTPCP. The following MCHB goals are to be examined in the HTPCP evaluation and in subsequent SPRANS evaluations:

- The promotion of the development of comprehensive, integrated systems of care for children;
- The promotion of the development of public-private partnerships to ensure the delivery of quality maternal and child health (MCH) services; and
- The promotion of the development of MCH services that are comprehensive, community based, family centered, and culturally appropriate.

This study also examines progress toward goals specific to the HTPCP.

During the summer and fall of 1997, survey questions were compiled to elicit responses germane to the goals of the HTPCP. Six project directors were consulted in the beginning stages of this process and were asked to contribute relevant topics. A draft survey was developed, circulated to MCHB staff and MCH researchers for comment, and revised accordingly. Five HTPCP sites field-tested the survey; their feedback helped produce a final survey covering topics in the following areas:

- Types and extent of new services provided;
- Strategies for reducing barriers to care;
- Perceived impact on communities;
- Project evaluation;
- Collaborative activities and community partnerships;
- Involvement of pediatricians and other pediatric health professionals; and
- Strategies used to promote long-term sustainability of the project.

The questionnaire was mailed to directors of all 85 HTPCP projects initially funded between 1989 and 1996. Responses to the survey were received from 74

The survey was field-tested at five HTPCP sites and the questionnaire was mailed to directors of all 85 HTPCP projects initially funded between 1989 and 1996



projects (87 percent). Nonresponding sites were typically those that had completed the 5 years of federal funding; in these cases staff turnover and reorganization made it difficult to locate original HTPCP project staff who could complete the questionnaire. Data from the surveys were supplemented by a review of project abstracts and available progress and final reports.⁶

Both numeric and narrative survey data were obtained. Quantitative data from survey items were entered into SPSS. Qualitative data were stored in a FileMaker Pro database so narrative responses could be summarized and examined for patterns. These patterns were categorized, and examples were drawn from the responses to illustrate each of the categories.

Although this study has yielded important findings, it is important to identify its limitations. First, the findings in this analysis are based on the self-reports of project staff, and many items on the survey request an opinion or a judgment on the part of respondents. It is possible that others in the community might have had opinions different from those of the project staff. Second, although the response rate is high, almost all nonrespondents (10 of the 11 nonrespondents) are from terminated projects, which introduces a bias, at least with respect to the issue of sustainability. Despite these limitations, this study provides important descriptive information about the HTPCP projects that has not been previously available and identifies areas for more in-depth analysis in a follow-up study.

⁶This review excluded material that is not available to the public under the Freedom of Information Act, such as budget and salary information.



Findings

Fully two-thirds
of all projects
are located
in urban,
primarily
inner-city areas



HTPCP Goal Number 1: Use innovative and cost-effective approaches to promote preventive health care among vulnerable children and their families, especially those with limited access to quality health services.

This descriptive analysis focuses on four aspects of HTPCP goal number 1: (1) populations served by the projects, (2) new service approaches, (3) strategies to ensure cultural competence, and (4) the perceived impact of these projects on the targeted communities.

Populations Served

The HTPCP is intended to assist vulnerable children and their families; thus, it is not surprising that fully two-thirds (66 percent) of all projects were located in urban, primarily inner-city areas. Several projects (16 percent) were rural, and several (10 percent) were multi-county or statewide. The remainder were located in suburban areas. (See Figure 2, Appendix A.)

Nearly half (49 percent) of all clients served by HTPCP projects were children between the ages of 1 and 12 years. Other clients included infants (20 percent), adolescents (16 percent), and mothers (15 percent). (See Figure 3, Appendix A).

Slightly more than half (54 percent) of the women and children served by HTPCP projects were Medicaid

New case management services were the most common component initiated in HTPCP projects



recipients; 42 percent had no insurance. Only a small percentage of recipients (4 percent) had private insurance. (See Figure 4, Appendix A.)

The survey findings on client demographics suggest that the HTPCP is quite successful in reaching its target population of vulnerable children and families.

Service Approaches

HTPCP grantees initiated a broad range of activities to meet the health needs of the children and families they serve. New case management services were the most common component added: fully half of grantees reported that they initiated case management as part of their HTPCP project. Other new services funded through HTPCP grants were parenting education (45 percent) and support groups (40 percent). More than one-third of projects used HTPCP funding to add home visiting to the array of services provided, and support services, such as transportation and child care, were new in 31 percent of communities. (See Table 1.)

TABLE 1. Types of Services Initiated Through HTPCP Grants

| Types of Service | Percentage of Projects Reporting the Service Developed as a Result of the New Grant (n = 74) |
|---|---|
| Case management/care coordination | 50 |
| Parenting education | 45 |
| Support groups | 40 |
| Home visiting | 32 |
| Support services (transportation, child care) | 31 |
| Health education | 28 |
| Nutritional services | 22 |
| Multidisciplinary team approach | 22 |

Projects reach their clients through a variety of settings. To maximize access to children and their parents, the projects reach out to where they live, learn, and play: services are delivered in homeless shelters, clients' homes, elementary and high schools, and recreational centers, as well as in more traditional care settings such as community clinics and hospitals. An array of providers located throughout the community participate in projects, and coordination and linkage are stressed. For example, a home visit to a family would identify unmet needs and the family would be linked to other community services, such as WIC or parenting education. Or, a child identified to be at risk by a school-based health clinic would receive follow-up services by more specialized health care providers in the community. These services are "innovative" in the sense that they were previously unavailable in these communities.

Strategies to Ensure Cultural Competence

One noteworthy aspect of service delivery in HTPCP projects is the attention to "cultural competency." For many years, MCHB has emphasized the need for all its grantees to address cultural competency, a concept that incorporates knowledge of and sensitivity to racial and ethnic differences, language, and beliefs that could affect access to care and treatment. HTPCP projects have been quite innovative in their work in this area.

Cultural competence is especially important to the HTPCP since the projects serve a racially and ethnically mixed population. In this survey, Hispanics were the most represented group, constituting 37 percent of the total target population, with African Americans representing 30 percent and whites representing 29 percent. Asians and Pacific Islanders made up 3 percent of the population served, and American Indians and Alaskan Natives represented 1 percent. (See Figure 5, Appendix A.)

Project settings include homeless shelters, homes, schools, recreation centers, and community clinics and hospitals



Cultural
competence is
especially
important
since HTPCP
serves a
diverse
population



Survey respondents provided a good deal of information on how they addressed cultural competence, and many were particularly thoughtful in their consideration of this issue:

We have trained members of the community to be health promoters. They share culture and socioeconomic status with the families they serve. They communicate in Spanish and English and tailor their messages for low-literate audiences when appropriate.

Service delivery [staff] highly reflect and respect the ethnicity of those receiving our services.

Our staff are multicultural and bilingual to ensure that each patient feels welcomed.

We complete 4 hours of cultural diversity and sensitivity training with each worker. We review all materials used in the program to ensure cultural relevancy.

Three types of cultural-sensitivity strategies were developed by HTPCP projects:

(1) *Recruitment and training of staff:* This strategy is designed to ensure that all project staff are knowledgeable about the client population and able to effectively communicate with them.

(2) *Use of culturally appropriate communication:* Typically, programs used written materials and other methods to communicate with the clients they served, but these materials were not always in the appropriate language or at the appropriate reading level, or in an accessible format. This approach is designed to rectify such problems.

(3) *Community strategies:* Communities have resources to improve cultural sensitivity that frequently go untapped. Projects developed innovative approaches to involve the entire community, or special sectors of the community, in improving cultural relations and understanding.

Table 2 presents some examples in each category.

TABLE 2. HTPCP Projects' Strategies to Promote Cultural Competence and Reduce Family- and System-Level Barriers

| Staff Recruiting and Training Strategies | Communication Strategies | Community Strategies |
|---|---|--|
| Recruit and hire staff who grew up in the same culture and speak the same language | Provide take-home handouts in patients' languages | Participate in cultural events in the community |
| Train staff in diversity issues | Display posters (in patients' languages) that are sensitive to specific cultural issues | Locate clinics in patients' neighborhoods |
| Review literature on new developments in cultural competency | Use signs written at a fourth-grade reading level | Maintain a culturally diverse advisory board |
| Recruit staff experienced in caregiving in the patients' cultures | Solicit cultural experts' comments on mailings | Consult with racial/ethnic minority community leaders |
| Assess staff performance in cultural competence | Ensure that all intake materials are in patients' languages | Train community pediatricians on cultural issues |
| Make materials on cultural competency available to staff | Distribute outreach materials (in common patient languages) to neighborhoods | Offer Spanish-language classes for community professionals |
| Use bilingual volunteers | Market the program throughout the community | Consult the advisory board on ways to make services culturally competent |
| Address cultural competency in regular staff supervision | Use bilingual patient education videos | Train affiliated professionals and service staff in cultural competence |
| Hire staff who live in the community they serve | | Exchange cultural education programs with other agencies |
| Train staff members in non-traditional forms of health care | | Conduct community focus groups to learn about cultural issues |
| Hire front-desk personnel who speak Spanish or the predominant patient language | | Provide program services in families' homes |
| Hire interpreters on staff | | Conduct outreach programs through other organizations such as social service agencies, schools, etc. |
| Give staff any information gained from family support groups | | Tap community residents for advice on cultural issues |
| Encourage family story-telling and cultural traditions, and build these into services | | Participate in an interagency cultural-competency committee |

More than one project noted the HTPCP's catalytic effect on the community



More than 70 percent of the HTPCP projects reported that they recruited and selected staff from the communities they served, and that they hired persons who spoke the language and were familiar with the racial and ethnic issues important to families. Special training and supervision were added to ensure cultural competence. Projects also used community strategies to work toward cultural competency: almost one-third of the HTPCP sites reported that they employed this approach. Some projects used all three approaches to address cultural competency, and slightly more than one-third reported employing at least two of the approaches.

Interestingly, projects serving primarily African-American clients tended to favor staff recruiting/training strategies, while those serving Hispanics emphasized communication strategies, and those serving whites were more likely to utilize community strategies. Overall, the projects demonstrated an appropriate level of attention to this important attribute of service delivery.

Perceived Impact of HTPCP Projects

The HTPCP aims to increase the number of new and innovative services delivered in communities and to ensure that these services are effective in meeting children's needs. To capture project experience and insights about the impact of HTPCP projects on their communities, the questionnaire solicited open-ended responses on the perceptions of project directors and staff. The technique yielded more than 250 examples of achievements, which were grouped into eight categories, as shown in Table 3. The following statements from survey respondents illustrate some of the program's accomplishments:

The HTPCP was considered a huge success in our community because the community recognized the problems, studied (them), and designed and implemented solutions.

Table 3. Eight Ways in Which HTPCP Projects Improved Their Communities (n = 74)

Raising Awareness among Community Partners

1. *Community Awareness*: The project increased community residents' general awareness of issues surrounding access to care by low-income families (n = 21).
2. *Professional Awareness*: Health and social service providers developed a greater awareness of factors in the access and use of services by at-risk groups (n = 30).

Developing Innovative Services

3. *New or Expanded Services*: The project created new services or expanded existing services (n = 24).

Reducing Barriers to Care

4. *Reducing Family-Specific Barriers*: The projects improved clients' use of needed services by addressing obstacles such as parents' unfamiliarity with resources, their language differences, and their lack of understanding of the importance of preventive pediatrics (n = 18).
5. *Reducing System-Level Barriers*: Projects successfully promoted new partnerships, advocated for system models in service planning, and bridged services across agencies and fiscal guidelines (n = 35).
6. *Reducing Fiscal Barriers*: Access to health and social services improved for low-income families when projects found solutions to economic barriers (n = 7).

Improving Outcomes

7. *Short-Term Outcomes*: Immediate benefits were observed in targeted families, such as higher immunization compliance or better school attendance (n = 20).
8. *Long-Term Outcomes*: Projects predicted specific long-term effects of programs (e.g., child readiness for school, parental employment) (n = 9).

The catalytic effect of the HTPCP, being the first home visiting program in the area, resulted not only in collaborative efforts with other agencies and hospitals, but [also] . . . awakened interest in the concept of home visitation . . . as a prevention modality against child abuse and neglect.

Children who were previously served only in hospitals were served in community-based settings. Children who were previously served in isolation were served in settings that included non-medically fragile children. The health care system and the early intervention system were drawn closer together in direct cooperation than ever before.

We highlighted some of the challenges for the population – lack of transportation, access to phones, confusion about complex medical plans, and limited financial resources – which affect compliance.

We started collaborative relationships with key agencies who had not worked together. They came together towards a common goal of assisting . . . families.

The impact of HTPCP projects as reported by these respondents represents a wide range of successful outcomes. Projects were characterized as operating outside the traditional boundaries of existing programs and moving into new territory in their communities. Most projects challenged their communities to acknowledge the unmet needs of low-income children and their



families. Health professionals were educated (1) in the systems approach to care, which emphasizes integrating all service systems (e.g., social, education) needed by families; (2) on the effectiveness of certain interventions with at-risk populations; and (3) on how new approaches to primary care (e.g., school-based clinics) could succeed alongside traditional clinic and hospital services.

This analysis of the HTPCP's first goal suggests that the program is in fact targeting the vulnerable families it has identified as its focus, and that the projects have successfully instituted many services new to their communities. They have accomplished this with particular attention to race/ethnicity and culture.

HTPCP Goal Number 2: Foster cooperation among community organizations, individuals, agencies, and families.

A decade ago, when the HTPCP was initiated, MCHB and the AAP recognized the value of partnerships and collaborative working agreements among a variety of groups. Many public health programs have encouraged collaborations, but not all attempts to form them have been successful. Research on the process of developing community coalitions is currently under way and will identify factors that contribute to success (IOM, 1997, p. 71). It is already well known, however, that impediments to successful coalition building and to the forming of partnerships are formidable.

Organizations typically have budget commitments to specific issues in mandated populations; it may not be easy to shift these commitments. Often the most forward-thinking, visionary staff have the heaviest workload. Pressed by demands from many quarters, administrators may question the advisability or the feasibility of adding tasks associated with interagency agreements and other linkages. Individual and organizational barriers such as territoriality, the desire to take rather than share credit, and the desire to control resources can impede effective partnerships. Good leadership is probably the most important factor in the success of coalitions

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Good leadership is crucial to successful coalitions and partnerships, but it is not always available



and partnerships, but it is not always available. In short, there are many factors that affect the ability of a collaboration to be successful – but the rewards of success can be great (Melaville and Blank, 1991; White and Wehlage, 1995; Bazzoli et al., 1997).

HTPCP projects generally attempted to work collaboratively in three venues: (a) developing partnerships with a core of direct service partners; (b) establishing a community network (for promoting awareness of common interests and encouraging cooperation from local service professionals and organizations); and (c) selecting influential persons to serve on an advisory committee. Their experiences were mixed: Some collaborations were quite successful while others did not appear to be especially productive.

Respondents commented on their experiences collaborating with others in the community:

We were fortunate to have excellent collaborators and partners. They actually participated in both direct [health] service [delivery] and program planning. They continue almost 10 years later to be actively involved.

Advisory committee members were also committee members on numerous other community committees/task forces that we participated in. Often, the focus of these community committees was on our efforts . . . so the advisory committee became more a duplication of other more routine meetings [than] a help.

In the beginning, there were boundary issues; it was difficult to bring all the partners together to focus on a common goal. Since then, trust has been built and it is much easier.

As a physician, I initially felt that there was resistance to my becoming involved in a community-based initiative that traditionally had been the territory of other disciplines.

The best experiences [are] with representatives who are themselves direct health service providers.

Table 4 presents the grantees' experiences of collaborative partnerships that worked and those that did not. Respondents mentioned 20 types of problems encountered in their efforts to develop partnerships and collaborations. In general, when direct service providers had a mutual interest in partnering – that is, common target populations, high-level administrative commitment to collaboration, and personnel to carry out interagency communication – substantial benefits were realized. However, when any one of the ingredients was absent, working together became more problematic. Another important finding was the necessity for partners, representatives, and advisory committee members to be consistently present at meetings; when meeting attendance dropped off, joint efforts occurred only minimally, turf issues were not resolved, and roles were never adequately defined. It was also difficult to define roles when multiple partners were involved in a collaboration. Lack of high-level organizational support and failure to appoint liaisons were other frequently cited problems.

Projects involved a broad array of partners: In fact, half the grantees had five or more partners with whom they worked toward local program goals. Community professionals, human services groups, community-based organizations, hospitals, businesses, and other groups were all involved in these projects. Table 5 shows the variety of organizations that collaborated with HTPCP projects.

Surveyed sites were asked to rate, on a five-point scale, how “helpful” their partners were in achieving project goals. More than two-thirds (68.9 percent) judged partners “very helpful,” the highest score. About one project in 10 was dissatisfied with their partners' performance, rating them as “neutral” or “not helpful.” Using the same rating scale, programs indicated that their advi-

Substantial benefits were achieved when partnering providers had common populations, high-level commitment to collaboration, and personnel for interagency communication



TABLE 4. HTPCP Projects' Representative Experiences with Partnerships and Collaborations

| Successful Experiences | Problematic Experiences |
|--|---|
| Very useful in bringing the community's point of view to the project | Unable to mobilize a parent community advisory group that represented the targeted inner-city population |
| Helpful in reviewing program plans | Difficult to bring all the parties together at the same time |
| Pediatrician participation was invaluable | Didn't feel that partners had a strong impact on our program |
| Talking with agencies helped build and repair relationships with them and with their individual staff members | Initially there was passive resistance on the part of [professional staff], but this was overcome in time |
| It helped form a larger focus than just HTPCP | Dealing with the government bureaucracy has been a challenge |
| Helped us form linkages | We need new partners as we transition to sustained efforts |
| Partners were clients' advocates when they needed them | Our success came after 2–3 years of committee meetings with the involved parties, before we could reach a consensus |
| Excellent support from school district partner | The partners set overly ambitious goals for the program |
| Support in partner group when some agencies faced funding reduction | Partner meetings were initially very helpful, but ran out of steam, partly because of the demands for partners to collaborate |
| Parents helped to target needs | Some members were unhappy when they thought others were not doing their share |
| Partners helped raise funds for the HTPCP | Members at meetings were lost with staff turnover |
| The opportunity to collaborate with partners was critical to the success of the project | Advisory group had no defined role |
| Always able to dialogue with partners | Didn't have active partnership meetings, as they met quarterly |
| Partners continue to be involved in direct services | Reorganizing and downsizing hospitals and clinics caused unstable attendance at meetings |
| Relationships with partners who could contribute funds were more substantial than with partners who did not contribute funds | Difficult to get others to recognize the difficult financial picture for the project |
| Partners helped reach other people and organizations in the community | Some services competed with territory claimed by other community organizations |
| A lot of support was received from partners, particularly with evaluation | Attendance was a problem because in a small community everyone wears several hats; difficult to assemble people |
| Partners who had "protected" (paid) time could make a more substantial contribution | Some came to meetings only to raise their agendas |
| | Partners worked well, but the advisory committee was a burden |
| | Partnering with hospitals has been the most challenging |

sory committees were less important in reaching project goals. Over one-third (36.1 percent) thought they were “neutral” or “not helpful.” The mean rating for all projects on partner contribution was 4.6 (of 5), but only 3.8 (of 5) for advisory committees. Analysis showed that when HTPCP projects included health and human services agencies in their operations (e.g., pediatric clinics, local health departments, social service agencies), they were significantly more satisfied with their partnerships. Programs rated the contributions of partners higher when the program had a wide variety of partners, rather than a few. Despite the problems they encountered, staff repeatedly emphasized that forging collaborative relationships was critical to the success of their projects.

In sum, HTPCP projects appear to have met the national program goal of forging collaborative or cooperative relationships among a variety of community groups. Many grantees found this aspect of program development challenging and at times frustrating, and yet most ultimately concluded that it was extremely important.

Half the grantees had five or more partners with whom they worked toward local program goals



HTPCP Goal Number 3: Involve pediatricians and

TABLE 5. Types of Organizations Collaborating with HTPCP Projects

| Category of Partner | Percentage of Projects Reporting a Collaboration with This Category |
|---------------------------------|---|
| Community professionals | 81 |
| Health or human services groups | 77 |
| Schools | 72 |
| Community-based organizations | 69 |
| Hospitals | 68 |
| Foundations | 50 |
| Universities | 43 |
| Businesses | 30 |

Leadership positions in HTPCP projects are held primarily by pediatric-trained providers

other pediatric health professionals.

The majority (77 percent) of projects reported that they had pediatricians on staff. Many programs had nurses (50 percent) or nurse practitioners (40 percent) on staff, including pediatric nurse practitioners. Although a handful of projects secured full-time pediatricians, most pediatricians on staff were part time. On-staff pediatricians averaged 14 hours per week on the project. Most pediatricians worked on a paid basis, but a small number served on a volunteer basis. Approximately one-half of projects were directed by individuals with medical degrees, the majority of whom were pediatricians. (See Figure 6, Appendix A.)

Given that HTPCP projects address complex medical and social needs, other types of providers are also needed and were utilized: social workers were included in 50 percent of project teams, psychologists in 24 percent, health educators in 20 percent, and nutritionists in 15 percent. Service coordinators, who play an important role in ensuring that clients use available services, were included in 27 percent of projects. (See Table 6.)

M.D.-led projects were more likely to have stable

TABLE 6. Composition of HTPCP Project Staff

| Provider | Percentage of Projects Reporting That This Provider Was Included on Staff (n = 74) |
|----------------------|---|
| Pediatricians | 77 |
| Nurses | 50 |
| Social workers | 50 |
| Nurse practitioners | 40 |
| Service coordinators | 27 |
| Psychologists | 24 |
| Health educators | 20 |
| Nutritionists | 15 |

staffing (i.e., only one project director during the course of the grant) than projects led by R.N.s/Ph.D.s (chi-square = 4.90 [n = 58]; p < .05). Such stability is sometimes associated with more successful projects, and at least in terms of sustainability, that appeared to be the case with these projects: Projects that had only one project director were somewhat more likely to obtain long-term funding.

Thus, it appears that HTPCP projects are successful in integrating a variety of health professionals into the program and that leadership positions are held primarily by pediatric-trained providers.

HTPCP Goal Number 4: Build community and statewide partnerships among professionals in health, education, social services, government, and business to achieve self-sustaining programs.

To some degree, this fourth goal identified by the HTPCP program overlaps with the second (which addresses cooperation and collaboration). However, goal number 4 stresses partnership building in the context of projects becoming self-sustaining. Thus, this component of the study addresses the issue of sustainability.

The HTPCP projects are required to secure additional matching funds by year 2 of their grant. They are encouraged to seek support from a broad base of partners in both the public and private sectors, and by the completion of the 5-year funding period to have funding arrangements in place to ensure the long-term sustainability of the project.

A 1-year “snapshot” approach was taken to assess the ability of projects to leverage their federal dollars. Budget data for FY 1997 were obtained for the 54 active projects funded during that year. During FY 1997, MCHB granted a total of \$2.7 million, and projects leveraged \$10.34 million. On average, each project leveraged \$182,241 during FY 1997, with three-quarters of projects exceeding the minimum annual matching requirement of

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\$100,000. Interestingly, even projects that were only in their first year of funding during FY 1997, and thus had no matching requirement, reported that they had leveraged funding.

Information was also obtained from MCHB program files on the total amount leveraged by projects over the first 9 years of the program. During the period FY 1990 to FY 1997, MCHB invested \$15.95 million in these projects, which in turn leveraged a total of \$67 million.

While grantees are permitted to count “in-kind” support (such as contributed space or staff time) as part of the match, MCHB strongly encourages grantees to obtain actual monetary contributions and to obtain these funds from numerous partners so as to enhance the likelihood of sustainability. In fact, close to 60 percent of grantees indicated that more than half of their match was in the form of “hard money” from sources such as foundations (55 percent), state government (46 percent), local government (33 percent), and corporations (19 percent).

Questionnaire data from a subset of projects (n = 40) that had either completed their grant or were in the last 2 years of funding were analyzed with respect to sustainability issues. (Note: 53 projects in the study met these criteria but 13 did not provide useable data in the questionnaire.) Almost a third of these projects (30 percent), including some completed ones, indicated that they were still in the process of securing long-term funding. However, the majority of these 40 projects (68 percent) indicated that they had some type of long-term funding arrangement in place. It should be noted, however, that several of the projects for which this issue is most salient—namely, 10 completed projects—are not included in this study since project staff could not be located. It is not clear whether these projects were more or less likely to secure long-term funding than those who did respond to the survey. Given that information on sustainability was not available for 13 projects (25

percent) of all projects that were completed or in their last 2 years of funding (either because staff could not be located or did not provide information), the true percentage of projects that secured long-term funding is unknown.

Five distinct funding approaches emerged from the data. This analysis examined only the primary source of additional funding for each project, although many projects indicated that they relied on multiple sources of funding. The approaches with specific project examples are displayed in Table 7.

The majority of projects reported that they sustained their HTPCP activities by integrating some or all of the activities into the operations of the grantee agency. They used a variety of funding mechanisms to accomplish this: securing state or federal support (30 percent), maximizing medical reimbursement (22 percent), acquiring local or foundation support (22 percent), and forging contractual arrangements with managed care organizations (7 percent). Some grantees (19 percent) reported that project components were adopted by another organization other than the grantee, usually a local hospital or provider network. Only two projects had successfully forged contracts with managed care organizations at the time of the survey, although many



TABLE 7. Sources of Long-Term Funding Secured by Fourth-Year, Fifth-Year, and Completed Projects

| State or Federal Support | Maximizing Reimbursement | Local or Foundation Support | Contracts with Managed Care Organizations | Adopted by Another Local Provider |
|---|--|--|--|---|
| State Department of Health supports program | Established billing mechanism | Receive local business and county support | Secured revenue contracts with local managed care organizations | Project picked up by three rural hospitals |
| Other state government resources support program | Maximized medical reimbursement | Receive contributions from Valley Family Health Care | Signed formal contracts with several managed care organizations as well as with a network of hospitals and providers | Project bought by local children's hospital |
| State-level Early Intervention department supports program | Received designation as a Federally Qualified Health Center so can receive cost-based Medicaid reimbursement | Receive local municipal support | | Project integrated into managed care programs |
| State grants and Indian Health Service funds support program | Medicaid reimbursement has kept project solvent | Receive funding from St. Joseph's Health System | | Local home care department picked up home care nursing position |
| Program supported through NIH perinatal research funding | Improved reimbursement from patient care | Receive support from Gerber | | Incorporation of project's case management protocol into Head Start |
| Program received state funding to develop training modules for state's universal home-visiting project for adolescent mothers | Maximization of fee-for-service reimbursement opportunities | Receive United Way funding | | |

more said they were working toward this goal. They commented on the need to market their activities more aggressively to managed care organizations and to exploit this market more fully.

Projects used a variety of means to secure long-term support. Local, project-specific evaluation data were successfully used by some grantees to demonstrate project efficacy in their bid to obtain long-term support. Numerous projects reported that receipt of the HTPCP grant in and of itself was helpful to them in leveraging funds; they commented that the federal funding gave their projects added prestige, credibility, and legitimacy in the eyes of potential funders.

Sustainability data were further analyzed to determine if certain project characteristics (e.g., organizational type, location, project year, project director's discipline) were associated with the use of specific funding arrangements. Only one characteristic – project director's discipline – was found to be related to the type of funding arrangement used. Projects directed by R.N.s or



Ph.D.s were three times more likely than those directed by M.D.s to use state or other federal sources of reimbursement to sustain their projects. The M.D.-led group, on the other hand, was three times more likely than the R.N./Ph.D. group to rely on local approaches to sustainability, including raising contributions from local sources, contracting with managed care organizations, and merging with the

local system of care (chi-square = 6.24 [n = 28]; p < .02). This somewhat surprising finding may be related to the personal connections of these groups: it may be that

The prestige and credibility of the HTPCP grant helped the projects leverage funds



physicians have strong ties with local hospitals and managed care organizations that can facilitate these arrangements. Nurses, particularly those with years of community health experience, may be more familiar with and more inclined to turn to state child health programs or Medicaid for funding. These different approaches deserve further analysis.

Too few projects in this study had secured long-term funding arrangements that would permit comparative analyses that might have identified patterns regarding the characteristics of projects that succeeded in this endeavor versus those that did not.

In summary, a substantial portion of HTPCP grantees appear to be successful in meeting the program goal of forging partnerships that can lead to additional support for children's health and the long-term sustainability of projects.



Project Evaluations

Like other MCHB grantees, HTPCP grantees are required to evaluate their projects. Each applicant must submit an evaluation component as part of the initial grant application. The objective review panel must approve the evaluation design before a project can be funded. Grantees are supposed to “measure changes in child health outcomes and monitor progress in meeting the program’s goals and objectives.” Table 8 lists examples of evaluation strategies reported by grantees in this survey.

The majority of projects did undertake a process evaluation and monitored their own progress toward meeting project goals and objectives. Few grantees (six) reported that they attempted an outcome evaluation. Some projects formally solicited information from clients, providers, and others on a variety of topics, such as parent satisfaction with the services that were delivered, provider and advisory committee member opinions of the project and ways to strengthen it, and the opinions of other agency staff of various aspects of the project. Only one project reported that it had collected client information such as the number of children referred and the extent to which other service providers accepted these referrals.

A few grantees noted that the evaluation process had a positive, transforming effect on their agencies. For example, one project commented that in their community

TABLE 8. Types of Evaluation Approaches Used by HTPCP Projects

| Tracking Community Health Indicators | Measuring Client Outcomes | Assessing Patient Satisfaction | Assessing Staff's and Others' Views | Tracking and Assessing Services | Tracking Costs |
|---|--|--|--|---|--|
| <p>Followed occurrence of unfavorable events (e.g., reports of child abuse and neglect).</p> | <p>Obtained information on clients' utilization of a defined set of health services (e.g., TB screening, family planning appointment, STD screening, school attendance).</p> | <p>Information obtained on the satisfaction expressed by patients. Grantees learned about the utility of program changes to increase accessibility and patient perception on other topics.</p> | <p>Project managers watched program operations over time, then compared results with their experience in other service delivery venues, forming impressions on success with improving health outcomes.</p> | <p>Service utilization, clinic attendance, and compliance with provider recommendations were monitored.</p> | <p>Calculated cost of providing services that were desired by the community, but that were not available through any existing organizations.</p> |
| <p>Used information in a database on ER and hospitalization use to compare utilization by clients receiving comprehensive integrated services with similar persons.</p> | <p>Pre- and post-program tests of parenting skills, youth risk behavior, or stress-related risk factors were obtained from patients and/or parents.</p> | | <p>Noted observations of changes in the process of service delivery itself and feedback in staff meetings to see whether their ideas resulted in improved operational efficiency (e.g., "Are we working smarter?" and "What is the effect of having a pediatrician present?").</p> | <p>Collected comprehensive data on system of care, including the number of community providers participating in the project, the number of children referred to the providers, and the extent providers accepted these HTPCP referrals.</p> | |

Table 8 continued on next page

TABLE 8. Types of Evaluation Approaches Used by HTPCP Projects (continued)

| Tracking Community Health Indicators | Measuring Client Outcomes | Assessing Patient Satisfaction | Assessing Staff's and Others' Views | Tracking and Assessing Services | Tracking Costs |
|--|---|--------------------------------|--|---|----------------|
| <p>Used health data collected by the health department as a baseline against which to compare the status of previously underserved program participants.</p> | <p>Reviewed the medical records of infants, toddlers, and children at the start and later in their program participation to determine overall project success with a high-need, chronically ill target group.</p> | | <p>Through supervision of line staff, the project director was able to obtain "key informant" opinions about communitywide progress toward integrating health and family support functions.</p> | <p>Documented work output and the number of persons served using intake and service records. These included not just health services, but also housing, education, and parenting services. Also asked, "How many units of service were delivered to new patients not seen before in the program?"</p> | |
| | <p>Pre-program and follow-up knowledge surveys were administered for health education program.</p> | | <p>Obtained feedback from field staff on their observations about the most effective outreach service delivery tactics. Also, determined from supervisors the types of training and supervision required for outreach staff.</p> | <p>The number of families without health funding who received medical care for their children was tracked.</p> | |
| | | | <p>Conducted a focus group among advisory committee members, obtaining information on perceived strengths and limitations of services provided.</p> | <p>The number of professionals who received educational information about the program's focus was counted, and follow-up telephone calls obtained suggestions for future topics.</p> | |

*Grantees
expressed
frustration in
conducting
outcome
evaluations for
their projects*



clinic, staff not involved in the HTPCP project observed HTPCP staff members' efforts to evaluate the funded activities and, as a result, began to design and implement evaluations of their own programs as well. Soon evaluation became a standard part of many programs in their clinic.

However, some respondents commented that their evaluation resources were very limited and that technical assistance was not easily available in this area. One grantee responded to this challenge by obtaining a foundation grant specifically for the purpose of hiring an evaluation consultant to measure the impact of the HTPCP project. Another formed a partnership with a local university, and together they applied for and received a grant to implement a full-scale evaluation of the project. A few grantees scaled back their initial evaluation plans because they discovered that these plans were too ambitious given the resources and the time frame they had to work within.

In short, grantees expressed considerable frustration with this aspect of their projects: They believed that there were neither sufficient funds nor adequate technical assistance to conduct a meaningful evaluation—certainly, in almost all cases, the resources were too limited to conduct an outcome evaluation.

Program Oversight and Technical Assistance

MCHB provides a range of support to its grantees. The MCHB program director provides telephone consultation on an ongoing basis and covers a multitude of topics, ranging from administrative issues (e.g., budget changes) to modification of project objectives and methodology to issues of sustainability. One project director might call to request help in linking the program with the state’s Title V program; the next project director might request assistance on developing a plan for securing matching funds; and a third might request information on resources available on a particular substantive programmatic issue. The MCHB program director establishes the HTPCP policy and develops all guidance materials for dissemination; reviews all written materials from the projects, including budgetary information, requests, and annual continuation applications; and provides oral and written feedback as well as recommendations and conditions on grant awards as appropriate.

The MCHB program director, with assistance from the AAP staff, plans, coordinates, implements, and evaluates an annual meeting of all active grantees to facilitate networking among project directors and with MCHB and AAP staff. Technical assistance workshops are provided at this meeting on a diverse array of topics—from fundraising to media promotion to enhancing cultural competence. The MCHB program director also provides technical assistance and consultation to support

their ongoing project implementation, evaluation, and grant administration.

The HTPCP was initiated in an era of federal government downsizing. The availability of federal staff to implement and monitor the program has been extremely limited. In fact, only one federal position has ever been allocated for stewardship of this program. The creative partnership with the AAP has served to enhance technical assistance by securing, for example, additional resources through its array of connections and its thousands of members who are privately practicing pediatricians. It was also hoped and anticipated that AAP involvement would enhance the attention of the organization to public health community-based approaches to care and would encourage local pediatricians to become effective advocates for children.

The AAP Committee on Community Health Services (COCHS) participates as a partner with MCHB/HRSA in setting the direction of the HTPCP. The MCHB/HRSA partnership with the AAP is supported via a cooperative agreement, which is a special type of grant that establishes responsibilities for both the grantee and the funding agency. AAP was tasked with providing technical assistance through both site visits



and telephone consultation. Under its cooperative agreement, which was initially supported in 1991, each project is visited twice, in year 1 and year 4 of the grant. The technical assistance site visit team, which is led by an AAP pediatrician and includes the AAP project manager for the HTPCP, participates in problem solving and provides suggestions and advice during the visit and through a subsequent written report. Due to restrictions in travel funds, the MCHB project director is only occasionally able to participate in these site visits. Other site visit team members include a HRSA field office MCH program consultant, a state Title V representative, and the state AAP chapter president. In addition to organizing site visits, the national office of the AAP (represented by the AAP project manager for the HTPCP) contacts all new grantees, assists them in identifying appropriate AAP resources, and responds to telephone requests for technical assistance.

The grantee questionnaire found that 74 percent of grantees obtained technical assistance from MCHB and 68 percent from the AAP project manager for the HTPCP. Grantees also relied on regional MCH program consultants (35 percent), the state Title V office (30 percent), local AAP chapters (30 percent), and state AAP chapters (23 percent) for assistance. HTPCP staff also showed resourcefulness in seeking out other sources of technical assistance, including schools of public health, colleges of nursing, and foundations. Assistance was most frequently sought in the areas of evaluation (78 percent), substantive program issues (67 percent), long-term sustainability (57 percent), and securing matching funds (44 percent).

Grantees gave high ratings to their technical assistance providers. Those receiving assistance from MCHB and the national AAP office reported that technical assistance was timely, relevant, and helpful. Grantees who received technical assistance from local AAP fellows, however, gave more mixed reactions to the assistance. Several grantees pointed out that MCHB and AAP

One grantee noted, "The connections I made at the annual project director's meeting have been wonderful and supportive. I think this is a unique benefit of this grant."



staffs have been accessible, knowledgeable, and supportive. Numerous grantees also offered positive comments about the annual project director's meeting:

The connections I made at the annual project director's meeting have been wonderful and supportive. I think that this is a unique benefit of this grant.

The annual director's meeting has been very helpful—a great opportunity to meet like-minded people and to share ideas.

The experience of working with other project directors was wonderful. The idea of community, private, federal, and AAP partnerships was inspiring.

The money was minimal but the contact with other project directors was outstanding. I learned how many other people are as crazy as I am about kids in need.

While reactions were generally favorable to the technical assistance and support provided by MCHB and the AAP, a few grantees pointed out that the amount of reporting and documentation required by the agency is excessive for a grant of this size. These grantees suggested that reporting requirements be reduced.



Conclusions

The goals of these grantees tend to be modest, attainable, and consonant with the small size of the grant



The HTPCP appears to be an effective strategy for promoting children's access to health services at the community level.

The HTPCP has clearly initiated new and enhanced existing community-based service programs. The goals of these grantees tend to be modest, attainable, and consonant with the small size of the grant: namely, to implement proven strategies, such as case management, home visiting, and transportation, that have been demonstrated as effective elsewhere. This is a worthy and laudable achievement.

Modest funding provided to community organizations, with a matching funds requirement, can leverage significant amounts of money for children's health care.

HTPCP grants are quite small by federal program standards. Yet, this amount appears to be adequate both to provide a valuable service and to attract additional funding. The match requirement forced grantees to solicit additional funding from the outset, and in fact, the amount leveraged is quite remarkable, representing almost a fourfold increase in available dollars for children's health.

The HTPCP includes elements that successfully foster long-term sustainability of services.

Several elements of this program may help to secure permanence for the services it funds: The match



requirement forces grantees to begin searching for additional funds immediately. At the same time, grants are funded for a long enough period (5 years) both to demonstrate success and value locally and to enable grantees to develop the relationships with other groups that are needed to secure the resources that can sustain the program.

Small, community-based projects often do not have the expertise or resources to conduct outcome evaluations.

Valid outcome evaluations are challenging and often expensive to conduct. Expertise in evaluation design is required; such expertise is typically costly and may be difficult to acquire. Thus, it is not surprising that few HTPCP projects even attempted an outcome evaluation. Even a process evaluation in a services program may be considered an innovation—and in fact, the process evaluations and client and staff satisfaction surveys undertaken by these grantees were viewed locally as innovative and valuable.

Meaningful multiagency partnerships and collaborations can greatly improve the delivery of services for children, but they are challenging to develop and attempts to do so frequently fail.

Most HTPCP projects ultimately developed what they considered to be effective and productive partnerships, and project directors believed that these were critical to the success of their projects. However, many difficulties were encountered in developing these relationships. This finding suggests a need for specialized training and ongoing support for community-based projects in the development of partnerships and collaborations. Moreover, it might help to clarify different types of partnerships and collaborations, and what can be realistically expected from each. For example, partnerships with other health care providers can help ensure a “seamless” and comprehensive system of care; cooperative arrangements with other service providers (schools, social service agencies, etc.) can broaden the focus of health and

enhance the community's ability to prevent problems; coalitions with community groups (PTA, the faith community, etc.) can provide avenues for advocacy for children and children's services. It is not clear from this survey whether grantees distinguished between these types of partnerships in their responses.



Pediatricians and other pediatric health professionals, when provided with support through a mechanism such as a grant, can serve as leaders and advocates in improving children's access to services.

Advocacy efforts on the part of HTPCP grantees – primarily pediatric health professionals – led to improved service components, permanent changes in local services, and new dollars for children's health. Thus, while the survey data do not directly address questions of advocacy and leadership by pediatricians, these can be inferred as program achievements.

The activities of staff at the federal level and at the AAP provide important guidance and leadership to HTPCP projects and contribute to the program's success.

Projects received support from a variety of both public and private sources. Critical feedback from technical assistance site visits, ongoing telephone consultation, a written critique of continuation applications, and an annual grantee meeting helped keep projects on course and identified areas in need of additional attention. The overwhelmingly positive response of projects to the technical assistance they received, especially from MCHB and the AAP HTPCP staff, points to the effectiveness of this approach.



Recommendations

(1) Program attributes:

- Continue the programmatic focus on cultural competence. The ongoing struggle by projects with this issue demonstrate its profound importance for ensuring children's access to care. The rapidly changing demographics of the United States also argue for a strong, continued emphasis on cultural issues in health care.

(2) Collaboration:

- Continue to emphasize different types of partnerships with multiple groups. This requirement of the program appears to be important and successful.
- Consider providing intensive training in coalition building and partnership development for project staff within the first 6 months of the grant award. Projects appear to be repeating mistakes made by others in their attempts to create new collaborative arrangements. Intensive training—such as a 2-day workshop—on this topic might be one way to assist grantees at an early stage in their grant to be more successful. Such training could also help clarify for grantees what might reasonably be expected from a variety of community groups. Grantees appear to need special help in developing effective advisory groups.

(3) Evaluation:

- Continue to require outcome evaluation, and provide training and/or special technical assistance materials within the first 6 months of the grant award. Projects reported that even though they had difficulty conducting outcome evaluations, these evaluations were critical for ensuring that programs were indeed effective in meeting their objectives and in securing funds for sustaining the program. However, grantees indicated that they had particular difficulty in obtaining technical assistance on this topic. While the sophistication and resources needed for outcome evaluation are often not available to such modestly funded, community-based grantees as those in the HTPCP, another entity could be supported solely for providing ongoing technical assistance in program evaluation.
- Consider modifying the HTPCP grant guidance to include specific outcome measures and other process/performance measures appropriate for the program. MCHB might even specify a greater emphasis on collecting data for a small number of outcomes (1-3) rather than devoting significant resources to collecting process data.
- Consider adding community performance monitoring requirements for some projects to assess the usefulness of this approach to improving children's health care. In recent years, the field of public health has come to recognize the value of performance monitoring, with specified accountability, as a model for achieving community-based improvements to health. The HTPCP would appear to be an excellent vehicle for demonstrating the potential worth of this approach.

(4) HTPCP Management:

- Continue the MCHB/HRSA/AAP partnership: This public-private partnership provides prestige, visibility, and resources to local programs. It also helps extend the capability of MCHB to manage this

extensive program with limited staff.

- Increase the HTPCP staff at the federal level: It is remarkable that only one person is managing such a large and complex program. Attending to the myriad administrative details of such a program obviously limits the time available for program planning, implementation, and evaluation; participation on the AAP technical assistance site visit team; and other important aspects of program management. An increased level of staffing could enhance MCHB's ability to administer this program.
- Increase technical assistance and consultation capacity: While MCHB and the AAP both provide phone consultation to grantees and the AAP provides technical assistance site visits, such efforts are still not of sufficient capacity to meet the technical assistance needs of grantees. MCHB should consider adding staff in order to provide more intensive, tailored technical assistance and consultation to projects. Assistance in a variety of areas – evaluation in particular – with greater sustained attention to each project could benefit these projects and improve their effectiveness. The goals of these grantees tend to be modest, attainable, and consonant with the small size of the grant: namely, to implement proven strategies, such as case management, home visiting, and transportation, that have been demonstrated as effective elsewhere.

(5) Sustainability

- Consider linking with CHIP programs. Lessons learned through the HTPCP experience, such as how to link uninsured children to needed health services, should inform the development of state CHIP plans and local outreach efforts. The extensive experience of HTPCP projects in working with culturally and linguistically diverse populations should be shared with state and local policymakers and program planners who are currently shaping the development of CHIP programs.



Questions for Further Study

This analysis has demonstrated many valuable and worthy features of the HTPCP and has provided insights that can inform a future study of the program. Additional information would help the national program further tailor its technical assistance and program requirements. Questions that could be explored in future evaluations include

- What strategies are being used to make services family centered?
- What are the barriers to achieving integration with managed care organizations, and what strategies have projects used that have succeeded in securing such support?
- What is the impact of project staff turnover on the accomplishments of the program?
- What are the specific roles that pediatricians play in HTPCP projects? What are the types of relationships that pediatricians and pediatric health providers form in their communities to support the development and sustainability of HTPCP?

Finally, it is important to the nation to understand how projects such as those funded under the HTPCP can continue to improve children's health. The United States' health care system is currently in the midst of two revolutions that, in theory, could dramatically improve chil-

dren's access to coordinated, preventive health services: (1) the growth of managed care programs, which are designed to improve the coordination of preventive and primary health services for children and families; and (2) the implementation of CHIP, which will address the financial barriers currently facing uninsured children from working-poor families. It is the movement from theory to practice that will determine whether children's health improves as a result of these two revolutions. When the Medicaid program was expanded to increase access to health services for pregnant women and children, the public health and medical communities learned that providing financial access to health services did not necessarily improve access to care. Nonfinancial barriers persisted, including transportation problems, uncoordinated services, inadequate attention to language and cultural issues, and the needs beyond health care that affect a child's health. MCHB/HRSA and the AAP sought to address these barriers by developing and implementing the HTPCP.

The challenge now is to infuse the lessons learned from the HTPCP into managed care systems that serve children and into each state's CHIP program. This evaluation of HTPCP projects can serve as one means of communicating these lessons. Many more conduits are needed.

Community-based prevention programs like the HTPCP that focus on nonfinancial barriers to care and that coordinate health and other systems of care for children and families can go a long way toward transforming these promising theories into practice and improving children's access to health care and, ultimately, their health. ■



References

Bazzoli GJ, Stein R, Alexander JQ, Conrad DA, Sofaer S, Shortell SM. 1997. Public-private partnerships in health and human service delivery: Evidence from community partnerships. *Milbank Quarterly* 75(4):533-562.

Centers for Disease Control and Prevention, National Center for Health Statistics. 1998. National Vital Statistics System. In National Center for Health Statistics [Web site]. Available at <http://www.cdc.gov/nchswww/about/major/nvss/nvss.htm>.

Centers for Disease Control and Prevention, National Center for Health Statistics. 1998. National Immunization Survey. In National Center for Health Statistics [Web site]. Available at <http://www.cdc.gov/nchswww/about/major/slichs/slichs.htm>.

Margolis PA, Carey T, Lannon CM, Earp JL, Leininger L. 1995. The rest of the access to care puzzle: Addressing structural and personal barriers to health care for socially disadvantaged children. *Archives of Pediatrics and Adolescent Medicine* 149(5):541-545.

Melaville A, Blank MJ. 1991. *What It Takes, Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services*. Washington, DC: Education and Human Services Consortium.

Meyer JA, Bagby NS. 1998. *Beyond Enrollment: Are SCHIP Plans Linking Children to Quality Health Care?* Washington DC: New Directions for Policy.

Millman M, ed. 1993. *Access to Health Care in America*. Washington DC: National Academy Press.

National Institute on Drug Abuse. 1996. *National Pregnancy and Health Survey: Drug Use Among Women Delivering Live Births: 1992* (NIH Publication No. 96-3819). Washington, DC: U.S. Government Printing Office.

Riportella-Muller R, et al. 1996. Barriers to the use of preventive health care services for children. *Public Health Reports* 111(1):71-77.

Short PF, Lefkowitz DC. 1992. Encouraging preventive services for low-income children: The effect of expanding Medicaid. *Medical Care* 30(9).

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. 1997. *Child Maltreatment 1996: Reports from the States to the National Child Abuse and Neglect Data System*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Justice, Bureau of Justice Statistics. 1998. National Crime Victimization Survey. In Bureau of Justice Statistics [Web site]. Available at <http://www.ajp.usdoj.gov/bjs/> or <http://www.icpsr.umich.edu/NACJD/home.html>.

U.S. General Accounting Office. 1987. *Prenatal Care: Medicaid Recipients and Uninsured Women Receive Insufficient Care* (GAO-HRD-87-134). Washington DC: U.S. General Accounting Office.

Weigers ME, Weinick, RM, Cohen JW. 1998. *Children's Health, 1996* (Medical Expenditure Chartbook No. 1,

AHCPR Pub. No. 98-0008). Rockville, MD: Agency for Health Care Policy and Research.

White JA, Wehlage G. 1995. Community collaboration: If it is such a good idea, why is it so hard to do? *Educational Evaluation and Policy Analysis* 17(1):23-38.



Appendix A: Descriptive Charts of HTPCP Projects

FIGURE 1. Organizational Type of HTPCP Grantees (n = 74)

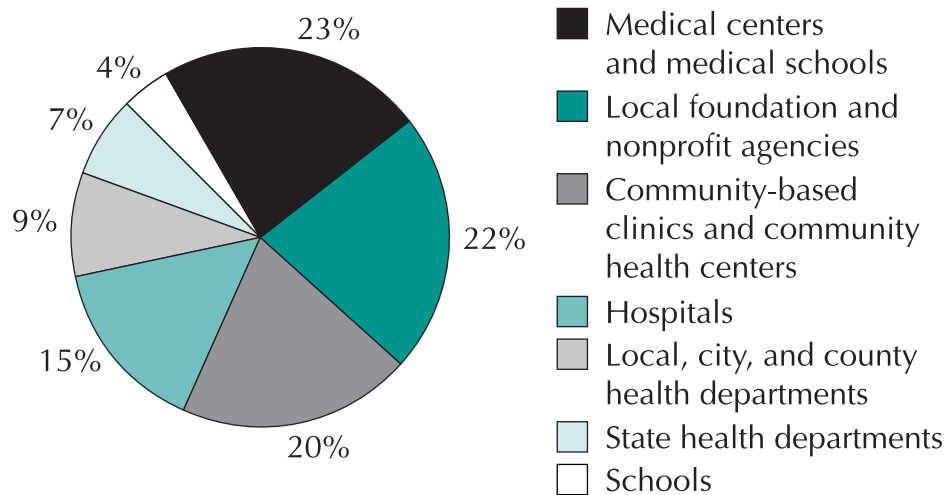


FIGURE 2. HTPCP Sites by Community Type

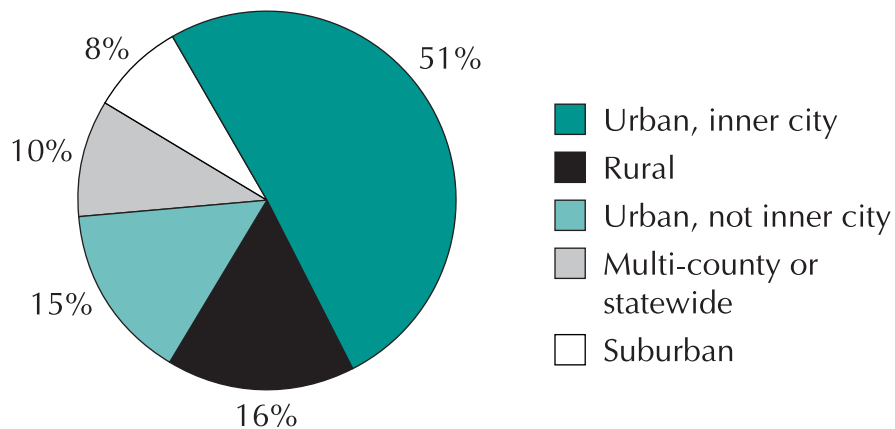


FIGURE 3. HTPCP Clients by Age Group

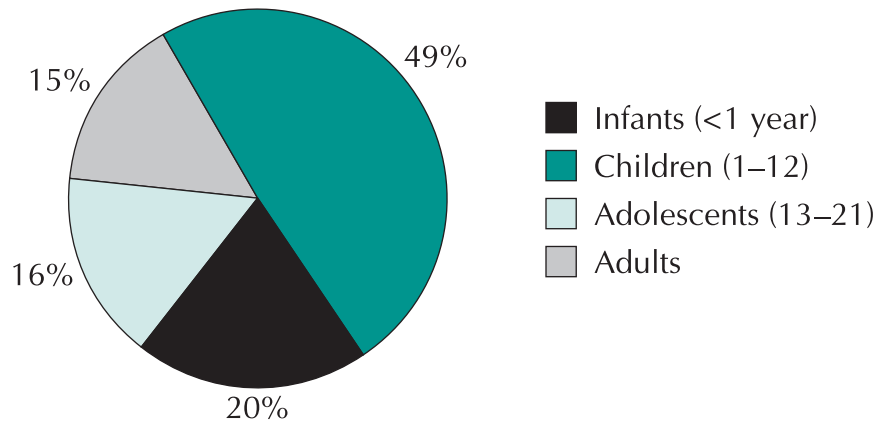


FIGURE 4. HTPCP Clients by Insurance Status

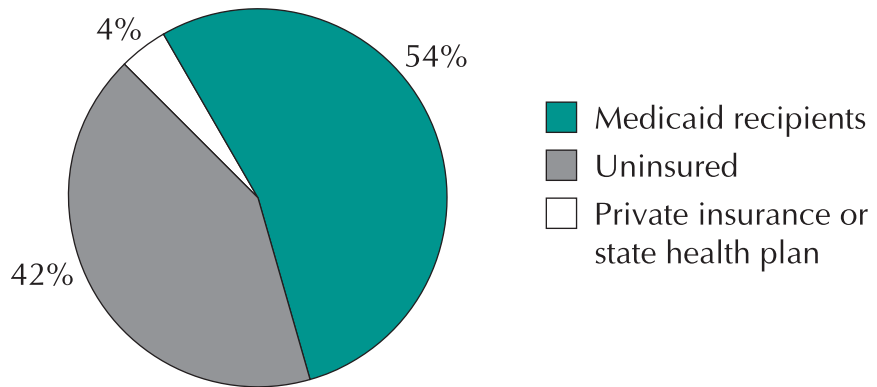


FIGURE 5. HTPCP Clients by Racial/Ethnic Group

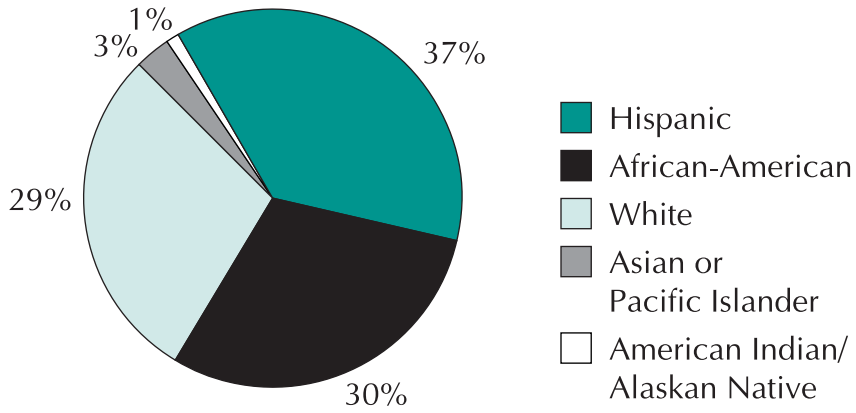


FIGURE 6. HTPCP Project Directors by Discipline

| Academic Degree | Number of Project Directors (n = 85) |
|---|--------------------------------------|
| M.D. | 40 |
| R.N. | 7 |
| Ph.D. | 6 |
| M.A. / M.S. / M.P.H. | 10 |
| M.S.W. / L.C.S.W. / L.M.S.W. / A.C.S.W. | 4 |
| B.S.N. | 2 |
| Dr.P.H. | 2 |
| Other | 7 |
| None reported | 7 |



Appendix B: HTPCP Survey

1. In what year was your Healthy Tomorrows (HT) project initially funded?

Year _____

2. In which year of federal HT funding are you currently operating? (Circle one.)

Year 1 2 3 4 5 Completed

3. Which best describes the community in which your HT project operates?

- Urban, inner city
- Urban, not inner city
- Suburban
- Rural
- Statewide
- Other (Specify.) _____

4. How many Project Directors (PDs) have you had and how long has each served?

No. PDs _____

Length of service for

PD #1 _____

PD #2 _____

PD #3 _____

PD #4 _____

5. Is the current Project Director responsible for daily management of the project?

- Yes
- No

If "no," who is responsible?

Name _____

Title _____

6. What populations were served by your HT project? What were the numbers served within each population? (Please include all participants enrolled in the program, regardless of length of time enrolled. Please provide an unduplicated count – i.e., do not include a participant in more than one population category.)

(Check all that apply.)

(Write no. for each one checked.)

- Infants (< 1 year) _____
- Children (1-12 years) _____
- Adolescents (13-21 years) _____
- Pregnant women _____
- Other _____

7. What proportion of the people ever served by your HT project fell into these insurance categories?

(Check all that apply.)

(Write % for each one checked.)

- Uninsured _____
- Medicaid recipients _____
- Other (Specify.) _____

TOTAL=100%

8. What proportion of the children ever served would you estimate to be in the following racial or ethnic groups? (Write a %, including any 0%.)

- Black, non-Hispanic _____
- White, non-Hispanic _____
- Hispanic _____
- American Indian/
Alaskan Native _____
- Asian or Pacific Islander _____
- Other (Specify.) _____

TOTAL=100%

9. What implementation strategies have you included in your HT project to ensure cultural competence?

MEETING COMMUNITY NEEDS

Maternal and Child Health Issues

10. On which child health issues did your HT project focus? (Check all that apply.)

- Access to medical services (financial barriers)
- Access to medical services (nonfinancial barriers)
- Child abuse/family violence
- Children with special needs
 - Broad population of children with special needs
 - Asthma
 - Hearing impairment
 - Developmental & learning disorders
 - Other (Specify.)

-
- Dental care
 - Health education
 - Homelessness
 - Immunizations/preventive care
 - Injury prevention
 - Mental health
 - Nutrition
 - Parenting education/support
 - Poor pregnancy outcomes/infant mortality
 - Sexually transmitted disease/HIV
 - Substance abuse
 - Teen pregnancy and parenting
 - Other (Specify.)
-

Services

11a. What services were provided to address the issues checked above?

(Check all that apply.)

- Primary health care services (a)
- Enhancement of access to medical care (b)
- Health education (c)
- Counseling (d)
- Peer counseling (e)
- Support groups (f)
- Home visiting (g)
- Case management/care coordination (h)
- Dental services (i)
- Nutritional services (j)
- Mental health services (k)
- Literacy education (l)
- Family empowerment (m)
- Parenting skills education (n)
- Multidisciplinary team for pediatric visit/family advisor (o)
- Community mentors (p)
- Health screening (q)
- Support services (e.g., transportation, child care, translation) (r)
- Services for special populations (s)
- Incentive gifts for preventive care (t)
- Other (Specify.)

_____ (u)

11b. Please go back to Question 11a and circle those services that are new (i.e., those services you initiated under the HT grant).

12a. Of the child health issues you checked in Question 10, which do you feel was the most critical?

Issue

12b. Please list up to four services that you provide to address this particular issue. (Refer to list provided in Question 11a and write the letter corresponding to the appropriate service in the boxes provided below.)

Services provided to address this issue (Write in letters.)

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

12c. Please describe which aspects of these services are new.

BUILDING PROGRAM CAPACITY

Program Operation

13. Briefly describe the new/enhanced system(s) of care created under your HT grant. Please highlight any linkages formed between your HT project and other initiatives in the community.

14. What function does the system of care serve? (Check all that apply.)

- Moving toward a full continuum of care
- Providing comprehensive primary care
- Building linkages to services
- Coordinating care
- Focusing on gaps in services
- Other (Specify.)

15a. In the table below, please indicate the type of arrangements you have in your coordination of efforts with the other MCH programs indicated. (Check all that apply.)

No substantive collaboration
Memorandums of agreement
Contractual arrangements
Common protocols
Joint staff training
Joint data collection efforts
Referral systems

| | | | | | | | | |
|---------------------------|--|--|--|--|--|--|--|--|
| Local health department | | | | | | | | |
| Social services | | | | | | | | |
| Education | | | | | | | | |
| Child care | | | | | | | | |
| State Title V (MCH) | | | | | | | | |
| Medicaid | | | | | | | | |
| WIC | | | | | | | | |
| Title X (family planning) | | | | | | | | |
| Head Start | | | | | | | | |
| Healthy Start | | | | | | | | |
| AAP state chapter | | | | | | | | |
| Other (Specify below.) | | | | | | | | |

15b. Please elaborate on any other coordination arrangements with the MCH programs indicated or any other MCH programs.

16. How has your HT project worked with managed care organizations in your community? For example, have you worked with managed care organizations to develop EPSDT standards for managed care contracts?

Partnerships

17. With whom has your HT project formed partnerships? (Check all that apply.)

- Professionals
- Families
- Businesses
- Foundations
- Schools
- Universities
- Hospitals
- Health or human service agencies
(Specify.) _____
- Community-based organizations
(Specify.) _____
- Other (Specify.) _____

18. When were new partnerships formed? (Check all that apply.)

- When planning and writing the grant proposal
- After the grant was awarded

19. Were there formal agreements regarding these partnerships? (Check one.)

- No
- Yes (Specify.) _____

20. Did partners contribute funds to the project? (Check one.)

- No
- Yes

If "yes," specify the name of the partner and the total dollar amount they contributed during the course of the project.

Name _____

Amt. \$ _____

Name _____

Amt. \$ _____

Name _____

Amt. \$ _____

21. Did partners assist in fundraising efforts? (Check one.)

- No
- Yes

22. How helpful were these partnerships in meeting the goals of your HT project? (Circle one number.)

| | | | | |
|-----------|-------------|---------|------------------|--------------|
| Hindrance | Not helpful | Neutral | Somewhat helpful | Very Helpful |
| 1 | 2 | 3 | 4 | 5 |

23a. In your estimation, to what extent are health, education, and social services integrated in your project? *(Circle one number.)*

Not at all Not very Partially Somewhat Very
Integrated Integrated Integrated Integrated Integrated

1 2 3 4 5

23b. How are health, education, and social services integrated into your HT project?

Advisory Committee

24. Was your HT advisory committee created from *(Check one.)*

- A preexisting advisory committee for other projects
- A community planning group that now assumes an advisory role
- A new group of individuals
- Other *(Specify.)*

25. How has your HT advisory committee evolved over time?

(Check one.)

- Remained part of another advisory committee
- Grew to be a major committee in the community
- Became a stand-alone committee for HT only
- Ceased to function as an advisory committee for HT
- Other *(Specify.)*

26. How often does/did your HT advisory committee meet? *(Check one.)*

- Weekly
- Twice a month
- Monthly
- Quarterly
- Other *(Specify.)* _____

27. On average, how many hours did HT advisory committee members volunteer per year?

_____ hours

28. Were committee member hours used toward the funding match by assigning a money value to the time? *(Check one.)*

- No
- Yes

29. What links were created in the community as a result of the HT advisory committee?

(Check all that apply.)

- With health care organizations/agencies *(Specify.)*

- With health care providers
- With policymakers
- With families
- With social services
- With support services
- With businesses
- With schools or universities
- With foundations
- Other *(Specify.)*

30. Who is on your HT advisory committee? *(Check all that apply.)*

- Pediatricians
 - Other physicians
 - Public health professionals
 - Psychologists
 - Psychiatrists
 - Dentists
 - Nutritionists
 - Nurses
 - Other health care providers
 - Educators
 - Social service agencies
 - Title V
 - Medicaid
 - Parents/consumers
 - Churches
 - Local media
 - Businesses
 - Representatives from minority organizations
 - Other *(Specify.)*
-

31. In which HT activities does the advisory committee participate? *(Check all that apply.)*

- Planning
 - Networking
 - Overseeing the HT program
 - Community organizing and recruiting
 - Influencing policymakers
 - Fundraising
 - Program implementation
 - Program evaluation
 - Other *(Specify.)*
-

32. How important was the advisory committee in helping you meet the goals of your HT project? *(Circle one number.)*

| | | | | |
|-----------|-------------|---------|------------------|--------------|
| | Not helpful | Neutral | Somewhat helpful | Very Helpful |
| Hindrance | | | | |
| | 1 | 2 | 3 | 4 |
| | | | | 5 |

33. Please comment on your experiences, both positive and negative, in collaborating with your partners and advisory committee members.

STAFF BACKGROUND AND LEVEL OF INVOLVEMENT

34. Please provide the following information in the table below.

a. What type of professionals are currently on the staff of your HT project, on either a paid or a volunteer basis? *(Check all that apply.)*

b. At what level of involvement?

(On the appropriate line, please indicate the average number of hours worked per week by paid and volunteer staff.)

c. Please circle your Project Director's discipline.

| | Paid Hrs/wk | Volunteer Hrs/wk |
|---|----------------|---------------------|
| <input type="checkbox"/> Pediatrician | _____ | _____ |
| <input type="checkbox"/> Obstetrician/gynecologist | _____ | _____ |
| <input type="checkbox"/> Psychologist | _____ | _____ |
| <input type="checkbox"/> Psychiatrist | _____ | _____ |
| <input type="checkbox"/> Nurse practitioner | _____ | _____ |
| <input type="checkbox"/> Home visiting nurse | _____ | _____ |
| <input type="checkbox"/> Nurse midwife | _____ | _____ |
| <input type="checkbox"/> Nurse | _____ | _____ |
| <input type="checkbox"/> Dentist | _____ | _____ |
| <input type="checkbox"/> Nutritionist | _____ | _____ |
| <input type="checkbox"/> Health educator | _____ | _____ |
| <input type="checkbox"/> Social worker | _____ | _____ |
| <input type="checkbox"/> Service coordinator | _____ | _____ |
| <input type="checkbox"/> Public health professional | _____ | _____ |
| <input type="checkbox"/> Physical therapist | _____ | _____ |
| <input type="checkbox"/> Educator | _____ | _____ |
| <input type="checkbox"/> Other <i>(Specify.)</i> | _____ | _____ |

TECHNICAL ASSISTANCE

35. What technical assistance (TA) have you received? (Check all that apply.)

- Assistance with your grant application
If so, who assisted you?
- Attending HT project directors meetings
- Site visits
- Other (Specify.)

36. From whom did you receive TA?

(Please address the full range of TA providers involved in your project, including those providing phone consultation, site visits, etc.)

- Maternal and Child Health Bureau
- Regional MCH Program consultants
- State Title V office (MCH Program)
- American Academy of Pediatrics (AAP)
(Elk Grove Village)
- State AAP chapter office
- Local fellows representing the AAP
- National Center for Education in Maternal and Child Health
- Schools of public health
- Other MCHB programs
- Other links in the community
- Other (Specify.) _____

37. On what topics did you receive TA?

(Check all that apply.)

- Programmatic issues
- Project scope of work
- Sustainability
- Evaluation
- Public relations
- Obtaining matching funds
- Networking
- Identifying resources for TA
- Grant administration
- Program advisory committee
- Other (Specify.) _____

38a. Please think of the most relevant TA that you received. Go back to Question 36 and circle the name of the one organization that provided this TA, and then, in Question 37, circle the topic of this TA.

38b. Rate this particular TA on the following dimensions:

| | Not | Somewhat | Very | Extremely |
|----------|-----|----------|------|-----------|
| Timely | 1 | 2 | 3 | 4 |
| Relevant | 1 | 2 | 3 | 4 |
| Helpful | 1 | 2 | 3 | 4 |

BARRIERS AND CHALLENGES

39. What challenges did you encounter?
(Check all that apply.)

I. Initially, when you were writing the grant proposal and first implementing the HT project

(a) In the community

- Obtaining resources to apply for HT
- Enlisting pediatric involvement
- Enlisting support from state Title V
- Enlisting business support
- Enlisting support of local community organizations
- Enlisting support of local government
- Other (Specify.) _____

(b) In the program

- Recruiting staff
- Obtaining space
- Other (Specify.) _____

II. Later, during full HT program operation

(a) In the community

- Obtaining matching funds
- Recruiting participants
- Using community workers
- Obtaining cooperation in integrating efforts with other agencies
- Implementing policy changes at various levels
- Maintaining family involvement
- Other (Specify.) _____

(b) In the program

- Staff turnover
- "Red tape," paperwork
- Setting overly ambitious goals
- Operationalizing management information systems
- Recruiting and retaining members for the advisory committee
- Convening the advisory committee
- Other (Specify.) _____

40. What was your most significant barrier and what steps did you take to try to overcome it?

FINANCES/SUSTAINABILITY

41. What was your total HT project budget for the last fiscal year, including the federal HT grant? (For projects that are already completed, please provide the budget from project year 5.)

Total budget \$ _____

42. What percentage of your two-thirds match in years 2 through 5 was obtained in

Hard money? _____%

In-kind contributions? _____%

43. From whom was the hard money match obtained in years 2 through 5? (Check all that apply.)

- Corporations
- Foundations
- State government
- Local government
- Other (Specify.) _____

44. Which of the following community resources have helped you implement/maintain your program with in-kind contributions? (Check all that apply.)

- Other health care providers
- Local health departments
- Local or state government
- Foundations/philanthropic groups or individuals
- Local community boosters (e.g., Kiwanis, Lions)
- Local churches
- Community schools
- Local managed care/health maintenance organizations
- Individuals
- Other (Specify.) _____

45. Which of the following in-kind contributions have helped support your program?

(Check all that apply.) (Check if applied to 2/3 match.)

- Free rent ○
- Free utilities ○
- Donated physician services ○
- Donated services from other health professionals ○
- Other nonmedical volunteer labor ○
- Donated medical supplies ○
- Donated nonmedical materials, such as furniture or food ○
- Other (Specify.) _____ ○

46. Did the HT grant help you secure funding from other sources?

(Check one.)

- No
- Yes *(Explain how.)*

47. What steps have you taken to ensure the sustainability of your HT project efforts at the end of your federal funding year?

EVALUATION

48. What kind of an evaluation have you done?

- Quasi-experimental design (comparison groups)
- Before-and-after comparison
- Process evaluation (description of program activities)
- Satisfaction survey
- Other *(Specify.)*

49. Please elaborate on your evaluation design and explain how you use it to measure progress toward project goals and objectives.

50. What do you see as your project's main accomplishments?

51. How did your HT project make a difference in your community?

CONSUMER IMPRESSIONS

52. How have you measured consumer reaction to your HT project services and what did you find?

OTHER COMMENTS

54. Do you have any other comments you would like to make about your HT program?

LESSONS LEARNED

53. Given your experiences, what lessons have you learned about how to establish and run a successful HT project? What key advice would you give to those trying to start a program?

CONTACT INFORMATION

On the first line below, please provide your name, highest degree, and job title. Below it, please fill in the name(s), degree(s), and job title(s) of the individual(s) who assisted you in completing this survey.

Name _____ Degree _____

 Job Title _____

Name _____ Degree _____

 Job Title _____

Name _____ Degree _____

 Job Title _____

Your phone number: _____



Appendix C: Healthy Tomorrows Partnership for Children Program (HTPCP) Projects

Projects are listed alphabetically by state and include all HTPCP grants funded from FY 1989 through FY 1996. For a longer description of projects, please visit the National Center for Education in Maternal and Child Health (NCEMCH) Web site at www.ncemch.org.

ALABAMA

TEEN (Teens Empowered through Education and Nurturing)

Shirley Worthington, L.C.S.W., P.I.P.
Family Oriented Primary Health Care Clinic
Mobile County Health Department
251 North Bayou Street
P.O. Box 2867
Mobile, AL 36652
Project Number 018632

The project aims to (1) reduce repeat adolescent pregnancy for the Family-Oriented Primary Health Care Clinic (FOPHCC) Women's Center primigravida adolescents through expanding community collaboration; and (2) reduce the incidence of child abuse and neglect among this high-risk, socioeconomically disadvantaged population of first-time adolescent mothers and infants. We will use prenatal and postnatal intensive case management, home visits, preventive health care, and community-based family strengthening programs, including parent-child interactive skill building and knowledge-based group programs.

ALASKA

Rural TOTS

Paula McMeen, B.S.
REACH, Inc.
Infant Learning Program
P.O. Box 34197
3272 Hospital Drive
Juneau, AK 99803-4197
Project Number 028675

Reducing the severity of chronic health and developmental disability for children and families in rural southeast Alaska is the aim of the project. The project will focus on providing families with local access to early intervention and medical services. Family service coordination and developmental assessments will be provided in the community. This program will shift the model from the medical model to the family-centered model.

New Beginnings

Keirsten Smart
Southcentral Foundation
64501 Diplomacy Drive
Anchorage, AK 99508
Project Number 028030

This program seeks to reduce child abuse and neglect in Alaska Native and American Indian families in the Anchorage area. The objective for the 5-year period is to reach approximately 200 families, resulting in a 50-percent reduction of child abuse and neglect. The prevention of child abuse and neglect will be facilitated by a family service worker. Home visit family support services will include crisis intervention, emotional sup-

port to parents, informal counseling, role modeling of family relationships, communication skills, life coping skills, and linkages to other services.

CALIFORNIA

East County Healthy Tomorrows

Bronwen Anders, M.D.
East County Community Clinic
10039 Vine Street, Suite 2
Lakeside, CA 92040
Project Number 068903

This project provides coordinated perinatal and comprehensive pediatric care to an underserved Hispanic population. A bilingual health educator makes contact with women at the time of delivery and schedules a prompt return to the clinic. The groups are run by a health educator, a pediatrician, and a research assistant. Health outcomes monitored include improved breastfeeding rates, more complete and timely immunizations, and reduced use of emergency rooms for minor pediatric problems.

The San Diego Homeless Adolescent Health Care Project

Nancy Bryant Wallis, Dr.P.H.
Logan Heights Family Health Center
1643 Logan Avenue
San Diego, CA 92113
Project Number 068918

This 5-year project has established the following goals: (1) Create a system of comprehensive, case-managed health care for the thousands of throwaway, runaway, and near-homeless adolescents in San Diego by bringing available services onsite to places where young persons and their families live and congregate; (2) create a coalition of community agencies and pediatric professionals to provide services to homeless adolescents; (3) collect and disseminate project data, including demographics, chronic and acute medical conditions diagnosed, and contagious diseases (such as sexually transmitted diseases, HIV infection, and tuberculosis); and (4) obtain a detailed risk assessment to

monitor clients' knowledge, attitudes, beliefs, and behaviors.

San Diego Dental Health Initiative

Amethyst C. Cureg, M.D.
County of San Diego, Department of
Health Services
3851 Rosecrans Street
P.O. Box 85222, Mailstop: P511F
San Diego, CA 92186-5222
Project Number 068005

The overall project goal is to improve the oral health of children in San Diego County. Health systems improvement goals are to (1) provide quality oral health care at no cost to culturally diverse, underserved income-eligible children with urgent dental needs, and (2) provide community-based cultural-specific approaches to oral health education for families. The health status improvement goal is to increase the number of children receiving oral care for urgent conditions of dental disease or injury. A public-private partnership will be created to provide family preventive oral-health education and appropriate and timely no-cost treatment for uninsured children of low-income families.

Healthy Tomorrows Partnership for Children

Lucinda Hundley, M.A.
Santa Ana Unified School District
1601 East Chestnut
Santa Ana, CA 92701
Project Number 068908

This collaborative project targets five elementary schools (4,000 students) in an ethnically diverse school district where 85 percent of the population is Hispanic and immigrants constitute 40 percent of the population. The project goals are to (1) provide accessible preventive health care for elementary school students in the school district, (2) provide school-linked social services, and (3) empower parents as primary caregivers through comprehensive health education. Objectives are being met through a mobile medical van staffed by a full-time bilingual pediatrician and a full-time bilingual regis-

tered nurse, who provide appropriate preventive and followup medical care; a bilingual health insurance counselor (who also functions as secretary and driver); five full-time, school-linked social workers; and a comprehensive parent education program (currently being developed).

Project for Attention Related Disorders

Phillip Nader, M.D.
San Diego Unified School District
2716 Marcy Avenue
San Diego, CA 92113
Project Number 068906

A school-community network will provide diagnostic and intervention services for low-income children and youth who exhibit symptoms of attention-deficit disorder. The network will include pediatricians, school nurses, teachers, school administrative and support personnel, after-school care providers, community mental health and medical clinic staff, and representatives from parent advocacy groups. Professional education will include didactic sessions, written guidelines and resource materials, and site consultation for multicase review and problem solving. Interdisciplinary collaboration will be stressed with the use of a common data base and cross-discipline training. Parental instruction will provide knowledge of the causes and implications of attention-related disorders and will build those skills needed to modify behavior and to facilitate academic performance and social interaction. Protocols for curriculum and classroom modifications will be developed for local and state distribution.

Brighter Tomorrows

Elisa Nicholas, M.D., M.S.P.H.
Long Beach's Children's Clinic
2801 Atlantic Avenue
P.O. Box 1428
Long Beach, CA 90801
Project Number 068904

International Elementary School, a multicultural public school serving low-income children, has developed a Family Center to meet

the needs of the school's children and families. This project addresses the Center's health components and aims to (1) improve immunization rates and lifestyle behaviors, and (2) reduce illness from delayed diagnosis and care of treatable diseases. Services include monthly immunization sessions; an onsite clinic for screening, diagnosis, and treatment services; and access to specialty services at The Children's Clinic and to a nonprofit mental health clinic for evaluations and referrals.

Advocates for Children Project

Paul Russell, M.D.
Pediatric Diagnostic Center Associates
3400 Loma Vista Road
Ventura, CA 93003
Project Number 068913

The Advocates for Children Project provides the first early intervention program to prevent child abuse in Ventura County. The 5-year project will prevent child abuse and neglect by (1) developing and implementing an assessment protocol at the Ventura County hospital via the creation of a full-time Early Identification Worker position; (2) developing and implementing a community-based, home-visitation family support system for-high risk families; and (3) promoting the involvement and coordinated participation of multiple public and private agencies in focusing resources on families at risk.

Humboldt Healthy Families Collaborative Project

Rebecca A. Stauffer, M.D.
Humboldt County Public Health
Department
712 Fourth Street
Eureka, CA 95501
Project Number 068606

This project intends to reduce child abuse and neglect and the postneonatal death rate to approach the *Healthy People 2000* goals. The project will (1) assess 90 percent of families giving birth each year through a uniform risk summary tool and postpartum nurse home visit, (2) identify risk factors for child

abuse and neglect, and (3) refer families to appropriate home visiting services. It will promote a standard for home visitation practice, including family-centered strengths-based interventions and professional support for home visitors. Systematic data collection will identify gaps and needs in existing home-based early intervention services.

COLORADO

Healthy Tomorrows for Denver

Jeffrey Brown, M.D., M.P.H.
Denver Health and Hospital Authority
660 Bannock, Third Floor
Denver, CO 80204
Project Number 088807

The goals of the Healthy Tomorrows for Denver project are to (1) increase the number of infants and children referred by the Denver Department of Health and Hospitals to Child Find, (2) increase the proportion of families following through on recommended treatment options, (3) increase utilization by low-income and minority parents, and (4) create an automated tracking/management system. A case management system will be implemented, and the project will serve 850 families during its 5-year duration.

Healthy Start/Children's Clinic

Barbara Hinson
Children's Clinic
400 Remington
Fort Collins, CO 80524
Project Number 088801

The Children's Clinic is dedicated to serving the children of Larimer County who cannot afford basic acute and preventive medical services. The clinic seeks the support and involvement of the community at large. It will provide both direct medical care and increased access to a broad referral base of health and social services, always respecting the right of every patient to quality health care and human dignity.

CONNECTICUT

Healthy Tomorrows for New Haven

William Quinn, M.P.H.
New Haven Health Department
Gateway Center
54 Meadow Street, Ninth Floor
New Haven, CT 06519
Project Number 098112

This project aims to strengthen the existing health resources at the elementary school- and middle school-based clinic that is located in an economically depressed and geographically isolated area of New Haven. Its purpose is to provide comprehensive health care for at-risk children, including primary pediatric services and mental health and child development consultation. These services are offered to all children, including newborns and preschoolers.

Prenatal-to-Pediatric Transition Project

Laurel Shader, M.D.
Fair Haven Community Health Clinic
374 Grand Avenue
New Haven, CT 06513
Project Number 098125

The Prenatal-to-Pediatric Transition Project will (1) increase coordination among existing health care resources in the community in order to improve access to culturally sensitive prenatal and pediatric care and reduce inappropriate use of emergency services, and (2) provide enhanced bilingual and bicultural health education, highlighting parenting skills, normal infant development, proper nutrition, and preventive pediatric care, including immunizations and anticipatory guidance.

DISTRICT OF COLUMBIA

Healthy Tomorrows Partnership for Children

Yvette Clinton-Reid, M.D.
D.C. Commission of Public Health
D.C. General Hospital
Building #9, AG12 – West Wing Fourth Floor
1900 Massachusetts Avenue, S.E.
Washington, DC 20003
Project Number 118339

This project promotes the concept of the primary health care home, wherein every child has one provider who ensures continuity of health care services. This can be accomplished through collaboration with hospitals and private practices and through individual empowerment relative to primary health care and community-based services. These community outreach goals include in-depth and culturally sensitive health education activities and appropriate assistance in enabling parents to access the medical and social service systems. Specific measurable objectives include (1) continuous Medicaid coverage for 90 percent of project participants for the duration of the project; (2) immunization rates of 90 percent for children younger than 2 years old; and (3) lead screening rates of 90 percent for children who are at environmental risk.

Making Dreams Possible for Hispanic Teens

Elida Vargas, M.A.
Mary's Center for Maternal and Child Care, Inc.
2333 Ontario Road, N.W.
Washington, DC 20036
Project Number 118337

The goals of this project are to (1) develop a system that links Hispanic adolescents in the community to essential bilingual, community-based services that prevent pregnancies, sexually transmitted diseases, and other adverse health outcomes for adolescents, and (2) provide bilingual, comprehensive supportive services to 200 hard-to-reach Hispanic pregnant adolescents and their infants enrolled at Mary's Center, with a

focus on the prevention of repeated pregnancies and adverse child health outcomes. Mary's Center will collaborate with The Latin American Youth Center to provide bilingual, culturally competent, community-based, family-centered comprehensive services to Hispanic adolescents. Pregnant adolescents and their infants will also receive nutrition education, a six-part "Strengthening the Family" series, home visits, developmental screenings and referrals, and parenting training.

GEORGIA

Grady First Steps to Healthy Families

Sandra Browner
The Fulton-Dekalb Hospital Authority
Mail Box 26158
80 Butler Street
Atlanta, GA 30335-3801
Project Number 138412

The Grady First Steps to Healthy Families project aims to decrease the risk of child abuse and neglect in Atlanta's inner-city population by providing intensive, home-based services, including parenting education, emotional and social support, linkage to community resources, and accessible health care. The program will result in healthier parenting practices and parent-child interaction, as well as a reduction in the demand for hospital and community services relating to tertiary child abuse and neglect interventions.

Improving Health Care Access for Hispanic Families

Noemi A. Carcar, M.D.
Mercy Mobile Health Care
60 Eleventh Street
Atlanta, GA 30309
Project Number 138425

Hispanic children with special health care needs and pregnant women in the Hispanic community of metropolitan Atlanta lack access to a coordinated system of pediatric and prenatal care. Barriers to care are especially limiting for Hispanics who are recent immigrants and have a limited English lan-

guage capability with which to learn about available health care services. Each year this project will (1) identify 50 Hispanic children with special health care needs who require assessment, treatment, and followup services; (2) improve awareness/usage of coordinated health care services by 50 Hispanic families with children with special needs; (3) help 100 pregnant Hispanic women to receive early prenatal care; and (4) improve the cultural awareness and sensitivity of health care providers regarding health issues affecting Hispanic families.

The Cobb Healthy Futures Alliance

Virginia Galvin, M.D., M.P.H.
Cobb County Board of Health
1650 County Services Parkway, S.W.
Marietta, GA 30060
Project Number 138420

The Cobb Healthy Futures Alliance is a comprehensive, coordinated system of primary health care for the medically indigent and Medicaid-eligible children of Cobb County. Developed as a result of a local planning initiative (Access to Health Care Task Force), the project began to enroll children in January 1993 and aims to enroll a minimum of 3,000 children within 2 years. Partners in this system include the Cobb County Board of Health, the Kennestone Regional Health Care System, the Department of Family and Children Services, Cobb Hospital and Medical Center, private sector physicians, and parents of children who are eligible for services within the framework of the project.

HAWAII

Enhanced Community Health Options

Loretta Fuddy, A.C.S.W., M.P.H.
Maternal and Child Health Branch
State of Hawaii Department of Health
741 A Sunset Avenue
Honolulu, HI 96816
Project Number 15938

The Ko'olauloa Healthy Tomorrows project seeks to address system problems that currently exist and to improve access to child health services for families residing in the

area. This goal will be realized through increased and coordinated outreach services, promotion of an integrated system of comprehensive health care, improved continuity of care through home visiting, increased paternal participation in accessing health care, and provision of developmental/psychological assessments of at-risk children. The project will work with the existing health care system and the community to provide a community-based, family-centered, comprehensive, and culturally relevant system of care.

Parent-Pediatric Partnerships

Jean Johnson, Dr.P.H.
Hawaii Department of Health
1600 Kapiolani Boulevard
Suite 1401
Honolulu, HI 96814
Project Number 158902

This project is a partnership between families and their medical home to develop a demonstration model for care coordination for environmentally at-risk infants and toddlers in low-income, culturally diverse urban and rural settings. The families are being served as part of the eligible population under Public Law 99-457, with an individualized family support plan being developed for each family. The target population includes many families of various ethnic origins.

IDAHO

Healthy Tomorrows Partnership Project

Heather Kemp, B.S.
YWCA of Pocatello
454 North Garfield
Pocatello, ID 83204
Project Number 168010

In Pocatello, unofficial reports by Intake and Treatment Services indicate that 75 to 80 percent of reported cases of child abuse/neglect involve some form of substance use. Project goals are to (1) identify for services 30 clients in year 1, 30 clients in year 2, and 30 clients in year 3 from the at-risk target population; and (2) provide home visitor services to

address the needs of substance-abusing parents. The program will emphasize early identification and intervention, which will be followed by intensive and prolonged visits coupled with referrals to other local resources. Home visits with each client/family will occur at a minimum of once a week.

Malheur Maternity Project

Hugh Phillips
Valley Family Health Care
1441 N.E. 10th Avenue
Payette, ID 83661
Project Number 168029

The Malheur Maternity Project will increase access to comprehensive maternal and child health care, provide individualized and continuous case management to pregnant and postpartum women and their newborns, and implement planned and systematic educational programs to stress the importance of early and adequate prenatal and child care.

ILLINOIS

REACH Futures

Cynthia Barnes-Boyd, Ph.D., M.S.N., R.N.
University of Illinois at Chicago
Mile Square Neighborhood Health Center
Office of the Vice Chancellor for Health Services
1737 West Polk, M/C 973
Chicago, IL 60612
Project Number 178507

REACH Futures is a 5-year innovative service project designed to prevent infant morbidity and mortality in a low-income inner-city community. Trained community residents, who are supervised by a maternal and child nurse, will make home visits to pregnant women and mothers with infants to promote and maintain health. During the project, the health-trained residents will encourage community activities and the development of peer support groups. Evaluation will include comparisons of the health outcomes with those of infants served by previous projects.

Luz del Corazon

Donald J. Camp

Children's Memorial Hospital
2300 Children's Plaza
Chicago, IL 60614
Project Number 178502

The project will increase the accessibility and use of bereavement services for Hispanic families in the metropolitan Chicago area by developing a program that is culturally sensitive and that can be easily replicated in the Hispanic community. The goals of this project are to (1) develop culturally sensitive modifications to a successful bereavement program through formal and informal collaboration with Hispanic community representatives; (2) create evaluation tools that document changes in the health status of bereaved children and adults and thereby assess program effectiveness; (3) implement the program by refining program content, training volunteers, and involving families during the second year; and (4) secure long-term funding.

Pediatric Care for Infants of Parenting Teens

Carol Rolland, Ph.D.
Pediatric Ambulatory Care Center
Illinois Masonic Medical Center
3048 North Wilton
Chicago, IL 60657
Project Number 178606

Child health and development will be enhanced by providing needed information and support to parenting adolescents. In a well-child care group setting, infants will receive pediatric care and young mothers will participate in activities to facilitate responsive mother-child relationships. Central to the program is a plan for intensive individual case management as well as linkage of the adolescent parents to community-based comprehensive services. Evaluation will focus on decreasing rates of emergency room visits, hospitalization, and injury as well as enhancing parents' skill and competence.

Infant and Family Follow-Up Program

Karen Walsh, M.D.
University of Chicago
Woodlawn MCH Center
950 East 61st Street
Chicago, IL 60637
Project Number 178531

The Infant and Family Follow-Up Program is an early comprehensive health and social intervention program for families to improve the outcome for very premature, very-low-birthweight babies and to encourage the maximal function of these children later in their lives. Parenting resources for these families through education and peer support groups are known to be necessary components for effective care coordination. Care coordination, therefore, is coupled with a sturdy family support group that supports and enhances parenting abilities to appropriately utilize social and health resources.

KANSAS

Healthy Children Project

Sechin Cho, M.D.
Wichita Primary Care Center
1125 North Topeka
Wichita, KS 67214-3199
Project Number 208006

Approximately 58 percent of the families with children in target schools have an annual income of \$25,000 or less. Approximately 33 percent of the children are minorities—the largest group of which is African American. The ultimate goal is to increase the high school graduation rate. Project goals are to (1) provide onsite comprehensive primary care services to improve the physical, mental, and dental health status of children attending middle and elementary schools in the target area and, in the long term, increase the graduation rate at West High School; (2) motivate children and extended families to adopt healthy lifestyles; (3) teach children and families how to use health care resources appropriately and effectively; and (4) teach pediatric residents, medical students, nurse practitioner students, and school nurses about school health,

community pediatrics, and multidisciplinary team functioning.

KENTUCKY

Family Care Center Health Project

Doane Fischer, M.D.
Lexington-Fayette Urban County
Government
1135 Red Mile Place
Lexington, KY 40506
Project Number 218402

The Family Care Center offers comprehensive services to low-income families through the integration of three onsite programs: (1) Developmental child care, (2) children's health services, and (3) parent education. Primary health care services include acute and preventive care, dental care, psychological services and speech, and physical and occupational therapy. Transportation and outreach programs of the clinic facilitate access to health care as well as outside services for participating families. The outcome of the project will be determined by examining the effects of services provided on access to care, health status, and parenting behaviors. Through the coordinated efforts of all of the programs, the Family Care Center strives to help families overcome the barriers to optimal health, overall well-being, and economic independence.

LOUISIANA

First Steps Primary Prevention Program

Jacinta Setton
Louisiana Council on Child Abuse
343 Third Street
Suite 510
Baton Rouge, LA 70801
Project Number 228613

This initiative has established a hospital-based program that seeks to reduce the stress experienced in the early weeks and months following childbirth for first-time and adolescent parents, with the goal of replicating the program statewide. Emotional support and education during the postpartum stay are offered by trained vol-

unteers; information on early childhood development and stress prevention is disseminated; and followup continues for 3 months after childbirth. In addition, this program has provided training and networking opportunities for public health nurses and has sponsored a statewide education conference for service providers.

MAINE

Homeless and At-Risk Youth Health Services

Nathan Nickerson, N.P.
City of Portland
Public Health Division
389 Congress Street, Room 305
Portland, ME 04101
Project Number 238639

Project goals are to (1) address personal issues that impair individual homeless and at-risk youth from functioning within their families or independently in the community, (2) change environmental conditions that provide barriers to their health and well-being, and (3) identify systemic problems that impede a youth's ability to achieve optimal wellness. The project will (1) expand its homeless Youth Clinic, (2) hire a nurse coordinator, (3) establish a partnership with a local hospital to provide free ancillary services, (4) recruit volunteer resident interns and attending pediatric physicians to increase clinic hours, and (5) provide salient inservice education to homeless and at-risk youth service workers.

Pediatric Partnership to Protect Children in Rural Maine

Lawrence Ricci, M.D.
The Spurwink Clinic Child Abuse Program
17 Bishop Street
Portland, ME 04103
Project Number 238623

The project goal is to reduce (1) the prevalence of abuse reports in Knox and Kennebec Counties by 10 percent over 5 years, and (2) the substantiation rate of recurring abuse among all families served by the project by 50 percent. Objectives are to (1) provide

diagnostic and treatment services to 300 children from 200 families per year, (2) decrease domestic violence in the households of referred children, (3) increase the positive interactions between children and their parents, and (4) increase the skills and knowledge of ancillary health professionals in the rural communities.

MARYLAND

Healthy Tomorrows Program for Children

Martha Gardiner, B.S.N., R.N.
Spanish Catholic Center, Inc.
1015 University Boulevard
Silver Spring, MD 20903
Project Number 248618

The major goals and principal objectives of the project include improving the health status of Hispanic children in the community by (1) expanding services at the Spanish Catholic Center (SCC) clinic and promoting access to primary care, (2) screening and referring 50 children with development delays, and (3) increasing the access to care for working families through Saturday clinics. Within the first year of the initiation of this program, one full-time pediatrician and one full-time registered nurse will be added to the SCC staff.

Families in Transition

Wayne Holden, Ph.D.
Western Health Center
700 West Lombard Street, Second Floor
Baltimore, MD 21201
Project Number 248327

Health care for homeless children in Baltimore suffers from a paucity of resources targeted specifically to their needs. That such resources are necessary is evidenced by literature suggesting that these children have (1) an increased prevalence and severity of health problems; (2) substantially decreased opportunities for preventive health care; and (3) competing parental and family needs that make preventive care a low priority. The Comprehensive Health Care for Homeless Children in Baltimore program will employ a focused but wide-ranging interdisciplinary

approach that allows for identification and treatment of the medical, psychosocial, and environmental needs of the child and family.

Healthy Tomorrow's Parenting Program at CAP

Lauren M. Jansson, M.D.
Center for Addiction and Pregnancy
Johns Hopkins Bayview Medical Center
4940 Eastern Avenue, D3C
Baltimore, MD 21224
Project Number 248326

This project aims to (1) improve parenting skills among a population of substance-abusing women, (2) facilitate mother-infant communication, (3) enhance maternal appreciation of normal child development, thereby negating unrealistic expectations, and (4) improve the cognitive, emotional, and social development of drug-exposed children.

MASSACHUSETTS

The Deaf Family Clinic

Stephan R. Glicker, M.D.
New England Medical Center
750 Washington Street
NEMC Box 471
Boston, MA 02111
Project Number 258116

In eastern Massachusetts, children who are deaf or hard of hearing, or whose parents are deaf or hard of hearing, lack access to linguistically and technologically appropriate sources of pediatric care. This 5-year Deaf Family Clinic project will (1) improve the access of target families to all aspects of the health care system; (2) improve the health status of children who are deaf or hard of hearing, or whose parents are deaf or hard of hearing; (3) improve the level of patient and parent satisfaction with the pediatric care delivery system; (4) enhance families' understanding of their children's medical problems and improve their management abilities; and (5) improve access to and satisfaction with adjunctive treatments such as mental health services.

Mothers' Mentors

Margaret Henderson, M.A.
Networking for Life/Project Mattapan
The Medical Foundation
95 Berkely Street
Boston, MA 02116
Project Number 258124

The Mothers' Mentors project will address the rates of infant mortality and low birth-weight in the three predominantly low-income, inner-city Boston neighborhoods with the highest risk of poor pregnancy outcomes. It will do so by ensuring that pregnant and parenting women have access to needed services. Specifically, the project will ensure that (1) at least 98 percent of project participants identify and secure needed preventive health services and benefits (including prenatal, perinatal, pediatric, and family support); (2) 100 percent of all infants enrolled in the project obtain developmental screenings; and (3) 100 percent of project participants enhance their parenting and nurturing skills.

Project Healthy Asian Teens (PHAT)

Esther H. P. Lee, R.N.
Family Life Center, South Cove Community
Health Center
145 South Street
Boston, MA 02111
Project Number 258672

This project seeks to serve Chinese, Cambodian, and Vietnamese immigrant and refugee youth by (1) decreasing the barriers they face in accessing primary health care services, (2) promoting awareness of the need for primary health care and healthy lifestyles, and (3) increasing access to primary health care services through screenings and followup. Objectives include (1) the use of focus groups to determine the youths' health needs, barriers to care, and motivation to seek health care, and (2) a 50-percent increase, over the course of 5 years, in the number of youth using primary health care.

Injury Prevention for Pregnant and Parenting Teens

Rebecca O'Brien, M.D.
Division of General Pediatrics and Adolescent Medicine
750 Washington Street
Boston, MA 02111
Project Number 258123

A home visiting model to reduce the risk of injuries in a high-risk population of children of adolescent parents will be implemented and evaluated. The introduction of a home visitor into a comprehensive program for pregnant and parenting adolescents is expected to improve outcomes and compliance with medical visits, including prenatal care, routine child health care, health status, and safety of the children. Duplication of the model and expansion of services to pregnant and parenting adolescents at 10 community health centers in high-risk neighborhoods of Boston will occur during the project.

Project SEED

Joan Pernice, M.S.
Dimock Community Health Center
55 Dimock Street
Roxbury, MA 02119
Project Number 258002

Informal reports from the Boston Public School system state that 25 to 30 percent of children entering school are not ready. The project goal is to ensure that young children are developmentally and educationally prepared to enter school. To reduce the risk of affective, behavioral, and cognitive delays, a family-centered, multidisciplinary, culturally competent developmental practice will be integrated into a pediatric health care system. The integration of a family advisor into the pediatric, primary care multidisciplinary team will provide the essential link between the family, the community, and health care providers. During a 5-year period, school readiness skills will increase from 70 to 85 percent.

Preschool Asthma Education Project

Suzanne F. Steinbach, M.D.
Boston Medical Center
Department of Pediatrics
818 Harrison Avenue
Boston, MA 02118
Project Number 258134

The goal of the Preschool Asthma Education Project is to reduce the excessive morbidity experienced by young inner-city children with asthma who are enrolled in a Head Start program. Objectives include (1) increasing asthma care knowledge among participating parents and teachers, (2) increasing asthma preventive-care visits to primary care providers by the enrolled asthmatic children, and (3) reducing excess health care use (emergency room treatment and hospitalization) among enrolled asthmatic children. The project physician will provide comprehensive training to the team of Head Start nurses regarding pediatric asthma and project implementation.

Pediatric Family Violence Awareness Project

Bonnie Tavares
The Commonwealth of Massachusetts
Department of Public Health
250 Washington Street
Boston, MA 02108-4619
Project Number 258101

The Pediatric Family Violence Awareness Project will (1) improve pediatric identification of child and maternal victims of family violence through educational interventions; and (2) increase access to an innovative pediatric service, the Boston Floating Hospital for Infants and Children Family Advocacy Clinic, which conducts comprehensive health and psychosocial evaluations of children and provides safety planning and advocacy services to their mothers.

MICHIGAN

Center for Healthy Beginnings

Molly Kaser, R.N., M.P.H.
Center for Family Health, Inc.
817 West High Street
Jackson, MI 49203
Project Number 268515

The goal of the center is to reduce the infant mortality rate in Jackson County by providing prenatal care access to a population that is approximately 90-percent Medicaid-insured. Services available at the center include the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), perinatal substance abuse treatment, and dietitian services. The center has a strong partnership with its local hospital and other providers of health and human services.

Madres y Ninos Colonia Health Program

Rosamaria Murillo, L.M.S.W.
Midwest Migrant Health Information
Office, Inc.
502 West Elm Avenue
Monroe, MI 48161
Project Number 268007

The women and children in the Hispanic colonias are incapable of accessing health care services because of language difficulties, poverty, physical isolation, lack of transportation, fear of professional health providers, and misconceptions about routine health exams and procedures. Project goals are to increase (1) the residents' knowledge of health issues and available health resources, and (2) the mothers' and children's access to needed health services. Health workers will be used to facilitate project goals. Evaluation methods include questionnaires and health assessment forms.

Collaborative Developmental Clinic

Marsha D. Rappley, M.D.
Michigan State University, College of
Human Medicine
Department of Pediatrics and Human
Development
B-240 Life Sciences Building
East Lansing, MI 48824-1317

With the goal of affecting school-related behavior and learning problems, the clinic will bring together a pediatrician, a child psychologist, and a school consultant to provide comprehensive evaluation and treatment. The focus will be family oriented, and interventions will be designed to address children's educational, psychological, and medical needs. Factors contributing to the poor representation of lower socioeconomic families will be examined. Another goal will be enabling the model of collaboration between community medical and educational institutions to become economically viable over the funding period.

Consultation Services for Children with Severe Chronic Illness

Jane Turner, M.D.
Michigan State University, College of
Human Medicine
Department of Pediatrics and Human
Development
B-240 Life Sciences Building
East Lansing, MI 48824-1317
Project Number 268509

In Michigan, children with severe chronic illness, representing 35,000-50,000 children in the state, are frequently unable to obtain access to effective primary health care services. This project will increase access to care and improve the health status of these severely ill children by providing annual comprehensive assessments that include family involvement in the development of Individual Health Plans and identification of appropriate support services for implementation by the child's primary care physician. Evaluation of process and outcomes for the physician, child, and family will be carried out with a variety of objective measures.

MINNESOTA

Partnership Project

Donna Zimmerman, M.P.H.
Health Start, Inc.
640 Jackson Street
St. Paul, MN 55101
Project Number 278516

The goals of this project are to (1) facilitate the development of secure mother/infant attachments, and (2) minimize closely spaced pregnancies within the client population. This population is composed of mothers who are at risk for having multiple problems in parenting and who demonstrate a need for and an ability to benefit from the project's services. These services include case management, home visits, pediatric health care, support groups, and nutrition and family planning services. Intervention efforts will begin in the last 4 months of each woman's pregnancy and will continue for 2.5 years.

North Star Elementary School-Based Community Health Center

M. Kathleen Amble, M.A., R.N.
Minneapolis Department of Health and Family Support
Public Health Center
250 Fourth Street South
Minneapolis, MN 55415-1372
Project Number 278538

This elementary school-based primary care clinic serves students, their families, and community residents in the near-north community of Minneapolis with the goal of improving the health and educational status of the community's families and children. Through multidisciplinary and multiagency approaches, the clinic provides comprehensive health and social services, which have been scarce in this diverse, underserved community.

Air Care

David Aughey, M.D.
Minneapolis Children's Health Care
Teen Age Medical Service
2525 Chicago Avenue South
Minneapolis, MN 55404
Project Number 278510

The project's overall objective is to improve the health status of inner-city children (especially minority children) who have severe asthma. Specially designed interview and assessment tools will be piloted with a group of six children. The protocols and curriculum prescribe at least 1 year of intensive and frequent home visits by the asthma home care nurse. A computerized data base will assist in tracking the progress of each child and the eventual cohort of 25 children toward selected outcome objectives.

Establishment of Habitat Health Services

Barbara Elliott, Ph.D.
Duluth School of Medicine
Department of Family Medicine
10 University Drive
Duluth, MN 55812
Project Number 278009

Habitat, a Duluth Public Schools' alternative high school track, provides a parenting class for adolescent mothers and in-school child care for their infants and toddlers. Unity High School, an alternative program for students with behavior or emotional problems, has some students who are single mothers with young children. Project goals are to (1) improve the overall health of Unity and Habitat adolescent mothers and their children; (2) improve their access to, continuity of, and completeness of medical care; (3) reduce the number of infant and toddler emergency department visits in this population; and (4) provide a realistic one-on-one adolescent and small-child care teaching setting for medical and nurse practitioner students.

MISSISSIPPI

Cary Christian Health Center

Patricia Thomas
The Luke Society, Inc.
P.O. Box 57
Cary, MS 39054
Project Number 288404

The Sharkey-Issaquena Health Alliance is a 5-year program designed to lower infant mortality in the poverty areas of rural Mississippi. The project uses an alliance of volunteers, providers, and civic institutions to provide a five-pronged solution. Community volunteers are trained to provide home visits and promote greater health awareness. Transportation is provided to health facilities and perinatal education is made available to parents. Education of young people is provided to combat adolescent pregnancy. Child abuse prevention and recognition education are provided.

MISSOURI

Family Friends

Edward Hoffman, M.D.
The Children's Mercy Hospital
2401 Gillham Road
Kansas City, MO 64108
Project Number 298719

This project will implement a comprehensive, family-centered program to decrease the prevalence of disabilities and infant mortality. Objectives include (1) developing linkages between the community and health care agencies to strengthen their ability to enhance health outcomes for children where substance abuse is a problem, (2) assisting 20 families per year through weekly visits by a trained visitor who is a community member, (3) ensuring regular visits and immunizations for each child or adolescent, (4) decreasing by 50 percent the repeat pregnancies among participating women within 18 months of delivery and increasing the birthweight of infants born to women who become pregnant during the project period, and (5) decreasing the incidence of child abuse in the population through a 70-percent

decrease in the abuse risk factors of participating families and a 20-percent increase in their level of parenting skills.

NEBRASKA

Rural Partnership for Children

Frederick A. McCurdy, M.D.
University of Nebraska Medical Center
Department of Pediatrics
600 South 42nd Street
Omaha, NE 68198-2165
Project Number 318717

Complementing the health care provided by local family physicians, this project seeks to improve access to community-based pediatric consultative care for children with special health needs in four rural counties in northwest Nebraska. Monthly, rotating, pediatric consultation clinics, which move among four sites to enhance geographic access, allow a team of pediatricians, behavioral psychologists, and a nutritionist to see children with chronic or recurrent illnesses who are referred by local providers. This team confirms diagnoses, recommends treatment, and develops, with the family, a coordinated, comprehensive health plan for the children served. In addition, an advocacy coordinator works with the providers, the families, and the team on issues of outreach and followup.

NEW HAMPSHIRE

Seacoast HealthNet

Gwendolyn Gladstone, M.D.
212 North Haverhill Road
Exeter, NH 03833
Project Number 3380048

Project goals are to (1) improve access to health care services by addressing the financial and nonfinancial barriers that exist for the target population; (2) increase the involvement of parents in their own education and awareness of child health needs; (3) increase the awareness and use of preventive wellness services and activities currently available to low-income families in their communities; (4) reduce the number of

injury admissions and admissions treatable through ambulatory care, and educate physicians in optimal patient management of medical conditions that result in frequent hospitalizations; and (5) develop community-wide coordination and integration around health education initiatives.

NEW JERSEY

Trenton Loves Children (TLC) Home Visiting Project

Sunday Parker, R.N., M.P.H.
City of Trenton
Department of Health and Human Services
222 East State Street
Trenton, NJ 08608
Project Number 348623

This project seeks to (1) improve the health and well-being of families with infants and young children by tracking health measures and providing in-home assessment, education, and support for appropriate use of primary health care and essential social support services; and (2) reevaluate the role of the local public health agency in response to the impending changes in health care and the move to managed care in New Jersey by working with the state agencies for Health and Human Services. Health outcome measures (prenatal visits, gestational age, birthweight, immunization status by age 2, lead screening, developmental assessments, vision and hearing testing) will be improved for infants, children, and families participating in the project.

NEW MEXICO

The Puentes Program

Naomi Hannah
Presbyterian Medical Services
P.O. Box 30
1219C Gusdorf Road
Taos, NM 87571
Project Number 358626

The Puentes Program seeks to (1) provide the means for adolescent parents to develop improved health and safety practices for themselves and their babies, (2) support ado-

lescent parents in developing positive child-rearing practices, and (3) increase possibilities of long-term self-sufficiency for adolescent parents. The program will identify first-time pregnant adolescents through referrals from various entities in the community. Intergenerational support and community involvement will be encouraged through documentation and communication of traditional Hispanic and Native American health and parenting practices.

Healthy Families Santa Fe

Robin Lackey, M.S.W., L.I.S.W.
605 Letrado Street
Santa Fe, NM 87505
Project Number 358626

There is a high incidence of child abuse and neglect in Santa Fe County that is due to a lack of parenting skills; inadequate knowledge of early childhood development; isolation; and a lack of knowledge of and access to community resources. Santa Fe First Steps will reduce child abuse and neglect in Santa Fe County by (1) disseminating early childhood development information and community resource information to all mothers giving birth; (2) providing early identification of parents who are at risk for maltreating their children; (3) making periodic home visits to parents at risk for maltreating their children; and (4) sharing aggregate data regarding numbers of at-risk parents with public and private agencies, as well as state, city, and county officials and the general community, to improve allocations of funds for child abuse and neglect prevention programs.

Helping Indian Children of Albuquerque

Katherine Mariano, M.S.
All Indian Pueblo Council, Inc.
3939 San Pedro, N.E., Suite D
P.O. Box 3256
Albuquerque, NM 87190
Project Number 358633

The first goal of this project is to improve access to and use of health care and related resources by urban Indian children and their

families. The second goal is to improve the health status, functional ability, and developmental capability of urban Indian children with limiting conditions and special needs. This long-term health status goal, relevant to Healthy People 2000 objectives, relates directly to problems inherent in the current health system (e.g., inadequate access to and utilization of services).

NEW YORK

Preventive Primary Services for Substance Abusing Families

Karen Blount, R.N.
Children's Hospital at Buffalo
219 Bryant Street
Buffalo, NY 14222
Project Number 368209

This 5-year project provides comprehensive services to drug-exposed children and their families. The ultimate purpose of this project is to decrease morbidity/mortality in both the children and their families by keeping families together and optimizing outcomes for the children. The project increases the likelihood that these families will access services through its use of trained, culturally sensitive, nondrug-using women to provide home-based intervention, advocacy, and role modeling, and through a center-based "one-stop shopping" model for primary pediatric health care. Linkages to multiple social service agencies in the community (Child Protection Services, foster care, early intervention programs, day care, drug treatment) have been established with the PACT Program to streamline service delivery to target families.

Fostering Improved Health Status for Foster Care Children

Michael Henrichs, Ph.D.
Kids Adjusting Through Support, Inc.
600 East Avenue
Rochester, NY 14607
Project Number 368218

This project develops (1) support groups for foster care children and their families, and (2) programs for families in which a family

member has a life-threatening illness or has died. Children's groups are led by mental health counselors and are organized by age groups. Foster parent groups meet simultaneously to assist parents in dealing with such issues as child behavior, limit setting, value systems, and forming attachments with their foster children. These support groups are led by volunteers and meet weekly for 10 weeks. Project staff conduct preparticipation and postparticipation evaluations to track the project.

Pediatric Comprehensive Asthma Management Program

David J. Valacer, M.D.
The New York Hospital-Cornell Medical Center
Division of Allergy, Immunology, and Pulmonology
525 East 68th Street, J-116
New York, NY 10021
Project Number 368214

The Pediatric Comprehensive Asthma Management Program at the Women and Children's Health Center of Western Queens has been established to provide specialty evaluation and long-term followup care to children with moderate to severe chronic asthma. The major goal of this program is to reduce asthma emergency room and hospitalization rates to a level commensurate with those of higher income communities in metropolitan New York City, by providing low-income patients with equal access to specialty medical care and 24-hour advice as well as respiratory health education programs.

NORTH CAROLINA

Mental Health Treatment for Sexually Abused Children

Thomas Frothingham, M.D.
Duke University Medical Center
Center for Child and Family Health
4020 North Roxboro Road
Durham, NC 27704
Project Number 378405

Sexually abused children often have poor

mental health. In north central North Carolina, access to appropriate mental health services fails for more than half of the children identified as sexually abused. This 5-year project will improve access to appropriate mental health services as well as the mental health and behavioral status of these children and their caretakers.

OHIO

Toledo Healthy Tomorrows

Bernard J. Cullen, M.D.
Toledo Hospital
2142 North Cove Boulevard
Toledo, OH 43606
Project Number 398536

This project seeks to reduce the incidence of child abuse and neglect among children of adolescent families participating in the program. The outcome objective is to reduce the need for children participating in the project to be referred to children's services for possible abuse or neglect, so that close to 0 percent of participants require referral during the project period. The project's impact objectives for program participants are (1) improvement in parent-child interaction skills shown by 80 percent of families, (2) at least nine well-baby visits by 70 percent of children by age 24 months, and (3) completion of age-appropriate immunization schedules by 75 percent of children by age 2.

Healthy Tomorrows/CFHS Pediatric Tracking Program

Edward F. Donovan, M.D.
University of Cincinnati College of Medicine
Department of Pediatrics
Medical Sciences Building, Room 6253
231 Bethesda Avenue
Cincinnati, OH 45229
Project Number 398511

The goals of the Cincinnati Healthy Tomorrows program are to improve (1) child health outcomes in three contiguous, inner-city neighborhoods for infants born to women with poor prenatal care, and (2) the outcome of subsequent pregnancies. Specific aims are to (1) significantly increase utiliza-

tion of well-child care, (2) significantly reduce infant mortality, (3) reduce emergency room and postneonatal hospitalization, (4) decrease the low-birthweight rate for subsequent pregnancies, and (5) reduce the cost of care for children and their mothers by implementing specific preventive health care strategies.

Collaborations for Healthier Children

Debbie Wilson, R.N.
Good Samaritan Medical Center
800 Forest Avenue
Zanesville, OH 43701
Project Number 398528

Children from indigent families living in rural southeastern Ohio often lack available and consistent access to primary health care. These underserved children often have inadequate well-child checkups, developmental screenings, immunizations, and followup treatment. This 5-year project will (1) establish an advisory board composed of representatives from the health departments of the six counties served by the Pediatric Well-Child Clinic; (2) improve access to health care for all indigent children ages newborn to 5 years in the project's six-county service area; (3) improve the coordination, quality, and continuity of care in the delivery of medical, nursing, social, and educational services provided to the target population; and (4) increase the availability of support services to adolescent parents.

OREGON

Latino Medical Access Coalition Well Child Care Project

Jeannette M. Brooke, M.S.
PeaceHealth Medical Group
1162 Williamette Street
Eugene, OR 97401
Project Number 418622

This project will initiate a nurse-based well-child care program to help meet the immediate clinical preventive service needs of Latino children ages newborn to 6. As a long-term solution, the coalition plans to help build the physician community's capac-

ity to offer culturally competent pediatric practices and to capitalize on the prenatal clinic's trusted position in the Latino community by providing onsite education to its Latino clients about the proper use of the health care system and the importance of establishing a medical home for their infants.

Kids' Clinic

Barbara Arnold, B.S.N.
Eugene School District Clinics
200 North Monroe
Eugene, OR 97402
Project Number 418017

Many students (grades K–8) in the Eugene School District are without health insurance or Medicaid coverage and use the hospital emergency room for care when medical attention is necessary. This project will give these students access to the school-based health clinics already established in two area high schools. School nurses will refer students and their families to the clinic; volunteers and district staff will provide transportation; and a nurse practitioner will see eligible students. Students needing further care will be referred to an established network of physicians, hospitals, or other providers who have agreed to provide free care. The growing number of Hispanic families will receive culturally sensitive care from bilingual clinic staff and will also receive printed materials in Spanish.

PENNSYLVANIA

Ken-Crest Centers

Mary Ellen Caffrey, Ph.D.
Philadelphia Children's Services
3132 Midvale Avenue
Plymouth Meeting, PA 19129
Project Number 428305

This 5-year project is designed to treat medically fragile, technology-dependent children (birth to 5 years) in the community near their home. The project aims to (1) sustain or improve the medical conditions of these children; (2) provide for their developmental needs; and (3) teach the parents to foster their child's health, growth, and develop-

ment. Children have an individually tailored health plan and receive developmental and educational treatment in a community-based center. Collaboration with parents is ongoing, and children are mainstreamed when possible.

Health Care for Children in Foster Care

Mary Carrasco, M.D.
Children's Hospital of Pittsburgh
3705 Fifth Avenue at DeSoto Street
Pittsburgh, PA 15213-2583
Project Number 428319

This project is dedicated to coordinating primary health care delivery and monitoring 500 children who are ages 6 years or younger and live in homeless shelters or are in foster care. Staff provide case management services through the hospital and develop individualized health care plans for each child. Assistance is also provided to link children with permanent medical homes.

Project Caring

Charles P. LaValle
Western Pennsylvania Caring Foundation
500 Wood Street, Suite 600
Pittsburgh, PA 15222
Project Number 428308

Project Caring is designed to promote family-centered, community-based care for chronically ill children of the working poor. A registered nurse provides care coordination services for 80 chronically ill children and their families. These services and a continuing medical education program are intended to facilitate an increased role for the primary care provider in managing care for special needs children. This project will assist the Pennsylvania Department of Health in identifying the prevalence of chronic conditions and the obstacles to obtaining care and in developing a statewide program of care coordination.

Family Growth Center Pilot Project

Richard Solomon, M.D.
Allegheny-Singer Research Institute
320 East North Avenue
Pittsburgh, PA 15212
Project Number 428321

The goal of this project is to use an integrated primary prevention approach to promote the health and development of at-risk adolescent and young parents and their children. To achieve this goal, the project increases the parents' social supports and enhances their parenting abilities through hospital-based perinatal coaching and by linking selected families with a Family Growth Center. These centers feature a drop-in/drop-off child care program and family-oriented social recreation programs; they also provide additional support services, such as a parent support group, parenting skills workshops, and a home-based involvement program for newborns and mothers.

PUERTO RICO

Cofani Medical Home of Coamo

Luisa I. Alvarado, M.D.
49 Florencio Santiago Street
Coamo, PR 00769
Project Number 728004

In Coamo, Puerto Rico, children with special needs lack primary preventive health services by qualified pediatricians; have poor access to diagnosis, consultation, and treatment services by specialists; and lack the coordination and followup needed to manage their complicated medical and developmental problems. Project goals are to (1) develop a family-centered medical home to provide quality pediatric primary care services, referrals, followups, and continuity of care to children with special needs; (2) provide developmental and behavioral consultation services onsite; (3) collaborate with other concerned agencies and organizations; and (4) educate other professionals in the field to improve the quality and timing of their services.

Centro Pediatrico De La Lactancia y Crianza, Inc.

Desiree Pagan, M.D.
Ashford Presbyterian Community Hospital
1357 Ashford Avenue, #304
San Juan, PR 00907-1403
Project Number 728001

Although current rates have not been studied, in 1982, the number of children totally breastfed at the age of 1 month was less than 4.5 percent for children born in both public and private hospitals in Puerto Rico. Project goals are to (1) increase the breastfeeding rates in the low-income families of the San Juan Health District by at least 100 percent over the measured baseline, and (2) improve the health status, functional ability, and developmental capability of these medically indigent infants. The baseline will be established by contacting a representative sampling of women who have delivered in one public or one private hospital and asking them questions related to their infant-feeding choice and the support they received.

RHODE ISLAND

Foster Children's Assessment, Referral and Care Coordination Project

Monica Schaberg, M.D., M.P.H.
Emma Pendleton Bradley Hospital
1011 Veterans Memorial Parkway
E. Providence, RI 02915
Project Number 448132

The goal of this project is to plan and develop a permanent system of foster children's assessment, referral, and medically indicated care coordination that will ensure all foster children of a medical home that delivers (1) preventive, diagnostic, and therapeutic care; (2) appropriate referral (and followup) for special medical, developmental, mental health, and inpatient services; and (3) referral to a qualified provider of comprehensive care coordination for medically indicated social services.

SOUTH CAROLINA

The Second Chance Club

Janice D. Key, M.D.
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425
Project Number 458422

Parenting adolescents and their infants are at increased medical, developmental, and social risk. A second pregnancy during adolescence further increases that risk. The Second Chance Club will provide family-centered, multigenerational peer education intervention for parenting adolescents and their families, coordinated with medical care in a school-based clinic. Trained peer educator interventions will take place both in participants' homes and in the school. The project will decrease the repeat adolescent pregnancy rate by (1) increasing effective contraception use, and (2) increasing and improving family discussion and knowledge of sexuality and family planning.

TEXAS

COPC Family-Focused Strategy

Laurie Dekat, M.D.
Dallas County Hospital District
6263 Harry Hines Boulevard, Suite 402
Dallas, TX 75235
Project Number 488611

The purpose of this project is to develop and demonstrate effective intervention strategies for the 10- to 15-year-old age group that can be carried out within a school-based comprehensive health care system to reduce the occurrence of premature and unprotected sexual intercourse in adolescents. More than 300 10-year-old children and their parents have been enrolled to receive annual health maintenance evaluations and a series of activities to enhance parent-child communication, parental knowledge of adolescent social and sexual development, and problem-solving and decision-making skills.

Pediatric Clinic for Denton County

Melinda Mashburn, R.N., M.S.N., P.N.P.
Cook Children's Community Clinics
505 South Locust Street
Denton, TX 76201
Project Number 488630

The Pediatric Clinic for Denton County provides well-child and sick-child care to low-income Medicaid-eligible children. The project uses pediatric nurse practitioners to demonstrate a replicable method of delivering comprehensive, family-oriented pediatric services with the goal of decreasing unnecessary emergency room visits, providing case-managed pediatric care, improving immunization rates, and proving the cost-effectiveness of the system.

Health Education and Literacy Partnership

Alice Pita, M.D.
City of Dallas
Department of Health and Human Services
1500 Marilla Street
Dallas, TX 75201
Project Number 488606

The Health Education and Literacy Partnership is a coalition of professionals in the fields of health (Dallas Department of Health and Human Services), education (Dallas Independent School District, Dallas County Community College District), and literacy (Dallas Public Library, Dallas County Adult Literacy Council). Concerned about the effect of illiteracy on health care choices, this project will (1) increase access to health and social support services for high-risk mothers and their children, (2) identify barriers to access for high-risk families, (3) increase the literacy rate among high-risk mothers and the emergent literacy of their children, and (4) increase awareness among pediatricians and community members of the importance of emergent literacy and parents' role in the early educational process.

School Based Health Center Project

Carmen Rocco, M.D.
Brownsville Community Health Center
2137 East 22nd Street
Brownsville, TX 78521
Project Number 488615

This project offers comprehensive health care, including medical care, health education, case management, and counseling, tailored to the unique needs of adolescents. The service area of the Teen Clinic in Brownsville is primarily Hispanic, and nearly half the population lives in poverty. Clinic providers strive to have an impact on the risk-taking behaviors of the adolescents they see—specifically, activities that result in unintended pregnancies and failure to graduate from high school. Each adolescent receives an in-depth risk assessment, with appropriate referrals and counseling as the primary intervention.

PediPlace

Cassandra Rochon-Bailey, R.N., M.S.,
C.P.N.P.
PediPlace, Inc.
502 South Old Orchard, Suite 126
Lewisville, TX 75067
Project Number 488627

Children of low-income and Medicaid families and insured families who cannot meet out-of-pocket expenses lack access to all but emergency care in southern Denton County. PediPlace will serve this population through pediatric nurse practitioners as primary caregivers, with local volunteer pediatricians providing call support and consulting service. The goal is to provide a medical home to 1,200 children while demonstrating that a project of this type can be cost effective and eventually self-supporting.

Project First Step

Susan Spalding, M.D.
Parkland Memorial Hospital, COPC
6263 Harry Hines Boulevard, Suite 405
Dallas, TX 75235
Project Number 488621

This project aims to reduce infant mortality and morbidity in targeted areas of Dallas

County by improving the health status of medically indigent, low-birthweight infants. Four geographically targeted low-birthweight clinics provide services one to three times a month, and staff work to ensure that all eligible infants have access to this quality health care. Public health nurses serve as case managers, and home visits are conducted by the staff as appropriate.

VERMONT

Peoples' Co-op Doulas: A Prenatal/Parenting Peer Support Program

Calvin Robinson
Minority Business Association
64 North Street
Burlington, VT 05401
Project Number 508651

This community-based project (1) provides health education and support for expectant and new parents in the Old North End who are not being reached by the existing professional outreach system, (2) improves birth outcomes and infant health for this population, and (3) coordinates more consistent pediatrician involvement with the target population so that the pediatricians are better able to provide culturally relevant pediatric care. An MCH nurse directs this project.

VIRGINIA

Comprehensive Health Investment Project of Abingdon

Robert G. Goldsmith, M.A.
People Incorporated of Southwest Virginia
1173 West Main Street
Abingdon, VA 24210
Project Number 518008

The program goals are to (1) provide an additional 60 children, ages newborn to 6 years, and 20 pregnant women in Washington County and Bristol, VA, with access to a comprehensive, coordinated community-based network of health and family support services; (2) improve the health status of these low-income pregnant women and children by providing health and social case management services, resulting in a

comprehensive health care and family assistance plan; (3) promote parental involvement as an integral part of each child's health and welfare, development, and education; and (4) assist families in moving toward self-sufficiency and empowerment.

WISCONSIN

Teen Pregnancy Service: Adolescent Primary Care

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Medical College of Wisconsin
Department of Pediatrics
8701 Watertown Plank Road
P.O. Box 26509
Milwaukee, WI 53226-0509
Project Number 558521

The Adolescent Primary Care model will combine care coordination/case management with the availability and accessibility of comprehensive primary health care in a community and familiar environment. The overall goal is to provide effective, comprehensive primary care to adolescents in a cost-effective and culturally relevant manner. Comprehensive health care in this project builds on the prenatal services presently provided and on an acute awareness of the special needs of this population to include not only medical but also social and psychological interventions. The project design will emphasize the goal of increasing community involvement and cultural sensitivity because of the critical effect of the composition of this primarily African-American, low-income community and the problems affecting this population.



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