

# Saving Our Nation's Babies

THE IMPACT OF THE FEDERAL HEALTHY START INITIATIVE







In 1991 the U.S. Department of Health and Human Services funded the Healthy Start initiative in 15 rural and urban areas which had infant mortality rates that were 1.5 to 2.5 the national average. These communities implemented innovative approaches to develop coordinated, comprehensive, culturally competent models of health and other support services. Healthy Start began as a demonstration program which utilized a community-driven, systems development approach to reduce infant mortality and improve the health and well-being of women, infants, children, and families.

Healthy Start was developed based on the premise that community-driven strategies were needed to attack the causes of infant death and low birthweight, especially among high-risk populations. Healthy Start focuses on the need to strengthen and enhance community systems of maternal and infant care, and works with communities to address the medical, behavioral, social service, and cultural needs of women, men, and infants.

When Healthy Start began, a great deal was already known about the chief causes of infant mortality such as congenital anomalies, complications from low birthweight and prematurity, and sudden infant death syndrome. In addition, early and regular prenatal care was known to play an important role in ensuring health pregnancies and birth outcomes. Less well known were the reason why many women were not accessing needed care, and the approaches that help break down barriers to care.

Healthy Start has contributed enormously to our knowledge of what works to reduce infant mortality and health disparities. Taking responsibility as innovators, Healthy Start has worked with key leaders, forming partnerships and drawing on the unique strengths of their own community to transform their neighborhoods.

Now, more than 20 years later, Healthy Start continues to empower communities with extremely high rates of infant mortality to provide community-based, culturally sensitive, family-centered, comprehensive perinatal services to women, infants, and their families – and to integrate these services into existing perinatal systems of care. The mission of Healthy Start requires reaching beyond the well-being of newborns and addresses the well-being and empowerment of mothers, fathers, families, and entire communities.

Much has been learned during the first 20 years of Healthy Start, and this booklet provides a brief introduction and overview of the 105 currently funded Healthy Start communities. It is designed to let each project tell its own story about how they are serving the women, children, men, and families in their community. Healthy Start continues its fight against infant mortality, and helps to ensure every baby is given a Healthy Start in life.

David S. de la Cruz, PhD, MPH  
Deputy Director  
Division of Healthy Start & Perinatal Services  
Maternal & Child Health Bureau





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## Maribeth Badura

In October 2010, the Healthy Start family lost a beloved leader and amazing trailblazer – Maribeth Badura. She was instrumental in the creation, implementation, oversight, and evaluation of the federal Healthy Start (HS) Initiative to eliminate health disparities and infant mortality, particularly among high risk populations.

Maribeth initiated her work in HRSA's Chicago Field Office serving as a Nurse Consultant for the Midwest area. She began working with communities applying for the HS infant mortality reduction demonstration program in April 1991, and served as a Project Officer for the first communities funded under the Initiative in 1991. In 1993, she relocated to Washington, DC, as Project Officer and became a HS Branch Chief in 1995. In 1998, she became the Acting Director for the MCHB Division of Healthy Start and Perinatal Services and was named as the Director in 2004. We will forever be grateful for her sincerity, great passion and relentless commitment to improving the health of women and children in this country.

In order to continue Maribeth's legacy, NHSA has developed the Maribeth Badura Memorial Fund. It will grant scholarships to individuals interested in pursuing study in the fields of nursing, public health or similar. Recipients will be selected from the 105 communities served by Healthy Start projects across the United States and Puerto Rico. In this way, the Association will continue to honor and remember this amazing woman and leader in maternal and child health!

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Second Edition

First Edition Published October 2011

# Introduction

**T**wenty years ago, the United States was advancing in many ways with the Internet becoming increasingly available to the public and one million computers online in 1991. Information and resources were now within reach by just using our fingertips. Yet the country was plagued by many social ills like high rates of poverty, lack of access to health services, and increased numbers of infants dying. While the U.S. saw an overall decline throughout the 1980s and 1990s of its infant mortality rate, the country ranked poorly at 21st in infant mortality among industrialized nations. The U.S. had a particularly high infant mortality rate among its communities of color, especially among the African American population. The rate of infant deaths for African American babies was 17.6/1000 live births versus 8.9/1000 for Caucasian babies. Some of our country's most vulnerable citizens were dying at alarming rates in the South, the Midwest, the West and the East and no one knew why. However, a strategy was needed to combat this critical public health issue. Thus, Healthy Start was born.

## THE BIRTH OF HEALTHY START

In 1989, George H.W. Bush created the White House Task Force to Reduce Infant Mortality and directed the members to research disparities and recommend interventions that could assist the nation in decreasing infant mortality rates. Federal Healthy Start was one of several funded activities recommended by the Task Force and was initiated in 1991 as a five-year demonstration project in Phase 1 of the federal Healthy Start funding timeline.

## OVERVIEW OF HEALTHY START

Healthy Start is distinguished as a unique delivery system where consumers are engaged and active in the quest to eliminate health disparities in their own lives, in their communities, and across the nation. Improving pregnancy and birth outcomes is achieved by providing the Healthy Start core services of direct outreach, case management, health education, interconceptional care, and screening for depression. Families are kept at the forefront of service delivery through a consortium composed of consumers, neighborhood residents, mental health and social service providers, faith and business community representatives and others. Collectively, the Healthy Start staffs, consortium, and the community work together to reduce or eliminate real and perceived barriers that exist around quality health care for women and children within local health systems.

Currently, all 105 federal Healthy Start projects in the country deliver home visitation services as a key method of providing perinatal case management, risk assessment, depression screening, health education, and core outreach services. They remain rooted in the community through the community consortium, maintain the longevity of their work through sustainability plans, transform systems via their local health systems action plans, work to improve the overall state of maternal and child health through advocacy efforts and collaborations with their state Title V Agency and ensure

### PHASE 1

- (1991) New funding for 15 urban and rural projects, in areas with infant mortality rates 1.5 to 2.5 times higher than the national average, to develop community-based efforts to reduce infant mortality by 50% and improve the health and welfare of women, infants and their families. The original four-year funding period was extended by an extra year to ensure five years of comprehensive implementation.
- (1994) New funding for seven additional "special project" sites to focus on infant mortality reduction through more limited interventions.

### PHASE 2

- (1997) New funding for 55 sites that were charged with replicating four core components of the original 15 sites: outreach, case management, health education, and community consortiums. Many of these projects were also mentored by the first 22 sites.
- (1999) New funding for 19 additional projects.
- (2000) New funding for three more sites for a one-year infrastructure/capacity building phase.

### PHASE 3

- (2001) New funding for nine new grantees.
- (2002) Renewed funding for 12 existing sites, previously approved, but unfunded in the most recent competition cycle.

### PHASE 4

- (2005) Renewed funding for the current 96 Healthy Start grantees.  
New funding for one additional project.
- (2007) New funding for two border health projects.
- (2009) New funding for three grantees.
- (2010) New funding for an additional two sites.

the effectiveness of the services provided and interventions implemented through ongoing evaluation from an external evaluator. In addition, all of the Healthy Start projects are evaluated on a national level to show the effectiveness and efficacy of the Initiative and highlight proven interventions of improved birth outcomes and reduced infant mortality rates. The national evaluation is spearheaded by the Maternal and Child Health Bureau, Division of Healthy Start and Perinatal Services and currently being conducted by Abt Associates.

Since 1991, all federal Healthy Start projects have shown effectiveness in programming based on increased positive birth outcomes and maternal health cataloged as evidence in the MCH Library at Georgetown University. The federal Healthy Start Initiative has a long-standing reputation of success as presented in both evidence-based research and promising practice designation (Programs that Work: Proven and Promising Programs, 2008). This reputation is apparent from numerous research and evaluative reports published in national publications for the past twelve years, using data from nearly half of the federal Healthy Start projects across the country.

Throughout its history, Healthy Start has used effective home visitation models to achieve positive outcomes for some 524,484 women, children, and families in underserved urban, remote rural, tribal, and border communities across America (reported in 2007 Healthy Start grant reports). In 2009, 113,863 families were served by Healthy Start projects in the areas of case management, breastfeeding education, parenting skills and so much more (HRSA/MCHB, 2011). This impressive and steady growth has been accompanied by a relatively modest investment by the federal government with a return that has been at least as much in savings as was spent – savings resulting from projects moving low weight births to healthy higher weight births and thus avoiding expensive and lengthy hospital stays as well as the costs of continued care throughout the early years of life and possibly beyond.

## THE NATIONAL HEALTHY START ASSOCIATION

The National Healthy Start Association (NHSA), the membership association for the federally-funded Healthy Start projects, was established as a non-profit organization in 1998. With Healthy Start projects situated in 39 states, District of Columbia, and Puerto Rico, NHSA promotes the development of community-based maternal and child health programs, particularly those addressing the issues of infant mortality, low birth weight and racial disparities in perinatal outcomes. It is our vision to be the

recognized leader in and advocate for reducing infant mortality and perinatal disparities and the hub for maternal and child health programs and services.

Prior to 2007, NHSA functioned for nine years as a growing organization with only volunteer board member leadership, a consultant/operations manager, and limited consultant support. Those personnel assets were fully utilized in supporting the Healthy Start program nationally and taking it to new heights. The addition of full-time staff in 2007 and respectively in 2009 has allowed the organization to expand its support and technical assistance for Healthy Start projects through improved communications as well as being more proactive in establishing critical partnerships with organizations and agencies that share our vision for families.

The work of NHSA moves back and forth across a continuum that flows from the national level to the project level and on to the consumers of Healthy Start. The role of NHSA is to ensure that project needs are addressed and that the key features of the Healthy Start model are strengthened and promoted among all member projects. The education and advocacy accomplished on the national level flows right back to impact the consumer – mothers, fathers and infants residing in Healthy Start communities. Since its inception, NHSA has been a strong leader for families by continued advocacy to political leaders about the results Healthy Start projects in communities across the U.S. As a result, NHSA has made significant contributions to the United States Congressional authorization and appropriations processes, ensuring level or increased funding for the federal Healthy Start program over the last 14 years. While there is still a great deal of work to be done for families in this country, NHSA is proud of what has been accomplished in such a short time.

## KEY NHSA ACCOMPLISHMENTS AND HIGHLIGHTS

- **Authorization and appropriation for Healthy Start**, resulting in both increased and level funding for the federal Healthy Start program over the last 14 years.
- **Preference language included in the Healthy Start bill** to help assure continuity of current services to at-risk families throughout the country. NHSA successfully achieved a nationally recognized Infant Mortality Awareness Month in September on an annual basis and consistently draws stronger endorsements from this nation's most influential leaders on both sides of the aisle.



- **Healthy Start Leadership Training Institute** was implemented in 2007 to provide technical assistance, training and support to Healthy Start project directors and other key staff. More than 600 individuals have been trained since the Institute's inception.
- **Healthy Start Regional Roundtables** were held 2003-2004 to promote the NHTA's community-driven philosophy, encourage leadership at all staff levels, encourage identification and sharing of best practices, and provide a process for communication between NHTA and projects.
- **Infant Mortality and Racism Action Learning Collaborative** was created and implemented in partnership with CityMatCH and Association of Maternal and Child Health Programs to engage state and local teams to address racial disparities and focus on ways to improve coordinated systems building in communities that have a disproportionate burden of infant mortality.
- **National Infant Mortality Awareness Campaign** was launched in 2006 to promote the effectiveness of programs and efforts to reduce infant deaths, low-birth weight, pre-term births and disparities in perinatal outcomes. Today the *Celebrate Day 366...Every Baby Deserves a Chance* toolkit has reached hundreds of communities across the United States.
- **NHTA has a recognizable logo and brand.** In 2011, NHTA launched a logo and brand in order to give the organization a national identity as well as more clearly communicate the mission and work of the Association, the efforts of members to reduce infant mortality, and the goal for consumers to have healthier families. **A new website was also launched in 2011**, employing interactive and user-friendly ways to share resources and tools, general information about maternal and child health issues, NHTA programs and initiatives, stories of Healthy Start consumers/families, and partner initiatives. The site also has a secure member area and integrates the NHTA blog, Healthy from the Start.
- **NHTA's Where Dads Matter** fatherhood program was initiated in 2007 and designed to ensure the issue of fatherhood is a priority concern for the organization and its members.
- **The annual spring education conference** over the last 12 years has provided Healthy Start projects, NHTA members and NHTA partners a venue to connect, learn, and strategize. Conference speakers and presenters have included Dr. Michael

Lu, Dr. Fleda Mask Jackson, Dr. Vijaya Hogan, Dr. James Collins, Dr. John Agwunobi- Former Assistant Secretary of Health, Ms. Tonya Lewis Lee, and Dr. Camara Jones.

- **Development of communication tools and resources** for members, Healthy Start projects and NHTA constituents:
  - › The Healthy Start Guide to Financial Sustainability
  - › The Healthy Start Guide to Evaluating Success and Measuring Program Impact
  - › The Healthy Start Guide to Risk Factor Assessment and How to Communicate About Risk to Local Communities
  - › The Healthy Start Guide to Strategies for Success
  - › Getting off to a Healthy Start Newsletter
  - › Healthy from the Start Blog
  - › *Celebrate Day 366...Every baby deserves a chance* Toolkit and Fact Card
  - › Federal Healthy Start Initiative: A National Network for Effective Home Visitation Delivery
  - › It Takes Two to Tango: Defining the Role of Fathers
  - › Two Pieces of the Puzzle (in partnership with the Centers for Disease Control and Prevention, Division of Reproductive Health)
  - › The Social Emotional Development of Young Children (in partnership with the American Academy of Pediatrics)

## STRATEGIES FOR THE FUTURE

Developing strategic partnerships, advocating for policy change, engaging consumers in programmatic activities, and successfully communicating the outcomes of Healthy Start projects are among the goals NHTA has put in place to become a more effective and vital organization. As we work in collaboration with our members to improve birth outcomes, NHTA has outlined the following comprehensive and strategic goals to help us move forward with the ongoing efforts of the Association over the next three years:

- |                |  |
|----------------|--|
| <b>GOAL 1:</b> | Generate the "Brand" of NHTA and Healthy Start by strengthening efforts in communication, partnerships and membership. |
| <b>GOAL 2:</b> | NHTA will be an effective and viable organization.   |
| <b>GOAL 3:</b> | Improve birth outcomes by strengthening capacity of the Association and its members.                                   |
| <b>GOAL 4:</b> | Sustain and strengthen the voice of Healthy Start families.  |

Through these strategic goals, NHSA will expand on its mission and strengthen our brand and commitment to our members. Within the three years, NHSA is focusing its energy on transitioning our Healthy Start projects from the Life Course concept to practical application within their communities, where we know the most vulnerable populations are represented and can benefit the most from this method. Our goal is to institutionalize Life Course strategies and interventions throughout all Healthy Start projects through the implementation of a Life Course practice network. This practice network will transform how Healthy Start and other community-based MCH agencies restructure themselves and link various social as well as clinical practices to improve the health of women and infants.

In addition, the Association is dedicated to actively demonstrating the effectiveness of the Healthy Start Initiative. The Healthy Start Network has been in the forefront of providing preconception through interconception care to the thousands of women it serves annually. It is the only network of its kind, and has the community connectivity, authenticity, and infrastructure operating in the many urban, rural, tribal, and border communities throughout most of the United States. We want to make sure it is no longer the “best kept secret” and aim to share the successes of the 105 projects over the last twenty years and years to come. Our national evaluation workgroup is working tirelessly to create strategies and tools that will guide Healthy Start projects in the areas of data collection, measurement of outcomes, scientific evaluation, peer review publishing, and quantitative evaluation methods. These tools will further aid projects in demonstrating the positive impact they have made in their communities in reducing infant mortality and improving the health of families.

NHSA is committed to telling the stories of Healthy Start and the profiles shared by the projects on the following pages is just the beginning. The work that these community-based organizations and agencies have accomplished over the last 20 years is remarkable and the mark they have made on communities across this nation is significant. From a community health worker in Arizona helping a new mother navigate the health care system to a project coordinator in Boston showing a dad how to prepare nutritious foods for his children, Healthy Start projects are making a powerful impact on our country’s families. They are change agents for communities and champions for those who don’t feel they have a voice. Healthy Start is a system of care that is proven and has demonstrated its effectiveness through reduced infant mortality rates, lower number of babies born with low birthweights, increased number of women accessing prenatal care, higher number of women having full term babies, improved screening for depression among women and more linkages and services to families.

Over the course of the next several years, as health reform rolls out, federal Healthy Start, with support from NHSA, is positioned to assist the nation in expanding the capacity of community-based maternal and child health programs and infant mortality preventive health services, thereby ensuring that all families have access to a continuum of affordable quality health care and related services. As our mission statement reflects, we have the desire and the drive **to be our nation’s voice in providing leadership and advocacy for health equity, services and interventions that improve birth outcomes and family well-being.**

And so as we mark this 20th Anniversary, we are very proud to introduce you to the Healthy Start stories shared by the projects in this publication.

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*For more information on Healthy Start and NHSA, please visit our website at [www.nationalhealthystart.org](http://www.nationalhealthystart.org).*

A photograph of three young children playing on a patterned rug. The child on the left is a young girl with dark skin and braided hair, wearing a white t-shirt with a basketball graphic and the word 'CHAMP' visible. The child in the center is a young boy with light skin and curly hair, wearing a dark vest over a white shirt and light-colored pants. The child on the right is a young girl with light skin and blonde hair, wearing a pink jacket. They are all looking down at something on the rug. The background is dark and out of focus. The text 'Saving Our Nation's Babies' is overlaid in white, with 'THE IMPACT OF THE FEDERAL HEALTHY START INITIATIVE' below it in a smaller font.

# Saving Our Nation's Babies

THE IMPACT OF THE FEDERAL HEALTHY START INITIATIVE

## Birmingham Healthy Start

1600 20TH STREET SOUTH, SUITE G • BIRMINGHAM, AL 35205



Birmingham Healthy Start (BHS) is one of the original fifteen HRSA funded Healthy Start Programs. Originally a component of the Jefferson County Department of Health (JCDH), BHS became a Division of Birmingham Health Care, Inc. on June 1, 2009. Since its inception, BHS has been

on a journey aimed at reducing infant mortality in the city of Birmingham, and later to eliminate disparities in fourteen BHS designated communities. BHS provides outreach and comprehensive home visitation, health education (childbirth and parenting classes), case management, interconceptional care, depression screening and referral, and other valuable supportive services to perinatal clients. BHS has provided direct services to over 35,000 perinatal clients and their families, and pertinent information, and disseminated pertinent health awareness information to over 54,000 community members.



*Since its inception, BHS has been on a journey aimed at reducing infant mortality in the city of Birmingham, and later to eliminate disparities in fourteen BHS designated communities.*

## TEEN Center

MOBILE COUNTY HEALTH DEPARTMENT • 248 COX STREET  
MOBILE, AL 36604 • 251-694-3954 • WWW.MOBILETEENCENTER.ORG



The Mobile County Health Department-TEEN (Teen Empowered through Education and Nurturing) Center is located in Mobile, Alabama. Initially funded in 1997, the program has

had the privilege of serving teenagers (male and female) ages 10yrs to 19yrs and their families for over 15 years. The TEEN Center is committed to reducing infant mortality and racial disparities among African American pregnant and parenting teens in the Mobile County area through education, awareness, and interventions. Since 1999, the TEEN Center has been successful in addressing the infant mortality rate through FIMR (Alabama Baby Coalition team) which focuses on the leading causes of infant deaths, Low Birth Weight (LBW), and pre-term birth. The TEEN Center services include: home visitation, FIMR, case management, outreach/recruitment, referral and linkage, counseling, health

education (Life-Skills), prenatal/childbirth classes, child care (for medical/WIC appointments, and Group Meetings) and transportation.

### ACCOMPLISHMENTS:

- 90% of participating clients are on birth control since the implementation of ICC-LC Cycle 2
- Decrease repeat pregnancy rate from 10.3% in 2006 to 3.1% in 2010
- FIMR developed the Alabama Baby Coalition team that consists of community partners. The group review fetal and infant death cases, make recommendations, and translate the information into community action and public education.

*The TEEN Center is committed to reducing infant mortality and racial disparities among African American pregnant and parenting teens in the Mobile County area through education, awareness, and interventions.*



## Alaska Healthy Start

NOME, ALASKA

The Alaska Healthy Start project is the newest federal Healthy Start with the first award occurring in 2011. The project will serve high-risk pregnant women and new moms in the Nome census area, located in the northwestern part of the state. This area has a population of about 4,000, is 55% Alaska Native or American Indian, and is not accessible by the road system. Norton Sound Health Corporation hired their first Healthy Start staff person in April 2012 and is continuing to recruit. Services will include outreach, case management and home visiting, and community health education sessions that will cover a wide range of prenatal, postpartum, newborn, and interconceptional topics, including screening for depression and other behavioral health problems.

We expect a key accomplishment to be establishing the first Healthy Start program in Alaska and, specifically, in a town that marks the finish of the annual 1,100-mile Iditarod Trail Sled Dog Race, commemorating the diphtheria serum run of 1925!



*The project will serve high-risk pregnant women and new moms in the Nome census area, located in the northwestern part of the state.*

## Mariposa Community Health Center Healthy Start Program

1852 NORTH MASTICK WAY • NOGALES, AZ 85621 • 520-375-6050

WWW.MARIPOSACHC.NET

Mariposa Community Health Center (MCHC) located in Nogales, Arizona is a 501(c)(3) community based organization established in 1980. The mission of MCHC is to provide the highest quality,



community-focused, accessible and culturally appropriate medical, dental, and preventive services to all residents, without regard to economic status or any aspect of discrimination. MCHC's Healthy Start program is located on the U.S.- Mexico border and serves predominantly a Hispanic population. Services include: prenatal/post natal home visitation, FASD, depression, domestic violence and child development screenings, prenatal and interconceptional health care educations, ¿Es Difícil Ser Mujer? (Is it Difficult Being a Woman?) classes, and breastfeeding classes and support.

### KEY ACCOMPLISHMENTS FOR MCHC INCLUDE:

- A total of 36 women have been certified in *Train the Trainer* for the ¿Es Difícil Ser Mujer? depression curriculum. These women work in both the U.S. and Mexico to serve women in the border region.
- Healthy Start and WIC staff have been providing breastfeeding education to all moms birthing at the Holy Cross Hospital in Nogales, Arizona on a daily basis since 1999.
- A total of 829 women have received home visits via Maternal and Child Health programs including Healthy Start since 2007.



## South Phoenix Healthy Start

2737 W. SOUTHERN AVENUE, SUITE 8 • TEMPE, AZ 85282

Wow! As National Healthy Start celebrates their 20 year Anniversary, South Phoenix Healthy Start celebrates our 10th year. Our initial staff of 4 has grown to a team of 17 committed to reaching our community with the message that together we can make a difference. We can make a difference in infant mortality. We can make a difference in Woman's Health. We can make a difference in the lives of children. We can make a difference for fathers, mothers and families across their life span. Over the past 10 years, we have more than tripled our capacity to serve prenatal families, added an innovative Doula Program that is improving our birth outcomes, implemented a Healthy Father's Initiative that has served nearly 300 men, and we now work with pregnant and parenting teen groups in 10 high schools. Together with our many partners and the community, we are making a difference.

*We can make a difference in infant mortality. We can make a difference in Woman's Health. We can make a difference in the lives of children. We can make a difference for fathers, mothers and families across their life span.*

## ARKANSAS

### Mississippi County Healthy Start Initiative

MISSISSIPPI COUNTY, ARKANSAS E.O.C., INC • 1400 N. DIVISION ST.  
BLYTHEVILLE, AR 72315 • 870-776-1054 • WWW.MCAEOC.COM

The Mississippi County Healthy Start Initiative (MCHSI) began June 1, 1999, as a culturally appropriate, community based maternal and infant health project. Our primary focus is the reduction of infant mortality and low birth weight (LBW) births in Mississippi County, Arkansas. Our project searches a variety of valuable resources to offer seamless services with the intent of improving the quality of the life of infants, youths, and parents.

Our project's target population is principally comprised of native-born lower income African American, White, and Hispanic women, children, and families living in Mississippi County. However, proposed extensions to the program seek to concentrate limited resources on the following higher risk groups within this population: women with a previous LBW or preterm birth or perinatal death, tobacco using pregnant and parenting women, adolescents at high risk or pregnancy.

The MCHSI is strategically located throughout neighborhoods located in south and north Mississippi County. In addition to seeing an increase in the number of consumers receiving first trimester prenatal care from 2010 to 2011, the MCHSI has improved quality of life in the communities served, as evidenced by the decrease in the infant mortality rate for Mississippi County from 18.1 (1999) to 16.5 infant deaths per 1,000 live births in 2006.

However, even though the infant mortality rate has dropped, other birth outcome rates remain high. These rates can be influenced by factors such as teen pregnancy, and the MCHSI works diligently to provide pregnancy prevention education to facilitate better birth outcomes. The core services provided by the MCHSI include free parenting classes, case management, care coordination, home visiting, and transportation services for program participants. The MCHSI is pleased that the services they provide are being regarded as satisfactory by their consumers, as last reported via 2011 quarterly satisfaction surveys.

*Our primary focus is the reduction of infant mortality and low birth weight (LBW) births in Mississippi County, Arkansas.*

## Babies First

1221 FULTON MALL • FRESNO, CA 93721

WWW.BABIESFIRSTFRESNO.COM



Babies First, a Healthy Start project since 1997, has been working to improve birth outcomes in Fresno for over 14 years. The program services are provided by Public Health Nurses, health education and administrative support staff. It

has served over 13,500 pregnant and parenting women and babies, providing case management, health education, referral linkages and support.

Its consortium has convened task forces to address breastfeeding, substance abuse, and preconception health and collaborated to sponsor over a dozen conferences and trainings to increase community awareness and expertise.

### ACCOMPLISHMENTS INCLUDE:

- Over 2,000 walk participants in the annual Breastfeeding Walk and Celebration since 2005 to increase community awareness.

- The SART (Screen, Assess, Refer and Treat) Leadership Group developed a comprehensive system of care to intervene with perinatal: substance abuse, mental health disorders and co-occurring disorders. The system includes screening, assessment and referral of pregnant and post-partum women and children 0-5 years of age to treatment services.
- The SART Leadership Group sponsored the Perinatal Mental Health Summit in 2010 which resulted in the planning and now implementation of the Perinatal Mood and Anxiety Disorders: Strategic Plan for Fresno County to increase provider resources, knowledge and community awareness.
- Development of media materials to promote preconception health, reproductive life planning, and birth spacing.
- Establishment of a Community Involvement Group in 2012 with program and community participants and their family and friends.
- Development of the Planning for a Healthy Future Questionnaire™ to be administered to all postpartum program participants.



## California Border Healthy Start

121 E. 31ST ST. SUITE A • NATIONAL CITY, CA 91950 • WWW.PCIGLOBAL.ORG



The California Border Healthy Start, a project of PCI formerly Project Concern International in San Diego, serves a catchment area with a Latina focus of

predominantly high-risk pregnant women. Patient Navigators provide outreach, case management (prenatal and interconceptional), health education, and depression screening. Between 2007-2010, CBHS case managed 1012 families: 408 pregnant women, 413 interconceptional women, 326 children <1 year and 271 children <2 years and 252 births. All women were screened for domestic violence and depression. A mental health 7- week session is provided for depressed women with resulting 60% improvement. A community volunteer-based doula service is also offered. Life skills enhancement for the program include: Leadership/Consortium Membership; Continuing Education- High School or College; Business Development/ Employment; Financial Skills/Budgeting; and Other Skills: Photography, Jewelry Making. Monthly educational quality circles are provided to professionals and para-professionals with total attendance of 790 with 468 CEUs provided in the last 4 years.

*The California Border Healthy Start, a project of PCI formerly Project Concern International in San Diego, serves a catchment area with a Latina focus of predominantly high-risk pregnant women.*





## Improving Pregnancy Outcomes Program

1000 SAN LEANDRO BLVD. SUITE 100 • SAN LEANDRO, CA 94577

The Improving Pregnancy Outcomes Program (IPOP) reduces infant mortality and improves birth outcomes among low-income, reproductive-age, African American, pregnant, postpartum, and inter-conceptional women; their children, age 0-2; and male partners in nine Alameda County zip codes where infant mortality rates are the highest. IPOP serves clients through three program components: case management, community education, and fatherhood services.

### OUR KEY ACCOMPLISHMENTS INCLUDE:

- **IPOP Community Baby Showers.** Intimate celebrations that combine case finding with community health education. Quarterly showers serve 40 – 60 women who happily identify as pregnant, without the stigma of being labeled “at-risk” for a poor birth outcome.
- **ClubMom.** Three monthly sessions provide parenting women with a neighborhood level “health education home.” Women



- commune with peers, receive health education in a non-stigmatizing way, build relationships with staff and have fun!
- **Maintenance of the Peer Health Leadership Program.** Ten trained Peer Health Leaders annually provide 900-1200 information & referral contacts to their neighbors, friends and family. This lasting partnership with natural and informal helpers expands IPOP’s outreach efforts.

## SHIELDS for Families, Inc.

HEALTHY START PROGRAM • 1315 N. BULLIS ROAD #15  
COMPTON, CA 90221 • 310-668-9091

SHIELDS for Families, Inc. is a private, non-profit community-based organization dedicated to developing, delivering, and evaluating culturally sensitive, comprehensive service models that empower and advocate for high-risk families for over 20 years.



Incorporated in 1991 in response to the high incidence of infants born prenatally exposed to drugs in South Los Angeles, SHIELDS began providing services to this unique population and has since grown to provide 35 comprehensive family-centered programs addressing the needs of high-risk families in South LA. This includes substance abuse treatment, mental health services, child welfare programming, vocational services and housing.

SHIELDS’ Healthy Start program was funded in 1998 to specifically serve substance abusing pregnant and parenting women with children 0-2. In addition to the core Healthy Start components, we also provide an on-site early intervention substance abuse treatment program and child development center.

### ACCOMPLISHMENTS:

- 100% of births were substance free
- Less than 1 % of births were at low/very low birth weight
- 0 % infant mortalities since 2009
- Successful Consortium with over 75% client participation



## Aurora/Arapahoe Healthy Start

3292 PEORIA STREET • AURORA, CO 80010 • 303-360-6276

Aurora/Arapahoe Healthy Start, a program of community health center MCPN, works with Black, Hispanic or other at-risk families in six zip codes. Services are provided by a grassroots team of eight. To help Healthy Start better focus education and outreach efforts, local health data was analyzed in a two-phase (2009; 2011) Perinatal Periods of Risk (PPOR) Assessment. The data provided overall birth weight and age-specific infant mortality rates, and information on excess mortality for each age group among the black population. In addition, the Local Health Systems Action Plan (LHSAP) resulted in the establishment of “The Healthier Beginnings for African American Black Communities: An Aurora Healthy Baby Initiative” (AHB). AHB implements promotional activities on the birth outcome health disparities. Finally, in response to shifting demographics in the service area, Aurora/Arapahoe Healthy Start has adapted education efforts, outreach strategies and staffing, allowing them to reach growing African immigrant and new refugee populations.



*Aurora/Arapahoe Healthy Start has adapted education efforts, outreach strategies and staffing, allowing them to reach growing African immigrant and new refugee populations.*

**healthystart**  
PROJECT

## CONNECTICUT

## Hartford Healthy Start

410 CAPITOL AVENUE • MS# 11-MAT • HARTFORD, CT 06106



The City of Hartford, Connecticut joined Healthy Start in June, 2009. Using a

combination of clinic-based and home visiting perinatal services, the Hartford Healthy Start (HHS) program places a special focus in the Black/African American community. The perinatal program is the only in Hartford to provide enhanced outreach and recruitment efforts in the Northeast neighborhood of Hartford, which has percentages of low birth weight and inadequate prenatal care that are over 2.4 times higher than the statewide percentages. It is also the only within Hartford to coordinate services among the four clinics serving perinatal women, and includes additional services at two community-based centers. The



HHS program is an active participant on statewide committees such as the Women's Health subcommittee of the Connecticut Medicaid Care Management Oversight Council, providing a unique opportunity to influence state and local policy to address the needs of perinatal women enrolled in public insurance programs.

*The perinatal program is the only in Hartford to provide enhanced outreach and recruitment efforts in the Northeast neighborhood of Hartford, which has percentages of low birth weight and inadequate prenatal care that are over 2.4 times higher than the statewide percentages.*



## New Haven Healthy Start

70 AUDUBON STREET • NEW HAVEN, CT 06510

WWW.NHHEALTHYSTART.ORG



Since its beginning in 1997, the New Haven Healthy

Start (NHHS) program has served over 14,000 women and 8,000 infants. The IMR is lower for program participants and most have medical homes, proving that program participants experience better birth outcomes. Black infant mortality remains 2.5 times the rate of White infants. NHHS has been successful in addressing infant mortality (IM) for more than a decade, targeting leading causes: IM, LBW and pre-term birth. Our vision is the elimination of IM and racial and ethnic health disparities. Our mission is to continue implementing the NHHS program, utilizing community-driven approaches to address IM through the lens of the Life Course Perspective, targeting SDOH that create health inequities and inequalities. NHHS has maintained a comprehensive perinatal health system for over 14 years due to its strong Consortium, the core value behind the federal Healthy Start belief in a “community-driven” approach to reducing IM.

## DISTRICT OF COLUMBIA

### Healthy Start Healthy Families Mary's Center for Maternal and Child Care

2333 ONTARIO ROAD, NW • WASHINGTON, DC 20009

WWW.MARYSCENTER.ORG



**Mary's  
Center**

Healthy Start Healthy Families (HSHF) provides intensive, long-term home visitation services to pregnant and post-partum women and their families. HSHF's mission is to partner with families to ensure that their children are healthy, safe, and ready to learn. An interdisciplinary team of outreach and assessment workers, family support workers, registered nurses, mental health providers, an attorney, and education specialists ensures that clients receive quality, comprehensive medical care and support services along with education and advocacy services. HSHF combines the Healthy Families America home visiting model—a national movement to prevent child abuse and neglect—and the federal Healthy Start program, an initiative to reduce infant mortality.



HSHF operates under the leadership of Mary's Center for Maternal and Child Care. Founded in 1988, Mary's Center is a nonprofit, non-religious organization that provides comprehensive and integrated health care, education, and social services to individuals and families whose needs often go unmet by public and private systems.

#### PROGRAM ACCOMPLISHMENTS INCLUDE:

- Selected as demonstration project for Medical-Legal Partnership services through HRSA;
- Family Strengthening Award recipient from National Council of La Raza and Annie E. Casey Foundation; and
- Credentialed through Healthy Families America.

## DC Healthy Start I and II

DC DEPARTMENT OF HEALTH, COMMUNITY HEALTH ADMINISTRATION  
899 NORTH CAPITOL STREET NE, 3RD FLOOR • WASHINGTON DC 20002  
202-442-9405 • [HTTP://DOH.DC.GOV/DOH/SITE/DEFAULT.ASP](http://DOH.DC.GOV/DOH/SITE/DEFAULT.ASP)

DC Healthy Start (DCHS) Projects I and II are administered by the District of Columbia (DC or District) Department of Health, Community Health Administration. The District is comprised of eight wards with varying economic, social and health status indicators. Since its inception in 1991, DCHS I aim is to improve the prenatal/interconception health status and birth outcomes of women residing in Wards 7 and 8. In 1996, the DC Department of Health applied for and received additional funds to expand Healthy Start services to Wards 5 and 6. Within these four wards, residents live well below the federal poverty level and have the highest perinatal disparities. Project services include: client outreach and recruitment, case management, health screenings, referrals, and health education.

### KEY ACCOMPLISHMENTS

- Spearheaded efforts to decrease of the District's infant mortality rate from 21.0 deaths per 1000 live births in 1991 to 8.0 deaths per 1000 live births in 2010.
- Enhanced case management services by adding a male case management component; expanded nurse case management services to include Family Support Workers; and implemented the evidence based curriculum, Parents As Teachers.
- Expanded DC Healthy Start services and activities to include collaborative efforts with the Safe Crib Program, bi-weekly sessions to pregnant incarcerated women, Baby Showers, Father's Day events, and implementation of *I am a Healthy DC Mom*; *I am a Healthy DC Baby*; and *I am a Healthy DC Dad* public awareness campaign.

*Project services include: client outreach and recruitment, case management, health screenings, referrals, and health education.*







## Central Hillsborough Healthy Start Project REACHUP, Inc.

2902 N. ARMENIA AVENUE, SUITE 100 • TAMPA, FL 33607  
813-712-6300 • WWW.REACHUPINCORPORATED.ORG

Central Hillsborough Healthy Start Project (CHHS), a program of REACHUP, Inc., works to narrow the gap in the existing racial disparities in perinatal outcomes in Tampa neighborhoods where Black infants die in the first year of life at a rate more

than twice that of White infants. CHHS currently serves mothers and babies in 4 Tampa zip codes where over 55.8% of the births are to Black mothers who are typically young, unmarried, undereducated, and Medicaid eligible. For 12 years, CHHS has tackled health inequalities by investing in grassroots and faith-based organizations and hiring indigenous staff.

Three major accomplishments include the transformation of CHHS from a University of South Florida-based organization to REACHUP, Inc., a fully independent, 501(c)3, non-profit community-based organization; publication of seven peer-reviewed journal articles; and the reduction of low birth weight and preterm delivery by about 30% among service recipients as indicated by a 2008 comparison study.

*For 12 years, CHHS has tackled health inequalities by investing in grassroots and faith-based organizations and hiring indigenous staff.*

**REACHUP**  
where there's a will, we are the way

## Gadsden Woman to Woman Project Center for Health Equity, Inc.

231 EAST JEFFERSON STREET • QUINCY, FL 32351 • 850-875-5005



The Gadsden Woman to Woman Project has been providing quality services to families since 1991. The mission of the project is to reduce the high rates of infant mortality among African Americans in Gadsden County, FL which

experiences 2 to 4 times the rate of infant deaths, particularly among African Americans.

The Gadsden Woman to Woman Project enrolls eligible pregnant and non-pregnant women and their families and provides them with a nurse, a nutritionist, a counselor, and a social worker. All services are provided in the consumer's home.

The project has seen a number of accomplishments in the system of care through increased collaborative partnerships that reduce duplication of services and create a seamless system of care. Improvements in the community have been observed with greater knowledge about risk factors and healthy behaviors. At the individual level we have found significant improvements in women's health including BMI, blood pressure and others.

*The Gadsden Woman to Woman Project enrolls eligible pregnant and non-pregnant women and their families and provides them with a nurse, a nutritionist, a counselor, and a social worker. All services are provided in the consumer's home.*



## The Jasmine Project: A Perinatal Health Initiative

1120 NW 14TH STREET, SUITE 1264, MIAMI, FL 33136 • 305-243-4078

UNIVERSITY OF MIAMI  
MILLER SCHOOL  
of MEDICINE



The Jasmine Project, focused on reducing racial disparities in Black infant mortality and improving maternal/infant health, represents a joint collaboration between the

University of Miami Perinatal CARE Program and the Healthy Start Coalition of Miami-Dade County. Funded in June of 2010, the Jasmine Project is located in North Miami-Dade where on average Black infant mortality rates are more than double that of White infants. Jasmine Project services are based on a life-course approach emphasizing cultural sensitivity and personal empowerment through the provision of maternal and infant health education, family planning, reproductive health education, depression screening/referral, healthy infant care and parenting, smoking cessation and substance abuse screening and prevention to pregnant women and infants for up to two years.



The Jasmine Project has successfully engaged the community in the fight against Black infant mortality and greatly impacted the health and well-being of pregnant women and infants living in the project area.

## The Magnolia Project

5300 NORTH PEARL STREET • JACKSONVILLE, FL 32208

NEFHEALTHYSTART.ORG/FOR-WOMEN/MAGNOLIA-PROJECT



Established with federal Healthy Start funding in 1999, the Magnolia Project addresses racial disparities in birth outcomes by

addressing the health of women before pregnancy. Over the last decade, the project has provided outreach, well-women and prenatal care, case management and related services to more than 700 women annually who were at-risk of a poor birth outcome. Beyond individual services, the Magnolia Project focused attention on improving the health of the entire community through education, outreach and neighborhood engagement activities.

### KEY ACCOMPLISHMENTS INCLUDE:

- Demonstrated impact on subsequent birth outcomes of project participants;
- Development and implementation of a social marketing campaign and a community outreach program to train

residents on the key factors affecting women's health and infant mortality; and

- Leadership in a statewide Black Infant Health Practice Initiative (BIHPI) to address disparities in birth outcomes.



*Over the last decade, the project has provided outreach, well-women and prenatal care, case management and related services to more than 700 women annually who were at-risk of a poor birth outcome.*



*The St. Petersburg Healthy Start Federal Project has been serving families in a four zip code area of south St. Petersburg, Pinellas County, Florida since 1997.*

## St. Petersburg Healthy Start Federal Project

205 DR. MARTIN LUTHER KING, JR. STREET N • ST PETERSBURG, FL 33701

The St. Petersburg Healthy Start Federal Project has been serving families in a four zip code area of south St. Petersburg, Pinellas County, Florida since 1997. Successful services include:

- **“What About Mom?”** is a nurse who provides interconceptional care to women during other routine health visits including a pediatric and WIC office and has been recognized nationally as most innovative.
- **Themed Baby Showers** provide an opportunity to address the issues of infant mortality and chronic health diseases through education in a personal, yet fun atmosphere. Benefits include networking with other families, receiving infant care items and education such as Safe Sleeping. Service satisfaction is also surveyed.
- **“Discover Me” Groups** are considered to be a “pre-health care” strategy, facilitated by the case management staff, and provides opportunity for women to talk about self-chosen topics including relationships, finance and budgeting, self-esteem, STDs, and positive affirmations.

## Women’s Health Initiative Children’s Services Council Prevention Partnerships for Children

2300 HIGH RIDGE RD. • BOYNTON BEACH, FL 33426



The Women’s Health Initiative (WHIN) is located in Palm Beach County, Florida. It is supported

through the Prevention Partnerships for Children, the nonprofit arm of the Children’s Services Council of Palm Beach County (CSC). CSC is a special district of local government providing a dedicated source of funding to ensure that children are born healthy, are safe from abuse and neglect, and enter school ready to learn. WHIN works within CSC’s Healthy Beginnings system of care which offers an array of perinatal services to Palm Beach County families.

The ultimate goal of WHIN is to reduce the racial disparities that negatively impact the infant mortality rate for WHIN’s target population – black women in identified zip codes. WHIN provides high-risk pre-natal and interconception women with

nutrition, dental, nurse case management and Community Voice services that help to mitigate and improve existing life conditions for its participants.

### PROGRAM ACCOMPLISHMENTS INCLUDE:

- Launched Community Voice, which educates volunteer community members regarding positive life choices and black infant mortality. To date, more than 300 volunteers have been trained.
- The nurse program recently started health education work groups. They are working with Community Voice educators to develop a male component to increase male engagement.
- The dental program increased utilization by 95%.



## Atlanta Healthy Start Initiative

477 WINDSOR STREET, SW, STE. 309 • ATLANTA, GA 30312  
404-688-9202 • WWW.CBWW.ORG



The Atlanta Healthy Start Initiative (AHSI) began in 1998 as a culturally appropriate, community based, maternal and infant health program. AHSI serves approximately 200 women a year in six neighborhoods located immediately south of downtown Atlanta in Fulton County, Georgia.



AHSI has made tremendous progress in improving perinatal health outcomes in the communities served. Between 2005 and 2007, AHSI had an average low birth weight rate among Black women of 8.53 per 1,000 live births—significantly lower than that of Black women in our program area (15.73), county (15.23), and state (14.43). Moreover, from 2009 to 2010, there was an increase in the percent of AHSI clients receiving prenatal care in the first trimester, from 68.1% to 84.8%. Finally, client satisfaction has remained high, which is measured through phone interviews conducted annually. In 2010, on a scale of 1 to 5 (with 5 being the highest), clients gave an average rating of 4.7, citing appreciation of received emotional support, health education, referrals, and knowledge gained regarding the care of their infants.



## Augusta Partnership for Children, Inc. Healthy Start Initiative

353 TELFAIR STREET • AUGUSTA, GA 30901  
WWW.AUGUSTAPARTNERSHIP.ORG



The Augusta Partnership for Children, Inc.'s Healthy Start Initiative (APCHSI) addresses disparities in perinatal health and works to reduce high infant mortality and low birth weight rates. APCHSI serves pregnant and parenting women and teens in Augusta-Richmond County, Georgia via a partnership with local agencies/organizations, businesses, healthcare providers and hospitals.

The APCHSI provides outreach, case management, health education, consortium building, and systems change activities. ACPHSI has collaborated with the East Central Health District, Georgia Health Sciences University and Enterprise Community Healthy Start to implement a series of Regional Perinatal Symposia to provide awareness of perinatal health, available local/state resources and encourage collaboration amongst



agencies, leaders and healthcare professionals. August-Richmond County is the only county in Georgia that implemented the Fetal Infant Mortality Review process which allowed the community to identify issues within the perinatal health system and begin to address those needs. Additionally, ACPHSI has leveraged dollars to work with community agencies to address teen pregnancy.



## Enterprise Community Healthy Start

ESTABLISHED JULY 1, 1999

1120 15TH STREET • AUGUSTA, GA • WWW.ECHEALTHYSTART.ORG.

Target area: Burke, McDuffie Counties, two rural counties near Augusta, GA. Target population: high-risk pregnant women, interconceptional women at risk for subsequent poor outcomes, and high risk infants, particularly NICU graduates. Intensive problem-focused case management services that include home



visitation, education and linkages to needed services serve to reduce client risks, address health changes in a timely manner and enhance individual outcomes. Consortium building, health education, outreach activities and collaborative partnerships with county agencies and providers strengthens ECHS as a whole and the one-to-one relationship with clients. Major accomplishments: Of all ECHS clients who delivered during the years 2002-2009, 65.7% (470/727) remained non-pregnant > 12 months, 48.6% (353/727) >18 months, and 31.5% > 24 months; a web-based documentation system linked to state-designated regional perinatal system; implementation of a postpartum fitness program for overweight clients; from LHSAP, a 10 county school based outreach program to enroll uninsured children in SCHIP.

*Intensive problem-focused case management services that include home visitation, education and linkages to needed services serve to reduce client risks, address health changes in a timely manner and enhance individual outcomes.*

## Heart of Georgia Healthy Start Initiative

912 BELLEVUE AVENUE • DUBLIN, GA 31021

WWW.HEARTOFGEOORGIAHEALTHYSTART.ORG



Heart of Georgia Healthy Start Initiative (HGHSI) is a rural ten-county project in middle Georgia which addresses perinatal health disparities and infant mortality. HGHSI provides a range of activities

including case management for high risk women and infants as well as perinatal health education to a larger segment of the community. Home visitation, parenting knowledge assessment, depression and other risk screening, infant development screening, and effective referrals are key aspects of case management by teams of nurses and paraprofessionals. Case-managed families as well as preconceptional/perinatal women/families in the wider community benefit from an array of support groups, classes, lactation support, and outreach.



### KEY ACCOMPLISHMENTS

- Inclusion of consumers (perinatal women from the higher risk community served) as case managers, planners, and advocates.
- Zero infant deaths among participants in four calendar years.
- Establishment of a broad base of partnerships to identify community resources and collaboratively address infant mortality and perinatal health on multiple fronts.



## Big Island Perinatal Health Disparities Project

HAWAII STATE DEPARTMENT OF HEALTH

WILCOX BLDG., 741-A SUNSET AVENUE, ROOM 100 • HONOLULU, HI 96816

Big Island Perinatal Health  
Disparities Project



The Hawai'i State Department of Health has received Healthy Start funding since 1999. In 2006 the

Big Island Perinatal Health Disparities Project (BIPHDP) began contracting a local social services agency to provide outreach and client recruitment; case management; health education; risk assessments, including depression screening, and referral activities to pregnant/parenting adolescents of any ethnicity and women of Hawaiian, Other Pacific Islander, Hispanic and Filipino ethnicities. Clients are followed for two years following their pregnancy. The Big Island Consortia and four Local Area Consortia work to engage the community in efforts to improve the overall perinatal system of care.

### KEY ACCOMPLISHMENTS

- Since 2006, the project has case managed 700 pregnancies in 632 women resulting in 695 live births, including nine sets of twins and one set of triplets, and 16 fetal deaths.
- In 2010, the Consortia arranged for ethnically-Marshallese physicians to provide in-service training regarding the Marshallese cultural approach to general health care, pregnancy, labor and delivery and post-partum care for the staff of the Hilo Medical Center.
- In 2011, the East Hawai'i Consortia partnered with the State Department of Labor and Industrial Relations to increase employers' awareness of and resources for support of breastfeeding employees and partnered with the Big Island's WIC office to recognize businesses for their support of breastfeeding mothers during the 2011 World Breastfeeding Week, August 1-7. Local businesses that were nominated by WIC clients were presented with a certificate for their outstanding commitment to the community through their support of breastfeeding.



## ILLINOIS

## Aunt Martha's Health Centers

19900 GOVERNORS HIGHWAY, SUITE 300 • OLYMPIA FIELDS, IL 60461

WWW.AUNTARTHAS.ORG



Aunt Martha's Youth Services has proudly been a member of the National Healthy Start Association since 1999 servicing 5 south suburban Cook County communities. These at-risk communities include Sauk Village, Ford Heights, Chicago Heights, Harvey and South Holland. Through our core services we engage 200 high risk pregnant women and 400 infants and children annually. Our core services include: Outreach, Case Management, Health Education, Doula, and Interconception Care.

A few of our proudest accomplishments or successes include:

- Increased awareness regarding health and wellness.
- Our clients have become more proactive regarding preventative care for their children.
- Partnering with our mobile health and dental unit to bring much needed services to underserved high risk areas.



*Through our core services we engage 200 high risk pregnant women and 400 infants and children annually.*



## Chicago Healthy Start

ILLINOIS DEPARTMENT OF HUMAN SERVICES

401 SOUTH CLINTON • CHICAGO, IL 60607



The Illinois Department of Human Service's Chicago Healthy Start Initiative (CHSI), contracts with four community providers for service delivery in seven different community areas. Each subcontractor grantee runs a Family Center, which

offers social services and medical care on site. The providers and community areas they serve are: Erie Family Health Center (Hermosa), Henry Booth House (Near South, Douglas and the western half of Grand Boulevard), Near North Health Services (Washington Park, Greater Grand Crossing, and the eastern half of Grand Boulevard), and, West Side Future (Near West). These culturally diverse communities have a predominance in African American, Latino, and Chinese residents. Major accomplishments for CHSI include:

- reduction in the infant mortality rate from 20.6 in 1991 to 9.4 in 2007;
- development of an Interconceptional Care model that has been adopted within the perinatal care system; and
- development of a Fetal and Infant Mortality Review program that has been replicated city wide.

*The Illinois Department of Human Service's Chicago Healthy Start Initiative (CHSI), contracts with four community providers for service delivery in seven different community areas.*



## Greater Englewood Healthy Start Chicago Department of Public Health

641 WEST 63RD STREET • CHICAGO, IL 60621

[HTTP://UICNI.ORG/PROGRAMS](http://UICNI.ORG/PROGRAMS)



The Chicago Department of Public Health Greater Englewood Healthy Start Initiative target population includes pregnant women,

infants, and women with children up to the age of two years old, fathers, and fathers-to-be in the Englewood and West Englewood community areas. The Greater Englewood Healthy Start Program is located on the south side of Chicago in the Englewood Neighborhood Health Center. The program services include: outreach and recruitment, case management, social services, health education, home visits, parenting classes, breastfeeding and prenatal care classes, and smoking cessation.



In 2009 and 2010, there were 171 males that participated and completed the Male Responsibility Nurturing Fathers Parenting classes. Between 2008 and 2010, there were 297 women who participated in the breastfeeding classes; 75% of the women reported that they would breastfeed once the baby was born.

*In 2009 and 2010, there were 171 males that participated and completed the Male Responsibility Nurturing Fathers Parenting classes.*

## Healthy Start Southeast Chicago

1350 E. SIBLEY BLVD. SUITE 200 • DOLTON, IL. 60419



Healthy Start Southeast Chicago works to assure individuals in our service areas own the issue of infant mortality. Our partners and our consortium members work to identify the social determinants of health that cause infant deaths in our communities. Healthy Start Southeast Chicago identified six high-risk community areas with significant disparities in perinatal health care: South Chicago, Roseland, Riverdale, Pullman, West Pullman, and South Deering. For thirty-four years the high risk population of these areas has been served by two community-based, Federally Qualified Health Centers (FQHC's): Chicago Family Health Center and TCA Health, Inc. – NFP which obtain a collaborative goal of reducing infant mortality.

- From the inception of the program in 2001 the infant mortality rate has decreased 35% from 14.3 to 9.5 in 2010.



- Development of our male initiative C.H.A.M.P.S (Coaching Health Through Advocacy, Mentoring and Prevention Services) in 2011.
- Implemented Leadership Trainings in 2011 within the six community service areas for clients enrolled in the program.

*Our partners and our consortium members work to identify the social determinants of health that cause infant deaths in our communities.*



## Southern Illinois Healthcare Foundation Healthy Start

8080 STATE STREET • EAST ST. LOUIS, IL 62201 • 618-397-3303

WWW.SIH.F.ORG



A skyrocketing infant mortality rate, disparities in birth outcomes among African Americans, and lack of access to health care spurred the initiation of Southern Illinois Healthcare Foundation Healthy Start in East St. Louis, Illinois.

Since Healthy Start implementation in 1998, the infant mortality rate among African Americans in the project service area declined from 18.9 (1999-2001) to 14.1 (2005-2007). The percentage of low birth weight infants decreased from 15% (1999-2001) to 10.3% (2005-2007). First trimester entry into care increased from 56% ((1999-2001) to 63% (2005-2007).

East St. Louis Healthy Start supports the needs of pregnant women, their babies, and families. Healthy Start provides case management services to more than 600 women in greater East St. Louis and Belleville, Illinois. Healthy Start provides prenatal and parenting classes, referral to medical and social services, free transportation to medical appointments and health education activities, Certified Dads program, and community outreach and health education.





## Westside Healthy Start

3800 WEST MADISON • CHICAGO, IL 60624



Westside Healthy Start's (WHS) goal is to reduce the

incidence of infant mortality and low birth weight babies on Chicago's Westside affecting the communities of North Lawndale, Austin, East and West Garfield. We collaboratively work with neighborhood community members, paraprofessionals, program participants and staff. We are proud to have served over 1,500 participants last year and are pleased to continue our work as an invaluable resource for so many of our partners, participants, community stakeholders and consortia members. In the last twenty years some accomplishments of WHS include:

- A consumer represented WHS on the NHSA Board of Directors;
- We provided participants with doula services and lactation support; and



- WHS held two community health worker and breastfeeding peer counselor trainings in which 14 participants have obtained employment.

These successes demonstrate the benefits of the healthy start program!

*We collaboratively work with neighborhood community members, paraprofessionals, program participants and staff.*

## INDIANA

### Indianapolis Healthy Start

4087 MILLERSVILLE ROAD • INDIANAPOLIS, IN 46205

WWW.MCHD.COM



The Indianapolis Healthy Start (IHS) project addresses the factors that directly contribute to infant mortality in Marion County, Indiana. The IHS coverage area is limited to 7 zip

codes within Marion County that include women at risk by demographic factors, medical conditions preceding and arising during pregnancy, behavioral and environmental exposures, and newly evolving concepts of risk. Specifically targeted racial and ethnic groups include African American and Hispanic women and families who experience high rates of poor birth outcomes. Core services provided by HIS include: Case Management, Health Education, Outreach, Depression and Domestic Violence Screening and Referral.

### ACCOMPLISHMENTS

- Implementation of prenatal group care based on the Centering Pregnancy® Model in one hospital and one community health center (Spanish group).
- Grant award from HHS/OMH for a 3 year Bilingual/Bicultural demonstration project to replicate the Healthy Start Model of Case Management and Health Education within the Hispanic population.
- Decrease in the number of low birth weight births.



*Specifically targeted racial and ethnic groups include African American and Hispanic women and families who experience high rates of poor birth outcomes.*

## Northwest Indiana Healthy Start

6939 GRAND AVENUE • HAMMOND, IN 46323

WWW.HEALTHYSTARTLAKECOUNTY.ORG



Northwest Indiana Healthy Start is one of the 15 original demonstration projects. Located in the northwest region of Indiana, our project area is comprised of four contiguous

cities in Lake County, Indiana. These urban cities are: East Chicago, Gary, Hammond and Lake Station. While each service area is a separate and distinct municipality, one common thread is the need to improve birth outcomes for their smallest citizens. For years, each city had attempted to devise strategies to improve maternal child health delivery systems with varying degrees of success. The formation of the Northwest Indiana Health Department Cooperative, the grantee agency for the Healthy Start project was a uniting of the area mayors and health officers to combat infant mortality.

Healthy Start has become synonymous with women and infant well being in the project area. Pregnant and parenting women in these



communities now benefit from coordinated, individualized case management and health education services, along with now having a voice in how these services are designed and delivered.

### PROGRAM ACCOMPLISHMENTS INCLUDE:

- Created a multi-municipal partnership to eliminate perinatal disparities;
- Cited by the Indiana State Department of Health, Maternal and Child Health as a major contributor to the improved perinatal statistics in the county; and
- Developed the county's first Fetal-Infant Mortality Review.

## Des Moines Healthy Start Project

1111 9TH STREET, SUITE 320 • DES MOINES, IA 50314

WWW.VNSIA.ORG



The Des Moines Healthy Start Project (DMHSP) provides comprehensive child, family and community development services for pregnant or postpartum/interconceptional women, infants, toddlers and their families. The program offers participants in a nine zip-code project area in Polk County, Iowa identified as “high-risk” for poor perinatal (maternal and child) outcomes home-based outreach, recruitment, case management, health education, interconceptional care, depression screening, and referral services. Three key accomplishments include a centralized intake process for family support services in Polk County led by the DMHSP; 22 case managers are employed by the project to serve a very culturally diverse target population and seven case managers and 18 outreach workers speak a combined total of 21 different languages; and comprehensive mental health services are offered to participants regardless of their insurance status including in-house therapists and linkages to a community-based psychiatrist.

## KANSAS

### Healthy Babies Sedgwick County Health Department

434 N. OLIVER, SUITE 110 • WICHITA, KS 67208 • 316-660-7433

[WWW.SEDGWICKCOUNTY.ORG/HEALTHDEPT/HEALTHYBABIES](http://WWW.SEDGWICKCOUNTY.ORG/HEALTHDEPT/HEALTHYBABIES)



*Sedgwick County...  
working for you*

The Northeast Wichita Healthy Start Initiative (NEWHSI), part of the Healthy Babies Program in Wichita, Sedgwick County, KS, is a free preconception, prenatal and parenting group, individual and community education program designed to reduce unwanted pregnancies and infant deaths among at-risk moms. From 2005 to 2010, we have seen the following improvements in birth outcomes: Low Birth Weight (10.34% down from 14.65%), Very Low Birth Weight (1.03% down from 2.44%) and Prematurity (9.31% down from 12.10%). Additionally, we lead the county's Fetal Infant Mortality Review (FIMR) project. While the Kansas



black infant death rate is the worst in the nation and the county's black infant mortality rate (18.79 infant deaths per 1,000 live births) is more than triple the white rate (5.73), from 2000 through 2009, only three infant deaths were experienced by Healthy Babies clients residing in one of the three high-risk federally-funded Healthy Start zip codes.

## KENTUCKY

### Louisville Metro Healthy Start Louisville Metro Public Health & Wellness

400 EAST GRAY STREET • LOUISVILLE, KY 40202

[WWW.LOUISVILLEKY.GOV/HEALTH/PERSONALANDPOPULATION/HEALTHYSTART](http://WWW.LOUISVILLEKY.GOV/HEALTH/PERSONALANDPOPULATION/HEALTHYSTART)



For the past 13 years, Louisville Metro Healthy Start has been saving the lives of babies in west Louisville neighborhoods.

Louisville Metro Healthy Start provides case management, education and preventive health services for pregnant women and for children up to age 2. Based on the 2009 Greater Louisville Project Competitive City Report, Louisville now has the lowest infant mortality rate among 15 comparably-sized cities including Nashville, Charlotte, Cincinnati, and Indianapolis. Since it was established in 1998, Healthy Start has helped more than 7,000 families. Louisville Metro Healthy Start is one of only a very few across the country that had no infant deaths among participants from 2002 to 2005 and in 2007.





## Voices of Appalachia Healthy Start

114 N. 2ND STREET • WILLIAMSBURG, KY 40769 • 606-549-9296

WHITLEYCOUNTYHEALTHDEPARTMENT.COM



The Voices of Appalachia Healthy Start project has been serving families in Whitley County, KY since 1997 through its grantee agency, Whitley County Health Department.

Whitley County is in the southeastern part of the state near the TN border. This is a very rural area, and this Healthy Start project covers the entire county of 444 square miles. We provide home visits, community outreach to prenatal and postpartum participants, case management, depression screening and referral, interconceptional care, community based consortium, and resource referral and linkage.

### KEY PROJECT ACCOMPLISHMENTS:

- Women entering prenatal care in their first trimester of pregnancy has increased from 66% when the project began to the current rate of 86.4 percent.

- 99.2% of program participants from birth to age 18 have a medical home.
- 100% of participating women have an ongoing source of primary and preventive care services.



*We provide home visits, community outreach to prenatal and postpartum participants, case management, depression screening and referral, interconceptional care, community based consortium, and resource referral and linkage.*

## LOUISIANA

## Family Road Healthy Start

323 E. AIRPORT AVENUE BATON ROUGE, LA 70806

WWW.FAMILYROADGBR.ORG



The Family Road Healthy Start Program is a community-based program designed to give babies the best possible start in life by improving families' access to healthcare, social services and community resources. Healthy Start provides intensive case management

services, outreach and client recruitment, health education, interconceptional care and depression screening/referral to reduce the high rate of infant mortality, eliminate racial disparities in perinatal outcomes and improve access to quality maternal and child health services. Family Road Healthy Start provides services to eight zip code areas in East Baton Rouge Parish covering 107 square miles.



### MAJOR ACCOMPLISHMENTS FOR THE PROGRAM INCLUDE:

- Since July 2002, services have been provided to 4,616 women and children.
- From 2002 to 2010, the number of pregnant program participants that received prenatal care in the first trimester of pregnancy increased by 44.5%.
- From 2005 to 2009, the number of live single births weighing less than 2500 grams was reduced by 18.2%.

## Healthy Start ABCs

1513 DOCTORS DRIVE, SUITE 2 • BOSSIER CITY, LA 71111

NLAHEC.ORG



Healthy Start ABCs is a project of North Louisiana AHEC serving 7 rural parishes: Bienville, Claiborne, DeSoto, Morehouse, Richland, Sabine, and Union.

The project was designed in response to the high infant mortality rates, low birth weight babies, and inadequate health care resources for women of child bearing age. The core interventions are: outreach, home visitation, parenting, interconceptional care, case management, health education, and depression screenings. Any pregnant or parenting female, receiving services in the public health unit can receive participate.

### PROJECT ACCOMPLISHMENTS INCLUDE:

- Maintaining a MOU with the Louisiana Office of Public Health to facilitate information sharing, provide in-kind space and supervision of project staff;
- Established complimentary services, such as a mentoring program, to promote healthy behaviors and lifestyles among program participants; and
- Endowments from sponsors have allowed us to replicate the program in other parts of the state while securing over \$300,000 in additional funding, to augment existing services.



## Healthy Start New Orleans

1515 POYDRAS STREET, SUITE 1150 • NEW ORLEANS, LA 70112

504-658-2600



Healthy Start New Orleans seeks to serve a culturally diverse population of women of child bearing age, specifically addresses issues for pregnant women and their children from birth to the age of two. The

core services provided are Outreach/Participant recruitment, Case Management, Health Education, Interconception Care, Depression Screening and Referral to improve Care Coordination. The mission overall seeks to reduce infant mortality servicing residents of Orleans Parish. Key accomplishments are:

- Healthy Start New Orleans Consortium
- Resettlement after Hurricane Katrina- Community Needs Assessment (CNA)
- Grantee of Partnership to Eliminate Disparities in Infant Mortality-Action Learning Collaboration (ALC).





## The Family Tree Healthy Start

4540 AMBASSADOR CAFFERY PKWY, SUITE B-220 • LAFAYETTE, LA 70508  
WWW.ACADIANAFAMILYTREE.ORG



The Family Tree Healthy Start Program consists of staff members who are committed, dedicated, and determined to reduce the infant mortality rate through collaboration with other agencies, home visitation, and community outreach. Education and incentives are instrumental in our programs accomplishments.

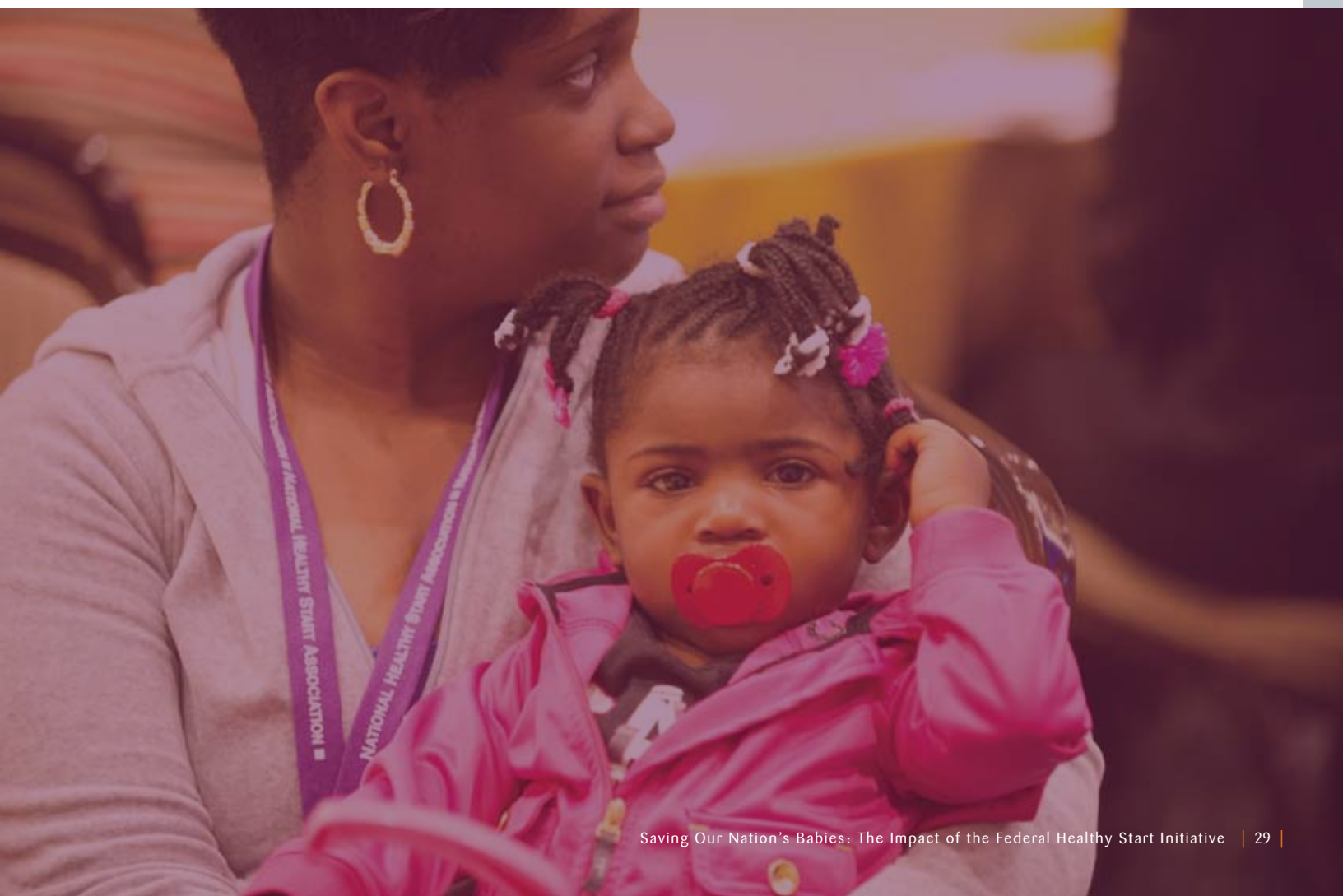
Through the years, our program has established strong partnerships with Nurse Family Partnership, Acadiana Breastfeeding Coalition, local shelters, BabiesRUs, FIMR, and Family Drug Court.

Another one of our great accomplishments is the “Parent Store,” which is an incentive program that provides bottles, clothes, hygiene and baby-related items to participants. This program allows clients who actively participate in the program and attain their goals to purchase necessities with points earned.



*Another one of our great accomplishments is the “Parent Store,” which is an incentive program that provides bottles, clothes, hygiene and baby-related items to participants.*

Our staff’s attitude is providing quality over quantity. In 2010, we provided services to 174 families. With our continuous efforts, we are discovering innovative ways of reaching our community.





## Baltimore Healthy Start, Inc.

2521 NORTH CHARLES STREET • BALTIMORE, MD 21218

410-396-7318 • WWW.BALTIMOREHEALTHYSTART.ORG



**Baltimore  
Healthy Start, Inc.**  
*Celebrating 20 Years: 1991-2011*  
[www.baltimorehealthystart.org](http://www.baltimorehealthystart.org)

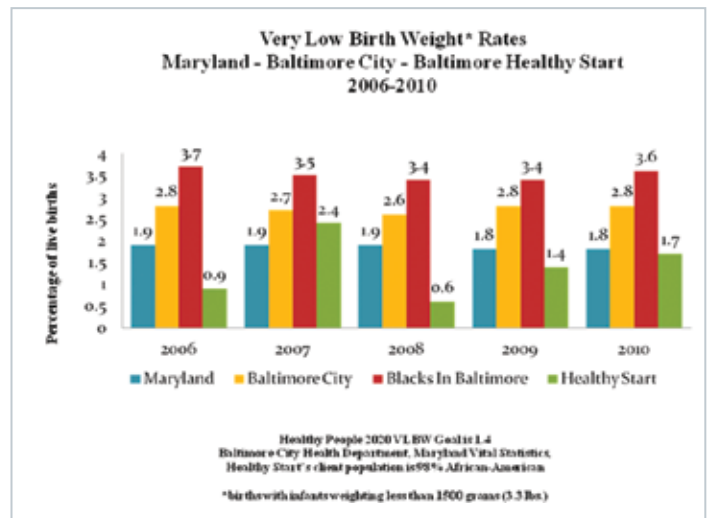
- One of the original 15 Healthy Start projects
- The only federally funded program of its kind in Maryland with largest annual client base of about 1600 families
- Has served 14,000 pregnant and postpartum women in its 21 years
- Was Barbara Bush Maryland Family Literacy Initiative Grantee (2009-2010)
- Our Chief of Medical Affairs was selected as a CMS Innovator for 2011-2012
- Certified under Maryland Nonprofits' Standards of Excellence
- Lead Agency in Baltimore on a NIH funded national Community-based participatory research study on the impact of stress and racism on birth outcomes



### MARYLAND NONPROFITS



**STANDARDS FOR  
EXCELLENCE**



*Direct Service*  
*Community Collaboration*  
*Research*  
*Advocacy*

## Boston Healthy Start Initiative

BOSTON PUBLIC HEALTH COMMISSION

725 MASSACHUSETTS AVENUE, MEZZANINE LEVEL • BOSTON, MA 02118

617.534.4669



Boston Healthy Start Initiative (BHSI) is a program of the Boston Public Health Commission and one of the original 15 cities funded by HRSA in 1991. The goal of BHSI is to reduce infant mortality in the Black community. BHSI funds 13 community based agencies that include eight community-based health centers and five neighborhood agencies that provide comprehensive social services. Highly skilled case managers offer an array of services, which include intensive case management, health education, screening for maternal depression, and interconceptional care. The Father Friendly Initiative is also a funded program of the Boston Healthy Start Initiative that provides support, education and services to fathers in high risk areas serving BHSI Women, children and families.

- The Boston Department of Public Health reports a 50% reduction in Black infant mortality rate for 2009 in the city of Boston.

- The establishment of the Boston Task Force on Improved Perinatal Clinical Care. This group is comprised of a blue-ribbon team of Medical Directors of the leading OB/GYN Departments and other clinicians that serve BHSI. The goal is to improve quality of care, increase awareness of preterm births rates and birth disparities, reduce provider uncertainties in clinical decision-making, and influence the clinician's role in social services referral.
- Establishment of the Boston Healthy Start Consortium which includes an Advisory Team. The Consortium has served as a strong link to the communities that BHSI serve and has successfully executed its quarterly meetings and Family Fun Day events to attract cumulatively over 300 participants each year.



## Worcester Healthy Start Initiative

631 LINCOLN STREET • P.O. BOX 15007 • WORCESTER, MA 01615



The Worcester Healthy Start Initiative (WHSI) supports Worcester families with comprehensive perinatal services both during and after pregnancy in a culturally competent manner. Through community involvement, case management, and educational programming WHSI strives

to improve the health and well-being of all mothers, babies, and families in the city. Worcester Healthy Start is open to all expectant or new moms living in the city.

The Worcester Healthy Start Initiative has been funded since 1999 and operates out of four locations in the city including 2 FQHCS, a major teaching hospital, and a small, non-profit health services agency. The Edward M. Kennedy Community Health Center serves as the lead grantee.

### PROGRAM ACCOMPLISHMENTS INCLUDE:

- From 1999 through 2008, the black infant-mortality rate in Worcester fell steadily from 27.43 to 14.13 (using three-year rolling averages).
- Enrollees consistently achieve better birth outcomes than the city population as a whole.
- Established a very successful "New Mom's Support Group" for participants that is well-attended by women from a variety of backgrounds and cultures. The group meets monthly and gives women a chance to both discuss common challenges and swap parenting tips and techniques.



## Detroit Healthy Start Project

1151 TAYLOR, BLDG 6 • DETROIT, MI 48202

The Detroit Healthy Start Project, located in Detroit, MI, was established in 1992 as 1 of the original 15 projects. Initially the project served 40% of Detroit as well as the City of Highland Park. In 2009, the area was changed to the northeast section of Detroit. Healthy Start provides core services. The Consortium works on advocacy. The project goal is to prevent infant mortality by improving the health of the child bearing age population through promoting family health and well-being.

### THREE KEY ACCOMPLISHMENTS FOR THE PROJECT INCLUDE:

- Detroit was one of the few communities with a decline in the infant mortality rate compared to the control community in the national evaluation. The infant mortality rate has not returned to the previous unacceptably high rates since the inception of Healthy Start.



- Healthy Start established a Fetal Infant Mortality Review (FIMR) process that included a case review team, a community action team, and a home interview component. Clinic wait times were reduced, education protocols for infant sleep practices were modified, and awareness the importance of preconception care has increased.
- Detroit has continuously provided services to non-pregnant women. In 1992, Inreach began as a program that linked newly delivered women who had little or no prenatal care to ongoing services. The Alumni Club, established in 1993, provided staff and peer support to women whose infant's had reached 2

years of age. In 1994, HS partnered with Share Our Strength to address nutrition issues. Healthy Start-led life skills groups have added health promotion services to programs for high risk women of child bearing age for over 5 years. Male support services were added in 2009 in response to the Consortium's concern about a lack of programming for fathers.

## Genesee County Health Department

630 S. SAGINAW STREET, SUITE 4 • FLINT, MI 48502

810-257-3202 • WWW.GCHD.US/BABIES

The Genesee County, Michigan Healthy Start Project (GCHS) aims to reduce infant mortality, prematurity, low birth weights, perinatal depression, and improve maternal health and neonatal outcomes among African American women and infants (birth to two years of age) in Flint, Michigan. The services are delivered in collaboration with Michigan's Maternal-Infant Health



Program (MIHP), a Medicaid home-visit program aimed at reducing infant mortality. Services (outreach, case management, health education, depression screening and interconceptional care) are delivered by community health workers, nurses, social workers, and dietitians who are employed by a community-based organization and two local hospitals. The GCHS Consortium has partnered with over 30 organizations to provide education, encouragement, and resource support to approximately 235 families each year.

Between 2001 and 2009 GCHS participants consistently demonstrated better birth outcomes (1,258 total births) compared to outcomes among African American residents in the project area:

- Average **Low Birth Weight** is **12.2%** compared to 16.3%.
- Average **Very Low Birth Weight** is **1.2%** compared to 3.5%.
- Average **infant mortality rate** is **2.8** compared to 18.3.

*The Genesee County, Michigan Healthy Start Project (GCHS) aims to reduce infant mortality, prematurity, low birth weights, perinatal depression, and improve maternal health and neonatal outcomes among African American women and infants (birth to two years of age) in Flint, Michigan.*



## Great Beginnings Healthy Start Project

SAGINAW COUNTY DEPARTMENT OF PUBLIC HEALTH

1600 N. MICHIGAN AVE. • SAGINAW, MI 48602 • 989-758-3853



The Great Beginnings Healthy Start Project was initiated in 2001 and serves the residents of Saginaw County, Michigan focusing primarily on the City of Saginaw. The Great Beginnings Project services are delivered by employees of the Saginaw County Department of Public Health. The Great Beginnings Healthy Start Project aims to reduce infant mortality

and prematurely born infants of the African American mothers of Saginaw County. The Great Beginnings Healthy Start Project is a trusted program providing case management services, community outreach and education, a maternal/child health system change agent and a recognized advocate for families in Saginaw County, Michigan.



- Initiated the “Time to Talk” educational support group facilitated by Healthy Start consumers and staff providing education and fellowship.
- Infant Mortality Rates for program participants remains far below the State, County and City rates at less than 4.0.
- Reproductive Life Plans created with 100% of program participants and reviewed at “every” home visit.

## Healthy Babies Healthy Start

HEALTH AND COMMUNITY SERVICES DEPARTMENT

3299 GULL RD. • KALAMAZOO, MI 49048

### Healthy Babies Healthy Start

*In Kalamazoo, Michigan*

Kalamazoo Healthy Babies Healthy Start (HBHS) serves a target area in the city of Kalamazoo that is home for 68% of all county residents

living below poverty level. Initiated in 1997 as a response to unacceptable infant death rates, particularly among black infants, HBHS has been providing case management services with a home visitation model and a community education program that fosters provider collaboration and grass roots participation. The flexibility of the program and the continuous assessment of needs and strategies based on local evaluation have resulted in positive measurable outcomes.

#### PROGRAM ACCOMPLISHMENTS INCLUDE:

- “The Impact of Case Management in Reducing Racial Disparities” won the best clinical research award in 2010 from Michigan State University Kalamazoo Center for Medical Studies.



- “Assessing Maternal Risk for Fetal-Infant Mortality: A Population Based Study to Prioritize Risk Reduction in a Healthy Start Community” was published in the Maternal Child Health Journal in January 2010.
- As a result of the Mother Mind Matters Initiative, in collaboration with the Kalamazoo Center for Medical Studies, depression screening and referral went from 6% in 2002 to 90% by 2008, identification of depression went from 2% to 18%, and depression treatment after referral went from 3% to 12 % in the target area.

## Maaajtaag Mnobmaadzid Inter-tribal Council of Michigan

2956 ASHMUN STREET, SUITE A • SAULT STE. MARIE, MI 49783

WWW.ITCMI.ORG/SERVICES/CHILD-AND-FAMILY-SERVICES/HEALTHY-START



The Inter-tribal Council of Michigan Healthy Start Project is named “Maaajtaag Mnobmaadzid”, which means “the start of a healthy life” in the traditional language of Michigan’s Anishnabe population. The project serves 8 American Indian communities statewide, including 6 tribes and 2 urban communities. In addition to prenatal support and education, we focus on helping women become and stay healthy between pregnancies. Key services include home visits by a nurse, education and referrals based on identified needs, breastfeeding support, depression screening, transportation, and



community health events and classes. Keeping women and babies safe and healthy has always been an honorable and expected way of life for Anishnabe. We affirm the sacred role of women in the community and promote health throughout the lifespan. Since project initiation in 1998, infant mortality in our target population has declined by 40%, rates of early prenatal care have increased above the State average, and the participating communities have built and sustained capacity to provide culturally competent MCH services.

## Strong Beginnings

301 MICHIGAN NE, SUITE 400 • GRAND RAPIDS, MI 49503

WWW.GRAAHI.ORG



Strong Beginnings is a partnership of six community agencies in Grand Rapids, MI. Our goal is to reduce

infant mortality and low birth-weight among African Americans by providing outreach, case management, education, dental care and mental health services and by addressing systemic factors that impact maternal-child health. Community health workers, nurses and social workers conduct home visits to provide social support, peer education and assistance in accessing resources. Two mental health therapists offer care coordination and individual counseling as well as facilitating support groups for women struggling with mental health issues. Women receive services from pregnancy until two years after delivery. We also offer a fatherhood program for men. An Education Coordinator provides education to the community at large. A consumer consortium and an Advisory Board provide program oversight. A coalition of twenty agencies carries out local systems work,



addressing issues such as racism, transportation, pregnancy prevention, perinatal mood disorders, breastfeeding and access to care. Some key accomplishments include:

- 6-year infant mortality rate for program participants is 8.8 per 1000 live births. The infant mortality for African Americans in Grand Rapids was 22.4 when our program began in 2004 and decreased to 17.3 in 2009.
- Low birth-weight rate for program participants dropped from 16.3% in 2005 to 5.8% in 2010 while the LBW rate for African Americans in Grand Rapids dropped from 16% to 13.5%.
- The number of program participants becoming pregnant within 18 months of delivery is only 9% vs. a rapid repeat pregnancy rate of 30% for African American women in Grand Rapids.

## Twin Cities Healthy Start

MINNEAPOLIS DEPARTMENT OF HEALTH & FAMILY SUPPORT  
250 SOUTH 4TH STREET, ROOM 510 • MINNEAPOLIS, MN 55415  
612-873-2622 • [WWW.CI.MINNEAPOLIS.MN.US/DHFS](http://WWW.CI.MINNEAPOLIS.MN.US/DHFS)



Twin Cities Healthy Start (TCHS) was established in 1991 to reduce infant mortality in communities that have high rates of infant deaths. TCHS works in partnership with communities to address the medical, behavioral, and cultural needs of high-risk pregnant women in the Twin Cities.

The TCHS Consortium functions as an advisory board and community think tank that removes barriers to early prenatal care and ensures that high-risk pregnant women have access to quality health care. Consortium members include program participants, community leaders, social service providers, health care providers, faith-based organizations, and other vested partners.

The program has been successful in implementing programs and policies that improve access to prenatal health care. This past year, the program successfully partnered with several community leaders and organizations to get the Minnesota Legislature to modify the substance abuse mandated reporting law to encourage early entry into prenatal care.

*This past year, the program successfully partnered with several community leaders and organizations to get the Minnesota Legislature to modify the substance abuse mandated reporting law to encourage early entry into prenatal care.*

## Tougaloo College Owens Health and Wellness Center

500 WEST COUNTY LINE ROAD • TOUGALOO, MS 39174  
[WWW.TOUGALOO.EDU/HEALTH/DHP](http://WWW.TOUGALOO.EDU/HEALTH/DHP)



Tougaloo College/Delta Health Partners (TC/DHP) Healthy Start Initiative was established in 1994, poised within seven rural Mississippi Delta Counties, with the purpose of improving perinatal health outcomes for minority teens ages 10-19 and women ages 19 and older, who are referred from local hospitals, their infants and male partners. These counties have

high infant mortality rates, poverty, chronic unemployment, teen pregnancy, and a high rate of school dropouts. TC/DHP provides intervention to its clients through a home visiting case management program which includes health education, outreach and recruitment, interconceptional care and depression screening.



### TC/DHP'S ACCOMPLISHMENTS INCLUDE:

- An intensive one week staff training on Effective Black Parenting skills;
- A healthy DIVA campaign promoting healthy lifestyles in collaboration with Delta State University; and
- We partnered with the Mississippi State Department of Health to establish a systematic system of reviewing infant deaths in the Delta counties.



## Kansas City Healthy Start

6400 PROSPECT AVENUE, SUITE 216 • KANSAS CITY, MO 64132

WWW.MCHC.NET



Kansas City Healthy Start (KCHS) works to decrease infant mortality and ethnic disparities by providing services based on a home visiting model that seeks to improve the health and well-being of pregnant

women, babies, and families in the Kansas City area, which includes Kansas City, Missouri and Kansas City, Kansas. It offers outreach, care coordination, depression screening, health education and interconception care to over 300 families each year. Health education is offered to the community and members of the Mother & Child Health Coalition, the Consortium for KCHS.



### KEY ACCOMPLISHMENTS:

- Sponsored numerous cultural competency training programs for the community, including a Multicultural Breakfast Club Conference series with sessions on Latino, Native American, Vietnamese, African-American and Refugee cultures;
- Led the creation of the Fetal Infant Mortality Review (FIMR) program to study the causes of fetal and infant deaths and to advocate for system improvements; and
- Initiated a new program, Dedicated Dads, to connect fathers and male figures to programs and services to help them be better role models for their families.

*Kansas City Healthy Start offers outreach, care coordination, depression screening, health education and interconception care to over 300 families each year.*



## Missouri Bootheel Regional Consortium, Inc

903 S. KINGS HIGHWAY, SUITE A • SIKESTON, MO 63801

888-317-4949 • WWW.MBRCINC.ORG

Missouri Bootheel Healthy Start provides perinatal and health education services in the rural southeast corner of Missouri, commonly referred to as the Bootheel due to its shape. The target area includes the entire five counties of Dunklin, Mississippi, New Madrid, Pemiscot and Scott. Currently entering its fourteenth year of providing services, MBHS's presence in the communities has resulted in a 16-23% decrease in infant mortality while addressing the critical issue of racial disparity between African American and Caucasian populations.

### KEY ACCOMPLISHMENTS INCLUDE:

- Current grantee organization evolved from the Healthy Start Regional Consortium;
- Male Involvement has played a key role in MBHS presence in the community; and
- Impact of core services and community driven education initiatives continue to strengthen partnerships and client success stories.



## St. Louis Healthy Start Project

MATERNAL, CHILD AND FAMILY HEALTH COALITION

539 N. GRAND BLVD, SUITE 403 • ST. LOUIS, MO 63103

WWW.STL-MCFHC.ORG



The St. Louis Healthy Start program, a partnership of the Maternal, Child and Family Health Coalition and Nurses for Newborns, works to reduce infant mortality and other negative birth outcomes. The program operates in three

zip codes in the St. Louis, Missouri area identified as having some of the highest infant mortality rates in the region. The primary population served is African American women of childbearing age at risk for poor birth outcomes due to medical and/or social risk factors. Nurses and community outreach mothers provide intense case management to improve birth outcomes in the client population. Three key accomplishments include:

- PhotoVoice Empowerment Project that taught Healthy Start clients to use photography to express their neighborhoods' needs in a compelling and powerful way;



- Development and implementation of a culturally competent maternal depression screening tool; and
- A published research study on the impact of St. Louis Healthy Start Program on Perinatal Indicators.

*The primary population served is African American women of childbearing age at risk for poor birth outcomes due to medical and/or social risk factors.*

## NEBRASKA

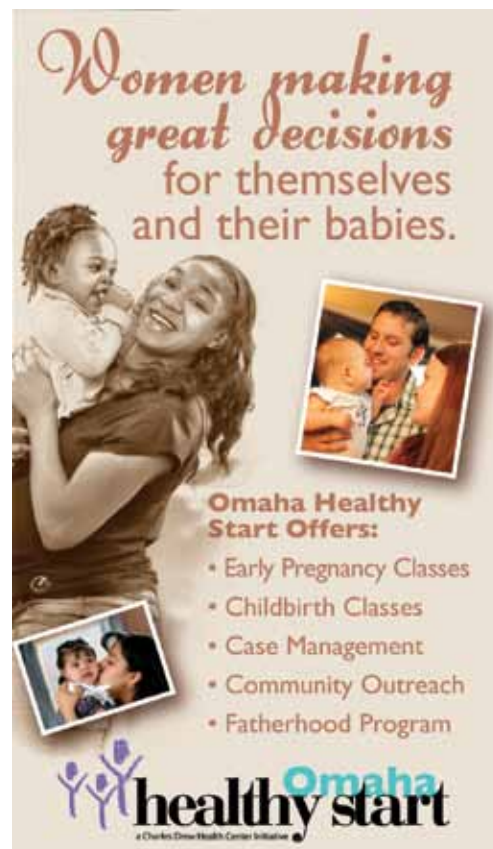
## Omaha Healthy Start

2915 GRANT STREET, 2ND FLOOR • OMAHA, NE 68111-3863

402-455-2229 • WWW.OMAHAHEALTHYSTART.ORG

Omaha Healthy Start (OHS) was funded to implement innovative evidence-based strategies designed to reduce the infant mortality rate in the East/Northeast sector of Douglas County in Omaha, Nebraska. OHS was originally funded as a consortium only project in 1997. Today, OHS employs 11.5 full time employees. Three accomplishments that are especially meaningful to OHS staff and program participants include:

- The creation of the OHS father involvement initiative – Fathers for a Lifetime in 2002;
- The restructure of the OHS HealthNET case management program in 2009-10 to focus on high-risk program participants; and
- The development, piloting and implementation of the OHS Wellness Assessment Tool (risk-assessment) through the ICC-LC learning collaborative in 2010-11. The ICC-LC change project has resulted in marked improvements between OHS program participants and OHS' case management team.



## Camden Healthy Start

2600 MT. EPHRAIM AVE, SUITE 401-403 • CAMDEN, NJ 08104

WWW.SNJPC.ORG/PROGRAMS/HEALTHYSTART\_ABOUT.HTML



Camden Healthy Start (CHS), under the direction of the Camden City Healthy Mothers, Healthy Babies (HMHB) Coalition, is a program of the Southern New

Jersey Perinatal Cooperative (SNJPC). On behalf of the HMHB Coalition, SNJPC received the first of four federal Healthy Start grants in 1997.

### SINCE 1997, CHS HAS:

- Developed the web-based Client Health Record Information System (CHRIS), a sophisticated client record keeping system, to better monitor our efforts. The system generates notification of referrals to Healthy Start case managers, captures essential client data and follow-up information and serves as the foundation of the client record. CHRIS provides reliable, timely and accessible information that assures program interventions are truly data-

driven. The efficacy of CHRIS has led to its adoption by other Healthy Start Projects in New Jersey and nationwide.

- Created a county-wide Home Visitation Task Force that has resulted in the development of a single point of entry referral and triage process for referral of women in the Camden County area to Camden Healthy Start, Nurse Family Partnership, and Camden County Healthy Families-TIP program.
- Developed, in 2002, a Prenatal Screening and Referral form used by prenatal providers in Camden City which became the basis for the Perinatal Risk Assessment (PRA) tool, implemented statewide



in 2009. Adopted by the New Jersey Department of Human Services and the New Jersey Department of Health and Senior Services, PRA is now required to be completed by all NJ Medicaid Managed Care prenatal providers on the first prenatal visit. In 2011 10,597 women in NJ were screened utilizing the PRA.



## Children's Futures

16 WEST FRONT STREET • TRENTON, NJ 08608

609-695-1977 • WWW.CHILDRENSFUTURES.ORG



Children's Futures' Trenton, NJ Healthy Start Project, is a

comprehensive community — wide interagency partnership that integrates core services — consortium, outreach, recruitment, screening, case management, health and parent education with the perinatal health care system to improve access to care

and reduce disparities for the most at-risk pregnant women, infants and families. The program strengthens and integrates recruitment and screening activities at the prenatal clinics to: refer at-risk clients to the project; provide intensive home visitation and center-based case management to assist families with transportation and translation; provide parent and health education in self-efficacy and child growth and development; and assist with referrals for insurance and WIC. Our accomplishments include increasing the first trimester entrance into prenatal care to 75% of clients we serve through providing free pregnancy testing at our centers and home visiting programs, increasing the screening for alcohol, tobacco, other drugs, depression and domestic violence to almost 100% of clients in our project and increased to almost 100% the eligible children with insurance and medical home.





## Healthy Start Mother & Child Program

50 EAST STATE STREET • PO BOX 364 • TRENTON, NJ 08625 • 609-292-5616

The New Jersey Department of Health contracts with Newark Community Health Center, a Federally Qualified Health Center to provide Healthy Start services in the cities of East Orange, Orange and Montclair. The goal of the project is to improve access to care, reduce black infant mortality, and to improve pregnancy outcomes.

The purpose is to ensure culturally competent and coordinated care with healthy life style promotion. The program provides outreach, recruitment, screening, case management, health and parent education throughout the prenatal and interconception period to improve access to care and reduce disparities for the

most at-risk pregnant women, infants and families. A consumer driven advisory board was established and meets quarterly.

To compliment the Healthy Start project in the metropolitan Essex County area, Newark Community Health Center receives an Access to Prenatal Care grant from the New Jersey Department of Health to implement Centering Pregnancy for low risk pregnant women.

Other accomplishments include increasing the first trimester entrance into prenatal care, providing free pregnancy testing, linkages with home visiting programs, increasing the screening for alcohol, tobacco, other drugs, post partum depression, depression and domestic violence to almost 100% of clients in project.

*The program provides outreach, recruitment, screening, case management, health and parent education throughout the prenatal and interconception period to improve access to care and reduce disparities for the most at-risk pregnant women, infants and families.*

## NEW MEXICO

## La Clinica De Familia Healthy Start Program

570 W. GRIGGS • LAS CRUCES, NM 88005 • 575- 524-0767



The La Clinica De Familia Healthy Start Program, also known as Doña Ana Healthy Start, one of the HRSA/MCHB Division of Healthy Start

US/Mexico Border Initiatives, is located in South Central New Mexico. Initially funded in 1999, the program has had the honor of serving families for over 11 years. Charged with reducing health disparities experienced by white-Hispanic pregnant women and parenting families with children, ages zero through three, approximately 90% of participants served are of Mexican descent with Spanish as their primary language. Annually, the program recruits, screens, and links between 600 to 700 participants to needed services. Approximately 400 “high-risk” pregnant women and 200 parenting families receive on-going case management, health education, home visiting/infant mental health and other support services directly from the program.



### OTHER NOTABLE ACCOMPLISHMENTS INCLUDE:

- Partnership with medical, dental and mental health providers;
- Creation of an early childhood network; and
- Infant Mental Health endorsed workforce.

*Initially funded in 1999, the program has had the honor of serving families for over 11 years.*

## Luna County Healthy Start

321 W. SPRUCE • DEMING, NM 88030



Luna County Healthy Start was implemented in 2000. We are situated in southern New Mexico; 3 miles north of the US/Mexico border. Currently,

our project services three communities: Deming, Lordsburg, and Columbus. LCHS assists low income, un/under-insured families with identifying and utilizing local resources. LCHS provides



home visits, transportation services, family health education, mentorship, and support services.

### THREE IMPORTANT ACCOMPLISHMENTS SINCE 2000 INCLUDE:

- Growth - Our project has expanded from just 50 annually to approximately 400! We have expanded services from Luna County to Hidalgo County.
- Service Enhancements - We increased services to include interconceptional health education, Male Involvement support services, and created a Mother's Support Group.
- Data - We redeveloped our data collection and processing to allow our project to gain a better perspective of the clients we serve. LCHS is extremely proud of our accomplishment, in collecting the most accurate and up-to-date information to allow better service to our community.

*LCHS provides home visits, transportation services, family health education, mentorship, and support services.*

## Central Harlem Healthy Start Northern Manhattan Perinatal Partnership

127 WEST 127TH STREET • NEW YORK, NY 10027

212-665-2600 • WWW.SISTERLINK.COM

Northern Manhattan Perinatal Partnership is a HRSA/MCHB grantee agency (16 years) for the Central Harlem Healthy Start (CHHS) Program. CHHS program is committed to reducing racial disparities in birth outcomes and improving family health status. CHHS implements outreach, case management, perinatal depression screening, interconceptional care, health education and health systems change interventions to reduce excess infant mortality and low birth weight rates in Central Harlem.

CHHS was instrumental in reducing the infant mortality rate from 27.7 deaths per 1,000 live births in 1990 to 6.1 deaths by 2008.



CHHS was also instrumental in reducing the low birth weight rate (< 2,500 grams) of babies from 17.8 LBW per 1,000 live births in 1990 to 11.7 by 2008.

CHHS helped improve women birthing experiences by assisting Harlem Hospital to establish a Birthing Center in 2003 staffed with mid-wives and doctors and also assisted Harlem Hospital in obtaining a Baby-Friendly designation from the World Health Organization in 2008.

*CHHS implements outreach, case management, perinatal depression screening, interconceptional care, health education and health systems change interventions to reduce excess infant mortality and low birth weight rates in Central Harlem.*

## Downstate New York Healthy Start Columbia University Mailman School of Public Health

722 WEST 168TH STREET, 9TH FLOOR • NEW YORK, NY 10032  
212-305-6600

Downstate New York Healthy Start (DNYHS) was created in 1997 under Phase II of the Healthy Start Initiative. Since 1999, the project is a partnership of Columbia University Mailman School of Public Health (CUMSPH) and three subcontracting agencies: Economic Opportunity Commission of Nassau County Inc., Queens Comprehensive Perinatal Council, Inc., & Suffolk Perinatal Coalition, Inc.

DNYHS provides case management services, referrals, home visitation, Baby Basics health education, smoking cessation and Circle of Caring psychosocial support group sessions. DNYHS's accomplishments are:

- Community-University partnership providing MCH care within high risk/resource poor communities.
- Development of motivational interviewing manual for improved smoking cessation services.



- Implementation of Circle of Caring psychosocial support group sessions for pregnant and interconceptional women.

DNYHS is committed to reducing infant mortality; system-wide changes include: dissemination of preconception care surveys at local high schools, integration of postpartum mental health protocol in local clinics and a county-wide breastfeeding awareness campaign.

## Healthy Start Brooklyn

NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
BROOKLYN DISTRICT PUBLIC HEALTH OFFICE  
485 THROOP AVE • BROOKLYN, NY 11221  
[WWW.FPHNY.ORG/PROGRAMS/GIVING-BROOKLYN-FAMILIES-A-HEALTHY-START](http://WWW.FPHNY.ORG/PROGRAMS/GIVING-BROOKLYN-FAMILIES-A-HEALTHY-START)

The Healthy Start Brooklyn program seeks to improve the health and wellness of women, infants, and families in Central Brooklyn. Rates of infant death, premature birth, and illness in the



underserved and predominantly minority neighborhoods of Bedford-Stuyvesant, Brownsville, Bushwick, East New York, and Flatbush are far higher than elsewhere in New York City and the United States. In order to address these grave disparities in maternal and child health, HSB provides comprehensive support services to families in Central Brooklyn and leads system-wide initiatives to improve the quality of health care networks in the area.

Over the nine years that Healthy Start has worked in Central Brooklyn, the program has:

- Served over 5000 families with case management services and has been a leader in the community in addressing important maternal and child health issues.
- Implemented several initiatives covering such topics as perinatal depression screening and treatment, family planning, labor and birth support, food security, community referral networking and tracking, and early childhood and parenting education.

The impact and success of each of the projects has contributed to a 13.5% overall decrease in the infant mortality rate in the project area since 2001.



## Healthy Start Rochester Perinatal Network of Monroe County

339 EAST AVE, SUITE 203 • ROCHESTER, NY 14604

585-546-4930 • WWW.PERINATALNETWORK.NET



The development of strong partnerships with two hospital systems in Rochester, NY has led to the addition of two center-based programs enhancing the service provision for pregnant and parenting women with babies less than 2 years in Rochester's most challenged

9-zipcode area: Healthy Start Center/Unity Health System providing prenatal health education, mental health, support groups, education groups, job training/coaching, childcare, and transportation; and Comienzo Sano/Rochester General Hospital serving a primarily Spanish-speaking population and a variety of refugees. Prenatal health education, yoga, case management, and childcare are provided within the context of the OB Centering Pregnancy program at Clinton Family Health Center. In project



year 2010-2011, there were no infant mortalities among the Healthy Start Rochester participants. The Perinatal Network of Monroe County/Health Start Rochester in partnership with the Department of Health and the Healthy Mom Healthy Baby initiative is developing a central referral system for perinatal services and an Outreach initiative.

## Syracuse Healthy Start

ONONDAGA COUNTY HEALTH DEPARTMENT

501 EAST FAYETTE STREET • SYRACUSE, NY 13202

WWW.ONHEALTHYFAMILIES.COM



In the 1990's, Syracuse, NY had the highest infant mortality in the country for a mid-sized city. During the past 10 years of Syracuse Healthy Start, the overall infant mortality rate has been cut in half although the disparity between white infant deaths and black infant

deaths persists today. Syracuse Healthy Start promotes healthy pregnancies and healthy babies through community partnerships, community referrals, health education, and case management. Key accomplishments for the Project include:

- Depression Clinic services that provide therapy and medications.
- Sleep Safe and Sound Campaign aimed at reducing bed sharing with infants which has been a leading cause of accidental infant death in Syracuse. The Campaign has been utilized by NYS Center for SIDS and National Association of County and City Health Officials.
- PeerPlace data system that allows for real time data reporting.



*Syracuse Healthy Start promotes healthy pregnancies and healthy babies through community partnerships, community referrals, health education, and case management.*

## Healthy Start CORPS

THE UNIVERSITY OF NORTH CAROLINA AT PEMBROKE

PO BOX 1510 • PEMBROKE, NC 28372

WWW.UNCP.EDU/HEALTHY\_START



The Healthy Start CORPS (HSC) project is administered through the University of North Carolina at Pembroke (UNCP) and partners with the Robeson County Health Department (RCHD) for case management and other core services. HSC Primarily operates in Robeson County, a

predominantly rural area located within the southeastern part of North Carolina with a more than 62% minority-majority population including African Americans and Native Americans whose health outcomes adversely differ from the general population.

### THREE OF OUR NOTABLE PROGRAM

#### ACCOMPLISHMENTS INCLUDE:

- Effective evaluation – consistently analyzing and reporting positive data trends over the course of our program.



- Infrastructure consortium building – continually building partner relationships to further our collective collaboration efforts.
- Increasing consumer engagement through learning objective activities such as Spa Day, Campbell Soup Luncheons, and various educational nutrition classes.

Our services captured local media attention with recent publications in the *Laurinburg Exchange*, the *Robesonian*, and the *UNCP Brave Bulletin*.

## North Carolina Healthy Start Baby Love Plus Program

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

NC DIVISION OF PUBLIC HEALTH

5601 SIX FORKS ROAD BLDG 2, 2ND FLOOR • RALEIGH, NC 27699-1929

WHB.NCPUBLICHEALTH.COM/SERVICES.HTM#TOP

The North Carolina Healthy Start Baby Love Plus Program addresses infant mortality, morbidity and other health disparities in three regions of the State. The **Eastern Baby Love Plus Program**, established in 1997, covers 7 eastern counties: Bertie, Edgecombe, Greene, Pitt, Martin, Tyrrell and Washington.

The **Northeastern Baby Love Plus Program**, established in 1999 as a planning grant, serves 5 northeastern counties: Gates, Halifax, Hertford, Nash and Northampton. The **Triad Baby Love Plus Program**, a disparity grant established in 1999, serves Forsyth and Guilford Counties. *[continued on next page]*



*The North Carolina Healthy Start Baby Love Plus Program addresses infant mortality, morbidity and other health disparities in three regions of the State.*

[North Carolina Healthy Start Baby Love Plus Program, continued from previous page]

These project areas have recorded some of the highest infant mortality rates in the State. Aside from core services, each program is tailored to serve a specific region.

#### **EASTERN BABY LOVE PLUS KEY ACCOMPLISHMENTS INCLUDE:**

- Lay Health Advisors Program – Barbers, beauticians and volunteers, trained in preconception and interconception health information, recruit, offer information and refer women of childbearing age to local health departments and other perinatal health providers.
- Regional Consortium – In existence for more than fourteen years, this entity has maintained consistent representation of program participants, local health department representatives, community members and other key stakeholders.
- Community Health Advocates (CHAs) are responsible for referral and follow-up on program participants that missed appointments or were lost to follow up. In an average year, CHAs reach over 12,000 women of childbearing age through dissemination of maternal child health and local resource information and educate about 60,000 community members through 2,500 health education presentations at local churches, schools, baby showers, and community events.

#### **NORTHEASTERN BABY LOVE PLUS KEY ACCOMPLISHMENTS INCLUDE:**

- Strengthening Systems of Care to Address Family Violence During and Around the Time of Pregnancy Initiative – With HRSA funding, trainings were conducted that emphasized integration of service delivery systems to facilitate removing barriers to service imposed by agencies. Each health department received a “Responding to Family Violence training manual to help them to respond appropriately to family violence in their clinics and communities.
- Regional Consortium Empowerment – During the last ten years, consortium participation has continually increased and participants are very vocal in expressing their concerns and needs. Feedback received has led to the implementation of Customer Service training for healthcare providers in the region.

Trainings were repeated consecutively for five years with a different customer service focus.

- Ministry Of Health Initiative – Implemented in 2005, this effort supports 9 regional churches in implementing health and wellness activities such as Exercise Saturdays, Healthy Sunday Sermons, and Weight Loss Competitions, one of the most competitive activities.

#### **TRIAD BABY LOVE PLUS KEY ACCOMPLISHMENTS INCLUDE:**

- Full Regional and Consumer Leadership Development Consortiums – In 2006, the Regional Consortium Executive Committee voted to carve out four meetings per year designed specifically for and focus directly on consumers and their families. By creating an intimate atmosphere where consumers can relate to one another, converse with educational speakers in smaller settings and have a greater “voice” in the program, consumers have gained more confidence and increased their knowledge of maternal child health. 60 to 80 adults and children attend each consumer meeting. The Full Regional Consortium meets bi-annually. Consumers play a role in this meeting by handling registration, welcoming the attendees and sharing programmatic updates.
- Small Group Facilitators – Because our Consumer Leadership Development Consortium grew beyond capacity, we needed to make room for new moms, dads and infants to join. Consumer members with children age three who attended consortium meetings for three years graduated and have been trained as “Small Group Facilitators” to share health messages into their communities, host meetings, and provide support and updates to the Full Consortium twice a year.
- 17P DVD – In 2008, the TBLP Health Systems subcommittee decided to focus on 17P awareness (17 alpha hydroxyprogesterone caproate) as a way to directly reduce high preterm birth rates in the region. Using a collaborative two-pronged approach, a provider tool kit was developed by Forsyth County Coalition on Infant Mortality. TBLP created a documentary style DVD entitled Footprints of Hope. This educational resource highlights moms who experienced a previous preterm birth prior to taking 17P and then a healthy, full term birth after using the medical intervention.

*Because our Consumer Leadership Development Consortium grew beyond capacity, we needed to make room for new moms, dads and infants to join. Consumer members with children age three who attended consortium meetings for three years graduated and have been trained as “Small Group Facilitators” to share health messages into their communities, host meetings, and provide support and updates to the Full Consortium twice a year.*





## Caring for 2

COLUMBUS PUBLIC HEALTH • 240 PARSONS AVE. • COLUMBUS, OH 43215  
614-645-1697 • [WWW.PUBLICHEALTH.COLUMBUS.GOV/CARING-FOR-2](http://WWW.PUBLICHEALTH.COLUMBUS.GOV/CARING-FOR-2)



Columbus Public Health **Caring for 2** funded since 2000, provides critical health and social services for pregnant and parenting African American women and their infants up to 2 years of age in three Columbus neighborhoods: Near East, Near South and South Linden. **Caring for 2** uses an interdisciplinary team model of public health nurses, social workers and care

coordinators to provide in-home family centered services including health education, referral, psychosocial risk and health assessments, infant assessment and linkages. Accomplishments include:

- Helped create and fund Pregnancy Care Connection (PCC), a centralized system for scheduling first prenatal care appointments, over 21,978 PNC appointments have been scheduled since August, 2003.
- Formed The Franklin County Maternal Depression Task Force, a collaboration of medical, mental health and social services agencies. Created "A Mother's Guide": Maternal Depression Care Providers directory, referral posters, training toolkit. Distributed over 1,500 directories and trained over 400 providers. Initiated participant in-home clinical counseling. Task Force's work has been presented nationally at CityMatCH and March of Dimes.
- Spearheaded the work of Kellogg funded national Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative (ALC), co-sponsored by CityMatCH, AMCHP, and the National Healthy Start Association. Through ALC's advocacy on the State's Infant mortality Task Force a stand alone" recommendation around racism is in the final report. Continue to participate on Ohio Collaborative to Prevent Infant Mortality.

## MomsFirst

CLEVELAND DEPARTMENT OF PUBLIC HEALTH  
75 ERIEVIEW PLAZA, 2ND FLOOR • CLEVELAND, OH 44114



Founded in 1991, the Cleveland MomsFirst Project is one of the original 15 Healthy Start sites. MomsFirst targets African American women in Cleveland's most impoverished neighborhoods, with special efforts to reach adolescents, as well as homeless, substance abusing or incarcerated women. The Project addresses direct and indirect risk factors that contribute to the disparity in infant mortality and poor birth outcomes. Core services include outreach, case management, health education and interconceptional care. The Project also provides screening and referral for perinatal/postpartum depression, breastfeeding support, child developmental screening, self-sufficiency coaching, and smoking cessation services.

### PROJECT ACCOMPLISHMENTS INCLUDE:

- Over the last 20 years, the infant mortality rate has reduced by 48% when comparing the first and most recent 6 years of participant birth outcomes, IMR of 16.0 and 8.4.



- Securing a diversified funding stream to expand program capacity and develop a seamless system of perinatal care for families.
- Perinatal depression project has served as a catalyst for the beginning of significant integration among the medical, mental health and social service systems and has led the way in addressing perinatal depression as a public health issue in Ohio. The model has also been recognized nationally and was awarded the CityMatCH award for the Most Innovative Response to Specific Problems, Issues, or Barriers.

## Central Oklahoma Healthy Start Initiative Community Health Centers, Inc.

3017 N MARTIN LUTHER KING, JR. AVE. • OKLAHOMA CITY, OK 73111  
405-427-3200 • WWW.CHCIOKC.ORG/HEALTHYSTART



Based on the premise that “Healthy Babies Begin Before Birth,”

the Central Oklahoma Healthy Start Initiative (COHSI) is a comprehensive network of services for mommies, daddies, and babies. COHSI draws its strength from being a service site of Oklahoma’s Community Health Centers, Inc., (CHCI) one of a few federally qualified community health centers in Central Oklahoma.



CHCI’s vision of engaging in work that will reduce infant mortality, improve perinatal outcomes, and strike at the heart of disparities in health care that impacts minorities as well as poor, under-served

populations, is underscored by the belief that positive perinatal outcomes should exist regardless of a family’s zip code.

### SINCE ITS INCEPTION IN 1999, THE CENTRAL OKLAHOMA HEALTHY START INITIATIVE HAS:

- Served well over 15,000 families through case management services, home visitations, health education classes, medical, dental, and depression screenings/referrals, inter-conception care services, smoking cessation programs, homeless and housing referral services as well as other family resource services;
- Developed specialized, enabling/empowerment support groups and activities for moms (COHSI’s Women’s Empowerment Group) and dads (COHSI’s Signature Parenting for Dads) as well as the family units as a whole (COHSI’s Consumer Advisory Council and Child Birth Education Group); and
- Launched community-based forums for families to connect with local business leaders as well as local, state, and federal policy makers and legislators so that families have been empowered to communicate their needs and their respective communities’ needs thereby creating a system of constituent-representative accountability on the local, state, and national levels.

## Tulsa Healthy Start

HEALTHY START PROGRAM • 4616 E. 15TH ST. • TULSA, OK 74112

Tulsa Healthy Start is a community-based project that focuses on high medical and social risk for infant mortality. Nearly significant progress has been made in improving rates of very low birth weight, infant mortality, and preterm delivery in program participants. The Family Health Coalition (Consortia) increases community and consumer awareness and involvement, project sustainability, and information system improvements. The case management provides assessment and case management for risks identified. The case managers conduct the service from pregnancy to 2 years post-partum. All program participants are screened for depression, substance use, family violence and smoking. The outreach core service conducts door-to-door canvassing, a centralized appointment system (Babyline), and free pregnancy testing to increase entry into prenatal and family planning services. Transportation services reduce the barrier women experience in receiving expedient services. The Health Education core service employs social marketing strategies to deliver community health messages, and conduct the fatherhood coalition.



Tulsa Healthy Start has served over 6,000 highest risk pregnant and parenting women in the 14 years of service. The infant mortality for the county has decreased from 8.5 in 1998 to 8.1 in 2008 with a low of 7.9. This is significant because during the timeframe the growth of the minority race and ethnic population giving birth doubled. A number of years the very low birth weight and infant mortality were 0 for the Tulsa Healthy Start population.

## Health Care Coalition of Southern Oregon

P.O. BOX 1419 • MEDFORD, OR 97501 • WWW.HCCSO.ORG

The Health Care Coalition of Southern Oregon is a member-based non-profit organization comprised of three local health departments and three Federally Qualified Health Centers located in three southern Oregon counties: Jackson, Josephine, and Douglas. We serve at-risk pregnant and parenting women. The services provided by these six organizations include core services of outreach and client recruitment, case management, health education, interconceptional care, and depression screening and referral provided by either nurses or nurse/bilingual outreach worker teams. Field staff members receive quarterly training on subjects including maternal depression, the effects of substance use during pregnancy, and domestic violence prevention.

*Field staff members receive quarterly training on subjects including maternal depression, the effects of substance use during pregnancy, and domestic violence prevention.*



### PROGRAM ACCOMPLISHMENTS INCLUDE:

- Reduced the rate of low birth weight infants among program women from 8.1 in 2002 to 3.7 in 2008.
- Reduced the infant mortality rates among program women from 7.8 in 2002 to 4.2 in 2008.
- Increased the percentage of program women who entered prenatal care during the 1st trimester from 56.1% in 2006 to 90.1% in 2011 (as of May 31, 2011).

## Healthy Birth Initiatives

5329 NE MARTIN LUTHER KING, JR. BLVD. • PORTLAND, OR 97211



The Healthy Birth Initiatives (HBI) program has been funded by Healthy Start since 1997. Although there are many, here are three of the

accomplishments our program would like to share:

- Through the services, support and interventions of the HBI program we have reduced the infant mortality rate of African Americans from 11.2 per 1,000 live births from 1994-1998 to 9.1 from 2003-2007.



- Due to the elimination of our Mental Health Consultant and through the implementation of our ICC Project/Maternal Depression focus, the HBI program was able to temporarily offer: individual counseling, mental health groups and mental health education using the Seeking Safety Curriculum.
- Male participation in the program, services and activities has increased tremendously. This accomplishment is due to contract with Portland State University and the Black Parent Initiative, where they offered trainings on how to administer blood pressures, health education & forums, father focused family activities and more!

The awareness and education to our clients & community are key to the continued success for improving birth outcomes!

*Through the services, support and interventions of the HBI program we have reduced the infant mortality rate of African Americans from 11.2 per 1,000 live births from 1994-1998 to 9.1 from 2003-2007.*



## Chester County Healthy Start

30 W. BARNARD STREET, SUITE 1 • WEST CHESTER, PA 19382

WEB ADDRESS: WWW.CCMCHC.ORG



MATERNAL AND CHILD  
HEALTH CONSORTIUM  
OF CHESTER COUNTY

Chester County Healthy Start has provided services since 1997, focusing on improving birth outcomes for black and Hispanic women. Our bilingual, bicultural Family Health Advocates work from sites in five low-income communities in Chester County, PA, providing participants with home visiting, emotional support, health insurance enrollment, linkages to prenatal providers, maternal depression screening and support, prenatal health education, access to needed social services (such as WIC, food stamps and domestic violence assistance), and translation/interpretation at medical appointments.



### ACCOMPLISHMENTS FOR CHESTER COUNTY HEALTHY START INCLUDE:

- From 1/1/96-12/31/09, 4.9% of singleton Healthy Start babies (187/3,839) were born at a low birthweight, surpassing the 2020 Healthy People objective of 7.8% low birthweight births.
- From 1/1/96-12/31/09, 6.6% of singleton Healthy Start babies (251/3,788) were born preterm, surpassing the 2020 Healthy People objective of 11.4% preterm births.
- From 1/1/96-12/31/11, Healthy Start assisted 3,780 women and children with applying for Medicaid or CHIP coverage. 96% (3,631) obtained coverage.



*Chester County Healthy Start has provided services since 1997, focusing on improving birth outcomes for black and Hispanic women.*

## Crozer-Keystone Healthy Start

2600 W. NINTH STREET • CHESTER, PA 19013 • 610-497-7460

WWW.CROZERKEYSTONE.ORG/SERVICES/HEALTHY-START



CROZER-KEYSTONE  
HEALTHY  
START  
A PROGRAM OF  
WOMEN AND  
CHILDREN'S  
HEALTH SERVICES

Crozer-Keystone Healthy Start provides services for pregnant women, and families of young children age 0-24 months. Health promotion, prevention and early intervention are the methodologies used to serve "at-risk" program participants. Crozer-Keystone (CK) Healthy Start provides a range of culturally relevant supportive services to meet the health and bio/psychosocial needs of the project's program participants, families and children. Services include case management; care coordination; clinical social

work; health education; home visiting; transportation, advocacy; resource linkage; translation and interpretation. CK Healthy Start's mission is to reduce the high rates of infant mortality and morbidity in Chester, Pennsylvania and the surrounding community.

### PROGRAM ACCOMPLISHMENTS INCLUDE:

- Program participant's maternal and birth outcomes have steadily improved.
- Contributed to lowering the community's infant mortality and morbidity rates.
- All program participants have a medical home.
- Children are immunized on time.
- Use of technology to support service delivery, education, data collection and evaluation.

*Crozer-Keystone (CK) Healthy Start provides a range of culturally relevant supportive services to meet the health and bio/psychosocial needs of the project's program participants, families and children. Services include case management; care coordination; clinical social work; health education; home visiting; transportation, advocacy; resource linkage; translation and interpretation.*

## Greater Harrisburg Healthy Start

HAMILTON HEALTH CENTER • 2814 GREEN STREET, SUITE 2  
HARRISBURG, PA 17110 • 717-920-9908



Greater Harrisburg Healthy Start serves the Harrisburg City and Steelton Borough communities, focusing on the African American and Latina women who exhibit higher birth disparity rates. Services are offered to all women, and the program has enrolled African American, Puerto Rican, Mexican, Dominican, Peruvian, Cuban, Bosnian, Middle Eastern, Native American, Caucasian, and multiracial women and infants. The ages of our consumers have ranged from 13 to 42. We focus on our five core services, which include: case management, outreach, education, family planning and birth spacing. We have been actively working with the Interconceptional Care Collaborative on family planning. Our hope is to increase our engagement with consumers and their partners, and in turn promote healthier pregnancies and lives following their children's births through the use of a Reproductive Life plan. We recently



started a Fatherhood Initiative, Men Matter, to engage and educate men in our community on health and family. We have only existed for two years and are looking forward to further progress in the years to come. Some program accomplishments include:

- We had 57 referrals in Year 1, and 319 in Year 2.
- We held 62 outreach/education events in Year 2; we were only required to hold 2.
- Out of the 149 women enrolled in 2 years, we've only had 2 repeat pregnancies.
- Initiative – We've started a Fatherhood Initiative program in January 2011, only 1 ½ years into our programming.

## Pittsburgh/Allegheny County

400 N. LEXINGTON AVENUE • PITTSBURGH, PA 15208

412-247-4009 • HELPLINE 412-247-1000

WWW.HEALTHYSTARTPITTSBURGH.ORG



In 1991 Healthy Start was created to combat a little-known problem in the United States. We had a ranking of 26th on the infant mortality list which has since worsened, increasing

to 46 in the last 20 years. In 1991, in Pittsburgh's Healthy Start target area, the infant mortality rate was 19.8. As of 2009, the infant mortality rate in our Healthy Start project area is 8.3. This Healthy Start project was the only Healthy Start project of the original 15 to reduce the infant mortality rate within 5 years. As of today, Healthy Start remains committed to the cause for the next 20 years, or however long it takes, so that all babies have a chance to be born healthy and survive.



Healthy Start Pittsburgh Celebrates 20 Years.

*"Thank you for providing this program.  
You are truly respected for having concern  
in the upbringing of our children."*

— CASAUNDR A G., PROGRAM PARTICIPANT

## Fayette/Westmoreland Counties

1266 PITTSBURGH ROAD • UNIONTOWN, PA 15401

724-425-1799 • WWW.HEALTHYSTARTPITTSBURGH.ORG



Despite the success of the Healthy Start Allegheny/Pittsburgh Project, infant mortality and low birth weight babies continued to be a problem for women only 50

miles away in rural Fayette County, Pennsylvania. In 2000, the Pittsburgh Project expanded services into Fayette County. Core interventions of outreach, health education, case management, interconceptional care and depression screening & referral were employed to accomplish our goals. Ninety-three percent of the women enrolled during their pregnancy received prenatal care during their first trimester. Healthy Start, Inc. remains committed for the next 20 years and beyond, with the primary goal of ensuring that every baby within our region has a healthy start!



Healthy Start Fayette Celebrates 10 Years.

*“When I became pregnant with my daughter last year I called Healthy Start to reenroll. I have learned so many new things and my daughter loves the infant massage classes! I know firsthand the importance of Healthy Start.”*

— ASHLEY K.

## Philadelphia Healthy Start

PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH

1101 MARKET STREET, 9TH FLOOR • PHILADELPHIA, PA 19107

215-685-5225 • WWW.PHILA.GOV/HEALTH/MCFH/HEALTHYSTART.HTML



Since 1991, the PDPH/MCFH has been the grantee for a Healthy Start project in West/Southwest Philadelphia.

In 2000, the program was

expanded to include a 2nd Project in North Philadelphia, then South Philadelphia and has since branched out into communities across the City in areas with high infant mortality. Philadelphia Healthy Start has grown into an innovative community-based program focusing on reducing infant deaths in underserved areas of the city. Collaborative relationships with other community based agencies have strengthened Philadelphia Healthy Start's capacity to provide a network of health and social services to pregnant, postpartum and interconceptional women and their infants.

### KEY ACCOMPLISHMENTS

- The Philadelphia Healthy Start Case Management Unit partnered with Cheyney State University to study obesity among medically high-risk ICC program participants.
- In June 2009, the Healthy Start Behavioral Health Consultant collaborated with Drexel-Hahnemann University, located in Philadelphia, to create a one-year BH training institute for the purpose of improving perinatal depression among healthy start clients. From June 2009-June 2010, 30 therapists from within the CBH System have been trained on how to provide informed and effective depression treatment to low income pregnant and postpartum women of diverse ethnic and racial backgrounds.
- Philadelphia HS has harnessed non-traditional community-based agencies (such as emergency food cupboards, family planning clinics, day care centers and homeless shelters) to significantly increase the number of HS eligible clients enrolled in their first trimester of pregnancy.





## Puerto Rico Eliminating Disparities Project

P. O. BOX 70184 • SAN JUAN, PR 00936-8184



The Puerto Rico Healthy Start Project (PRHSP) endeavors to minimize disparities in pregnancy outcomes and maternal and child health status on the island by providing case management/ care coordination, outreach and client recruitment, health education, maternal depression screening and interconceptional

care to pregnant women and children from birth to age 2 at high risk for adverse birth outcomes, infant mortality and morbidity. It strives to link participants to the network of health and human services they require, including prenatal and interconceptional

care for women, and preventive health services for infants and children. Education on maternal and child health issues is provided to participants, staff, providers and the community. The Participants' Committees (local consortia) gather consumer input and the Central Consortium works to achieve the goals of the Local Health Systems Action Plan. The project encompasses 34 municipalities in the southern and central mountain regions of PR.

### PROGRAM ACCOMPLISHMENTS INCLUDE:

- Participants' Committees – Through these committees, participants identify situations that affect their health and well being, and are empowered to find solutions.
- Reduction of Infant Mortality – The PRHSP was funded in 1997, when the IMR was 11.3/1,000 live births. Since that time the IMR has decreased island wide to 8.9.
- The PRHSP has reached over 30,000 persons per year with diverse MCH topics.

*PRHSP strives to link participants to the network of health and human services they require, including prenatal and interconceptional care for women, and preventive health services for infants and children.*

## SOUTH CAROLINA

## Low Country Healthy Start (LCHS)

1732 VILLAGE PARK DRIVE • ORANGEBURG, SC 29118

WWW.LOWCOUNTRYHEALTHYSTART.COM



Focused on improving African American birth outcomes in rural Allendale, Bamberg, Hampton and Orangeburg

counties, LCHS is known for client engagement, empowerment, education, advocacy and for connecting pregnant women with health, social services, housing, employment and education resources needed to improve lives and increase health. Strong, trusting relationships with perinatal providers and state and community leaders is a program hallmark. Through understanding women, translating needs and finding resources, LCHS has strengthened the lives of hundreds of African American families. Social workers and perinatal navigators use home visiting as a central strategy to educate women and decrease African American infant mortality.

### ACCOMPLISHMENTS:

- In the decade from 2000 to 2009, the LCHS service area African American infant mortality rate dropped from 19.7 per 1,000

live births (2000) to 6.2 per 1,000 live births (2009, the most recent year for which final data are available).

- LCHS built and carefully maintains a strong collaborative partnership with the obstetric providers caring for the majority of LCHS clients. Since 2001 hundreds of obstetric and LCHS staff multi-disciplinary team meetings have been conducted to problem solve and address individual client needs and perinatal system issues.
- Annually, the LCHS team provides approximately 1,328 pregnant and post-partum African American women and infants with targeted case management services, care coordination, counseling, focused home visiting, reproductive health planning, perinatal education, referral and follow-up and other direct services to improve perinatal health.



## Palmetto Healthy Start

223 STONERIDGE DRIVE • COLUMBIA, SC 29210 • 803-296-3780

WWW.PALMETTOHEALTH.ORG/HEALTHYSTART



Palmetto Healthy Start (PHS), under the auspices of Palmetto Health, is a well-established program for reducing infant mortality and health disparities in the Midlands area of South Carolina. PHS was funded in 1997 to serve four zip code areas in Richland County; it later expanded into all of Richland and Fairfield in 2001. In 2010, PHS received another grant to expand into Lexington and Sumter Counties. The PHS main office is located in Columbia, SC, with a satellite office in Sumter, SC. PHS staff works with community stakeholders to build strong relationships with women and infants for bridging racial gaps in existing service programs and promoting healthy outcomes from pregnancy to the infant age of 2. Services include: outreach

and recruitment, risk assessments, case management, home visitation, referrals, parenting education, childbirth classes, infant CPR classes, repeated pregnancy prevention, male involvement initiative, support groups, oral health services, and many more.

- PHS provides services to hundreds of low-income pregnant women. The number of participants served increased significantly every year. In 2010, PHS provided prenatal and interconceptional care services to 2,449 women, among whom more than 80% are African American women.
- PHS provides health education, referrals and other services to participants through in-person visits and telephone calls. In 2010, PHS staff made 4,232 home visits or phone contacts to 566 pregnant women, 831 interconceptional women, and 683 infants.
- PHS services have made a great impact on reducing low birth weight babies and infant mortalities. Among PHS participants, there was one death among infants born in 2010 with an infant mortality rate of 1.8 per 1,000 in 2010. The infant mortality rates among PHS participants in 2006-2010 were significantly lower than the overall rate of 7.8 per 1,000 among African Americans in Fairfield and Richland counties in 2009.

## Pee Dee Healthy Start

314 WEST PINE STREET • FLORENCE, SC 29501 • 800-747-2229



Pee Dee Healthy Start began in 1991 as one of the original 15 communities funded by HRSA in response to high rates of infant mortality and other factors in six rural counties.

United Way of South Carolina, a statewide organization was the grantee from 1991 to 1997. In 1997, Pee Dee residents transitioned to become a 501(c)3 community-based,

nonprofit organization. In January, 1998, Pee Dee Healthy Start, Inc. (PDHSI), assumed leadership of the program.

Presently, services are provided in four rural counties (Chesterfield, Darlington, Marion, and Williamsburg) to women of child-bearing age and at high social and environmental risk for poor pregnancy outcomes, adolescents and infants up to age 2.

Pee Dee Healthy Start promotes healthy birth outcomes and the reduction of racial disparities in infant mortality through outreach and home visitation services. Indigenous lay home



visitors provide the core services of outreach, education, interconceptional care, perinatal depression screening and referral.

### PROJECT ACCOMPLISHMENTS INCLUDE:

- Evolving into a 501(c)3 community based organization;
- Continuity of Project leadership and core volunteers; and
- Increase in breastfeeding among clients based on our education and community-based intervention.

## Northern Plains Healthy Start

1770 RAND ROAD • RAPID CITY, SD 57702 • 605-721-1922

We are a very unique Healthy Start Program. Our program is one of the original Healthy Start projects but also Northern Plains Healthy Start (NPHS) covers 4 states with offices on various Indian Reservations. We work closely with each individual tribe to provide the services to high risk women and children on the



reservations. We work collaboratively with key stake holders in the community, Indian Health Services and Tribal Programs to ensure services in areas with high poverty levels and limited resources. In the past twenty years, our program has proven to be a primary resource in each community for pre-natal and post-partum education, support and services. We have joined programs to work in the communities through our consortia, multi-disciplinary team meetings and collaborations to enhance the level of services available to high risk women on our reservations. In 2010, an independent group did a documentary on our Healthy Start Program featuring our office on the Pine Ridge Reservation which is being considered for publication on the Public Television.

*We have joined programs to work in the communities through our consortia, multi-disciplinary team meetings and collaborations to enhance the level of services available to high risk women on our reservations.*

## TENNESSEE

## Healthy Start Initiative Shelby County Health Department

814 JEFFERSON AVENUE, 3RD FLOOR • MEMPHIS, TN 38105

901-222-9295 • WWW.SHELBYCOUNTYTN.GOV

The Healthy Start Initiative, at the Shelby County Health Department (SCHD), has been providing home visitation and case management services to high-risk pregnant and parenting women living throughout Shelby County, Tennessee, since 2000. Healthy Start also focuses on strengthening and enhancing existing community systems of maternal and infant care. The SC Healthy Start program provides a variety of services, such



as: curriculum-based education & follow-up; translation services; health education; breastfeeding counseling/education; nutrition education; and social service and health care referrals.

- **Supportive Fatherhood Training:** Through a partnership with the Shelby County Department of Corrections (SCDC), the Health Start Initiative developed and implemented training for over 150 male inmates. In a 2-hour education and activity session, Healthy Start staff provided interactive education sessions about caring for infants and being supportive fathers. Inmates at the SCDC participated in a lecture and interactive stations to learn ways in which to support the mother of their child and ways to care for an infant including feeding, comforting, and bathing.
- **Cradles of Love Project:** In 2009, the Healthy Start program received \$12,000+ from the March of Dimes, Tennessee Chapter to provide safe sleeping environments for infants. This project allowed the Healthy Start Initiative to provide enhanced SIDS education to program participants, distributed 100 portable infant cribs, and ensured enhanced training for staff.
- **Implementation of New Program Model & Record Keeping:** In 2007, the Healthy Start program began a strategic process of evaluating program outcomes, reviewing best practices for home visitation services, and receiving input from clients about the services needed to improve outcomes for families.



## Music City Healthy Start

311 23RD AVE NORTH • NASHVILLE, TN 37203



The Music City Healthy Start (MCHS) of Nashville, TN, is one of the newest healthy start sites, beginning in 2010. MCHS provides home visiting and case management services to pregnant and newly parenting families in the North Nashville area. We have a male involvement

coordinator that has actively recruited the fathers, significant others and males in our target area to participate in our responsible fatherhood classes and activities.

We are partnered with Metro Parks, Metro Social Services, Matthew Walker Comprehensive Health Center, Meharry/General Hospital, Prevent Child Abuse Tennessee, HBCU Wellness, as well as many departments in Metro Public Health



Department, which is our lead agency. Our mission, of course, is to reduce infant mortality among African American families, as well as empower them to be healthy prior to, during, and between pregnancies through awareness, education, interventions, and mentorship.

## BCFS Healthy Start Laredo

7019 VILLAGE BLVD, SUITE 205 • LAREDO, TX 78041 • WWW.BCFS.NET



Since 2001, BCFS Healthy Start Laredo has provided a myriad of health and wellness services to over 3,000 medically-underserved

colonia families located along the U.S.-Mexico border in south Texas. Currently, BCFS Healthy Start Laredo, in professional collaboration with a broad array of local medical and social services providers, provides a variety of wellness-based services including prenatal and postpartum care, health and parenting

education, wellness care, laboratory services and referrals, as well as case management services focused on the medical, social, financial, educational, legal, housing, parenting and employment needs of its clients.

Since 2001, BCFS Healthy Start Laredo has consistently served over 300 low-income, medically-underserved, families every year. In July of 2003, BCFS Healthy Start Laredo became an active and founding member of the Texas Healthy Start Alliance (TXHSA), a state-level 501(c)(3) corporation organized for the purpose of addressing community-based maternal and child health-related issues. Currently, BCFS Healthy Start Laredo remains one of only a handful of national MCH programs focused on the delivery of high quality perinatal healthcare services via an innovative mobile platform.

*Since 2001, BCFS Healthy Start Laredo has consistently served over 300 low-income, medically-underserved, families every year.*



## Dallas Healthy Start Parkland Health and Hospital System

4917 HARRY HINES BLVD • DALLAS, TX 75235

WWW.PARKLANDHOSPITAL.COM/MEDICAL\_SERVICES/WOMEN\_INFANTS/  
HEALTHY\_START

Dallas Healthy Start (DHS) was established in 1994 to reduce infant mortality in communities that have high rates of infant deaths. DHS is a program of Parkland Health and Hospital System (The Dallas County Hospital District) within the Division of Women and Infants Specialty Health. DHS works in partnership with communities to address the medical, psychosocial, and cultural needs of high-risk pregnant women and infants in 5 zip codes throughout Dallas County.

In 2011, the program implemented third-party Medicaid reimbursement for case management to high risk pregnant women and children. Further, DHS has become a new United Way of Greater Dallas service provider and the recipient of nearly \$423,000.00. The program has partnered with the March of Dimes – Dallas Chapter and has received program funds for the implementation of Comenzando Bien – outreach and education geared to pregnant Hispanic women.



*DHS works in partnership with communities to address the medical, psychosocial, and cultural needs of high-risk pregnant women and infants in 5 zip codes throughout Dallas County.*

## Healthy Start Initiative Fort Worth

CATHOLIC CHARITIES DIOCESE OF FORT WORTH, INC.

249 W. THORNHILL DRIVE • FORT WORTH, TX 76115

817-289-3843 • WWW.CATHOLICCHARITIESFORTWORTH.ORG



Healthy Start Initiative Fort Worth began in 1998 as a response to the high number of infant

deaths in Tarrant County, Texas. Tarrant County has the second-highest infant mortality rate in Texas and also has one of the highest rates in the nation. Healthy Start works in Fort Worth and surrounding communities to help ensure that more families in our community have healthy births and that children reach their first birthday. The program promotes healthy family



lifestyles, works with fathers to encourage positive involvement and educates the community about infant mortality and health disparities that exist. Services include: home visitation, health education, supportive services for fathers, depression screenings, and referrals to other resources.

### ACCOMPLISHMENTS

- Healthy Start Initiative Fort Worth consortium “The Infant Mortality Task force” was influential and supportive of Congressman Michael Burgess, M.D. of Fort Worth, TX in introducing HR 402, a Resolution directing Congress to observe September as Infant Mortality Awareness Month.
- Serving up to 270 clients per year Healthy Start has maintained less than 2% infant Mortality with our clients.
- Healthy Start has successfully started a male involvement program growing it to 24 members within one year.

*Services include: home visitation, health education, supportive services for fathers, depression screenings, and referrals to other resources.*

## San Antonio Healthy Start

210 N. RIO GRANDE • SAN ANTONIO, TX 78202 • 210-207-4725

San Antonio Healthy Start (SAHS) has been operating for over 10 years. The program case manages pregnant women in 13 zip codes within Bexar County, Texas. Black and Hispanic women experience approximately 2 times and 1 ½ times the fetal and infant mortality rate of educated white women respectively.

Participants have experienced fewer low birth weight babies and higher access to prenatal care has increased from 61% in 2003 to 87% in 2010. The program has an excellent track record of no infant deaths from inception through 2010.

Another significant contribution to the reduction of infant mortality was through a program called “KISS”, Keep Infants Sleeping Safely, brought on by a spike in the SIDS/SUID deaths in 2007. The campaign, initiated by the Healthy Start lead FIMR team, was a collaborative effort with three community partners. The intervention targeted safe sleep practices of nurses in the counties hospitals through an intensive training program. Pre-Intervention to



¡Vamos juntos! To a bright tomorrow!

Post-Intervention nursery safe sleep practice observations showed a range of 43-57% improvement after the training. The taught practices were then instituted into policy in each Hospital District.

Most recently, SAHS launched the Healthy Families Network of Greater San Antonio and Bexar County, an aggressive initiative to reduce fetal and infant mortality through the use of Perinatal Periods of Risk (PPOR) analysis. The Network was formed in June 2011, with over 30 participating community partners. CityMatCH provided 2 days of training for Network members. County, city and community members are eager to explore the community risk factors directly associated with fetal and infant mortality in San Antonio and create a targeted intervention plan sensitive to the community assets at hand.

## SUNNY FUTURES Healthy Start

5280 GRIGGS ROAD • HOUSTON, TX 77021

WWW.NEIGHBORHOOD-CENTERS.ORG



In 1998, Neighborhood Centers Inc., a United Way Agency, formed the SUNNY FUTURES Healthy Start site (SFHS) in Houston, Texas. SFHS provides community-based perinatal services to women and their families in the Sunnyside, Third Ward, and Fifth Ward communities of Houston, Texas.

### KEY SFHS ACCOMPLISHMENTS:

- Since 2002, SFHS has provided in-home case management services to 757 pregnant women, 457 interconception women, and 945 infants/toddlers.
- In 2009 developed a postpartum reminder card to serve as a mailed reminder for women to obtain their postpartum visit within 60 days of delivery.
- Since 2005, the SFHS Consortium has educated 705 providers, parents and community members through hosting 4 Infant Mortality Summits and one Health Fair and Community Forum.







## Richmond Healthy Start Initiative

400 EAST CARY STREET • RICHMOND, VA 263219

804-250-3684 • WWW.RICHMONDGOV.COM

The Richmond Healthy Start Initiative, located in Richmond, VA (RHSI) serves African American women and families using an intensive home visiting model to eliminate structural, financial, and personal barriers that negatively impact maternal and child health outcomes. Through 3 community partnerships, the RHSI provides services to zip codes most at-risk for poor birth

outcomes. We provide treatment services to pregnant/post partum women identified with substance use disorders.

### PROJECT ACCOMPLISHMENTS INCLUDE:

- Presented The Richmond Regional Summit on Preventing Infant Deaths – A State of Emergency, *How Do We Save the Next Baby*, which was attended by over 350 participants;
- Development of the Peer Mentor Program which provides program participants with an opportunity to work in the RHSI central office; and
- Community Advisory Board (CAB) – *Faithful Beginnings, Help, Hope and Healing*, a 40 member board which has received over 300 hours of training on maternal, child and family health topics through the Richmond Healthy Start Leadership Institute. 65% of the CAB are Certified Lay Health Advisors and currently serve as the review committee for the VA Department of Health's Title X Family Planning grant.



## Virginia Healthy Start Initiative

VIRGINIA DEPARTMENT OF HEALTH

109 GOVERNOR STREET, 8TH FLOOR • RICHMOND, VA 23219

WWW.VAHEALTH.ORG/LOVINGSTEPS

The Virginia Healthy Start Initiative (VHSI) began in 1997 with the goal of decreasing perinatal health disparities in our African American community. Through collaboration with consortia, the VHSI multidisciplinary team (composed of registered nurses, registered dietitians and community health workers) has touched the lives of over 5,000 women and infants. Home visiting has been the major strategy of service delivery to pregnant and parenting women and teens, and their infants in Westmoreland County, Norfolk, and Petersburg, areas with historically high health disparities.

### KEY ACCOMPLISHMENTS INCLUDE:

- The addition of a registered dietitian to our multidisciplinary team to provide comprehensive nutrition assessment, counseling and physical activity programs;
- Expanded depression screening and referral services that include evidence-based stress management techniques for women experiencing stress and/or depression; and



- As a member of the Virginia Home Visiting Consortium, collaboration with other home visiting programs to enhance the effectiveness and efficiency of services.

## The WV Healthy Start/HAPI Project

1 MEDICAL CENTER DRIVE • ROOM 4616, HEALTH SCIENCES CENTER  
MORGANTOWN, WV 26506 • WWW.HSC.WVU.EDU/SOM/OBGYN/HAPI



The WV Healthy Start/HAPI (Helping Appalachian Parents and Infants) Project works collaboratively with existing systems, specifically the WV Office of Maternal, Child and Family Health Title V Program called Right From The Start (RFTS), to provide

comprehensive, integrated services to those women, infants and families at highest risk. Services for both programs are delivered by the same staff and maximize the use of state and federal resources. Simultaneous enrollment in HAPI and RFTS allow the blending of resources to provide a comprehensive package of services that would otherwise be unavailable to women, infants and families.

The WV HAPI Project's service region includes eight mostly rural counties in north central WV. Services are targeted to

improve maternal well-being during pregnancy, postpartum and the interconceptional period. Services provided in-home include education, assessment, and referral for healthy pregnancy behaviors, oral health, substance abuse, postpartum depression (screening, referral and payment for treatment), and interconceptional health.



## WISCONSIN

### Honoring Our Children

2932 HIGHWAY 47 NORTH • LAC DU FLAMBEAU, WISCONSIN 54538



Honoring Our Children provides prenatal and infant health services to eight sovereign tribal communities in northern Wisconsin: Bad River, Forest County Potawatomi, Lac Courte Oreilles, Lac du Flambeau, Red Cliff, Sokaogon Chippewa, St. Croix, and Stockbridge-Munsee. The program addresses infant

mortality, pre-term birth, and inter-conception health. Each site has an outreach worker and an MCH nurse to provide Medicaid Prenatal Care Coordination, case management, outreach, transportation services, home visitation, health education, and depression screening. Staff members at each site work closely with other providers to ensure the needs of the family are met. The evaluation provides feedback for quality improvement.



### PROGRAM ACCOMPLISHMENTS

- Honoring Our Children served an increasing number of families each year from 1998 to 2007, when 687 families and 1,440 individuals were served. Even with budget limitations in 2010, 591 families and 1,234 program participants were served.
- In 2010, 84% of pregnant Honoring Our Children participants began prenatal care in the first trimester, compared to 72% of all American Indian women in Wisconsin.
- The infant mortality rate has decreased. Using a 5-year rolling average for 1998–2002 compared to 2006–2010, the IMR for Honoring Our Children participants decreased from 15.5 deaths per 1,000 live births to 7.7, while the statewide American Indian IMR decreased from 11.1 to 8.5.

*The program addresses infant mortality, pre-term birth, and inter-conception health.*



## Milwaukee Healthy Beginnings Project

BLACK HEALTH COALITION OF WISCONSIN

3020 WEST VLIET STREET • MILWAUKEE, WI 53208

414-933-0064 • WWW.BHCW.ORG

The Milwaukee Healthy Beginnings Project (MHBP) is a project of the Black Health Coalition of Wisconsin, Inc. The Project is located in Milwaukee, Wisconsin and began in 1998. MHBP serves African Americans in seven zip codes in the central city. MHBP has been able to establish, with the help of its partners, a comprehensive system of community care designed to increase healthy birth outcomes and decrease infant mortality rates.

### MHBP ACCOMPLISHMENTS:

- Through its Consortium, MHBP has increased consumer voice and leadership in program, policy and practice in the city of Milwaukee and the State of Wisconsin;
- Program evaluation has documented that clients served by MHBP have lower percentages of preterm and very low birth weight infants than infants in the MHBP Project Area; and
- Developed a training module that highlights the protective factors of Life Course and African American culture in reducing health disparities. To date, training has been conducted with over 800 service providers and community residents.







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