

**ARIZONA DEPARTMENT OF HEALTH
SERVICES**

**OFFICE OF WOMEN'S AND CHILDREN'S
HEALTH**



**HEALTH START PROGRAM
COORDINATION STUDY**

AS REQUIRED BY LAWS 1996, CHAPTER 247

OCTOBER 1, 1996

Prepared by Cannon & Gill, Inc.

Leadership for a Healthy Arizona



Fife Symington, Governor
State of Arizona

Jack Dillenberg, D.D.S., M.P.H., Director
Arizona Department of Health Services

Mission

To assess and assure the physical and behavioral health of all Arizonans through education, intervention, prevention, delivery of services, and the advancement of public policies that address current and emerging health issues in a manner that demonstrates our efficiency, effectiveness, integrity and leadership.

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October 1, 1996



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September 30, 1996

Representative Robert Burns
House of Representatives
1700 West Washington
Phoenix, Arizona 85007

Dear Representative Burns: *Bob*

The Arizona Department of Health Services conducted a study to assess the feasibility of comprehensive coordination of prenatal/early childhood health outreach and prevention programs. In accordance with the language of HB2277 [Laws 1996, Chapter 247] for the Arizona Children and Families Stability Act, the enclosed report on this study is provided to you, as a member of the Joint Committee on Community Program Evaluation, which has oversight of the study.

The report includes the results of a survey of programs that might provide services to pregnant women and children. It includes a summary of services provided, populations served, and program goals. The report also identifies community needs from the perspective of those responding to the survey. Finally, it analyzes potential strategies for collaboration and coordination of programs, including those currently employed by the Health Start Pilot program.

If you have any questions about the report or need additional copies, please contact Dr. Ruthann Smejkal at 602-220-6550.

Sincerely,


Jack Dillenberg, DDS, MPH
Director

cc: Reed Spangler

JD/RMS:tjm

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I. EXECUTIVE SUMMARY

In 1982, Arizona began experiencing a steady decline in the rate of women receiving adequate prenatal care. Since 1985, Arizona has also experienced persistent outbreaks of vaccine-preventable diseases among its children, due, in part, to low immunization rates. In response to these poor health conditions for pregnant women and young children, the Arizona Department of Health Services (ADHS) initiated the Health Start Program in 1992. Health Start is a neighborhood outreach program designed to assist pregnant women in communities at high-risk for poor birth outcomes and/or inadequate immunization rates to obtain early and consistent prenatal care and to assist their children to receive timely immunizations. This program is delivered by Lay Health Workers, primarily in the client's home, and is intended to reduce barriers to services. The program's mission is to educate, support, and advocate for families at risk by promoting optimal use of community based family health and education services to reduce the incidence of low birthweight babies, increase prenatal services to pregnant women, and improve childhood health through a variety of means.

The Health Start Pilot Program was placed into statute in 1994 when the Arizona Legislature established the program's overall goals and structure and expanded the family follow-up period to the child's first four years of life. That legislation also required the Arizona Office of the Auditor General to conduct an evaluation of the Health Start program. The first evaluation report, completed in 1996, stated, in part, that although the ADHS Office of Women's and Children's Health was coordinating among programs, the agency should conduct a study to assess the feasibility of comprehensive program coordination. The report also listed several programs that it considered similar in some way to the Health Start program. In response to that report, the Arizona Legislature passed H.B. 2277 [Laws 1996, Chapter 247] which required a report from ADHS by October 1, 1996 on prenatal and early childhood health programs and a plan for coordinating services to minimize duplication.

This report addresses the issues raised by the legislation and the Office of the Auditor General. **Section II** identifies the programs considered by the Office of the Auditor General to be similar in some way with the Health Start program. An analysis of those similarities and differences for these specific programs is included in Appendix 10.

Section III provides information on Arizona's Health Start Pilot Program, including its mission, goals, and service populations. The mission of the Health Start program is:

To educate, support, and advocate for families at risk by promoting optimal use of community based family health and education services through the use of Lay Health Workers, who live in, and reflect the ethnic, cultural and socioeconomic characteristics of the community they serve.

The Health Start Pilot Program Contractors are included in Appendix 1.

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Section IV describes the survey process that was used to gather information about programs in Arizona that might provide services to pregnant women and children. This survey went beyond the programs identified by the Office of the Auditor General to ensure that as many programs as possible were included in the future collaboration efforts by the ADHS Office of Women's and Children's Health. The ADHS Office of Women's and Children's Health received responses from 74 agencies that in some way serve pregnant women and/or children. These agencies represent thirteen program types. These thirteen program types fall into three program groups: Group 1 serving pregnant women and providing child health related services, Group 2 providing child health related services (but not serving pregnant women), and Group 3 providing pregnancy-related services (but not providing health related services to children). Of the 74 respondents in these three groups, a total of 29 meet the criteria of providing prenatal and early childhood health outreach and prevention programs. Ten of these 29 programs are Health Start contractors. Even with the apparent similarities, however, each of these programs has some aspect that makes it unique from the others -- age group, financial eligibility, ethnicity, "diagnosis", for example. In addition, some provide a program emphasis significantly different, such as the Food and Nutrition programs.

Section V reviews the goals and intervention strategies of these 74 programs to identify similarities and differences. The key factors used included mission statements, goals, age range of the program's target population, service setting, use of Lay Health Workers, special eligibility requirements, and whether or not services were provided face-to-face or by telephone.

Although there are several types of programs in Group 1 that provide services to pregnant women and health related services for young children, there are no responding programs in this group that appear to be duplicative in specific mission and goals (focus), eligibility or service methodology. Each program serves a different population, provides a different set of services or delivers services using a different methodology. The closest program to Health Start is the Opening Doors American Indian Outreach Project which was modeled on the Health Start program and is administered by a current Health Start contractor. The Opening Doors program was designed specifically for a Native American population, incorporating education on traditional cultural beliefs into the program, and only serves the residents of three small communities. Funding for this program will expire in December 1996.

The programs in Group 2 differ from Health Start in a number of ways. Of these, the Healthy Families programs have the least difference in goals and the NICP programs have the greatest difference in goals. The primary emphasis of the Healthy Families programs, however, is directed towards the family environment rather than the physical health of the mother and child, and providing services to pregnant women is incidental to the purpose of the Healthy Families program.

Of the programs in Group 3, only Project Comadre is similar to the Health Start program in most of the points of assessment. This program is based on the Health Start model, uses Health Start

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forms for data collection and is administered by a current Health Start contractor, using grant funding. The grant ends October 1 of this year.

Section VI summarizes community needs from the point of view of the Health Start Contractors and the providers responding to the survey and identifies additional sources of existing needs assessment information. The Health Start program has been designed to address a number of these needs; however, as can be seen from the responses of the programs to the survey, even programs that are designed to meet needs attest to the fact that this is a monumental task. One way that all programs can better address community needs is through improved collaboration.

Section VII analyzes potential strategies for collaboration and coordination of programs, including those currently employed by the Health Start Pilot Program at both the State and Contractor levels. Collaboration offers the greatest number of benefits of the program relationship strategies summarized in this study, allowing for the unique needs of clients and communities to be met, yet at the same time providing the opportunity for programs to cooperate in critical ways to avoid duplication and maximize resources. The Health Start program uses some of these strategies to collaborate with other programs at the state and local levels.

Because of the types of services provided by many of the respondents in this study, there are unique opportunities for collaboration and creation of networks to expand and improve the availability of services to the target populations. *Section VIII* includes examples of existing coordination by the ADHS Office of Women's and Children's Health and the Health Start Pilot Program. These activities include:

- Development of a draft model on service coordination;
- Development of an Intergovernmental Agreement with the Coconino County Department of Public Health to implement a service coordination plan in the area of Page, Arizona with Healthy Families and Health Start programs, facilitated through shared office space and personnel;
- Completion by the ADHS Office of Women's and Children's Health of the Home Visiting for At-Risk Families Project in collaboration with several programs, including the Arizona Department of Economic Security. Part of this work included the development of guidelines for delivering home based services.
- Representation of the Health Start Program on several interdepartmental committees, including the ADHS System of Care Team, which provides a mechanism to coordinate service delivery to children with special health care needs. This activity produced the *Family Resource Guide*.

Additional steps to future collaboration and coordination are contained in the High Level Plan for Coordination in *Section VIII* of this report.

II. BACKGROUND

In 1992, the Arizona Department of Health Services (ADHS) Office of Women's and Children's Health initiated the Health Start Program in response to poor health conditions for pregnant women and young children.¹ Health Start is a neighborhood outreach program designed to assist pregnant women in communities at high-risk for poor birth outcomes and/or inadequate immunization rates to obtain early and consistent prenatal care and to assist their children to receive timely immunizations. In 1994, with the passage of the Arizona Children and Families Stability Act [Laws 1994, 9th Special Session, Chapter 1, §8], the Health Start Pilot Program was formalized and expanded.²

The 1994 legislation established the overall goals and structure for the Health Start Program and extended the family follow-up period from two years to four years. The legislation required the Health Start Program:³

- To be delivered by Lay Health Workers
- To use home visits as the primary method of service delivery
- To begin services during a woman's pregnancy and continue until the child is four years of age.

The legislation further required the ADHS to use, at a minimum, the following criteria in establishing Health Start programs in identified neighborhoods statewide:⁴

- A high incidence of inadequate prenatal care,
- A high incidence of low birth weight babies,
- A high incidence of inadequate infant health care, or
- Inadequate early childhood immunizations.

¹ In 1982, Arizona began experiencing a steady decline in the rate of women receiving adequate prenatal care. By 1990, Arizona ranked 45th in the nation for the number of women receiving adequate prenatal care. In addition, since 1985, Arizona has experienced persistent outbreaks of vaccine-preventable diseases among its children. This is due in large part to the state's low immunization rates, particularly among its disadvantaged children. In 1993, only 42.6% of two-year-olds statewide had completed the basic series of immunizations. In rural Arizona, the rate was 40%, putting Arizona three to thirteen percent below the national average. Current local research confirms that minority children account for the majority of the under-immunized group and comprise the fastest growing segment of the population. (Morrison Institute for Public Policy, Kids Count Factbook: Arizona's Children 1994)

² Health Start Policy and Procedure Manual, June 1, 1995; page 1-2

³ A.R.S. §36-697.A.

⁴ A.R.S. §36-697.A.

HEALTH START PROGRAM COORDINATION STUDY

BACKGROUND

In 1996, the Arizona Office of the Auditor General conducted the first annual evaluation of the Health Start Program as required by Laws 1994, 9th Special Session, Chapter 1, §9. Finding II of the Auditor General's report determined that the ADHS Office of Women's and Children's Health needed to "increase its efforts to coordinate Health Start with other services available to pregnant women and their families". The Auditor General was concerned that because "Health Start's target population is broadly defined, other programs may be serving families with needs similar to those served by Health Start". Although the Auditor General recognized that the Office of Women's and Children's Health was coordinating among programs, the report raised the issue that barriers to coordination remain.⁵

The Auditor General recommended that the ADHS should conduct a formal study to assess the feasibility of comprehensive program coordination that includes the following:

- A comprehensive listing of all prenatal/early childhood health outreach and prevention programs, including state, local, federal, and county programs.
- An assessment of related programs' goals, type of intervention, availability throughout the State, and costs.
- An assessment of the needs of target populations, target communities, and current community resources meeting these populations' needs.
- An analysis of various consolidation strategies, to determine how program consolidation, consolidation of different programs' administration, or block granting could help the ADHS Office of Women's and Children's Health to improve comprehensive service delivery.⁶

In particular, the Auditor General suggested that several programs in Arizona appeared to share some of the Health Start Program's goals or services for prenatal care or post-natal and family follow-up.

⁵ First Annual Evaluation of the Health Start Program; Office of the Auditor General; 1996; page 14.

⁶Ibid.; page 16

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The programs which the Auditor General identified for possible overlap were:^{7, 8}

- Baby Arizona
- Children’s Information Center
- Community Health Advisor Training Project
- Community Health Nursing (see NICP)
- Community Nutrition Education Services
- Coordinated Care (under AHCCCS Plan)
- First Steps
- Healthy Families
- Healthy Mothers, Healthy Babies
- Indian Health Services Public Health Nursing
- Newborn Intensive Care Program (NICP)
- Opening Doors (Havasupai, Hualapai Reservations)
- Pregnancy and Breastfeeding Hotline
- Prenatal Care Initiative
- Preventive Nutrition Services
- Project Chance
- Project Comadre
- Project Thrive
- Support for Obstetrical Services
- Teen Prenatal Express (program closed)
- Wellness on Wheels
- Woman to Woman

In response to the Auditor General’s report, the Arizona Legislature passed H.B. 2277 (Laws 1996, Chapter 247 -- Supplemental Appropriation; Family Programs). This law requires the ADHS to “conduct a study to assess the feasibility of comprehensive program coordination for the Health Start Pilot Program”. The requirements of the legislation are addressed in this report, as follows:

LAWS 1996, CHAPTER 247	REQUIREMENT	REPORT SECTION
Sec. 2. A. 1	List of all of prenatal and early childhood health programs that are available in this state at the federal, state, county and municipal levels	Sec. IV
Sec. 2. A. 2	Assessment of goals, types of interventions and costs of available programs	Sec. V
Sec. 2. A. 3	Assessment of needs of target populations and communities and to what extent current community resources are meeting the needs	Sec. VI

⁷ Ibid.; page a-vii

⁸ Analysis of these specific programs is contained in Appendix 10.

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BACKGROUND

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| Sec. 2. A. 4. | Analysis of various consolidation strategies within and among current programs and administration of programs and block grant strategies to improve comprehensive program services | Sec. VII |
| Sec. 2. A. 5. | Plan for coordinating all available services to minimize the duplication of the provision of services to program service recipients | Sec. VIII |

III. WHAT IS ARIZONA'S HEALTH START PROGRAM?⁹

Two health conditions in particular are considered to have a significant rippling effect throughout an individual's life. These are lack of adequate prenatal care for pregnant women and lack of appropriate and timely immunizations for young children. Lack of adequate prenatal care puts the woman and her baby at risk. Lack of immunizations for a young child puts the child at risk, other children in the community at risk, and the unborn children of pregnant women at risk.

Many Arizona women and children experience barriers that keep them from seeking or receiving adequate prenatal care and immunizations. These barriers include social, cultural and geographic factors. African American, Hispanic and Native American women are four times more likely than Non-Hispanic Whites (Anglos) to receive no prenatal care. These same groups have the highest infant mortality rates in Arizona. The low birthweight rate among African Americans is twice that of any other group. Teens of any ethnic group are three times more likely to receive inadequate or no prenatal care, and, therefore, are at special risk for poor pregnancy outcomes.

Since 1985, Arizona has experienced persistent outbreaks of vaccine-preventable diseases among its children. This is due in large part to the state's low immunization rates, particularly among its disadvantaged children. In 1993, only 42.6% of two-year-olds have completed the basic series of immunizations. In rural Arizona, the rate drops to 40%, putting Arizona from three to thirteen percent below the national average. Current local research confirms that minority children account for the majority of the under-immunized group and comprise the fastest growing segment of the population.

Arizona's Health Start Pilot Program was designed to address the critical health issues of prenatal care and childhood immunizations and reduce barriers to service. The mission of the Health Start Pilot Program is:

To educate, support, and advocate for families at risk by promoting optimal use of community based family health and education services through the use of Lay Health Workers, who live in, and reflect the ethnic, cultural and socioeconomic characteristics of the community they serve.

⁹ Health Start Policy and Procedure Manual; Chapter 1; June 1, 1995

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ARIZONA'S HEALTH START PROGRAM

By using Lay Health Workers who reflect the ethnic, cultural and socioeconomic makeup of the neighborhoods they serve, Health Start connects pregnant women with community resources which provide prenatal and related infant / child services. The families are followed for up to four years after the birth of the child to assist with identification of a "medical home" for each family member and to encourage immunizations for all children in the family. The Lay Health Workers also provide education on normal child development and parenting skills, and may serve as a referral source in the identification of children with special needs.

Health Start recruits its Lay Health Workers from within the targeted communities, because it is felt that they are most knowledgeable of the local customs, problems, cultures and service systems. By utilizing neighborhood or community Lay Health Workers, Health Start strives to assure that the program respects the differences in culture, family structure, personal and family resources which are found in the different communities throughout the state, while addressing the needs of women, children and their families based on the unique characteristics of the communities in which they live. By making the program sensitive and responsive to local concerns, Health Start promotes collaborative efforts within the community to improve the health of women, children and their families.

Specifically, the Health Start Pilot Program is designed to:

- Reduce the incidence of low birth weight babies
- Increase prenatal services to pregnant women
- Reduce the incidence of children affected by childhood diseases
- Increase the number of children receiving age appropriate immunizations by two years of age
- Educate families on the importance of good nutritional habits to improve the overall health of their children
- Educate families on the importance of developmental assessments to promote the early identification of learning disabilities, physical handicaps or behavioral health needs
- Educate families of the benefits of preventive health care and the need for screening examinations, such as hearing and vision
- Assist families to identify private and public school readiness programs.

The ADHS, through its Office of Women's and Children's Health, provides the criteria, policies and requirements for developing and implementing the Health Start Program in neighborhoods and communities. These guiding principles reflect the core requirements of the Arizona law and also promote the community and client-centered approach that is the cornerstone of this program.

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ARIZONA'S HEALTH START PROGRAM

The ADHS contracts with local public and private agencies (Contractors) based on recognition of communities with high risk of poor pregnancy and child health outcomes. The Health Start Pilot Program contracted providers tailor the local program to meet the needs of local communities as a way of reducing barriers to services. The role of the Contractors is to:

- Recruit, train and manage the Lay Health Workers
- Use Lay Health Workers to perform outreach into the designated community to enroll pregnant women in the program
- Provide basic prenatal and family health education, referral and advocacy services (Health Start connects women and families to health services, they do not provide these directly through the Health Start program)
- Design the method of outreach and community work that best fits the geographic, ethnic, socio-economic, etc. factors of their community

In SFY 1996, the Health Start Program operated under 12 Contractors serving 62 communities, neighborhoods and surrounding rural areas. [*Appendix 1: Health Start Neighborhoods and Communities for SFY 1996*]

IV. IDENTIFICATION OF PRENATAL AND EARLY CHILDHOOD HEALTH OUTREACH AND PREVENTION PROGRAMS IN ARIZONA

SURVEY DOCUMENT

In preparing this report, the ADHS Office of Women's and Children's Health designed a survey instrument that requested information on service populations, eligibility requirements for services, linkages to other programs, demographics of the populations served, numbers of clients served, missions and goals for programs, geographic areas of services, types of service interventions, types of services, methodology for providing services, program budget, types of staffing, frequency and type of contact with clients by type of staff and community needs. [*Appendix 2: Survey Document*]¹⁰

The ADHS Office of Women's and Children's Health sent the survey to representatives of the medical community; state, county and city governments; Tribes; other state agencies; and private providers. The ADHS Office of Women's and Children's Health received 86 responses with representation from each of the types of organization to whom surveys were sent: AHCCCS / health plans / hospitals / clinics (11 responses received); county and city governments / associations / health departments (25 responses received); private health / parent / family service providers (30 responses received); Tribes / Tribal Associations / Indian Health Services (11 responses received); and state agencies (9 responses received).¹¹

Since the purpose of this report is to identify strategies for coordination among providers of prenatal and early childhood health outreach and prevention services, the ADHS Office of Women's and Children's Health applied several organizational assumptions in selecting the recipients of the survey and in analyzing the responses. These organizational assumptions are:

1. Surveys should be sent to a sampling of entities who are likely to provide services to pregnant women or provide health related services for children. In addition, surveys were also sent to entities that provide similar services for children even if these services cannot be strictly classified as "health".
2. Surveys should be sent to all entities cited in the Office of the Auditor General Report.

¹⁰ All of the information about programs came from written responses to the survey.

¹¹ Three responses were not used in this report because they represented services significantly different from those under consideration -- Child Protective Services and services to children with developmental disabilities. It was felt that the services provided by these types of respondents are significantly specialized to the needs of the population.

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IDENTIFICATION OF PRENATAL AND EARLY CHILDHOOD HEALTH OUTREACH AND PREVENTION PROGRAMS

3. Because the ADHS Office of Women's and Children's Health has the greatest amount of direct control over the Health Start program for the purposes of developing a plan for coordination, the responses to the survey should be categorized in groupings by target population. These categories are:
 - Respondents who provide services to pregnant women and health related services for children [most similar to the Health Start target population]
 - Respondents who provide health related services for children but do not provide services to pregnant women
 - Respondents who provide services to pregnant women but do not provide health related services for children
 - Respondents who provide other services for children or include children in their service population. These respondents may also happen to serve pregnant women, although the woman's pregnancy is generally not the primary reason for entry into the program. This group was included in the previous category because they provide some service to pregnant women.
4. The ADHS Office of Women's and Children's Health established the following criteria to classify a respondent as providing "prenatal and early childhood health outreach and prevention" services. Programs that provide the following services by referral, service coordination or as direct services are considered to meet the criteria of providing prenatal and early childhood health outreach and prevention services for this population:
 - Client education on neonatal care
 - Client education on nutrition
 - Client education on prenatal care
 - Client education on preventive health care and child wellness
 - Outreach to identify pregnant women
5. Programs that predominantly use Lay Health Workers are considered most like the Health Start Program in philosophy.
6. Programs that are predominantly home-based are considered most like the Health Start program in service delivery methodology.

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IDENTIFICATION OF PRENATAL AND EARLY CHILDHOOD HEALTH OUTREACH AND PREVENTION PROGRAMS

Of the 83 survey responses used in this report, a total of 74 respondents stated that they provide some type of service to pregnant women or for children or both. These 74 respondents have been categorized as the following 13 program types identified in Table 1 below.¹²

TABLE 1: PROGRAM TYPES

• Adolescent / Young Adult	• Health Start
• Advocacy	• Healthy Families
• AHCCCS, Health Plan, Indian Health Services (IHS) and Other Medical	• Information / Referral / Prevention
• Behavioral / Substance Abuse	• Newborn Intensive Care Program (NICP) ¹³
• Birthing and Pregnancy Support	• Parental Support
• Food / Nutrition	• Well Child
• Head Start / Early Head Start	

As will be identified in Section V, however, there are significant differences in goals and intervention strategies among these program types.

From survey responses, the programs were categorized into three major groupings according to service populations. These categories are:

- GROUP 1: Pregnancy and Child Health Related Services
- GROUP 2: Child Health Related Services
- GROUP 3: Pregnancy Related Services

Some programs are more difficult to categorize than others. For example, several programs responded that they provide services to pregnant women. In fact, however, service to pregnant

¹² Although it is recognized that programs like Health Start and Healthy Families might fall into more than one of the above identified program types, because of the interest of the Legislature in these programs, a separate program type category has been created for them.

¹³ Includes Community Health Nursing

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IDENTIFICATION OF PRENATAL AND EARLY CHILDHOOD HEALTH OUTREACH AND PREVENTION PROGRAMS

women may be incidental to the purpose of the program. If a woman is already receiving services from Healthy Families, for example, and subsequently becomes pregnant, Healthy Families assists the woman to access medical care through referrals. This is not considered a program that serves pregnant women in the same way as the Health Start program which puts primary emphasis on the pregnancy itself.

GROUP 1: PREGNANCY AND CHILD HEALTH RELATED SERVICES

Twenty-six (26) of the respondents provide both services to pregnant women and an early childhood health program. These 26 respondents represent eight (8) program types, as identified below in *Table 2*:

TABLE 2: PROGRAM TYPES FOR RESPONDENTS WHO SERVE PREGNANT WOMEN AND PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

• Adolescent / Young Adult (1 response)	• Food / Nutrition (4 responses)
• AHCCCS, Health Plan, IHS & Other Medical (5 responses)	• Health Start (10 responses)
• Behavioral / Substance Abuse (1 response)	• Information / Referral / Prevention (2 responses)
• Birthing & Pregnancy Support (2 responses)	• Parental Support (1 response)

The Group 1 respondents are those with an emphasis on pregnancy and early childhood health services. One of the respondents focuses on adolescent women. Four are AHCCCS providers and one is the Phoenix Indian Health Services, all of which focus on the direct provision of medical services. Four Women, Infants and Children (WIC) program respondents are in this grouping. Their focus, as will be seen in Section V, however, is on nutrition. Ten of the respondents are Health Start providers. One respondent, Wellness on Wheels, is a medical and social services mobile clinic in Yavapai County that provides services to a much broader population than just pregnant women and young children. [*Appendix 3, "Respondents Serving Pregnant Women and Providing Health Related Services for Children"*, provides a listing of the programs by category, the geographic areas of service, parent organization, and demographics of the population being served.]

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IDENTIFICATION OF PRENATAL AND EARLY CHILDHOOD HEALTH OUTREACH AND PREVENTION PROGRAMS

The respondents in Group 1 generally meet the ADHS Office of Women's and Children's Health criteria of providing prenatal and early childhood health outreach and prevention programs by providing some type of service -- referral, service coordination and / or direct services -- in the areas of client education on neonatal care, education on nutrition, education on prenatal care, education on preventive health care and child wellness and outreach to identify pregnant women. There are some exceptions, however. The WIC programs appear less likely to provide services on neonatal care and outreach to identify pregnant women. The Wellness on Wheels program provided information on its services, including "guidance to promote health, prevent illness and manage health problems . . . and family planning counseling and education". The Children's Information Center only addresses education on preventive health care and child wellness. The following programs do **not** appear to provide outreach to identify pregnant women: one of the EPSDT respondents¹⁴, Signature Home Health Care, the Phoenix Area Indian Health Services, the ADHS/WIC office, Wellness on Wheels, the Children's Information Center, and the Grandparents Adopted for Parental Support (GAPS) program. [*Appendix 4, "Prevention and Outreach Services Provided by Respondents Serving Pregnant Women and Providing Health Related Services for Children"*, provides information for Group 1 on prevention and outreach services.]

Opening Doors American Indian Outreach Project meets all of the criteria for prenatal, outreach and prevention services and provides in-home services 85% of the time. This program, however, is small and indicated that 95% of its service population is Native American residents of Peach Springs, Valentine and Supai. It is administered through private grant funding by an organization which is a current Health Start contractor. The grant expires December 31, 1996.

A total of eighteen (18) of the twenty-six (26) respondents in Group 1 meet the preliminary criteria of providing prenatal and early childhood health outreach and prevention programs. Ten of these eighteen are the Health Start contractors. The respondents are:

- AHCCCS Prenatal Case Management Program
- Direct Teen Case Management
- Health Start (10 respondents)
- Las Amigas
- Opening Doors American Indian Outreach Project
- Pima Health System
- Prenatal Notch Clinic & Case Management
- Salt River WIC Program
- Tribal Health Maintenance and WIC Program

¹⁴ Early, Periodic Screening, Diagnosis and Treatment program under AHCCCS Health Plan

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GROUP 2: CHILD HEALTH RELATED SERVICES

Twenty-four of the respondents provide health related services for children but do not serve pregnant women. These 24 respondents are represented by the four (4) program types identified in *Table 3*.

TABLE 3: PROGRAM TYPES FOR RESPONDENTS WHO PROVIDE HEALTH RELATED SERVICES FOR CHILDREN BUT WHO DO NOT SERVE PREGNANT WOMEN

- | | |
|---|---|
| • Head Start / Early Head Start (7 responses) | • NICP (Newborn Intensive Care Program) (6 responses) |
| • Healthy Families (8 responses) | • Well Child (3 responses) |

Although some of the respondents in Group 2 indicated that they serve pregnant women, this service is incidental to the main purpose of the program. Generally, the service that is provided to pregnant women in this group occurs because the woman becomes pregnant while her child is already receiving services. In such cases the program may assist her in finding medical care or other services. [*Appendix 5, "Respondents Providing Health Related Services for Children But Not Services to Pregnant Women"*, identifies the programs, their service locations and ethnicity of clients being served.]

Respondents in Group 2 are less likely than respondents in Group 1 to meet all of the criteria of prenatal and early childhood health outreach and prevention programs. For example, the Head Start / Early Head Start programs generally do not provide client education on neonatal care or prenatal care. One exception is the Phoenix Early Head Start program that provides services to pregnant teens. The Healthy Families programs assist and coordinate services for women in the program who become pregnant, but this is not the primary focus of the program. Neither the NICP programs nor the Well Child programs generally provide client education on prenatal care. In most cases none of these programs provide outreach to identify pregnant women in the community. These factors make these programs distinctly different from Health Start and the other programs in Group 1. [*Appendix 6, "Prevention and Outreach Services Provided by Respondents Providing Health Related Services for Children But Not Services to Pregnant Women"*, provides information for Group 2 on prevention and outreach services.]

Only three (3) of the twenty-four (24) respondents in Group 2 meet the preliminary criteria of providing prenatal and early childhood health outreach and prevention programs:

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- Phoenix Early Head Start indicated that it provides outreach to identify pregnant women only for the purpose of recruitment into the program
- One of the NICP respondents and the Gila County Health Department Well Child Clinic indicated that they provide referral as a form of outreach for pregnant women

GROUP 3: PREGNANCY RELATED SERVICES

Twenty-four (24) respondents provide services to pregnant women but do not provide health related services for children. These respondents are represented by six (6) program types identified in *Table 4*.¹⁵

TABLE 4: PROGRAM TYPES FOR RESPONDENTS WHO PROVIDE SERVICES TO PREGNANT WOMEN BUT WHO DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

- | | |
|---|---|
| • Adolescent / Young Adult (6 responses) | • Birthing and Pregnancy Support (1 response) |
| • Advocacy (1 response) | • Food / Nutrition (3 responses) |
| • Behavioral / Substance Abuse (1 response) | • Parental Support (2 responses) |

Respondents in Group 3 are primarily serving pregnant women. They answered “no” to the question about providing health related services to children; however, some of these programs also include children in their service population or provide other services to children. Their greater emphasis is on the woman or teen mother. In one case, Healthy Mothers /Healthy Babies Coalition, children are included in the program’s focus, but its service is advocacy rather than direct service to women or children. [*Appendix 7, “Respondents Who Serve Pregnant Women and Who Do Not Provide Health Related Services for Children”*, identifies the programs, their service locations and ethnicity of clients being served.]

With the exception of the Food & Nutrition category, respondents in Group 3 are more likely to meet the criteria of providing prenatal / early childhood health outreach and prevention programs than are the respondents in Group 2. As with Group 2, however, there is not much emphasis on outreach to identify pregnant women. This is a significant difference from the respondents in

¹⁵ Thirteen (13) of the 23 respondents indicate that they include children in the service population, although they answered “no” to the question about providing an early childhood health program. These 13 programs are included in Appendix 9.

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Provided By Respondents Who Serve Pregnant Women and Who Do Not Provide Health Related Services for Children”, provides information for Group 3 on prevention and outreach services.]

Eight (8) of the twenty-four (24) respondents in Group 3 meet the criteria of prenatal / early childhood health outreach and prevention programs:

- Choices for Teen Parents
- Maternal & Child Health - Cochise County Health Department
- Project CAMI
- Direct Pregnancy Testing and Follow-Up
- Loving Me, Loving My Baby
- Project Comadre
- Woman to Woman
- Southern Arizona Collaboration -- Choices for Families

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SUMMARY

Of the seventy-four (74) respondents to the survey who stated that they provide some type of service to pregnant women or for children or both, a total of twenty-nine (29) meet the preliminary criteria of prenatal / early childhood health outreach and prevention programs. Ten of these 29 are Health Start programs. The programs are:

<u>Program Type</u>	<u>Program</u>
Adolescent / Young Adult	<ul style="list-style-type: none">• Choices for Teen Parents (Group 3)• Direct Teen Case Management (Group 1)• Maternal & Child Health - Cochise County Health Department (Group 3)
AHCCCS, Health Plan, Indian Health Services (IHS) and Other Medical	<ul style="list-style-type: none">• AHCCCS Prenatal Case Management (Group 1)• Pima Health System (Group 1)
Behavioral / Substance Abuse	<ul style="list-style-type: none">• Las Amigas (Group 1)• Project CAMI (Group 3)
Birthing and Pregnancy Support	<ul style="list-style-type: none">• Direct Teen Pregnancy Testing and Follow-Up (Group 3)• Loving Me, Loving My Baby (Group 3)• Opening Doors American Indian Outreach Project (Group 1)• Prenatal Notch Clinic & Case Management (Group 1)• Project Comadre (Group 3)• Woman to Woman (Group 3)
Food / Nutrition	<ul style="list-style-type: none">• Salt River WIC Program (Group 1)• Tribal Health Maintenance and WIC Program (Group 1)
Head Start / Early Head Start	<ul style="list-style-type: none">• Phoenix Early Head Start (Group 2)
Health Start	<ul style="list-style-type: none">• 10 Health Start respondents (Group 1)
NICP	<ul style="list-style-type: none">• 1 NICP respondent (Group 1)
Parental Support	<ul style="list-style-type: none">• Southern Arizona Collaboration - Choices for Families (Group 3)
Well Child	<ul style="list-style-type: none">• Gila County Health Department Well Child Clinic (Group 2)

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Even with the apparent similarities, however, each of these programs has some aspect that makes it unique from the others -- age group, financial eligibility, ethnicity, "diagnosis", for example. In addition, some provide a program emphasis significantly different from the others, such as the Food and Nutrition programs.

V. ASSESSMENT OF GOALS, TYPES OF INTERVENTION AND COSTS¹⁶ OF AVAILABLE PROGRAMS

ASSESSMENT FACTORS

In identifying similarities and differences for the respondents, the ADHS Office of Women's and Children's Health identified key factors related to goals and types of interventions by which to make comparisons. The key factors used to assess the goals are mission statements for the programs and a comparison of goals. The key comparison factors to identify compatibility of program functions for interventions include:

- Age range of target population
- Service setting
- Use of Lay Health Workers
- Special eligibility requirements
- Face-to-face provision of service / vs telephone service

Tables 5, 6, and 7, on the following pages, display the information on goals and types of interventions for programs in Groups 1, 2 and 3 respectively.

GROUP 1: GOALS AND INTERVENTIONS FOR PROGRAMS PROVIDING PREGNANCY AND CHILD HEALTH RELATED SERVICES

Table 5, "Mission, Goals and Intervention Styles for Programs that Serve Pregnant Women and Provide Health Related Services for Children", looks at goals and interventions for the programs providing services to pregnant women and health related services for children. This group

¹⁶ Although the survey did collect annual budget information for the programs, this report does not include a detailed analysis of the costs of the programs. Since the scope of the programs and services identified in this report vary so greatly, a detailed cost analysis would take significant time and require additional expertise. The budget information provided by the respondents demonstrate that the cost of these programs ranges from a high of \$45 million for the WIC program to a low of \$9,000 for a single NICP nurse in a rural part of the state. This does not tell us what the comparative unit costs are. Work by an auditor would be required to obtain an accurate picture of cost per client or cost per intervention of these programs.

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includes the Health Start program and programs most similar to the Health Start program based on the target service populations and the match with the criteria for prenatal and early childhood health outreach and prevention services.

Comparison Based on Service Setting

Health Start is primarily a home-based program, meaning that its workers visit families in their homes. Although not all services are suited to a home-based approach, e.g., certain medical interventions, the home-visiting approach uses the family's living environment as part of the service strategy to overcome barriers and strengthen the family's existing personal and community support system.¹⁷

In addition to the Health Start programs, only 25% of the respondents who provide services to pregnant women and health related services to children predominantly use a home-based approach. Those that are predominantly home-based, besides the Health Start programs, are:

- AHCCCS Prenatal Case Management Program[®] in the Phoenix Health Plan -- Focuses specifically on improving birth outcomes and addressing prematurity and low birthweight. It differs significantly, however, from several other programs in Group 1 in that it does not share the goals of reducing the incidence of childhood diseases, and providing education to families on nutrition, developmental assessments, and assisting with school readiness. The program is limited to women who are AHCCCS eligible and enroll with this AHCCCS provider.
- Signature Home Care -- Appears to be an NICP program and did not indicate that it provides outreach services to identify pregnant women even though it stated that it serves pregnant women. The program is limited to women who are AHCCCS eligible and enroll with this AHCCCS provider.
- GAPS -- Does not meet the criteria of a prenatal and early childhood health outreach and prevention program although it does serve pregnant women and children through referral and service coordination. Its primary emphasis is on prevention of child abuse and neglect. In this, it is closer to the Healthy Families model. It does not address the goals of reducing low birthweight and increasing prenatal services to pregnant women.
- Opening Doors American Indian Outreach Project[®] -- Is predominantly home-based in the method of service delivery, is based on the Health Start model, and is administered by a current Health Start contractor with grant monies which will be expiring shortly.

One of the programs in Group 1, Children's Information Center, is a phone based system that provides information and referral services. The Children's Information Center is a statewide,

¹⁷ The Home Visiting for At-Risk Families Project Final Report 1995; Arizona Department of Health Services - Office of Women's and Children's Health, page 9.

[®] Meets the criteria of a prenatal and early childhood health outreach and prevention program.

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One of the programs in Group 1, Children's Information Center, is a phone based system that provides information and referral services. The Children's Information Center is a statewide, bilingual toll-free number for families, caregivers, and health care professionals throughout Arizona designed to help facilitate access to needed services for children with special needs. It does not meet the prenatal, outreach and prevention goals in three areas -- reduction of low birthweight births, increase in number of prenatal visits, and access to school readiness programs.

Las Amigas[®] provides services in a residential treatment setting. It is specially designed to serve pregnant and post partum women who are substance abusers.

The remainder of the programs in this group are predominantly office and medical setting based.

Comparison Based on Use of Lay Health Workers

All of the Health Start contractors use Lay Health Workers. In fact, this is one of the distinguishing factors of this program's intervention methodology. Only four other respondents use Lay Health Workers, and none of the program types other than Health Start consistently uses Lay Health Workers. The three programs in addition to Health Start that use Lay Health Workers are:

- AHCCCS Prenatal Case Management[®] in the Phoenix Health Plan -- Is limited to women who meet the income and resource test to be eligible for AHCCCS, and select this Health Plan as their AHCCCS provider. Although it is a fully home-based program, and shares part of the mission of the Health Start program, it does not address several of the childhood health and public school readiness goals that are addressed by the Health Start program. The child may later be enrolled in the continuing medical services of the AHCCCS program, but since this enrollment is based on an action by the parent and a continuing financial eligibility, there is no guarantee that there will be medical follow up during the early years of childhood. The plan does not include case management follow-up for children.
- Wellness on Wheels program -- A much broader based program than just pregnant women and young children. As a mobile clinic in West Yavapai County, it also provides health promotion, immunizations for children and adults, referral for home visits for children at risk of developing medical conditions, referral for developmental screening, family planning, individual counseling, family therapy, mental health counseling, substance abuse counseling, home visitor nursing, health assessments and screenings for senior citizens, Medicaid eligibility screening, referral for HIV/AIDS testing and counseling, Tuberculosis screening, diagnosis and education, and coordination with other nutrition programs. With this broad emphasis, it does not share all of the Health Start goals.
- Opening Doors American Indian Outreach Project[®] --Although this program has a mission statement similar to that of Health Start, serves the same type of population -- pregnant women and children up to 4 years of age -- and is predominantly home

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based, it is designed specifically for the Native American population. In addition, the services are localized to the areas of Peach Springs, Valentine and Supai.¹⁸

- Tribal Health Maintenance Program/WIC[®] -- Although this program uses Lay Health Workers, it is a specialized program with emphasis on nutritional information and food, and, therefore, does not share mission or goals with the Health Start program.

Several of the programs in the category of serving pregnant women and providing health related services for children do not use Lay Health Workers and are either “specialty programs” or are limited to specific populations:

- Direct Teen Case Management[®] is limited to young women up to 17 years of age and is located only in Yuma County.
- Pima Health System[®] and Regional AHCCCS Health Plan are AHCCCS provider organizations. Their service systems and age ranges are broader than Health Start and have specific financial eligibility criteria. Eligibility is further linked to the coverage area of the specific AHCCCS provider.
- Prenatal Notch Clinic and Case Management[®] in Coconino County does not use Lay Health Workers and serves a broader population; however, it has a closer mission and goal match to Health Start than many of the other programs.
- Phoenix Area Indian Health Services is the Federal IHS program for American Indian and Alaskan Native persons. Its services are delivered primarily in medical settings by non Lay Health Workers.
- The InterTribal Council of Arizona (ITCA) WIC and the Salt River WIC programs are limited to low income, primarily Native American women and children and is a food and nutrition program.
- The ADHS WIC program also is limited to women and children up to 5 years of age who are at nutritional risk. The WIC programs can be a supplement to services provided by Health Start for a similar population if Health Start and WIC sites are located in the same geographic area.

Table 5 on the following pages provides more detailed information on the program mission statements. It also identifies where the various programs reported that they differ from Health Start in their goals. The goals, identified in the footnote to Table 5, are derived from the goals of the Health Start program. The survey respondents were asked to identify which of these eight goal statements they share with Health Start. Although some of the respondents provided copies of their goals, additional follow up work would be necessary to assess the complexity of this

¹⁸ This respondent stated that the Opening Doors program would close December 31, 1996.

HEALTH START PROGRAM COORDINATION STUDY

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information thoroughly. Table 5 identifies which goals each program stated that they did not share.

SUMMARY

Although there are several types of programs that provide services to pregnant women and health related services for young children, there are no responding programs in Group 1 that appear to be duplicative in specific mission and goals (focus), eligibility or service methodology. Each serves a different population, provides a different set of services or delivers services using a different methodology.

The closest program is the Opening Doors American Indian Outreach Project which was modeled on the Health Start program and is administered by a current Health Start contractor. The Opening Doors program was designed specifically for a Native American population, incorporating education on traditional cultural beliefs into the program, and only serves the residents of three small communities. Funding for this project will expire in December 1996.

In some cases, however, if these programs serve the same communities, their presence offers an opportunity for service coordination, and they may refer to each other when they have a client with special needs that can best be met by the more specialized providers. For example, Health Start does not provide immunizations for children but it assists the families to receive the immunizations, and may, therefore, help the family to enroll in AHCCCS or to seek services from the county health department.

TABLE 5: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN AND PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH START?
<u>Adolescent / Young Adult</u>	Direct Teen Case Management	0 - 204 months		No	up to 17 years of age	Yuma County Health Department mission is to promote the health of the community and prevent disease	
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	AHCCCS; prenatal case management program	0 - 252 months	home 100%	Yes	AHCCCS	To improve birth outcomes by decreasing prematurity and low birth weight rates of our members	c, e, f, h
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Phoenix Area Indian Health Services	all ages	medical 90%; home 10%	No	must be American Indian / Alaskan Native or non-Indian pregnant with Indian father's child with proof of paternity	To raise American Indians' / Alaskan Natives' health to the highest status possible	h
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Medicaid / EPSDT	252 months	phone 98%; office .5%; medical .5%; home 1%	No	AHCCCS enrolled	To manage a quality health care delivery system, dedicated to providing comprehensive health care to the eligible AHCCCS members residing in Pinal County.	

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

TABLE 5: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN AND PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH START?
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Pima Health System	0 - 240 months	phone 5%; medical 90%; home 2%; other 2%	No	PHS member / AHCCCS linked program	Vision: To improve the quality of life for the community and the people we serve through an integrated system of health and social services	h
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Signature Home Care - children = NICP	0 - 216 months (all ages)	home 100%	No	must be eligible for one of IPAs payors / programs / AHCCCS	To meet our customer's needs through the provision of high quality, cost effective home care products and services	a, b, h
<u>Behavioral / Substance Abuse</u>	Las Amigas	0 - 72 months	residential treatment program 100% (also medical offices; hospitals, public schools,	No	over 18 year old mothers who are pregnant or 12 months post partum, substance abuser	(program description) . . . a supportive community where pregnant and postpartum women participate in substance abuse treatment while remaining united with their children	g, h
<u>Birthing & Pregnancy Support</u>	Prenatal Notch Clinic & Case Management (moms); Children & Adolescent Services (children)	0 - 216 months		No	pregnant women / children up to age 18 years	To promote disease and disability prevention programs in partnership with the community	

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH START?
<u>Birthing & Pregnancy Support</u>	Opening Doors American Indian Outreach Project (program ends 12/31/96)	0 - 48 months	phone 5%; office 10%; home 85%	Yes	must suspect pregnancy, be pregnant or delivered child within last 2 months	To empower and promote the well being of American Indian people in northern Arizona by improving health care provider resources and service delivery through community-based initiatives	g, f
<u>Food / Nutrition</u>	Inter Tribal Council of Arizona WIC Program	0 - 60 months	phone <1%; office 95%; medical 5%; home <1%	No	pregnant, post-partum or breastfeeding; 185% of poverty; must have a nutritional risk		f, g, h
<u>Food / Nutrition</u>	Salt River WIC Program	0 - 60 months	phone 20%; office 80%	No	proof of pregnancy; income	The Health and Human Services Department shares its strength and vision for the enrichment of the Community . . .to provide culturally sensitive physical, mental, and social services . . .(etc.)	c, g, h
<u>Food / Nutrition</u>	ADHSWIC	0 - 60 months	office 80%; medical 20%	No	nutritional risk; reside in agency that is providing services		f, g, h

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

TABLE 5: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN AND PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH START?
<u>Food / Nutrition</u>	Tribal Health Maintenance Program / WIC	0 - 11 months and older	phone 25%; office 70%; Tribal Health Maintenance Program 5%	Yes	pregnant / breastfeeding; low income	Provide educational material and nutritional supplements for at risk women and children	c, d, f, g, h
<u>Health Start</u>	Health Start - Pima County	0 - 48 months	phone <1%; office <1%; medical <1%; home 96%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	
<u>Health Start</u>	Health Start - Comienzo Sano Yuma County	0 - 48 months	home 85%; school & community center 15%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	
<u>Health Start</u>	Health Start - Yavapai County	0 - 48 months	phone 5%; office 10%; home 85%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

TABLE 5: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN AND PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH START?
<u>Health Start</u>	Eloy Comienzo Sano / Health Start	0 - 48 months	phone 10%; 35% office; 3% medical; 50% home; 2% community	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	
<u>Health Start</u>	Health Start - Indian Community Health Service	0 - 48 months	office 3%; medical 1%; home 96%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	
<u>Health Start</u>	Health Start - Cochise County	0 - 48 months	phone 10%; office 10%; medical 10%; home 70%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	
<u>Health Start</u>	Health Start - Clinica Adelante	0 - 48 months	phone 5%; home 95%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

TABLE 5: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN AND PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH START?
<u>Health Start</u>	Health Start - North Country Community Health Center	0 - 48 months	phone 4%; office 3%; medical 1%; home 91%; mail 1%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	
<u>Health Start</u>	Health Start - Mountain Park (South Phoenix)	0 - 48 months	phone 10%; office 15%; medical 25%; home 25%; community 25%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	
<u>Health Start</u>	Health Start Centro de Amistad / Immunization and Well-Baby Clinic	0 - 204 months	phone 5%; office 5%; medical 10%; home 75%; exercise program 5%	Yes	live in service area; sign informed consent	To educate, support, & advocate for families at risk by promoting optimal use of community based family health & education services through use of lay health workers, who live in, & reflect ethnic, cultural & socioeconomic characteristics of community	
<u>Information / Referral / Prevention</u>	Wellness on Wheels -- West Yavapai Guidance Clinic & Family Resource Center	0 - 6 months	home 20%; mobile clinic / community center locations 80%	Yes	some services have eligibility restrictions based on income	To provide accessible, comprehensive, preventive health services to residents of rural areas of Yavapai County	b, h

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

TABLE 5: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN AND PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH START?
<u>Information, Referral, Prevention</u>	Children's Information Center		phone 100%	No	None	To ensure the health, safety and well being of children and their families through community-based, family centered, culturally sensitive systems of care	a, b, h
<u>Parental Support</u>	GAPS(Grand-parents Adopted for Parental Support)	0 - 36 months	phone 5%; home 95%	No	last trimester of pregnancy and child to 36 months of age; first time parents of any age; high risk for potential child abuse	(goal) To prevent child abuse and neglect in identified families with first children	a, b, h

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs



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GROUP 2: GOALS AND INTERVENTIONS FOR PROGRAMS PROVIDING CHILD HEALTH RELATED SERVICES

The respondents in this category stated that they provide health related services for children. Some of them responded “yes” to the question of serving pregnant women. However, because service to pregnant women is not a major reason for the program or the program is not primarily health based, these respondents were placed in Group 2. For example, some Healthy Families respondents answered “yes” to the question about serving pregnant women; however, the primary reason for program entry is not to receive services for pregnancy. If a woman who is enrolled in Healthy Families becomes pregnant while her family is receiving services, Healthy Families can help refer her to appropriate medical providers. Therefore, because services to pregnant women are incidental to the program, these respondents have been placed in this category rather than the “serves pregnant women” category.

Comparison Based on Service Settings

Nearly sixty-three percent (62.5%) of the respondents in Group 2 stated that they are predominantly home-based service providers. This is a common characteristic of two of the four program types in this group. The Well Child programs are office, medical or school-based. Most of the Head Start/Early Head Start respondents are not home based. The one exception in this category is the Phoenix Early Head Start program.

For those programs that are predominantly home-based:

- The Healthy Families programs serve families with children up to six years of age, which is generally older than other programs except for the AHCCCS and community/county public health services. Health Start, for example, serves families with children up to 4 years of age; Head Start programs generally serve 3 and 4 year old children and NICP serves children up to 3 years of age.

Although the Healthy Families programs do provide some health related services for children and do assist women who are enrolled in the program and subsequently become pregnant with referrals to appropriate providers, the program is directed more towards developmental issues for children and family stability issues than is the more public health orientation of the Health Start program. For example, the Healthy Families program goals are to reduce abuse and neglect, promote wellness and child development, strengthen family relationships, promote family unity and reduce dependency on drugs and alcohol.¹⁹ The Healthy Families program also bases eligibility on a stress assessment rather than a health risk. It is generally not directed

¹⁹ A.R.S. §8-701(C): The goals of the Healthy Families Pilot Program include: (1) Reducing child abuse and neglect, (2) Promoting child wellness and proper development, (3) Strengthening family relations, (4) Promoting family unity, (5) Reducing dependency on drugs and alcohol.

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towards the public health issues of reducing low birthweight babies, increasing prenatal services or improving pregnancy outcomes.

- NICP[®], which is also home-based, has a medical focus and is specifically directed towards reducing the mortality and morbidity of infants who are critically ill at birth. In order to be eligible for the program, the family must have a child who spent 72 of his/her first 96 hours of life in a Newborn Intensive Care Unit (NICU) because of medical need. The NICP provides in-home follow up nursing support services for these infants. Children can continue to receive these services until they are 3 years of age. These services are more medically involved than those provided through the Health Start program and are provided by medical personnel working with the families rather than Lay Health Workers.

The NICP is designed to improve the health status of Arizona's children by reducing the mortality and morbidity of infants who are critically ill at birth. The program strives to assure that risk-appropriate care is available and accessible to critically ill newborns in Arizona regardless of geographic location and ability to pay. The mission is accomplished by maintaining a regionalized system of transport and hospital care and ongoing developmental follow-up.

The NICP also includes follow-up services with developmental screenings and assessment through clinics for infants believed to be at higher risk for developmental problems because they meet certain medical criteria.

The NICP program includes Community Health Nursing -- home-based developmental screening, physical, and environmental assessments to identify potential developmental delays, support and teach parents, and refer families to intervention services in the community. The Community Health Nurse provides guidance on child care, developmental goals, parenting skills, and makes referrals to community resources as indicated. The Nurse reviews medications, treatments, follow-up appointments, and clarifies issues about infant care and development. An average of three visits are provided in the child's first year of life. This is in contrast with Health Start, in which visits should average about once per month prenatally and about six times during the first year of the child's life.

- The Phoenix Early Head Start[®] program has a goal of improving and enhancing the parent-child relationship and encouraging and supporting continuing education for parents and caregivers. Enrollment into the program is limited to pregnant teens with

[®] One of the NICP respondents met the criteria of providing a prenatal and early childhood health outreach and prevention program although prenatal services is not the primary emphasis of this program.

[®] Meets the criteria of providing a prenatal and early childhood health outreach and prevention program although prenatal services is not the primary emphasis of this program.

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infants under six months of age who live in certain areas of Phoenix. It also has an income eligibility criteria.

The remainder of the programs in this group provide services in other than a home-based setting.

Comparison Based on Use of Lay Health Workers

Two of the Head Start programs responded that they use Lay Health Workers -- the White Mountain Apache Head Start Program and Southwest Human Development Head Start Program. Both of these programs differ significantly from the Health Start program mission and goals because they are primarily child development rather than mother and child health programs. In addition, the White Mountain Apache Head Start Program is targeted to persons residing on or near the Fort Apache Reservation. None of the Head Start programs is home-based.

The remainder of the respondents in the category of providing health related services for children but not pregnant women serve a special population or provide a special medical service:

- Well Child Clinics and Immunization programs are offered by County Health Departments. Both of these types of programs offer services to which Health Start and other programs make referrals, but they do not provide the type of service coordination and family support of the other programs.

Table 6 "Mission, Goals and Intervention Styles for Programs That Provide Health Related Services for Children But Not Services to Pregnant Women", looks at goals and interventions for programs in Group 2 that are providing child health related services but are not primarily service providers to pregnant women.

Summary

Several programs in Group 2 that provide health related services for children do so only as a part of their overall program focus and responsibility. Reducing the incidence of low birthweight babies and improving prenatal care are not generally part of their purpose. Several of these programs generally have a specific purpose other than health. As can be expected from the category that these programs are in and from their specific focus, most of them differ significantly in their goals from the Health Start program. Most of them do not have a goal of reducing low birthweight or increasing prenatal services to pregnant women. Some of them also do not share the goals of increasing the immunization rate of children under two years of age. Generally, in this group, the Healthy Families programs have the least difference in goals and the NICP programs have the greatest difference in goals. The primary emphasis of the Healthy Families programs, however, is directed more towards the family environment than towards the physical

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health of the mother and child, and providing services to pregnant women is incidental to the purpose of the program.

TABLE 6: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN BUT NOT SERVICES TO PREGNANT WOMEN

PROGRAM TYPE CATEGORY	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Head Start / Early Head Start</u>	City of Phoenix Head Start	36 - 48 months	phone 15%; office 30%; home 20%; classroom 35%	No	up-to-date immunizations; 3 and 4 year olds; at or below federal poverty guidelines	To be a community leader in providing quality comprehensive child development services delivered by competent staff and collaborative community partnerships in order to promote family well-being and self-sufficiency	a, b
<u>Head Start / Early Head Start</u>	Phoenix Early Head Start	0-6 months enrollment; 0 - 3 years service	phone 5%; office 20%; home 75%	No	pregnant teen/child under 6 months to enroll; federal poverty guidelines; commit to immunize child and provide well-baby checks; 12% of service group must be children	(goals) To improve / enhance the parent-child relationship. To encourage and support continuing education of parents and other caregivers close to the child.	h
<u>Head Start / Early Head Start</u>	Colorado River Indian Tribes Head Start Program	36 months - 60 months	phone 10%; office 85%; home 5%	No	live within boundaries of La Paz County, Colorado River Indian Tribes Reservation and meet income guidelines	To serve the community of the Colorado River Indian Reservation throughout the year by providing high quality, cost effective, comprehensive, family focused child development services.	

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE CATEGORY	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Head Start / Early Head Start</u>	Head Start	36 months to 60 months	phone 1%; office 4%; home 20%; Head Start Site 75%	Yes	poverty guidelines; child 3 to 5 years of age	To provide a continuum of quality, direct services for children and families. The agency serves as a partner in the creation and development of programs, while advocating for innovation in service delivery.	a, b, d, h
<u>Head Start / Early Head Start</u>	White Mountain Apache Head Start	48 months	medical 5%; home 5%; Head Start 90%	Yes	reside on or near Fort Apache Reservation; to 4 years of age; meet ACF income guidelines		a, b, c, d
<u>Head Start / Early Head Start</u>	Head Start	36 - 60 months and up	home 10%; center based school setting 90%	No	must participate in health screenings; Salt River Pima-Maricopa Indian Community boundaries; 3 and 4 year olds; federal poverty guidelines		a, b

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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<u>Head Start / Early Head Start</u>	Havasupai Head Start	36 months to 60 months	phone 25%; office 50%; home 25%	No	all children 3 to 5 years of age living in remote area of Grand Canyon		a, b
<u>Healthy Families</u>	Healthy Families	0 - 60 months	phone 15%; medical 5%; home 80%	No	score on a stress index, parent of newborn		a, b, e
<u>Healthy Families</u>	SW Human Dev. / Healthy Families Maryvale	0 - 3 months	phone 10%; 2% office; 15% medical; 73% home	No	birth in prior 3 months; score 2.5+ on assessment	To provide a continuum of quality, direct services for children & families who the agency serves as a partner in the creation & development of programs, while advocating for innovation in service delivery	a, b

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE CATEGORY	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Healthy Families</u>	Healthy Families	0 - 60 months	phone 5%; office 20%; medical 5%; home 70%	No	newborn 0 - 3 months of age; family scores 25 points out of 100 on risk assessment	To systematically assess families strengths and needs to promote positive parent-child interaction, enhance family functioning and promote positive child development	b
<u>Healthy Families</u>	Healthy Families	0 - 60 months	phone 5%; office 5%; home 90%	No	child <90 days old & at risk of abuse/neglect		a, b
<u>Healthy Families</u>	Healthy Families	0 - 3 months	phone 5%; office 5%; home 90%	No	post partum women with risk assessment on family at time of birth		a, b

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE CATEGORY	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Healthy Families</u>	Healthy Families	0 - 60 months	medical 5%; home 90%; other (WIC, DES, etc.) 5%	No	enroll immediately following birth of at-risk child; score on assessment	A statewide system of delivery of home-based, family-centered services which promote health, prevent child abuse, and optimize child development, which will be made available to all families in need of such services	a, b, e
<u>Healthy Families</u>	Healthy Families	0 - 60 months	phone 4%; home 95%; family meetings 1%	No	family must enroll in program prior to baby's 3 month birthdate / score on assessment	To identify, intervene early & prevent abuse & neglect of targeted children under 5 years at risk for child abuse. . . provide preventive & early intervention services to identified parents . . . to promote child health & development . . .	a, b, c, e, g
<u>Healthy Families</u>	Healthy Families and Choices for Families	3 months - 216 months	phone 10%; office 10%; medical 10%; home 70%	No	mother who has had a live birth	Goal: The purpose of the Healthy Families America initiative is to support parents right from the start by laying the foundation for nationwide, voluntary home visitor services for all new parents through a network of statewide systems	

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PROGRAM TYPE CATEGORY	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>NICP</u>	NICP/AZEIP	0 - 36 months	phone 1%; office 1%; home 98%	No	up to 36 months of age		b, h
<u>NICP</u>	NICP & Office for Children with Special Health Care Needs	0 - 36 months	phone 10%; home 90%; WIC office 1%	No	96 hours postnatal in NICU for 72 hours	To reduce the mortality and morbidity in NICP infants who are critically ill at birth, and other children with special health care need who develop physical and developmental delays, through a state wide system of coordinated care	b, h
<u>NICP</u>	NICP	0 - 12 months	phone 10%; home 90%	No	newborn in neonatal intensive care unit for 72 hours or greater	To reduce the mortality and morbidity in NICP infants who are critically ill at birth and other children with special health care needs who develop physical and developmental delays, through a statewide system of coordinated care	a, b, c, h

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE CATEGORY	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>NICP</u>	Newborn Intensive Care Program (NICP)	0 - 36 months	home 100%	No	infants are post graduate of 48 hour stay in NICU or can be referred in	To reduce the mortality and morbidity of NICP infants who are critically ill at birth and other children with special health care needs who develop physical and developmental delays, through a statewide system of coordinated care	a, b, h
<u>NICP</u>	NICP	0 - 36 months	phone 5%; office 40%; medical 5%; home 50%	No	infants requiring more than 72 hours of Level III or Level II nursery care beginning within 96 hours of birth	To reduce the mortality and morbidity of infants who are critically ill at birth through a statewide system of coordinated care	a, b, c, d, e, h
<u>NICP</u>	NICP	0 - 36 months	phone 10%; home 90%	No	96 hours postnatal in NICU for 72 hours	To reduce the mortality and morbidity in NICP infants who are critically ill at birth and other children with special health care needs who develop physical and developmental delays, through a statewide system of coordinated care	a, b

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE CATEGORY	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Well Child</u>	John C. Lincoln Children's Health Services	0 - 216 months	office 100%; schools 40%	No	200 % of poverty level or below; uninsured	To build upon its successful Elementary Student Health Program and Children's Dental Clinic to enhance and expand primary care services to children and families of Sunnyslope	a, b
<u>Well Child</u>	Well Child Clinics	0 - 18 months	phone 20%; office 70%; medical 5%; home 5%	No			a, b, e, h
<u>Well Child</u>	Immunization Program	0- 216 months (all ages)		Yes			

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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GROUP 3: GOALS AND INTERVENTIONS FOR PROGRAMS PROVIDING PREGNANCY SERVICES

Table 7, "Mission, Goals and Intervention Styles for Programs that Serve Pregnant Women but Do Not Provide Health Related Services for Children", looks at goals and interventions for Group 3, programs that serve pregnant women but do not provide health related services to children. These are programs that responded "yes" to the question of providing services to pregnant women and "no" to the question of providing health related services for children. Some of these respondents may also be providing other types of services for children or including children in their service population.

Several of the respondents in Group 3 lack multiple intervention characteristics, thus making them significantly dissimilar from the Health Start program and other respondents to this survey.

- Healthy Mothers/Healthy Babies Coalition is an advocacy coalition for mothers and infants rather than a service provider. Its goal is for public education to improve maternal and infant health. Although it shares the mission and goals of encouraging healthy pregnancy outcomes and healthy children with the Health Start program, it does not provide services directly or coordinate services for clients. Examples of the types of activities performed by the Coalition(s) include public awareness campaigns, workshops and distribution of printed materials.
- Pregnancy and Breastfeeding Hotline is a bilingual, bicultural telephone based system that is primarily focused on improving pregnancy outcomes and providing information. It also does not provide services beyond referral directly to clients.
- The Commodity Supplementary Food Program, the Extension Food and Nutrition Education Program and the Family and Consumer Science Extension Education program are focused on providing nutritional information and do not address the goals of improving pregnancy outcomes or providing prenatal and childhood health services. These programs are office or community / classroom-based and do not use Lay Health Workers. The Commodity Supplemental Food Program also provides commodity foods such as cereal, canned meats, powdered and/or canned milk, canned fruits, canned vegetables, dried beans, peanut butter, and juices.

Comparison Based on Home-Based Service Setting

Thirty-three percent (33.3%) of the respondents in Group 3 use a predominantly home-based service delivery methodology:

- Choices for Families in Phoenix and Southern Arizona Collaboration on Choices for Families are directed at families needing support, education and crisis intervention.

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Choices for Families is limited to parents under 21 years of age. These two programs have broad mission statements and state that they share most of the Health Start goals.

- Maternal and Child Health in Cochise County is directed towards adolescent mothers. It did not indicate that its goals include developmental assessments, education on preventive health care and screenings or assistance to identify school readiness programs.
- Loving Me/Loving My Baby provides services through a variety of methodologies, which also include telephone, office, medical settings, and seminars. Like the Phoenix Birthing Project, this program is targeted to women in the African American community in Phoenix.
- Maternal Child Health (Phoenix Home Health) offers a maternal program for postpartum women who are AHCCCS enrolled and members of the health plan. It differs from Health Start, however, in a significant number of goals, particularly those dealing with improved pregnancy outcomes, childhood diseases and immunizations and school readiness issues.
- Woman to Woman focuses specifically on pregnant women to improve birth outcomes but does not provide services for children.
- The Next Step is primarily a child abuse prevention program provided through Parents Anonymous.
- Project Comadre is modeled on Health Start and provides services in a home-based setting using Lay Health Workers.

The remainder of the respondents in this category are not predominantly home-based and provide specialty services or serve special populations:

- Four of the respondents specifically address adolescent pregnancies and parents:
 - Center for Adolescent Parents in Tucson serves pregnant and parenting adolescents who have dropped out of school. The program is to assist these teens to overcome life barriers and become participating members of the community.
 - Choices for Teen Parents in the Yuma area offers programs in a classroom setting to pregnant or parenting teens under 21 years of age.
 - Maricopa Center for Adolescent Parents serves teen mothers between 16 and 19 years of age primarily from the Phoenix, Glendale and Peoria area. It also offers most of its programs in a classroom setting.
 - Yavapai County Health Department is providing nurse case management to pregnant adolescent girls under 18 years of age. This is a transitional

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program between the terminated Teen Prenatal Express program and the program to be developed using County Perinatal Block Grant.

- Project CAMI provides substance abuse services to women over 18 who are pregnant or parenting.
- Baby Arizona assists with AHCCCS eligibility and works to ensure that women are aware of the availability of medical care and assisted to access medical care early in their pregnancy. The program is educational and outreach based.
- First Steps is currently revising its mission statement. It serves teens and women who are receiving services from St. Joseph's Hospital and Maricopa Medical Center. It is not primarily home based and does not use Lay Health Workers.
- Yuma County provided a response on its Pregnancy Testing program. Other services can be provided as needed through referrals to program such as Health Start which has a contractor in the Yuma area.
- Phoenix Birthing Project is directed at improving pregnancy outcomes targeted to the African American Community.
- Surgery Referral is a medical based service through the Doctor's Health Plan. No additional information was provided.

Comparison Based on Use of Lay Health Workers

Only one of the respondents in this category uses Lay Health Workers -- Project Comadre in Pinal County. It is based on the Health Start model, uses Health Start forms for data collection and is administered by a current Health Start contractor, using grant funding. The grant ends October 1, 1996. The program is limited to pregnant women and their children up to one year of age. It is also predominantly home-based and meets all of the criteria of a prenatal and early childhood health outreach and prevention program. Of all of the respondents in Group 3, this is the most similar to the Health Start program.

Summary

Only one of the respondents in Group 3, Project Comadre, is similar to the Health Start program in most of the points of assessment. It is located in the communities of Casa Grande, Coolidge and Florence in Pinal County. There is also a Health Start provider in Pinal County that serves the community of Eloy.

TABLE 7: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN BUT DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Adolescent / Young Adult</u>	Center for Adolescent Parents	0 - 30 months	phone 10%; office 88%; medical 2%	No	pregnant & parenting teens who have dropped out of high school	. . . a place where teen parents who have dropped out of school learn to overcome life barriers, enhance self esteem, become self-sufficient & improve their life changes. . . goals are accomplished through education, skill development & community linkages	a, h
<u>Adolescent / Young Adult</u>	Choices for Families	0 + depends on family	phone 5%; home 90%; parks and stores 5%	No	parents under 21 years of age; 3rd trimester pregnancy	To enhance the quality of life for children and their families	a
<u>Adolescent / Young Adult</u>	Choices for Teen Parents	none	office 10%; classroom 90%	No	pregnant or parenting teens under 21 years of age	To enhance the quality of life for children and their families	c, d, g, h
<u>Adolescent / Young Adult</u>	Maricopa Center for Adolescent Parents	0 - 36 months	phone 5%; office 25%; classroom 75%	No	teen mothers between 16 and 19 years of age; pregnant with first child and in last trimester	To enhance the quality of life for all children and their families	a, b, h (also completion of GED)

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

TABLE 7: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN BUT DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Adolescent / Young Adult</u>	Maternal & Child Health	0 - 6 months and teens	phone 5%; office 1%; medical 3%; home 76%; other 15%	No	mother under 18 years of age	Agency's general mission is to promote and provide quality health & social services for vulnerable populations and to prevent and treat illness and social problems while increasing health awareness and behavior for all Cochise County residents.	f, g, h
<u>Adolescent / Young Adult</u>	Maternal & Child Health Block Grant	0 - 252 months	phone 40%; medical 50%; home 10%	No	teens under 18 are case managed by nurse; other services provided to women over 18; pregnant or in need of pregnancy test	(mission under development / services being provided on interim basis while planning Maternal & Child Block Grant)	c, e, f, g, h
<u>Advocacy</u>	Healthy Mothers / Healthy Babies Coalition Activities			No		(provides educational services)	h
<u>Behavioral / Substance Abuse</u>	CODAC BHS/ Project CAMI	none	phone 25%; office 25%; medical 15%; home 25%; other 10%	No	18 years and older parenting or pregnant	(Philosophy) . . .work toward the empowerment of clients as women in families, to deal more effectively with issues leading to alcohol and other drug abuse, by encouraging women to take control of their lives in fostering healthy connections. . .	g, h

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

TABLE 7: MISSION, GOALS AND INTERVENTION STYLES FOR PROGRAMS THAT SERVE PREGNANT WOMEN BUT DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Birthing & Pregnancy Support</u>	Baby Arizona		phone, office and medical settings	No	targets low-income pregnant women who may be Medicaid eligible through SOBRA or currently enrolled in AHCCCS	The goal of Baby Arizona is to get expectant mothers into care as early as possible, and to ensure that they continue that care and practice healthy habits during pregnancy.	c, d, e, f, g, h
<u>Birthing & Pregnancy Support</u>	Direct Pregnancy Testing and Follow-Up	none		No		Yuma County Health Department mission is to promote the health of the community and prevent disease	
<u>Birthing & Pregnancy Support</u>	First Steps	0 - 12 months	phone 30%; office 5%; medical 40%; home 10%; community 15%	No	receiving care at St. Joseph's Hospital or Maricopa Medical Center. Inpatient & follow up no age limit. Prenatal limited to 13 to 19 year olds.		c,g,h
<u>Birthing & Pregnancy Support</u>	Loving Me, Loving My Baby	- 24 months	phone 15%; office 15%; medical 15%; home 50%; seminars 5%	No			

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Birthing & Pregnancy Support</u>	Maternal Child Health (PHS)	0 - 1 month	home 100%	No	AHCCCS / post partum mothers and PHS members		a, b, c, d, h
<u>Birthing & Pregnancy Support</u>	Perinatal Case Management Program	0 - 252 months	phone 45%; office 5%; medical 5%; home 45%	No	AHCCCS eligible; mother under 20 years of age or over 34 years of age and at high risk due to medical, behavioral or social conditions	To provide realistic, individualized treatment goals to meet the medical and social needs of pregnant APIPA members	f, h
<u>Birthing & Pregnancy Support</u>	Phoenix Birthing Project	0 - 12 months	phone 73%; office 2%; medical 10%; home 15%	No	primary outreach is the African American community; prenatal		c, d, e, f, g, h
<u>Birthing & Pregnancy Support</u>	Pregnancy & Breastfeeding Hotline		phone 100%	No		To ensure the health, safety, and well being of pregnant women and their families through community-based, family-centered, culturally sensitive systems of care	c, d, e, f, g, h

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Birthing & Pregnancy Support</u>	Project Comadre	0 - 12 months	phone 15%; office 2%; medical 10%; home 70%; community 3%	Yes	children limited to one year of age; pregnant women; high risk pregnancies and high risk families referred to appropriate agencies	To positively impact infant mortality, low birth weight and infant immunization rates in rural Pinal County	
<u>Birthing & Pregnancy Support</u>	Surgery Referral of Pregnancy			No			
<u>Birthing & Pregnancy Support / Parental Support</u>	Woman to Woman	none	phone 20%; office 1%; medical 1%; home 50%; other 28%	No		To provide prenatal outreach, support, and education programs to strengthen families and our community by working with the beginning of all families, a mother and her unborn child	c, d, e, f, g, h
<u>Food & Nutrition</u>	Commodity Supplementary Food Program	0 - 71 months	office 100%	No	ages 1 - 5 and over 60 years; pregnant and up to one year post partum; women/children to 185% of poverty; elderly to 130% of poverty	To provide commodity foods and nutrition education in order to reduce nutrition-related health problems during critical periods of growth and development	a, b, c, d, f, g, h

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs

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PROGRAM TYPE	PROGRAM	AGES SERVED	SERVICE SETTING	LAY HEALTH WORKER	ELIGIBILITY REQUIREMENT	PROGRAM'S MISSION STATEMENT	GOALS DIFFER FROM HEALTH
<u>Food & Nutrition</u>	EFNEP Extension Food & Nutrition Education Program		phone 2%; home 18%; community 80%	No	low income & federal poverty guidelines	To empower families through nutrition education to healthy lifestyles and positive futures	b, c, d, f, g, h
<u>Food & Nutrition</u>	Family & Consumer Science Extension Education		phone 20%; home 20%; community center classes 60% (varies by county)	No		Educational outreach from the UofA with various curriculum and educational programs for limited resource or at-risk families and youth on life skills including family and personal development, nutrition/wellness, and family resource management	b, c, d, f, g, h
<u>Parental Support</u>	Southern Arizona Collaboration - Choices for Families	0 - 216 months	phone 5%; office 5%; home 90%	No	families needing family support, education and crisis intervention		
<u>Parental Support</u>	The Next Step	0 - 216 months	phone 10%; home 90%	No	pregnant and parenting teenagers	Parents Anonymous of Arizona strengthens families and prevents child abuse	a, c, f, h

a=to reduce incidence of low birthweight babies; b=to increase prenatal services to pregnant women; c=to reduce incidence of children affected by childhood diseases; d=to increase # of children receiving age appropriate immunizations by 2 years of age; e=to educate families on importance of good nutritional habits to improve overall health of their children; f=to educate families on developmental assessments to promote early identification of learning disabilities, physical handicaps or behavioral health needs; g=to educate on benefits of preventive health care and need for screening examinations, such as hearing and vision; h=to assist families to identify private and public school readiness programs



VI. ASSESSMENT OF THE NEEDS OF TARGET POPULATIONS AND COMMUNITIES AND THE EXTENT TO WHICH CURRENT COMMUNITY RESOURCES MEET THE NEEDS

Development of needs assessments is an ongoing endeavor in the State of Arizona. The ADHS, using a variety of methods, identifies needs of the Arizona populations. A significant amount of information about the needs of Arizona's women and children has been documented by the department and is currently being used by the ADHS and other organizations as the basis for planning decisions regarding programs -- both what services are needed and where they are needed.

Information used in this report came from a number of sources:

- Needs assessment information from the bids of the Health Start Contractors
- Responses to the survey question on the three top needs in the respondent's community
- The Health Needs of Arizona's Women, Children and Adolescents, 1995-1996; Arizona Department of Health Services - Office of Women's and Children's Health, February 1996
- Improving the Health of Arizona's Women, Children and Adolescents; Annual Plan 1995-1996; Arizona Department of Health Services - Office of Women's and Children's Health; February 1996

The respondents to the survey identified the following needs in their communities:

- Advocacy for teen parents and their children
- Awareness of service availability
- Bilingual early childhood education
- Bilingual Head Start classes
- Financial support
- Follow up and intervention services for medically and developmentally at risk infants, particularly in rural areas
- Foster homes
- Full continuum of services
- Prenatal support
- Prenatal nutrition services
- Prevention and intervention
- Primary health and vision care for school age children
- Residential services for substance abusing families

HEALTH START PROGRAM COORDINATION STUDY

Assessment of Needs

- Bilingual social workers
- Child care that is affordable and good quality
- Dental care
- Developmental therapies
- Emergency child care shelters
- Employment training for women
- Family based services
- Family support
- Financial resources for teen parents
- Housing
- Housing for teen parents
- Immunizations
- Improved access to prenatal care
- Improved services for medically complex children to remain the community
- In-home sick child care
- Increased funding for services
- Outreach to families with infants at risk due to dysfunctional environments
- Parenting and child abuse prevention classes
- Respite care
- School programs for young single mothers
- Service coordination
- Services for specific health conditions, such as diabetes, hypertension and alcoholism
- Social support networking for low income women
- Substance abuse services, particularly for substance exposed infants
- Teen pregnancy prevention education

Table 8, "Community Needs as Identified by Survey Respondents by County Area", on the following pages, displays the needs for the communities in which the respondent provides services, grouped by the county in which services are provided. Since responses were not received from providers in Graham or Greenlee Counties, there is no information provided for these counties. There are little significant differences among the respondents by county or by program type.

TABLE 8: COMMUNITY NEEDS AS IDENTIFIED BY SURVEY RESPONDENTS BY COUNTY AREA

STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Arizona	Perinatal Case Management Program	Coconino, Maricopa, Pima, Graham, Cochise, Yuma, Navajo and Apache Counties	inpatient treatment of pregnant substance abusers; shelters and housing; aggressive teen family planning
Arizona	Children's Information Center	statewide via telephone	effective ways to more preventive health and coordinated support services; accessible preventive health and support services; early prevention and intervention
Arizona	Pregnancy & Breastfeeding Hotline	statewide via telephone	fewer poor pregnancy outcomes; earlier identification of women at high risk for a poor pregnancy outcome; more women and infants accessing preventive health and support services
Arizona	Inter Tribal Council of Arizona WIC Program	Tribal -- Sells, Sacaton, Tucson, Kykotsmovi, Parker, Supai, Scottsdale, San Carlos, Whiteriver, Peach Springs, Phoenix (see service area list)	education; transportation; housing
Arizona	Healthy Mothers / Healthy Babies Arizona Coalition	16 sites in 14 counties; 3 subcommittee coalitions advocate statewide	public awareness of maternal and child health issues; increase of services for mothers and babies, transportation assistance for maternal and child health services in rural areas
Arizona	ADHS/WIC	statewide	family support services (summer programs for children); access to affordable, quality health care; public transportation
Arizona	Commodity Supplementary Food Program	statewide	greater CSFP services for older adults; improved public transportation

TABLE 8: COMMUNITY NEEDS AS IDENTIFIED BY SURVEY RESPONDENTS BY COUNTY AREA

STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Cochise	Healthy Families and Choices for Families	Sierra Vista, Benson, St. David, Tombstone, Palominas, Hereford, Fort Huachuca, Huachuca City	transportation, cheap counseling, more Head Start
Cochise	Health Start - Cochise County	Douglas, Pirtleville, Elfrida	jobs, housing, maternal & child education
Cochise	Maternal & Child Health	Willcox, Douglas, Efrida, Sunizona Pirtleville, Bowie, Bisbee, Sierra Vista, Benson, Naco	adolescent specific health care; sex education for teens; shelter for adolescents
Cochise, Pima, Santa Cruz	Healthy Families	Bisbee, Douglas, Naco, Pietrleville; Sierra Vistak Benson, Tombstone, Huachuca City, Nogales, Tucson (selected zip codes)	family based services, coordination of services, continuum of services for prevention and intervention
Cochise, Santa Cruz	Southern Arizona Collaboration - Choices for Families	Benson, Bisbee, Douglas, Sierra Vista, Naco, Pietrleville, Nogales, Rio Rico	family support, coordination of services, continuum of services
Coconino	Health Start - North Country Community Health Center	Page, Greenhaven; Marble Canyon; Bitter Springs; Gap/Cedar Ridge; Coppermine; Lechee; Kaibeto (all in Coconino County)	education / services to help youth gangs and teen pregnancy; activities / recreational opportunities to focus on families; prevention & treatment for drug and alcohol
Coconino	Havasupai Head Start	Havasupai Reservation in Grand Canyon	child abuse/neglect; drugs/alcohol; nutrition

TABLE 8: COMMUNITY NEEDS AS IDENTIFIED BY SURVEY RESPONDENTS BY COUNTY AREA

STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Coconino	San Juan Southern Paiute Tribe / Health & Human Services Department	Hidden Springs, Rough Rock Point, Tuba City, Cow Springs, Navajo Mountain (Utah)	health education; chronic illness home-based care; alcoholism
Gila, Pinal	Medicaid / EPSDT	Eloy, Coolidge, Red Rock, Toltec, San Manuel, Mammoth, Superior, Stanfield, Maricopa, Apache Junction, Casa Grande, Queen Creek, Sacaton, Mobile, Arizona City	immunization, early prenatal care; parenting skill
La Paz	Colorado River Indian Tribes Head Start Program	Parker, Poston; Colorado River Indian Reservation; Big River and Lost Lake (California)	Bilingual Head Start classes; immunizations; substance exposed infants; health problems such as diabetes, hypertension and alcoholism; lack of housing; parenting classes and child abuse prevention; foster homes
Maricopa	City of Phoenix Head Start	City of Phoenix	free and low cost dental and medical services; employment; education
Maricopa	SW Human Dev. / Healthy Families Maryvale	west Maryvale, Glendale, Phoenix	in-home prevention, service coordination, social supports
Maricopa	Health Start Centro de Amistad / Immunization and Well-Baby Clinic	Town of Guadalupe	dental care; school age children need primary health care and vision care
Maricopa	Phoenix Early Head Start	Phoenix Enterprize Zone: Camelback south to Elliott; 43 Avenue east to 40th Street	affordable, quality child care; housing and shelters for teens and their babies; bilingual early childhood education and social workers

TABLE 8: COMMUNITY NEEDS AS IDENTIFIED BY SURVEY RESPONDENTS BY COUNTY AREA

STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Maricopa	Head Start	Central Phoenix and Paradise Valley School Districts	medical services; dental services
Maricopa	Healthy Families	Chandler, Gilbert, Mesa	substance abuse; prevention services; community involvement
Maricopa	Phoenix Birthing Project	all of Maricopa County with primary outreach to the African American community	reduce low birthweight rate; reduce rate of infant death; support services
Maricopa	AHCCCS; prenatal case management program	Maricopa County	awareness; use services; duplication in outreach
Maricopa	Maricopa Center for Adolescent Parents	Phoenix; Glendale; Peoria (but will accept students from any location in the Valley)	financial resources for teen parents; housing resources for teen parents; more advocacy for teen parents and their children
Maricopa	Health Start - Clinica Adelante	El Mirage, Surprise, Queen Creek, Gila Bend, Buckeye, Wickenburg, Aguila	clients uninsured and underinsured; financial barriers to care - inadequate transportation; few referral sources; cultural barriers to care -- language, low literacy, little education
Maricopa	Choices for Families	Phoenix from Bell Road to Baseline and from 40th Street to 75th Avenue	financial / resources for teen parents; housing resources for teen parents; advocacy for teen parents and their children

TABLE 8 -- 4



TABLE 8: COMMUNITY NEEDS AS IDENTIFIED BY SURVEY RESPONDENTS BY COUNTY AREA

STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Maricopa	First Steps	n/a: recipients must be receiving services through St. Joseph's or Maricopa Medical Center in Phoenix	assistance to access services and resources; access to health care services and identifying a need to access services; child abuse prevention
Maricopa	NICP	Maricopa County zip codes 85007-85008; 85012; 85014; 85016; 85018; 85251 and 85257	follow up / intervention for infants at risk medically, developmentally; follow up / intervention for infants at risk -- delivery of services to those in rural areas; outreach to families with infants at risk due to dysfunctional social environments
Maricopa	John C. Lincoln Children's Health Services	Cactus south to Bethany Home Road; 35th Avenue east to 16th Street-- Royal Palm Junior High; Ocotillo Elementary School; Alta Vista Elementary School; Washington Elementary School	primary medical and dental care; juvenile delinquency; financially needy families
Maricopa	Salt River WIC Program	Lehi, Fountain Hills, Mesa, Phoenix, Scottsdale. Program located on the Salt River Indian Reservation	clients to keep their appointments; breastfeeding rates within the program
Maricopa	Loving Me, Loving My Baby	Maricopa County	emergency child shelter; finances; improved public transportation
Maricopa	Health Start - Indian Community Health Service	Phoenix zip codes: 85003-85009; 85012-85019; 85034 and others	diapers and clothing; food; transportation
Maricopa	Health Start - Mountain Park (South Phoenix)	South Phoenix neighborhoods for zip codes 85040 and 85041	education and prevention; career opportunities; economic development

TABLE 8: COMMUNITY NEEDS AS IDENTIFIED BY SURVEY RESPONDENTS BY COUNTY AREA

STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Maricopa, Pima	The Next Step	Maricopa and Pima County	transportation, bilingual service; teen support
Maricopa, Pinal, Pima	EFNEP Extension Food & Nutrition Education Program	(Maricopa County) central Glendale, Avondale, Central Mesa, Guadalupe, Phoenix, El Mirage; (Pinal County) Casa Grande; (Pima County) South Tucson, Davis Montham AFB; Catalina, Tohono	life skills education in parenting, nutrition, budgeting, etc; job training; transportation
Mohave	NICP	program serves state / respondent serves Mohave and Colorado City	developmental therapies; parent support; in-home sick child care
Navajo	NICP/AzEIP	Navajo County off reservation; Slow Low; Holbrook; Winslow	funding
Navajo, Apache	White Mountain Apache Head Start	McNary, Whiteriver; HonDah; Carrizo; Cibecue in Navajo and Apache Counties	parenting techniques; child abuse prevention; substance abuse prevention; building self-esteem
Pima	Pima Health System	Pima County	family planning; behavior modification; improvement education
Pima	CODAC BHS/ Project CAMI	Tucson	employment training for women; social support networking for low income women; good, low cost child care

TABLE 8: COMMUNITY NEEDS AS IDENTIFIED BY SURVEY RESPONDENTS BY COUNTY AREA

STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Pima	Healthy Families	areas of Tucson for zip codes 85713, 85711, 85205, 85745, 85719, 85635	respite care; residential services for substance abusing families with babies
Pima	Healthy Families	parts of zip codes 85705, 85706, 85711 - 85713, 85716, 85719, 85745, 85753	affordable, safe child care; affordable, safe housing; transportation
Pima	Woman to Woman	Areas of Tucson with high teen pregnancy and low birth weight	real neighborhood outreach; community involvement; addressing root problems, not symptoms such as pregnancy, behavioral problems, etc.
Pima	Center for Adolescent Parents	all of Tucson and outlying areas on south side of Pima County	pregnancy prevention; violence prevention and accountability for actions; mandatory parent education
Pima	Signature Home Care - children = NICP	all of Pima County	more financial assistance; more involvement by Child Protective Services
Pima	Maternal Child Health (PHS)	Pima County	patient education, availability of services, non-compliance
Pima	GAPS(Grand-parents Adopted for Parental Support)	Tucson city limits avoiding zip codes where families are already being served	prevention of child abuse; teen pregnancy prevention; violence and crime

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STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Pima	NICP	Tucson and South Tucson (primarily language of clients is Spanish)	teen pregnancy prevention education; job training; school programs/day care for young single mothers
Pima	Health Start - Pima County	Tucson: Richey FRWC/Menlo Park, the Vistas, Rosemeil area; Arivaca/Amado; Three Points; Continental/Sahaurita	transportation, social isolation, parenting skills
Pima, Pinal	Las Amigas	all of Pima and Pinal Counties and homeless throughout the state	affordable child care; employment preparedness and training; freedom from violence and drugs
Pinal	Eloy Comienzo Sano / Health Start	Eloy, Toltec, Pichaco, Arizona City, Red Rock	obstetrical and pediatric medical providers; transportation; local pharmacy
Pinal	Project Comadre	Casa Grande neighborhoods of Maricopa, Stanfield and 11 Mile Corner; Coolidge neighborhoods of Randolph, Twilight Trains and Valley Farms; Florence neighborhoods of Arizona Farms	transportation; better housing; more obstetrical and pediatric medical providers
Yavapai	Health Start - Yavapai County	Ashfork, Seligman, Chino Valley, Paulden, Dewey, Humboldt, Mayer, Cordes Lakes, Prescott Valley, Camp Verde	prenatal nutrition, substance abuse; parenting; low cost housing
Yavapai	NICP & Office for Children with Special Health Care Needs	Verde Valley; Clarkdale; Jerome; Camp Verde; Sedona; Rim Rock; Lake Montezuma; Pages Springs	prenatal education and care; sex education before conception; drug and alcohol education for teens and younger children

TABLE 8: COMMUNITY NEEDS AS IDENTIFIED BY SURVEY RESPONDENTS BY COUNTY AREA

STATEWIDE / COUNTY	NAME OF PROGRAM	GEOGRAPHIC AREA FOR SERVICE DELIVERY	WHAT DOES THE PROGRAM BELIEVE TO BE THE COMMUNITY'S NEEDS?
Yavapai	Maternal & Child Health Block Grant	Prescott, Prescott Valley, Dewey, Humboldt, Mayer, Spring Valley, Cordes Lakes, Black Canyon City; Congress, Yarnell, Bagdad, Chino Valley	easy access to prenatal care with physician; housing; transportation
Yavapai	Wellness on Wheels -- West Yavapai Guidance Clinic & Family Resource Center	Ash Fork, Seligman, Chino Valley, Camp Verde, Mayer, Humboldt	transportation; primary care; income assistance
Yuma	Tribal Health Maintenance Program / WIC	Cocopah Reservation (Somerton); Quechan Reservation (Winterhaven)	teen pregnancy prevention; information on proper nutritional needs, providing proper nutrition for mothers and children
Yuma	Health Start - Comienzo Sano Yuma County	San Luis, Gadsten, La Mesa, Yuma, Wellton, Dateland, Mohawk, Hyter, Tacna, Roy, Somerton	awareness, lack of education, barriers to care

HEALTH START PROGRAM COORDINATION STUDY

Assessment of Needs

A more comprehensive collection of health related needs assessment information can be found in The Health Needs of Arizona's Women, Children and Adolescents, 1995-1996. This is a comprehensive statewide assessment published by the ADHS - Office of Women's and Children's Health in February 1996. It was the second comprehensive five year needs assessment conducted for the federal Title V Maternal and Child Health Block Grant. The needs assessment and subsequent action plan, Improving the Health of Arizona's Women, Children and Adolescents: Annual Plan 1995-996, were designed to:

- Provide factual information that people and organizations can use to guide their activities and policies
- Provide a tool for better decision making about policies and use of resources among all groups concerned with women and children and
- Be a point for discussions around the state on certain key issues.

Another needs assessment, the Arizona Women's Health Survey, was conducted in FY 1993-1994 by the ADHS Office of Women's and Children's Health and the Centers for Disease Control to provide baseline population data for development of a statewide plan for reproductive health services. The resulting identification of needs is being addressed by the ADHS Office of Women's and Children's Health in the 1995 - 1996 Annual Plan. The documents referenced in this section provide detailed needs assessment information and can be obtained from the ADHS.

From these documents and the responses received from the survey, it is clear that many of the respondent programs are addressing community needs. It is also clear that the needs still exist and have not been completely met. In many instances, communities and their programs are only addressing the symptoms, without the underlying need having ever been identified. In these cases, systemic changes in the community and/or the system itself are required before the underlying need can be addressed.

These needs which have been identified arose due to a variety of causes. These include rapid population growth and unusual settlement patterns, broad cultural and social diversity, significant gaps in health service availability and use, a disproportionate share of uninsured Arizonans living in rural and frontier areas, great environmental diversity, and a variety of border/boundary issues. These encompass not only state boundaries, but also the United States-Mexico border and tribal lands.

HEALTH START PROGRAM COORDINATION STUDY

Assessment of Needs

Of the unmet needs identified by survey respondents, Health Start is designed to address:

- Advocacy for teen parents and their children
- Awareness of service availability
- Family based services
- Family support
- Immunizations
- Improved access to prenatal care
- Improved pregnancy outcomes
- Improved child health
- Parenting and child abuse prevention classes
- Prenatal nutrition services
- Prenatal support
- Prevention and intervention
- Service coordination
- Social support networking for low income women
- Teen pregnancy prevention education

Health Start assists women and communities in meeting these needs by:

- Helping women to obtain early and consistent prenatal care to reduce the number of low birthweight infants born in the community,
- Helping women to obtain age appropriate immunizations for their children to reduce the number of children affected by childhood diseases in the community,
- Helping women to receive information and appropriate assistance regarding parenting, child development, well-child care, hearing and vision screening and other issues to improve the early identification and treatment of developmental delays,
- Helping women to understand the importance of good nutritional habits so that the diets of their families will improve,
- Helping women to obtain a place to go to receive consistent health care to decrease the use of emergency room for routine medical care.

As will be seen in Section VII, Health Start enhances its ability to respond to these needs through collaboration with other programs and providers.



VII. ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES AND BLOCK GRANT STRATEGIES

DEFINITIONS OF PROGRAM RELATIONSHIP STRATEGIES

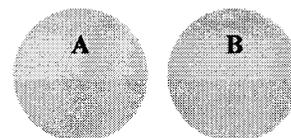
Different program relationship strategies can be used to deliver health and human services to a population or within a geographic area. These strategies may have greater or lesser benefits, depending upon the stakeholder and the primary goal of the strategy. The goals for the Health Start Program Coordination Study are:

1. To identify ways to improve comprehensive service delivery, and
2. To identify ways to minimize the duplication of the provision of services to Health Start program recipients.

The following information displays various program relationship strategies along a continuum from the least interactive to the most interactive. These points on the continuum are defined, for the purpose of this report as:

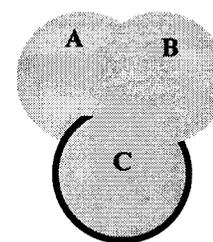
1. Separation

Each program operates totally independently in every respect. There is no voluntary or involuntary shared decision-making or shared service delivery. The target population for the programs may be the same, similar or different. The service goals and services may be the same, similar, different, or in conflict.



2. Collaboration

The programs collaborate in a series of interrelated activities designed to solve shared problems and create a system of services for community residents. It is a way to transcend systems, not necessarily to change systems. The programs have common goals, shared responsibilities in the collaboration, mutual investment in the collaboration and outcome, and shared accountability. It is an open, cooperative, communication and working relationship. Collaboration represents the highest degree of decision making among programs with common goals. It is generally voluntary and has formal mechanisms to document the collaboration, such as agreements, contracts, mission statements, etc.



The collaboration creates a third identity, while maintaining the individual identities of the participants. Relationships may or may not be equal within the collaboration, but each has a responsibility and contributes something to the new relationship. For example, two programs may

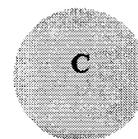
HEALTH START PROGRAM COORDINATION STUDY

ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES

make formal agreements to jointly participate in some activity. They develop a common set of goals, although each program may have other goals separate from and outside of the collaboration; they identify individual responsibilities that they will share in the collaboration; they each bring resources to the collaboration, although they may continue to account for their own resources separately; and there is mutual responsibility for the success of the venture.

3. Consolidation

The identities of the programs have totally merged into a new program. There is no longer any recognition of the earlier programs as separate entities. The new program takes on a new identity which will probably not be the same as either of the separate programs but is some combination of the earlier programs. (If the characteristics of one of the earlier programs totally disappears, it has not been consolidated -- it has been eliminated). The new entity replaces the earlier programs that were involved in the consolidation.



Separation and consolidation are two extremes of a program relationship strategy with collaboration being the middle ground that allows the benefits of each program's identity to remain intact while still also allowing for a maximization of service delivery.

PROS AND CONS OF VARIOUS PROGRAM RELATIONSHIP STRATEGIES

Separation and Consolidation are at opposite ends of the continuum of program relationship strategies that can be used to improve service delivery in health and human services. Both of these strategies represent extremes. Consolidation actually creates a new "separate" program, which, after becoming institutionalized, loses much of the benefit that it might have once had and begins to look and act like a separate program. Collaboration represents the middle ground, where aspects of both programs are still in effect, while some activities are shared.

Some of the pros and cons for these various program relationship strategies are identified on the next page:

HEALTH START PROGRAM COORDINATION STUDY

ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES

PRO

SEPARATION

- maintain autonomy
- maintain final control over program
- vision of program remains pure
- easier for funders to know what the program is

COLLABORATION

- does not change original program
- maximizes resources through pooling
- has potential to increase availability of resources for use by clients
- voluntary / easier for workers to adjust
- multidisciplinary approach to service
- may result in more available time by reducing hassles and duplication
- allows vision of each program to remain pure and adds additional vision to existing programs by improving ability of each program to serve its clients
- each program maintains control
- establishes new relationship
- uses resources more efficiently
- reduces duplication
- is more client friendly; reduces fragmentation
- may gain new supporters
- potential increased flexibility in use of funds
- may decrease competition / turf issues
- may increase percent of funds that can be used for services through administrative efficiencies
- sum result may be greater than any of the individual parts

CONSOLIDATION

- may use resources more efficiently
- may eliminate duplication
- may reduce fragmentation
- may gain new supporters
- potential increased flexibility in use of funds through block grants
- may decrease competition / turf issues
- may increase percent of funds that can be used for services through administrative efficiencies

- duplication of resources
- more utilization of administrative resources
- higher administrative costs
- potential for inefficiency
- decreased funds available for services
- increased competition of agencies and populations in need of a fixed amount of funds
- there is always a loser because there are never enough resources for all populations in need
- results in inequality / inequity
- fragmented service delivery system
- not user friendly because client must negotiate through the system(s)

- may take more time to develop because of the voluntary nature of the collaborative effort
- does not eliminate administrative overhead
- may have difficulty reaching consensus on different issues because of the more democratic approach
- may create some confusion for funders about what is being done with the funds they provide
- may be difficult to prove the intangible benefits of collaboration

- potential for complete loss of identity of old programs
- difficult for workers to adjust to new values
- difficult for clients to adjust to new programs and requirements
- may disenfranchise clients
- may reduce services if the new consolidated program is the "common ground"
- may lose supporters of old programs
- may result in loss of a program entirely if its identity / values / clients is too dissimilar from the new vision
- loss of original program's vision
- potential for reduced funds for services to all populations (i.e., block grant strategies)
- potential loss of control for funders

CON

HEALTH START PROGRAM COORDINATION STUDY

ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES

Separation results in the maximum in autonomy; however, autonomy may not be a benefit for the program, the service recipients or the funders, because it also maximizes fragmentation and duplication. Likewise, after programs have been consolidated, they eventually become a new separate program. Therefore, in the process of consolidating, this strategy may not only destroy the values of the original programs, but institute a new separate program with all of the benefits and drawbacks of any other separate program.

There are several factors that motivate people to perform jobs. One of them, particularly when the hours are long, working conditions are difficult and/or salary is low, is personal satisfaction from and personal commitment to the program's philosophy. When programs are consolidated, staff can lose this sense of "job identity". Similarly, the community and clients, or potential clients, recognize certain programs over time and begin to associate with these programs. This long term trust relationship that develops can be lost when programs consolidate. In communities which experience a number of health risk factors, such as those served by the Health Start program, and other programs which may appear similar, this loss of program identity has the potential to result in a decrease in the access to health care -- not because services do not exist, but because the members of the community do not know or trust the "new" program.

Collaboration, which includes cooperation and coordination, offers the most benefits to funders, programs and constituents of the programs because the strategy can be used to reduce the negative aspects of separate programs and enhance the opportunities for streamlining while maintaining the values and identity of the original programs and client base.

COMPONENTS OF PROGRAM RELATIONSHIP STRATEGIES

In preparing the Plan of Coordination the ADHS Office of Women's and Children's Health first reviewed the current status of its use of the various program relationship strategies across program components. For the purpose of this report, the program components have been identified as:

- a) Administration
- b) Needs Assessment / Program Planning
- c) Outreach
- d) Human Resource Development and Training
- e) Service Delivery
- f) Case Management / Service Coordination
- g) Tracking / Monitoring / Reporting

HEALTH START PROGRAM COORDINATION STUDY

ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES

Table 9, Program Relationship Strategies Currently Used by Health Start, is a review of what types of strategies are currently used and at what level -- State level or Contractor (local) level.



HEALTH START PROGRAM COORDINATION STUDY

ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES

Table 9: Program Relationship Strategies Currently Used by Health Start

PROGRAM RELATIONSHIP STRATEGY	PROGRAM COMPONENT	USE BY HEALTH START PROGRAMS	LEVEL THAT USES STRATEGY
SEPARATION	Administration	<ul style="list-style-type: none"> • Each employs own Lay Health Worker, contracts separately, runs own program, invoices separately • Health Start staff independently budget, contract, monitor and administer the Health Start program under guidelines specified by ADHS and the Arizona State Legislature 	<ul style="list-style-type: none"> • Contractor level • State level
	Needs Assessment / Program Planning	<ul style="list-style-type: none"> • Local level needs assessment and program planning to fit needs and resources of communities 	<ul style="list-style-type: none"> • Contractor level
	Outreach	<ul style="list-style-type: none"> • Direct outreach by Lay Health Worker includes door to door, talks, etc. Program level outreach includes news releases, radio broadcasts, etc. • Outreach by the state includes news releases, radio broadcasts, presentations at professional meetings and symposia, etc. 	<ul style="list-style-type: none"> • Contractor level • State level
	Human Resource Development & Training	<ul style="list-style-type: none"> • Each contractor hires and trains its own Lay Health Workers • The State develops Lay Health Worker training guidelines, notifies contractors of available training opportunities, hires staff (field coordinator) to do training and liaison and problem solving 	<ul style="list-style-type: none"> • Contractor level • State level
	Service Delivery	<ul style="list-style-type: none"> • Lay Health Worker serves their clients who are enrolled at a specific site. 	<ul style="list-style-type: none"> • Contractor level
	Case Management / Service Coordination	<ul style="list-style-type: none"> • Each site provides Case Management 	<ul style="list-style-type: none"> • Contractor level
	Tracking / Monitoring / Reporting	<ul style="list-style-type: none"> • Each agency monitors its own clients and service delivery, and has unique site level forms 	<ul style="list-style-type: none"> • Contractor level

HEALTH START PROGRAM COORDINATION STUDY

ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES

Table 9: Program Relationship Strategies Currently Used by Health Start (continued)

PROGRAM RELATIONSHIP STRATEGY	PROGRAM COMPONENT	USE BY HEALTH START PROGRAMS	LEVEL THAT USES STRATEGY
SEPARATION (continued)			
		<ul style="list-style-type: none"> The State performs site visits, maintains a centralized database, produces consolidated and site specific reports 	<ul style="list-style-type: none"> State level
COLLABORATION	Administration	<ul style="list-style-type: none"> Management tools may be shared between sites ADHS program staff collaborate with others who have expertise in certain areas to accomplish mutual goals 	<ul style="list-style-type: none"> Contractor level State level
	Needs Assessment / Program Planning	<ul style="list-style-type: none"> Between County Health Departments, Community Health Centers and Local Governments to do assessments necessary for MCH Block Grant and other planning purposes 	<ul style="list-style-type: none"> State, County, Local governments
	Outreach	<ul style="list-style-type: none"> Develop and participate in health fairs with other programs; part of brochures of parent agencies News releases with Karebook program, participate in attending meetings of the Healthy Families Steering Committee and Maricopa County Healthy Families Coalition; included in the OWCH brochure; collaborate with Safe Kids Coalition and Funeral Director's Foundation For Children 	<ul style="list-style-type: none"> Contractor level State level
	Human Resource Development & Training	<ul style="list-style-type: none"> Pinal, Clinica, Centro meet together to train and problem solve. NAHO and NAHEC do as well. ICHS collaborates with others in Maricopa County and through IHS and NAHO and NAHEC, as well 	<ul style="list-style-type: none"> Contractor level

HEALTH START PROGRAM COORDINATION STUDY

ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES

Table 9: Program Relationship Strategies Currently Used by Health Start (continued)

PROGRAM RELATIONSHIP STRATEGY	PROGRAM COMPONENT	USE BY HEALTH START PROGRAMS	LEVEL THAT USES STRATEGY
COLLABORATION (continued)			
		<ul style="list-style-type: none"> Provision of regional training for Health Start and other programs; Lay Health Workers Conference and other ADHS programs; training and technical assistance at individual sites 	<ul style="list-style-type: none"> State level
	Service Delivery	<ul style="list-style-type: none"> Community Health Nurses and Lay Health Workers make home visits together as needed. Lay Health Workers may follow-up Community Health Nurse clients. Since many Lay Health Workers are only part time, they often represent Health Start and other programs at the same site. 	<ul style="list-style-type: none"> Contractor level
	Case Management / Service Coordination	<ul style="list-style-type: none"> Some collaborations are occurring among programs for high-risk, high-need clients. For example, the following contractors participate in Inter-Agency Case Management Teams: NAAHEC, Mariposa, Mountain Park, Guadelupe, NAHO. In addition, all contractors appear to collaborate with other separately funded programs within their parent organization. 	<ul style="list-style-type: none"> Contractor level
	Tracking / Monitoring / Reporting	<ul style="list-style-type: none"> Collaborate with those who administer other databases, such as Office of Vital Statistics, DRG's, Newborn Intensive Care Program (NICP), Safe Kids, to share appropriate data; ongoing monitoring regarding car seats. 	<ul style="list-style-type: none"> State level

HEALTH START PROGRAM COORDINATION STUDY

ANALYSIS OF PROGRAM RELATIONSHIP STRATEGIES

Table 9: Program Relationship Strategies Currently Used by Health Start (continued)

PROGRAM RELATIONSHIP STRATEGY	PROGRAM COMPONENT	USE BY HEALTH START PROGRAMS	LEVEL THAT USES STRATEGY
CONSOLIDATION	Administration	<ul style="list-style-type: none"> • Health Start uses the State Procurement system • Management oversight of various programs is consolidated at the State Agency level among various public health programs 	<ul style="list-style-type: none"> • State level
	Needs Assessment / Program Planning	<ul style="list-style-type: none"> • Health Start uses the Block Grant Needs Assessment to plan programs 	<ul style="list-style-type: none"> • State level
	Outreach		
	Human Resource Development & Training		
	Service Delivery		
	Case Management / Service Coordination		
	Tracking / Monitoring / Reporting	<ul style="list-style-type: none"> • One Health Start database, one set of forms, standard reports across all program sites 	<ul style="list-style-type: none"> • State level

SUMMARY

Collaboration offers the most benefits of the program relationship strategies in allowing for the unique needs of clients and communities to be met, yet at the same time providing the opportunity for programs to cooperate in critical ways to avoid duplication and maximize resources.

The Health Start program uses some of these strategies to collaborate with other programs at the state and local levels. These collaborative strategies include sharing management tools, collaborating with others who have expertise in certain areas to accomplish mutual goals, coordination on needs assessments, development of and participation in health fairs with other programs, joint training and problem solving, coordination between Community Health Nurses and Lay Health Workers on home visits, and collaboration on databases.

VIII. PLAN FOR COORDINATING AVAILABLE SERVICES TO MINIMIZE DUPLICATION TO SERVICE RECIPIENTS

BACKGROUND

As is seen in the previous section, the Health Start Program already coordinates on the state and contractor levels. In addition to these contract specific examples, the ADHS Office of Women's and Children's Health has also embarked on a number of initiatives to improve coordination.

The ADHS Integration of Services Working Group looked at communities where Teen Prenatal Express (TPE), Health Start, Healthy Families and Community Health Nursing all provide services. All four of these programs have home visiting components, but with different purposes and different levels of intensity. ADHS has initiated the development of a draft model, with the assistance of representatives from the agencies contracting to provide those services, of how services could be coordinated in the ideal situation where there were enough providers available to accommodate all potential clients. This model, when completed, can be used to determine how service coordination can be accomplished to avoid duplication of service, while providing services that clients require.²⁰

Coconino County had contracts to provide Health Start, Healthy Families and Teen Prenatal Express (TPE) services in the relatively geographically isolated Page area. To gain insight into strategies by which service coordination and integration can be accomplished at the local level, ADHS developed a contract requisition with the Coconino County Department of Public Health in May 1995. The contract requisition was for the development of a plan to coordinate service delivery among women eligible for one or more of the three programs. In October 1995, ADHS finalized an Intergovernmental Agreement with the Coconino County Department of Public Health to provide the Health Start program in Page and surrounding communities. A key component of this IGA was the implementation of the service coordination plan with the Healthy Families, Teen Prenatal Express and Health Start programs.²¹ Since the termination of the Teen Prenatal Express program, the coordination will continue between the remaining two programs. This is facilitated through shared office space and some personnel working with both programs.

²⁰ Health Start Program: Annual Report for 1995; Arizona Department of Health Services; February 3, 1996. The draft model is based on the assumption that all services are available in all areas and that clients will avail themselves of all services.

²¹ *Ibid.*, page 15.

HEALTH START PROGRAM COORDINATION STUDY

PLAN FOR COORDINATING

In addition, in 1995 the ADHS Office of Women's and Children's Health organized and completed the Home Visiting for At-Risk Families Project funded through federal Title V funds. This was part of the larger efforts related to family preservation that are coordinated by the Department of Economic Security. The recognition by ADHS of the necessity for improved coordination of services throughout Arizona was one of the major factors that led to the creation of this project. The committee, which included representatives from various programs, developed guidelines for delivering home based services. Efforts are now focused on having these guidelines adopted by funding agencies and provider organizations to guide and evaluate their use of resources.²²

The Health Start program has also been represented on the ADHS System of Care Team which provides a mechanism to coordinate service delivery to children with special health care needs. It was in collaboration with this group that a simple, easy to use, easily portable and comprehensive statewide Family Resource Guide was developed.²³

PLAN FOR COORDINATION

Health Start is already using coordination and consolidation program relationship strategies to ensure appropriate use of resources. These have been identified in **Table 9** in the previous section.

As part of this study, the ADHS Office of Women's and Children's Health has identified a number of high level actions that can be addressed both immediately and long range. This Plan for Coordination is delineated on the following pages. It focuses on seven areas: Service Delivery; Training; Administration; Outreach/Program Location; Case Management and Service Coordination; Tracking/Evaluation/Monitoring/Reporting; and Needs Assessment and Planning.

In developing this plan for improved collaboration and coordination among programs, the ADHS Office of Women's and Children's Health has built upon the findings of the Home Visiting for At-Risk Families Report which identified the benefits to families, providers and stakeholders of improved coordination.

²² Ibid.

²³ Ibid.

HEALTH START PROGRAM COORDINATION STUDY

PLAN FOR COORDINATING

HIGH LEVEL PLAN FOR COORDINATION

SERVICE DELIVERY

IMMEDIATE	FUTURE
<ul style="list-style-type: none">• Continue to monitor Health Start Contractor efforts to coordinate with existing providers• Facilitate enhanced coordination at service level	<ul style="list-style-type: none">• ADHS will continue to work with sister state agencies to improve coordination on service delivery• Evaluate the feasibility of an appropriate “wrap around” service system approach• Develop a “family health card”• Continue to develop partnerships with other state and local agencies and providers

TRAINING

IMMEDIATE	FUTURE
<ul style="list-style-type: none">• Continue to provide collaborative training for home visitors on a regional basis based on needs identified by workers in the local regions• Request participation in trainings provided by other home visiting groups. This will not only increase knowledge of participants in the subject matter, but also facilitate networking and development of collaborative activities.	<ul style="list-style-type: none">• Work with universities to develop home based training and education for nurse and medical students on home based services• Collaborate with other agencies to develop protocols and training on home-based service• Work with universities and community colleges to develop curricula on home-visiting topics

HEALTH START PROGRAM COORDINATION STUDY

PLAN FOR COORDINATING

ADMINISTRATION

IMMEDIATE	FUTURE
<ul style="list-style-type: none">• Continue to hold joint Health Start meetings with Health Start coordinators to discuss common issues• Explore feasibility of joint personnel and service coordination across agency lines. For example use of one staff to share work on Healthy Families and Health Start	<ul style="list-style-type: none">• Participate in the development of universal application for services for social services and medical services with ADHS, AHCCCS and DES• Explore feasibility of joint RFP for services

OUTREACH (AND PROGRAM LOCATION)

IMMEDIATE	FUTURE
<ul style="list-style-type: none">• Use Perinatal Block Grants to identify community needs• Continue to inform populations of all available options and assist them to access these services. Assist the client to enroll	<ul style="list-style-type: none">• Establish state level coordinating council to identify most needy populations to be addressed by programs. The following should be included on the coordinating council: ADHS, AHCCCS, DES and ADE. Could use a combined needs assessment or needs assessment information from the Perinatal Block Grants• Continue to explore the feasibility of determining eligibility of clients on behalf of other agencies which serve women and children

HEALTH START PROGRAM COORDINATION STUDY

PLAN FOR COORDINATING

CASE MANAGEMENT AND SERVICE COORDINATION

IMMEDIATE	FUTURE
<ul style="list-style-type: none">• Provide case management training for all home visiting programs across agencies• Provide incentive to contractors to participate in local case coordination teams where they exist	<ul style="list-style-type: none">• Work with state and local agencies to explore where joint local case coordination and case review teams might be effectively implemented

TRACKING / EVALUATION / MONITORING / REPORTING

IMMEDIATE	FUTURE
<ul style="list-style-type: none">• Developing methodologies to link data bases from hospital discharge, AHCCCS, etc.	<ul style="list-style-type: none">• Develop common data definitions across programs and agencies• Collaborate in evaluation by developing common strategies and common surveys

NEEDS ASSESSMENT AND PLANNING

IMMEDIATE	FUTURE
<ul style="list-style-type: none">• Continue to develop and publish needs assessment information	<ul style="list-style-type: none">• Work with contractors, local communities and other providers to develop additional sources of data

HEALTH START PROGRAM COORDINATION STUDY

PLAN FOR COORDINATING

SUMMARY

The ADHS Office of Women's and Children's Health has an existing commitment to coordinate and collaborate with other programs at both the local and state levels to maximize the benefits of all programs serving similar geographic areas or populations. The distinction that the various programs carry in terms of their program philosophies and service delivery methods is critical for addressing the unique needs of clients at different phases of their lives and in different communities. Many of the programs serving Arizonans have identified service barriers and have responded to those barriers with unique service delivery methodologies. These unique features should not be lost.

The Health Start program will continue in the future to implement its Plan for Coordination to continue to improve services for pregnant women and children and increase the immunization rate in communities at risk for poor birth outcomes and/or inadequate immunization rates. This can be accomplished through enhanced program design, partnerships with other agencies, improved and expanded multidisciplinary training, participation in the development of a universal application form and process, joint contracting, coordinated outreach and assessment of populations in need, coordinated case management, and improved joint application of data and data collection.

IX. APPENDIX

HEALTH START PROGRAM COORDINATION STUDY

APPENDICES

APPENDIX 1: HEALTH START NEIGHBORHOODS AND COMMUNITIES FOR SFY 1996

HEALTH START PROGRAM COORDINATION STUDY

APPENDICES

HEALTH START NEIGHBORHOODS AND COMMUNITIES FOR SFY 1996

CONTRACTOR	NEIGHBORHOOD / COMMUNITY
CENTRO DE AMISTAD	Guadalupe
CLINICA ADELANTE	Suprise, Queen Creek, Aguila, Gila Bend, Buckeye, Wickenburg
COCHISE COUNTY	Douglas and surrounding area
COCONINO COUNTY	Page and surrounding area
INDIAN COMMUNITY HEALTH SERVICE	Native Americans in Metro Phoenix
MARIPOSA COMMUNITY HEALTH	Nogales and surrounding area , and Rio Rico
MOUNTAIN PARK	South Phoenix
NORTH COUNTRY COMMUNITY HEALTH CENTER	Winslow, Castle Butte, Sipaulovi, Teesto, Second Mesa, Topok, Dilkon, Keams Canyon, Bavaci, Seba Delkai, Mishongnovi, Cedar Springs, Shungopavai, Indian Wells, Poston, Ft. Mohave, Polacca, Hote Villa, Golden Shores, Bullhead City, Parker
PIMA COUNTY	Neighborhoods in Tucson, Amado, Aravaca, Continental, Three Points
PINAL COUNTY	Eloy
YAVAPAI	Yarnell, Dewey, Ashfork, Bagdad, Humbolt, Cordes Lake, Black Canyon City, Prescott, Mayer, Seligman
YUMA COUNTY	Yuma, San Luis, Welton, La Mesa, Mountain Park, Somerton, Roll, Hyder, Dateland, Gadsden, Texas Hill

HEALTH START PROGRAM COORDINATION STUDY

APPENDICES

Appendix 2: Survey Document

**ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF WOMEN'S AND CHILDREN'S HEALTH
HEALTH START PROGRAM COORDINATION SURVEY**

The ADHS / Office of Women's and Children's Health has initiated an effort to improve coordination between Health Start and related programs. These "related programs" have been identified as those that provide health services to pregnant women and young children. The purpose of this survey is to begin to identify which programs provide services and how the services and populations compare with the Health Start program.

We believe that the information from this survey will provide us with valuable information. We also would like to be able to provide you with information that may assist you in your planning and service delivery efforts. Copies of the report resulting from this survey will be sent to you in appreciation for the time you take to complete and return this survey.

=====

The Arizona Health Start Program, established in 1992, is a neighborhood outreach program that helps high-risk pregnant women obtain early and consistent prenatal care and, for their children, timely immunizations. The program is designed for pregnant women who live in communities which are considered to be at risk of poor birth outcomes.

The Health Start *mission* is to "educate, support and advocate for families at risk by promoting optimal use of community based family health and education services through the use of Lay Health Workers, who live in, and reflect the ethnic, cultural and socioeconomic characteristics of the community they serve."

The Health Start program is for women who may be or are pregnant and their families. Services can continue until the woman's child reaches four years of age. The woman must have her primary residence in a Health Start Contractor's Program Site area.

The ADHS / Office of Women's and Children's Health (OFFICE OF WOMEN'S AND CHILDREN'S HEALTH) recognizes that there are a number of programs in Arizona that provide services to pregnant women and children, and is interested in ensuring that appropriate coordination and collaboration of services is achieved to maximize the potential of service delivery to these women and children. OFFICE OF WOMEN'S AND CHILDREN'S HEALTH also recognizes that there is significant variance in the eligibility requirements, service locations, and service characteristics among these programs.

The purpose of this survey is to identify what programs may be providing similar services to similar populations throughout the state. The information collected in this survey will become part of a report that will be submitted to the Joint Legislative Committee on Community Program Evaluation in October 1996. We appreciate your cooperation in this information collection effort.

Please complete the attached information and return it in the enclosed envelope to the address below. You may also fax the survey to: (602) 266-3510. IF YOUR AGENCY HAS MORE THAN ONE PROGRAM THAT SERVES PREGNANT WOMEN AND YOUNG CHILDREN, PLEASE MAKE A COPY OF THE SURVEY AND FILL OUT ONE SURVEY FOR EACH PROGRAM (I.E., NICP AND HEALTH START SHOULD BE CONSIDERED TWO SEPARATE PROGRAMS).

Dr. Ruthann Smejkal
Office of Women's and Children's Health
411 North 24th Street
Phoenix, Arizona 85008
attn: Health Start Program Consolidation Survey

**ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF WOMEN'S AND CHILDREN'S HEALTH
HEALTH START PROGRAM COORDINATION SURVEY**

INSTRUCTIONS: IF YOUR AGENCY HAS MORE THAN ONE PROGRAM THAT SERVES PREGNANT WOMEN AND YOUNG CHILDREN, PLEASE MAKE A COPY OF THE SURVEY AND FILL OUT ONE SURVEY FOR EACH PROGRAM (I.E., NICP AND HEALTH START SHOULD BE CONSIDERED TWO SEPARATE PROGRAMS).

PART I: RESPONDENT INFORMATION

Name of Person Completing Survey: _____

Name of Agency / Company: _____

Respondent's Telephone Number: _____

PART II: TARGET POPULATION

1. Do you provide services to pregnant women, directly or through contract?

Yes ___ No ___

Please provide the name of the program: _____

2. Do you provide, directly or through contract, an early childhood health program?

Yes ___ No ___

Please provide the name of the program: _____

3. Please **check all of the following** that are eligible populations for the above identified program(s):

- a) women who believe they may be pregnant pending pregnancy test verification
- b) women who are pregnant
- c) newborns and infants up to _____ months of age
- d) children from _____ (months) to _____ years of age
- e) other members of the family of a pregnant or post partum woman
- f) other _____ please specify

If you answered "no" to both questions 1 and 2 and have not checked at least one box in "a" through "e" above, please go to question 22 in the last box on page 10 and return this survey in the enclosed envelope or fax the survey(s) to (602) 266-3510.

**ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF WOMEN'S AND CHILDREN'S HEALTH
HEALTH START PROGRAM COORDINATION SURVEY**

PART III: ELIGIBILITY REQUIREMENTS

4. What is the eligibility requirement for participation in your program -- please complete all that apply:

a) Geographic location

b) Age

c) Maternity status

d) Financial

e) Resources

f) Citizenship / residency status

g) Medical

h) Other (please describe)

5. Is eligibility for your program linked to some other criteria, such as:

a) AHCCCS

b) AFDC

c) Food Stamps

d) Other (please specify) _____

**ARIZONA DEPARTMENT OF HEALTH SERVICES
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HEALTH START PROGRAM COORDINATION SURVEY**

PART IV: CLIENT BASE INFORMATION

6. Please provide information on the demographic composition of your client population.
- a) White, non-Hispanic _____ % of client population
 - b) Hispanic _____ % of client population
 - c) Black _____ % of client population
 - d) Native American _____ % of client population
 - e) Asian / Pacific Islander _____ % of client population
 - f) Other _____ % of client population
7. Which of the following do you consider to be your PRIMARY CLIENT (check one):
- a) mother
 - b) child
 - c) family unit
8. How many pregnant / post partum women and children do you serve on average per month _____ . Per year _____. (Is the "client" used in this answer an individual, mother-child unit, family unit, other?-- Please circle)

PART V: PROGRAM MISSION AND GOALS

9. Which of the following is included in your program's Mission: -- please check all that apply:
- a) To educate families at risk
 - b) To provide emotional support families at risk
 - c) To advocate for families at risk
 - d) Promoting community based services
 - e) Use of lay workers from the community

**ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF WOMEN'S AND CHILDREN'S HEALTH
HEALTH START PROGRAM COORDINATION SURVEY**

10. Please write your program's Mission Statement in the space provided below or attach a copy:

11. Which of the following goals apply to your program -- please check all that apply:
- a) To reduce the incidence of low birth weight babies
 - b) To increase prenatal services to pregnant women
 - c) To reduce the incidence of children affected by childhood diseases
 - d) To increase the number of children receiving age appropriate immunizations by two years of age
 - e) To educate families on the importance of good nutritional habits to improve the overall health of their children
 - f) To educate families on developmental assessments to promote the early identification of learning disabilities, physical handicaps or behavioral health needs
 - g) To educate on the benefits of preventive health care and the need for screening examinations, such as hearing and vision
 - h) To assist families to identify private and public school readiness programs
12. If your program has other written goals, please attach a copy to this form and return it with the survey.

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PART VI: PROGRAM / SERVICE LOCATION

13. What community or geographic area does your program serve? Please be as specific as possible, for example:

<u>County</u>	<u>City/Town</u>	<u>Neighborhood</u>	<u>Zip Codes</u>

14. What do you consider to be your program's service setting? Please identify the percentage of time that your services are provided in the following settings:

- a) by telephone _____ % of time
- b) in an office _____ % of time
- c) in a medical setting (hospital/clinic, etc.) _____ % of time
- d) in the client's home / family home _____ % of time
- e) other _____ (please specify) _____ % of time

15. If services are provided in an office (b above) or in a medical setting (c above), please list all of the locations where this occurs in the space below. You may also provide a location list attachment if you prefer.

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PART VII: SERVICES AND INTERVENTIONS

16. Please "X" any of the services below that are provided by your program and identify the method of service provision:

Type of Service	Yes, We Provide . . .	Method by Which The Service is Provided (check all that apply)				
		Telephone / I & R	Mail Out Only	Face - to - Face with Client	Service Coordination	Direct Service Provision
a) Assessments -- i.e., parent skills, resources, child development, home safety, etc.						
b) Behavioral Management as a behavioral health service						
c) Client education on neonatal care						
d) Client education on nutrition						
e) Client education on prenatal care						
f) Client education on preventive health care and child wellness						
g) Counseling						
h) Crisis behavioral health interventions						
i) Developmental interventions, such as occupational therapy, physical therapy, speech therapy, etc.						
j) Discharge / Follow-up planning						
k) Emergency funds						
l) Financial assistance						
m) Financial management						

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Type of Service	Yes, We Provide . . .	Method by Which The Service is Provided (check all that apply)				
		Telephone / I & R	Mail Out Only	Face - to - Face with Client	Service Coordination	Direct Service Provision
n)Home architectural assessment / accessibility						
o)Home based therapy as a behavioral health service						
p)Home birthing						
q)Home delivered meals						
r)Immunizations						
s)In-home sick child care						
t)Intensive in-home services as a behavioral health service						
u)Meal preparation						
v)Other Social Services, including such things as employment services						
w)Outreach to identify pregnant women						
x)Parent skills training						
y)Prenatal care services						
z)Preschool and other school readiness programs						
aa)Primary Health Care services						

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Type of Service	Yes, We Provide . . .	Method by Which The Service is Provided (check all that apply)				
		Telephone / I & R	Mail Out Only	Face - to - Face with Client	Service Coordination	Direct Service Provision
bb)Respite						
cc)Shopping services						
dd)Transportation						
ee)Other (please list)						

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PART VIII: PROGRAM COST INFORMATION

17. What is the annual budget for this program named above? \$ _____

PART IX: PROGRAM STAFF

18. Which of the following types of workers do you use in delivering services to your clients and what type of contact do they generally have with clients (clients also include people who call in for information services from a telephone based program)

Worker	Phone Contact	Average Length of Time per Contact	Frequency per Client	Face-to-Face Contact	Average Length of Time Per Contact	Frequency per Client	Average Caseload per Month
a)Case Manager							
b)Social Worker (BSW or MSW)							
c)Social Services Worker with Degree							
d)Social Services Worker without Degree							
e)Nurse							
f)Physician							
g)Paraprofessional							
h)Lay Worker							
i)Volunteer							
j)Other (please specify)							



For "frequency" please use one of the following: one x (time) only; daily; 1 x per week; 2 x per month; 1 x per month; quarterly; semi-annually. Use the frequency that most closely fits your program.

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PART X: COMMUNITY NEEDS

19. What do you believe to be the top three needs in your community (or community where your program is located)?
- a)
 - b)
 - c)
20. Does your program address those needs? Yes _____ No _____
21. What would help your program better address the needs in your community?

22. Thank you for participating in this survey. Do you know anyone else who should receive a copy of this survey? If so, please provide their name, address or phone number and name of program in the space below:



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Appendix 3: Respondents Serving Pregnant Women and Providing Health Related Services for Children

APPENDIX 3: RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Adolescent / Young Adult</u>	Direct Teen Case Management	Yuma County Health Department	Yuma, Somerton, San Luis, Dateland, Wellton	45% White; 55% Hispanic; 3% Native American
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	AHCCCS; prenatal case management program	Phoenix Health Plan	Maricopa County	45% White; 45% Hispanic; 8% Black; 1% Native American; 1% Asian
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Phoenix Area Indian Health Services	Phoenix Area Indian Health Services	Nevada, Utah and Arizona (excluding Tucson Program Area and Navajo Program Area)	99% Native American; 1% other
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Medicaid / EPSDT	Regional AHCCCS Health Plan	Eloy, Coolidge, Red Rock, Toltec, San Manuel, Mammoth, Superior, Stanfield, Maricopa, Apache Junction, Casa Grande, Queen Creek, Sacaton, Mobile, Arizona City	20% White; 40% Hispanic; 20% Black; 18% Native American; 2% Asian
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Pima Health System	Pima Health System	Pima County	
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Signature Home Care - children = NICP	Arizona Physicians, IPA, Inc.	all of Pima County	
<u>Behavioral / Substance Abuse</u>	Las Amigas	CODAC Behavioral Health Services	all of Pima and Pinal Counties and homeless throughout the state	44% White; 21% Hispanic; 25% Black; 10% Native American

APPENDIX 3: RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Birthing & Pregnancy Support</u>	Prenatal Notch Clinic & Case Management (moms); Children & Adolescent Services (children)	Coconino County Health Department	Coconino County	54% White; 18% Hispanic; 3% Black; 16% Native American; 1% other
<u>Birthing & Pregnancy Support</u>	Opening Doors American Indian Outreach Project (program ends 12/31/96)	North Country Community Health Center	Peach Springs, Valentine, Supai	2% White; 2% Hispanic; 96% Native American
<u>Food / Nutrition</u>	Inter Tribal Council of Arizona WIC Program	Inter Tribal Council of Arizona (ITCA)	Tribal -- Sells, Sacaton, Tucson, Kykotsmovi, Parker, Supai, Scottsdale, San Carlos, Whiteriver, Peach Springs, Phoenix (see service area list)	5% White; 6% Hispanic; 1% Black; 87% Native American; <1% Asian
<u>Food / Nutrition</u>	Salt River WIC Program	Salt River Pima -Maricopa Indian Community	Lehi, Fountain Hills, Mesa, Phoenix, Scottsdale. Program located on the Salt River Indian Reservation	10% White; 2% Hispanic; 80% Native American
<u>Food / Nutrition</u>	ADHS/WIC	ADHS	statewide	39.8% White; 49.5% Hispanic; 6.6% Black; 3.1% Native American 1% Asian
<u>Food / Nutrition</u>	Tribal Health Maintenance Program / WIC	Cocopah Tribal Council	Cocopah Reservation (Somerton); Quechan Reservation (Winterhaven)	1% White; 5% Hispanic; 1% Black; 93% Native American
<u>Health Start</u>	Health Start	Pima County Health Department	Tucson: Richey FRWC/Menlo Park, the Vistas, Roselmei area; Arivaca/Amado; Three Points; Continental/Sahaurita	19% White; 52% Hispanic; 2% Black; 1% Native American; 1% Asian

**APPENDIX 3: RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES
FOR CHILDREN**

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Health Start</u>	Health Start / Comienzo Sano	Yuma County Health Department	San Luis, Gadsten, La Mesa, Yuma, Wellton, Dateland, Mohawk, Hyter, Tacna, Roy, Somerton	30% White; 60% Hispanic; .5% Black; .5% Native American; .5% Asian
<u>Health Start</u>	Health Start	Yavapai County Health Department	Ashfork, Seligman, Chino Valley, Paulden, Dewey, Humboldt, Mayer, Cordes Lakes, Prescott Valley, Camp Verde	75% White; 22% Hispanic; 3% Black
<u>Health Start</u>	Eloy Comienzo Sano / Health Start	Pinal County Health Department	Eloy, Toltec, Pichaco, Arizona City; Red Rock	9% White; 83% Hispanic; 4% Black; 4% Native American
<u>Health Start</u>	Health Start	Indian Community Health Services	Phoenix zip codes: 85003-85009; 85012-85019; 85034 and others	1% White; 3% Hispanic; 3% Black; 93% Native American
<u>Health Start</u>	Health Start	Cochise County Health & Social Services	Douglas, Pirtleville, Elfrida	17% White; 83% Hispanic; 1% Black; 10% Native American
<u>Health Start</u>	Health Start	Clinica Adelante, Inc.	El Mirage, Suprise, Queen Creek, Gila Bend, Buckeye, Wickenburg, Aguila	4% White; 96% Hispanic
<u>Health Start</u>	NAHO/Health Start	Northern Arizona Health Organization	Page, Greenhaven; Marble Canyon; Bitter Springs; Gap/Cedar Ridge; Coppermine; Lechee; Kaibeto (all in Coconino County)	1% White; 99% Native American

APPENDIX 3: RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Health Start</u>	Health Start	Mountain Park Health Center	South Phoenix neighborhoods for zip codes 85040 and 85041	70% Hispanic; 20% Black
<u>Health Start</u>	Health Start Centro de Amistad / Immunization and Well-Baby Clinic	Centro de Amistad	Town of Guadalupe	50% Hispanic; 50% Native American
<u>Information / Referral / Prevention</u>	Wellness on Wheels – West Yavapai Guidance Clinic & Family Resource Center	Yavapai County Health Department / Wellness on Wheels	Ash Fork, Seligman, Chino Valley, Camp Verde, Mayer, Humboldt	85% White; 10% Hispanic; 5% Native American
<u>Information, Referral, Prevention</u>	Children's Information Center	DHS / OWCH	statewide via telephone	80% White; 13.5% Hispanic; 5% Black; 1% Native American; 1% Asian; <1% other
<u>Parental Support</u>	GAPS(Grand-parents Adopted for Parental Support)	Pima County Health Department	Tucson city limits avoiding zip codes where families are already being served	15% White; 75% Hispanic; 5% Black; 5% Native American



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Appendix 4: Prevention and Outreach Services Provided by Respondents Serving Pregnant Women and Providing Health Related Services for Children

APPENDIX 4: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Adolescent / Young Adult</u>	Direct Teen Case Management		referral to prenatal classes / Health Start; service coordination and direct services	referral, service coordination and direct services	referral, service coordination and direct services	service coordination and direct services	direct services
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	AHCCCS; prenatal case management program	home 100%	referral, service coordination	referral	referral, service coordination	referral, service coordination	referral, service coordination
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Phoenix Area Indian Health Services	medical 90%; home 10%					
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Medicaid / EPSDT	phone 98%; office .5%; medical .5%; home 1%	referral	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified	
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Pima Health System	phone 5%; medical 90%; home 2%; other 2%	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services

APPENDIX 4: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>AHCCCS, Health Plan, IHS & Other Medical</u>	Signature Home Care - children = NICP	home 100%	referral, service coordination, direct services				
<u>Behavioral / Substance Abuse</u>	Las Amigas	residential treatment program 100% (also medical offices; hospitals, public schools, community etc.)	direct service	direct service	direct service	direct service	direct service
<u>Birthing & Pregnancy Support</u>	Prenatal Notch Clinic & Case Management (moms); Children & Adolescent Services		referral, service coordination, direct services	referral, service coordination, direct services			
<u>Birthing & Pregnancy Support</u>	Opening Doors American Indian Outreach Project (program ends 12/31/96)	phone 5%; office 10%; home 85%	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified
<u>Food / Nutrition</u>	Inter Tribal Council of Arizona WIC Program	phone <1%; office 95%; medical 5%; home <1%		direct service	referral, service coordination, direct services	direct service	referral, service coordination

APPENDIX 4: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Food / Nutrition</u>	Salt River WIC Program	phone 20%; office 80%	referral, service coordination	face to face services / methodology not identified	service coordination	face to face services / methodology not identified	face to face services / methodology not identified
<u>Food / Nutrition</u>	ADHS/WIC	office 80%; medical 20%	referral	referral	referral	referral	
<u>Food / Nutrition</u>	Tribal Health Maintenance Program / WIC	phone 25%; office 70%; Tribal Health Maintenance Program 5%	direct services	direct services	direct services	direct services	referral
<u>Health Start</u>	Health Start - Pima County	phone <1%; office <1%; medical <1%; home 96%	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services
<u>Health Start</u>	Health Start - Comienzo Sano Yuma County	home 85%; school & community center 15%	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services

APPENDIX 4: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Health Start</u>	Health Start - Yavapai County	phone 5%; office 10%; home 85%	referral, service coordination, direct services	referral, service coordination, direct services			
<u>Health Start</u>	Eloy Comienzo Sano / Health Start	phone 10%; 35% office; 3% medical; 50% home; 2% community	referral, service coordination, direct services	referral, service coordination, direct services			
<u>Health Start</u>	Health Start - Indian Community Health Service	office 3%; medical 1%; home 96%	referral, service coordination, direct services	referral, service coordination, direct services			
<u>Health Start</u>	Health Start - Cochise County	phone 10%; office 10%; medical 10%; home 70%	referral, service coordination, direct services	referral, service coordination, direct services			
<u>Health Start</u>	Health Start - Clinica Adelante	phone 5%; home 95%	referral, service coordination, direct services	service coordination, direct services			

APPENDIX 4: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Health Start</u>	Health Start - North Country Community Health Center	phone 4%; office 3%; medical 1%; home 91%; mail 1%	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified	face to face services are provided / methodology not identified	referral, service coordination, direct services
<u>Health Start</u>	Health Start - Mountain Park (South Phoenix)	phone 10%; office 15%; medical 25%; home 25%; community 25%	referral, service coordination, direct services	referral, service coordination, direct services			
<u>Health Start</u>	Health Start Centro de Amistad / Immunization and Well-Baby Clinic	phone 5%; office 5%; medical 10%; home 75%; exercise program 5%		referral	referral	referral, service coordination	
<u>Information / Referral / Prevention</u>	Wellness on Wheels -- West Yavapai Guidance Clinic & Family Resource Center	home 20%; mobile clinic / community center locations 80%		referral, service coordination			
<u>Information, Referral, Prevention</u>	Children's Information Center	phone 100%				referral, service coordination	

APPENDIX 4: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS SERVING PREGNANT WOMEN AND PROVIDING HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Parental Support</u>	GAPS(Grand-parents Adopted for Parental Support)	phone 5%; home 95%	referral, service coordination	referral, service coordination, direct services	referral	referral, service coordination, direct services	

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Appendix 5: Respondents Providing Health Related Services for Children But Not Services to Pregnant Women

APPENDIX 5: RESPONDENTS PROVIDING HEALTH RELATED SERVICES FOR CHILDREN BUT NOT SERVICES TO PREGNANT WOMEN

PROGRAM TYPE CATEGORY	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Head Start / Early Head Start</u>	City of Phoenix Head Start	City of Phoenix Head Start	City of Phoenix	18% White; 60% Hispanic, 19% Black, 2% Native American; 1% Asian
<u>Head Start / Early Head Start</u>	Phoenix Early Head Start	Southwest Human Development	Phoenix Enterprize Zone: Camelback south to Elliott; 43 Avenue east to 40th Street	10% White; 60% Hispanic; 30% Black
<u>Head Start / Early Head Start</u>	Colorado River Indian Tribes Head Start Program	Colorado River Indian Tribes	Parker, Poston; Colorado River Indian Reservation; Big River and Lost Lake (California)	1.1% White; 47.0% Hispanic; 51% Native American; <1% Asian
<u>Head Start / Early Head Start</u>	Head Start	Southwest Human Development	Central Phoenix and Paradise Valley School Districts	12% White; 80% Hispanic; 4% Black; 3% Native American; 1% other
<u>Head Start / Early Head Start</u>	White Mountain Apache Head Start	White Mountain Apache Tribe	McNary, Whiteriver; HonDah; Carrizo; Cibecue in Navajo and Apache Counties	2% White; 98% Native American
<u>Head Start / Early Head Start</u>	Head Start	Salt River Indian Community	reservation	100% Native American
<u>Head Start / Early Head Start</u>	Havasupai Head Start	Havasupai Tribal Council	Havasupai Reservation in Grand Canyon	100% Native American
<u>Healthy Families</u>	Healthy Families	La Hacienda	parts of zip codes 85705, 85706, 85711 - 85713, 85716, 85719, 85745, 85753	

APPENDIX 5: RESPONDENTS PROVIDING HEALTH RELATED SERVICES FOR CHILDREN BUT NOT SERVICES TO PREGNANT WOMEN

PROGRAM TYPE CATEGORY	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Healthy Families</u>	SW Human Dev. / Healthy Families Maryvale	Southwest Human Development	west Maryvale, Glendale, Phoenix	42% White; 41% Hispanic; 14% Black; 3% Asian
<u>Healthy Families</u>	Healthy Families	Tucson Association for Child Care	areas of Tucson for zip codes 85713, 85711, 85205, 85745, 85719, 85635	33% White; 54% Hispanic; 6% Black; 4% Native American; 3% Asian
<u>Healthy Families</u>	Healthy Families	Southwest Human Development	Chandler, Gilbert, Mesa	37.5% White; 37.5% Hispanic; 12.5% Black; 12.5% Native American
<u>Healthy Families</u>	Healthy Families	Tucson Association for Child Care / Arizona Child Care Resources	Bisbee, Douglas, Naco, Pietrileville; Sierra Vista, Benson, Tombstone, Huachuca City, Nogales, Tucson (selected zip codes)	
<u>Healthy Families</u>	Healthy Families	CODAC		
<u>Healthy Families</u>	Healthy Families	La Frontera	parts of Tucson and Marana. Zip codes 85711, 85713, 85719, 85745, 85705, 85635	3% White; 95% Hispanic; 1% Black; 1% Native American
<u>Healthy Families</u>	Healthy Families and Choices for Families	Arizona Child Care Resources	Sierra Vista, Benson, St. David, Tombstone, Palominas, Hereford, Fort Huachuca, Huachuca City	70% White; 15% Hispanic; 10% Black; 5% Asian
<u>NICP</u>	NICP/AzEIP	Navajo County Health Department	Navajo County off reservation; Slow Low; Holbrook; Winslow	80% W; 10% H; .5% B; 3% NA; .5% A; 6% other

APPENDIX 5: RESPONDENTS PROVIDING HEALTH RELATED SERVICES FOR CHILDREN BUT NOT SERVICES TO PREGNANT WOMEN

PROGRAM TYPE CATEGORY	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>NICP</u>	NICP & Office for Children with Special Health Care Needs	Yavapai County Health Department	Verde Valley; Clarkdale; Jerome; Camp Verde; Sedona; Rim Rock; Lake Montezuma; Pages Springs	primarily White
<u>NICP</u>	NICP	Children's Homecare	Maricopa County zip codes 85007-85008; 85012; 85014; 85016; 85018; 85251 and 85257	25% White; 60% Hispanic; 5% Black; 5% Native American; 5% Asian
<u>NICP</u>	Newborn Intensive Care Program (NICP)		city	
<u>NICP</u>	NICP	Mohave County Health Department	program serves state / respondent serves Mohave and Colorado City	100% White
<u>NICP</u>	NICP	Private Contractor	Tucson and South Tucson (primarily language of clients is Spanish)	100% Hispanic
<u>Well Child</u>	John C. Lincoln Children's Health Services	John C. Lincoln Children's Health Services	Cactus south to Bethany Home Road; 35th Avenue east to 16th Street-- Royal Palm Junior High; Ocotillo Elementary School; Alta Vista Elementary School; Washington	unknown; program begins August 1996
<u>Well Child</u>	Well Child Clinics	Gila County Health Department	(Gila County) Globe, Miami, Claypool, Hayden, Winkelman, Payson, Pine, Strawberry, Tonto Basin, Young, Roosevelt	30% White; 50% Hispanic; 5% Black; 10% Native American
<u>Well Child</u>	Immunization Program	Yuma County Health Department	Yuma, Somerton, San Luis, Dateland, Wellton	45% White; 55% Hispanic; 3% Native American

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Appendix 6: Prevention and Outreach Services Provided By Respondents Providing Health Related Services for Children But Not Services to Pregnant Women

APPENDIX 6: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS PROVIDING HEALTH RELATED SERVICES FOR CHILDREN BUT NOT SERVICES TO PREGNANT WOMEN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Head Start / Early Head Start</u>	City of Phoenix Head Start	phone 15%; office 30%; home 20%; classroom 35%	referral	referral, service coordination, direct service	referral	referral, service coordination	
<u>Head Start / Early Head Start</u>	Phoenix Early Head Start	phone 5%; office 20%; home 75%	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services	referral, service coordination, direct services	for recruitment only
<u>Head Start / Early Head Start</u>	Colorado River Indian Tribes Head Start Program	phone 10%; office 85%; home 5%		referral, service coordination, direct services		service coordination, direct services	
<u>Head Start / Early Head Start</u>	Head Start	phone 1%; office 4%; home 20%; Head Start Site 75%		face to face services / methodology not provided		service coordination, direct service	
<u>Head Start / Early Head Start</u>	White Mountain Apache Head Start	medical 5%; home 5%; Head Start 90%		referral, service coordination, direct service		referral, service coordination, direct service	
<u>Head Start / Early Head Start</u>	Head Start	home 10%; center based school setting 90%	referral	referral, direct services	referral	direct services	

APPENDIX 6: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS PROVIDING HEALTH RELATED SERVICES FOR CHILDREN BUT NOT SERVICES TO PREGNANT WOMEN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Head Start / Early Head Start</u>	Havasupai Head Start	phone 25%; office 50%; home 25%					
<u>Healthy Families</u>	Healthy Families	phone 15%; medical 5%; home 80%	direct services			direct services	
<u>Healthy Families</u>	SW Human Dev. / Healthy Families Maryvale	phone 10%; 2% office; 15% medical; 73% home	referral, service coordination, direct service	direct services		referral, service coordination, direct service	
<u>Healthy Families</u>	Healthy Families	phone 5%; office 20%; medical 5%; home 70%	referral, service coordination, direct service				
<u>Healthy Families</u>	Healthy Families	phone 5%; office 5%; home 90%		referral, service coordination, direct service	referral, service coordination	referral, service coordination, direct service	
<u>Healthy Families</u>	Healthy Families	phone 5%; office 5%; home 90%	direct services	direct services	direct services	direct services	

APPENDIX 6: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS PROVIDING HEALTH RELATED SERVICES FOR CHILDREN BUT NOT SERVICES TO PREGNANT WOMEN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Healthy Families</u>	Healthy Families	medical 5%; home 90%; other (WIC, DES, etc.) 5%	referral, direct service		referral	referral	
<u>Healthy Families</u>	Healthy Families	phone 4%; home 95%; family meetings 1%	referral		referral	referral	
<u>Healthy Families</u>	Healthy Families and Choices for Families	phone 10%; office 10%; medical 10%; home 70%	referral	some direct service	referral	referral, service coordination	
<u>NICP</u>	NICP/AzEIP	phone 1%; office 1%; home 98%		referral, service coordination		referral, service coordination, direct service	
<u>NICP</u>	NICP & Office for Children with Special Health Care Needs	phone 10%; home 90%; WIC office 1%	referral, service coordination, direct service	referral, service coordination, direct service		referral, service coordination, direct service	
<u>NICP</u>	NICP	phone 10%; home 90%	referral, service coordination, direct service	referral, service coordination, direct service		referral, service coordination, direct service	

APPENDIX 6: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS PROVIDING HEALTH RELATED SERVICES FOR CHILDREN BUT NOT SERVICES TO PREGNANT WOMEN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>NICP</u>	Newborn Intensive Care Program (NICP)	home 100%	direct services	direct services		direct services	
<u>NICP</u>	NICP	phone 5%; office 40%; medical 5%; home 50%	referral, direct service	referral, direct service	referral, direct service	referral, direct service	
<u>NICP</u>	NICP	phone 10%; home 90%	direct services	direct services	referral	direct services	referral
<u>Well Child</u>	John C. Lincoln Children's Health Services	office 100%; schools 40%		direct service	referral	service coordination, direct service	
<u>Well Child</u>	Well Child Clinics	phone 20%; office 70%; medical 5%; home 5%	referral	referral	referral	referral	referral
<u>Well Child</u>	Immunization Program						

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Appendix 7: Respondents Who Serve Pregnant Women and Who Do Not Provide Health Related Services For Children

APPENDIX 7: RESPONDENTS WHO SERVE PREGNANT WOMEN AND WHO DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Adolescent / Young Adult</u>	Center for Adolescent Parents	Tucson Association for Child Care	all of Tucson and outlying areas on south side of Pima County	43% White; 52% Hispanic; 5% Black
<u>Adolescent / Young Adult</u>	Choices for Families	Arizona Child Care Resources	Phoenix from Bell Road to Baseline and from 40th Street to 75th Avenue	50% White; 40% Hispanic; 10% Black
<u>Adolescent / Young Adult</u>	Choices for Teen Parents	Arizona Child Care Resources	general Yuma area	20% White; 75% Hispanic; 5% Black
<u>Adolescent / Young Adult</u>	Maricopa Center for Adolescent Parents	Arizona Child Care Resources	Phoenix; Glendale; Peoria (but will accept students from any location in the Valley)	47% White; 46% Hispanic; 4% Black; 2% Native American; 1% Asian
<u>Adolescent / Young Adult</u>	Maternal & Child Health	Cochise County Health & Social Services	Willcox, Douglas, Efrida, Sunizona Pirtleville, Bowie, Bisbee, Sierra Vista, Benson, Naco	17% White; 83% Hispanic; 1% Black; 10% Native American
<u>Adolescent / Young Adult</u>	Maternal & Child Health Block Grant	Yavapai County Health Department	Prescott, Prescott Valley, Dewey, Humboldt, Mayer, Spring Valley, Cordes Lakes, Black Canyon City; Congress, Yarnell, Bagdad, Chino Valley	90% White; 9% Hispanic; 1% Black; 2% Native American; 2% Asian
<u>Advocacy</u>	Healthy Mothers / Healthy Babies Coalition Activities	Healthy Mothers/Healthy Babies Coalition	statewide	
<u>Behavioral / Substance Abuse</u>	CODAC BHS/ Project CAMI	CODAC	Tucson	33.3% White; 44.4% Hispanic; 11.1% Black; 11.1% Native American

APPENDIX 7: RESPONDENTS WHO SERVE PREGNANT WOMEN AND WHO DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Birthing & Pregnancy Support</u>	Baby Arizona	DHS / OWCH		
<u>Birthing & Pregnancy Support</u>	Direct Pregnancy Testing and Follow-Up	Yuma County Health Department	Yuma, Somerton, San Luis, Dateland, Wellton	45% White; 55% Hispanic; 3% Native American
<u>Birthing & Pregnancy Support</u>	First Steps	Family Service Agency	n/a: recipients must be receiving services through St. Joseph's or Maricopa Medical Center in Phoenix	40% White; 52% Hispanic; 1% Black; 1% Native American; 1% Asian; 5% other/unknown
<u>Birthing & Pregnancy Support</u>	Loving Me, Loving My Baby	Phoenix Birthing Project	Maricopa County	2% White; 2% Hispanic; 95% Black; 1% Asian
<u>Birthing & Pregnancy Support</u>	Maternal Child Health (PHS)	Pima Home Health	Pima County	
<u>Birthing & Pregnancy Support</u>	Perinatal Case Management Program	Arizona Physician's IPA, Inc.	Coconino, Maricopa, Pima, Graham, Cochise, Yuma, Navajo and Apache Counties	
<u>Birthing & Pregnancy Support</u>	Phoenix Birthing Project	Phoenix Birthing Project	all of Maricopa County with primary outreach to the African American community	3% White; 3% Hispanic; 92% Black; 1% other
<u>Birthing & Pregnancy Support</u>	Pregnancy & Breastfeeding Hotline	DHS / OWCH	statewide via telephone	25% White; 65% Hispanic; 75% Black; 1% Native American; 1% Asian; <1% other

APPENDIX 7: RESPONDENTS WHO SERVE PREGNANT WOMEN AND WHO DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Birthing & Pregnancy Support</u>	Project Comadre	Pinal County Department of Health	Casa Grande neighborhoods of Maricopa, Stanfield and 11 Mile Corner; Coolidge neighborhoods of Randolph, Twilight Trains and Valley Farms; Florence neighborhoods of Arizona Farms and	30% White; 61% Hispanic; 4% Black; 5% Native American
<u>Birthing & Pregnancy Support</u>	Surgery Referral of Pregnancy	Doctor's Health Plan		
<u>Birthing & Pregnancy Support /</u>	Woman to Woman		Areas of Tucson with high teen pregnancy and low birth weight	20% White; 79% Hispanic; 1% Black
<u>Food & Nutrition</u>	Commodity Supplementary Food Program	ADHS / ONS / CSFP	statewide	46.7% White; 45.5% Hispanic; 5.3% Black; 1.3% Native American; 1.2% Asian
<u>Food & Nutrition</u>	EFNEP Extension Food & Nutrition Education Program	U of A Cooperative Extension	(Maricopa County) central Glendale, Avondale, Central Mesa, Guadalupe, Phoenix, El Mirage; (Pinal County) Casa Grande; (Pima County) South Tucson, Davis Montham AFB; Catalina, Tohono Oodham,	20% White; 63% Hispanic; 6% Black; 10% Native American ; 1% Asian
<u>Food & Nutrition</u>	Family & Consumer Science Extension Education	U of A Cooperative Extension		61% White; 28% Hispanic; 5% Black; 6% Native American
<u>Parental Support</u>	Southern Arizona Collaboration - Choices for Families	Arizona Child Care Resources	Benson, Bisbee, Douglas, Sierra Vista, Naco, Pietrville, Nogales, Rio Rico	
<u>Parental Support</u>	The Next Step	Parents Anonymous	Maricopa and Pima County	

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Appendix 8: Prevention and Outreach Services Provided by Respondents Who Serve Pregnant Women and Who Do Not Provide Health Related Services for Children

APPENDIX 8: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS WHO SERVE PREGNANT WOMEN AND WHO DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Adolescent / Young Adult</u>	Center for Adolescent Parents	phone 10%; office 88%; medical 2%	direct services	direct services	direct services	direct services	
<u>Adolescent / Young Adult</u>	Choices for Families	phone 5%; home 90%; parks and stores 5%	referral, service coordination	referral, service coordination, direct service	referral, service coordination	referral, service coordination, direct service	
<u>Adolescent / Young Adult</u>	Choices for Teen Parents	office 10%; classroom 90%	referral, service coordination, direct service	referral			
<u>Adolescent / Young Adult</u>	Maricopa Center for Adolescent Parents	phone 5%; office 25%; classroom 75%	referral, service coordination	referral, service coordination, direct service	referral, service coordination	referral, service coordination, direct service	
<u>Adolescent / Young Adult</u>	Maternal & Child Health	phone 5%; office 1%; medical 3%; home 76%; other 15%	referral, service coordination, direct service	referral, service coordination, direct service			
<u>Adolescent / Young Adult</u>	Maternal & Child Health Block Grant	phone 40%; medical 50%; home 10%	direct services	direct services	direct services	direct services	

APPENDIX 8: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS WHO SERVE PREGNANT WOMEN AND WHO DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Advocacy</u>	Healthy Mothers / Healthy Babies Coalition Activities						
<u>Behavioral / Substance Abuse</u>	CODAC BHS/ Project CAMI	phone 25%; office 25%; medical 15%; home 25%; other 10%	referral, service coordination, direct service	service coordination, direct services	referral, service coordination, direct service	referral, service coordination, direct service	direct services
<u>Birthing & Pregnancy Support</u>	Baby Arizona	phone, office and medical settings	referral, service coordination	referral, service coordination	referral, service coordination		referral, service coordination
<u>Birthing & Pregnancy Support</u>	Direct Pregnancy Testing and Follow-Up		direct service	direct service	direct service	referral	identification occurs through pregnancy testing
<u>Birthing & Pregnancy Support</u>	First Steps	phone 30%; office 5%; medical 40%; home 10%; community 15%		service coordination	referral	referral	
<u>Birthing & Pregnancy Support</u>	Loving Me, Loving My Baby	phone 15%; office 15%; medical 15%; home 50%; seminars 5%	referral	referral, service coordination, direct service	referral, service coordination, direct service	referral, service coordination, direct service	referral, direct services

APPENDIX 8: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS WHO SERVE PREGNANT WOMEN AND WHO DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Birthing & Pregnancy Support</u>	Maternal Child Health (PHS)	home 100%	face to face services / methodology not provided	face to face services / methodology not provided		face to face services / methodology not provided	
<u>Birthing & Pregnancy Support</u>	Perinatal Case Management Program	phone 45%; office 5%; medical 5%; home 45%	referral, service coordination	referral, service coordination	referral, service coordination	referral, service coordination	
<u>Birthing & Pregnancy Support</u>	Phoenix Birthing Project	phone 73%; office 2%; medical 10%; home 15%	referral, direct services	service coordination, direct services	referral, direct services	referral, direct services	
<u>Birthing & Pregnancy Support</u>	Pregnancy & Breastfeeding Hotline	phone 100%	referral, service coordination	referral, service coordination	referral, service coordination		referral, service coordination
<u>Birthing & Pregnancy Support</u>	Project Comadre	phone 15%; office 2%; medical 10%; home 70%; community 3%	referral, service coordination, direct service	referral, service coordination, direct service	referral, service coordination, direct service	referral, service coordination, direct service	referral, service coordination, direct service
<u>Birthing & Pregnancy Support</u>	Surgery Referral of Pregnancy						

APPENDIX 8: PREVENTION AND OUTREACH SERVICES PROVIDED BY RESPONDENTS WHO SERVE PREGNANT WOMEN AND WHO DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	SERVICE SETTING	CLIENT EDUCATION ON NEONATAL CARE	CLIENT EDUCATION ON NUTRITION	CLIENT EDUCATION ON PRENATAL CARE	CLIENT EDUCATION ON PREVENTIVE HEALTH CARE - CHILD WELLNESS	OUTREACH TO IDENTIFY PREGNANT WOMEN
<u>Birthing & Pregnancy Support / Parental</u>	Woman to Woman	phone 20%; office 1%; medical 1%; home 50%; other 28%	referral, service coordination	referral, service coordination	referral, service coordination	referral, service coordination	referral, service coordination, direct service
<u>Food & Nutrition</u>	Commodity Supplementary Food Program	office 100%	referral	referral	referral		
<u>Food & Nutrition</u>	EFNEP Extension Food & Nutrition Education Program	phone 2%; home 18%; community 80%		referral, service coordination, direct service	referral	referral	
<u>Food & Nutrition</u>	Family & Consumer Science Extension Education	phone 20%; home 20%; community center classes 60% (varies by county)		direct service			
<u>Parental Support</u>	Southern Arizona Collaboration - Choices for Families	phone 5%; office 5%; home 90%	direct services	direct services	direct services	direct services	referral
<u>Parental Support</u>	The Next Step	phone 10%; home 90%		referral, direct service	referral, direct service	referral, direct service	



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Appendix 9: Respondents From Appendix 8 Who Also Include Children in Their Service Population, Although They Do Not Provide Health Related Services For Children

APPENDIX 9: RESPONDENTS FROM APPENDIX 8 WHO ALSO INCLUDE CHILDREN IN THEIR SERVICE POPULATION, ALTHOUGH THEY DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Adolescent / Young Adult</u>	Choices for Families	Arizona Child Care Resources	Phoenix from Bell Road to Baseline and from 40th Street to 75th Avenue	50% White; 40% Hispanic; 10% Black
<u>Adolescent / Young Adult</u>	Maternal & Child Health	Cochise County Health & Social Services	Willcox, Douglas, Efrida, Sunizona Pirtleville, Bowie, Bisbee, Sierra Vista, Benson, Naco	17% White; 83% Hispanic; 1% Black; 10% Native American
<u>Adolescent / Young Adult</u>	Maternal & Child Health Block Grant	Yavapai County Health Department	Prescott, Prescott Valley, Dewey, Humboldt, Mayer, Spring Valley, Cordes Lakes, Black Canyon City; Congress, Yarnell, Bagdad, Chino Valley	90% White; 9% Hispanic; 1% Black; 2% Native American; 2% Asian
<u>Adolescent / Young Adult</u>	Center for Adolescent Parents	Tucson Association for Child Care	all of Tucson and outlying areas on south side of Pima County	43% White; 52% Hispanic; 5% Black
<u>Adolescent / Young Adult</u>	Maricopa Center for Adolescent Parents	Arizona Child Care Resources	Phoenix; Glendale; Peoria (but will accept students from any location in the Valley)	47% White; 46% Hispanic; 4% Black; 2% Native American; 1% Asian
<u>Birthing & Pregnancy Support</u>	First Steps	Family Service Agency	n/a: recipients must be receiving services through St. Joseph's or Maricopa Medical Center in Phoenix	40% White; 52% Hispanic; 1% Black; 1% Native American; 1% Asian; 5% other/unknown
<u>Birthing & Pregnancy Support</u>	Perinatal Case Management Program	Arizona Physician's IPA, Inc.	Coconino, Maricopa, Pima, Graham, Cochise, Yuma, Navajo and Apache Counties	

APPENDIX 9: RESPONDENTS FROM APPENDIX 8 WHO ALSO INCLUDE CHILDREN IN THEIR SERVICE POPULATION, ALTHOUGH THEY DO NOT PROVIDE HEALTH RELATED SERVICES FOR CHILDREN

PROGRAM TYPE	NAME OF PROGRAM	NAME OF AGENCY RESPONDING	GEOGRAPHIC AREA FOR SERVICE DELIVERY	ETHNICITY OF SERVICE POPULATION
<u>Birthing & Pregnancy Support</u>	Project Comadre	Pinal County Department of Health	Casa Grande neighborhoods of Maricopa, Stanfield and 11 Mile Corner; Coolidge neighborhoods of Randolph, Twilight Trains and Valley Farms; Florence neighborhoods of Arizona Farms and Cactus Forest	30% White; 61% Hispanic; 4% Black; 5% Native American
<u>Birthing & Pregnancy Support</u>	Maternal Child Health (PHS)	Pima Home Health	Pima County	
<u>Birthing & Pregnancy Support</u>	Loving Me, Loving My Baby	Phoenix Birthing Project	Maricopa County	2% White; 2% Hispanic; 95% Black; 1% Asian
<u>Birthing & Pregnancy Support</u>	Phoenix Birthing Project	Phoenix Birthing Project	all of Maricopa County with primary outreach to the African American community	3% White; 3% Hispanic; 92% Black; 1% other
<u>Food & Nutrition</u>	Commodity Supplementary Food Program	ADHS / ONS / CSFP	statewide	46.7% White; 45.5% Hispanic; 5.3% Black; 1.3% Native American; 1.2% Asian
<u>Parental Support</u>	Southern Arizona Collaboration - Choices for Families	Arizona Child Care Resources	Benson, Bisbee, Douglas, Sierra Vista, Naco, Pietrleville, Nogales, Rio Rico	
<u>Parental Support</u>	The Next Step	Parents Anonymous	Maricopa and Pima County	



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Appendix 10: Analysis of Programs Identified by the Auditor General as Being Similar to Health Start

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
Advocacy	Healthy Mothers / Healthy Babies Coalition Activities	Yes	No			No	(provides educational services)
Advocacy	Healthy Mothers / Healthy Babies Arizona Coalition	No	No			No	
AHCCCS, Health Plan, IHS & Other	Phoenix Area Indian Health Services	Yes	Yes	must be American Indian / Alaskan Native or non-Indian pregnant with Indian father's child with proof of paternity	medical 90%; home 10%	No	To raise American Indians' / Alaskan Natives' health to the highest status possible
AHCCCS, Health Plan, IHS & Other	Medicaid / EPSDT	Yes	Yes	AHCCCS enrolled	phone 98%; office .5%; medical .5%; home 1%	No	To manage a quality health care delivery system, dedicated to providing comprehensive health care to the eligible AHCCCS members residing in Pinal County.

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
Birthing & Pregnancy Support	Baby Arizona	Yes	No	targets low-income pregnant women who may be Medicaid eligible through SOBRA or currently enrolled in AHCCCS	phone, office and medical settings	No	The goal of Baby Arizona is to get expectant mothers into care as early as possible, and to ensure that they continue that care and practice healthy habits during pregnancy.
Birthing & Pregnancy Support	Project Comadre	Yes	No	children limited to one year of age; pregnant women; high risk pregnancies and high risk families referred to appropriate agencies	phone 15%; office 2%; medical 10%; home 70%; community 3%	Yes	To positively impact infant mortality, low birth weight and infant immunization rates in rural Pinal County
Birthing & Pregnancy Support	Pregnancy & Breastfeeding Hotline	Yes	No		phone 100%	No	To ensure the health, safety, and well being of pregnant women and their families through community-based, family-centered, culturally sensitive systems of care
Birthing & Pregnancy Support	Opening Doors American Indian Outreach Project	Yes	Yes	must suspect pregnancy, be pregnant or delivered child within last 2 months	phone 5%; office 10%; home 85%	Yes	To empower and promote the well being of American Indian people in northern Arizona by improving health care provider resources and service delivery through community-based initiatives

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
Birthing & Pregnancy Support	Perinatal Case Management Program	Yes	No	AHCCCS eligible; mother under 20 years of age or over 34 years of age and at high risk due to medical, behavioral or social conditions	phone 45%; office 5%; medical 5%; home 45%	No	To provide realistic, individualized treatment goals to meet the medical and social needs of pregnant APIPA members
Birthing & Pregnancy Support	First Steps	Yes	No	receiving care at St. Joseph's Hospital or Maricopa Medical Center. Inpatient & follow up no age limit. Prenatal limited to 13 to 19 year olds.	phone 30%; office 5%; medical 40%; home 10%; community 15%	No	
Birthing & Pregnancy Support /	Woman to Woman	Yes	No		phone 20%; office 1%; medical 1%; home 50%; other 28%	No	To provide prenatal outreach, support, and education programs to strengthen families and our community by working with the beginning of all families, a mother and her unborn child
Food & Nutrition	Project Chance	No	No	children with special health care needs		No	(program description) To improve the quality of nutrition care available to children with special health care needs in child care centers and in their homes through training and curriculum development

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
Food & Nutrition	EFNEP Extension Food & Nutrition Education Program	Yes	No	low income & federal poverty guidelines	phone 2%; home 18%; community 80%	No	To empower families through nutrition education to healthy lifestyles and positive futures
Food & Nutrition	Commodity Supplementary Food Program	Yes	No	ages 1 - 5 and over 60 years; pregnant and up to one year post partum; women/children to 185% of poverty; elderly to 130% of	office 100%	No	To provide commodity foods and nutrition education in order to reduce nutrition-related health problems during critical periods of growth and development
Food & Nutrition	Family & Consumer Science Extension Education	Yes	No		phone 20%; home 20%; community center classes 60% (varies by county)	No	Educational outreach from the UofA with various curriculum and educational programs for limited resource or at-risk families and youth on life skills including family and personal development, nutrition/wellness, and family resource management
Food / Nutrition	Salt River WIC Program	Yes	Yes	proof of pregnancy; income	phone 20%; office 80%	No	The Health and Human Services Department shares its strength and vision for the enrichment of the Community . . . to provide culturally sensitive physical, mental, and social services . . .(etc.)

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
Food / Nutrition	Inter Tribal Council of Arizona WIC Program	Yes	Yes	pregnant, post-partum or breastfeeding; 185% of poverty; must have a nutritional risk	phone <1%; office 95%; medical 5%; home <1%	No	
Food / Nutrition	Tribal Health Maintenance Program / WIC	Yes	Yes	pregnant / breastfeeding; low income	phone 25%; office 70%; Tribal Health Maintenance Program 5%	Yes	Provide educational material and nutritional supplements for at risk women and children
Food / Nutrition	ADHS/WIC	Yes	Yes	nutritional risk; reside in agency that is providing services	office 80%; medical 20%	No	
Healthy Families	Healthy Families and Choices for Families	No	Yes	mother who has had a live birth	phone 10%; office 10%; medical 10%; home 70%	No	Goal: The purpose of the Healthy Families America initiative is to support parents right from the start by laying the foundation for nationwide, voluntary home visitor services for all new parents through a network of statewide systems

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
Healthy Families	Healthy Families	No	Yes	family must enroll in program prior to baby's 3 month birthdate / score on assessment	phone 4%; home 95%; family meetings 1%	No	To identify, intervene early & prevent abuse & neglect of targeted children under 5 years at risk for child abuse. . . provide preventive & early intervention services to identified parents . . . to promote child health & development . . .
Healthy Families	SW Human Dev. / Healthy Families Maryvale	No	Yes	birth in prior 3 months; score 2.5+ on assessment	phone 10%; 2% office; 15% medical; 73% home	No	To provide a continuum of quality, direct services for children & families who the agency serves as a partner in the creation & development of programs, while advocating for innovation in service delivery
Healthy Families	Healthy Families	No	Yes	child <90 days old & at risk of abuse/neglect	phone 5%; office 5%; home 90%	No	
Healthy Families	Healthy Families	No	Yes	enroll immediately following birth of at-risk child; score on assessment	medical 5%; home 90%; other (WIC, DES, etc.) 5%	No	A statewide system of delivery of home-based, family-centered services which promote health, prevent child abuse, and optimize child development, which will be made available to all families in need of such services

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

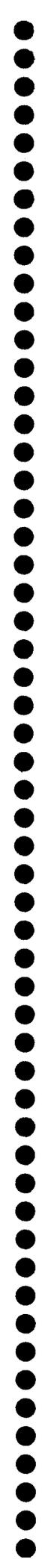
PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
Healthy Families	Healthy Families	No	Yes	newborn 0 - 3 months of age; family scores 25 points out of 100 on risk assessment	phone 5%; office 20%; medical 5%; home 70%	No	To systematically assess families strengths and needs to promote positive parent-child interaction, enhance family functioning and promote positive child development
Healthy Families	Healthy Families	No	Yes	post partum women with risk assessment on family at time of birth	phone 5%; office 5%; home 90%	No	
Healthy Families	Healthy Families	No	Yes	score on a stress index, parent of newborn	phone 15%; medical 5%; home 80%	No	
Information / Referral / Prevention	Wellness on Wheels -- West Yavapai Guidance	Yes	Yes	some services have eligibility restrictions based on income	home 20%; mobile clinic / community center locations 80%	Yes	To provide accessible, comprehensive, preventive health services to residents of rural areas of Yavapai County

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
Information, Referral, Prevention	Children's Information Center	Yes	Yes	None	phone 100%	No	To ensure the health, safety and well being of children and their families through community-based, family centered, culturally sensitive systems of care
NICP	NICP	No	Yes	infants requiring more than 72 hours of Level III or Level II nursery care beginning within 96 hours of birth	phone 5%; office 40%; medical 5%; home 50%	No	To reduce the mortality and morbidity of infants who are critically ill at birth through a statewide system of coordinated care
NICP	NICP	No	Yes	96 hours postnatal in NICU for 72 hours	phone 10%; home 90%	No	To reduce the mortality and morbidity in NICP infants who are critically ill at birth and other children with special health care needs who develop physical and developmental delays, through a statewide system of coordinated care
NICP	NICP/AzEIP	No	Yes	up to 36 months of age	phone 1%; office 1%; home 98%	No	

APPENDIX 10: ANALYSIS OF PROGRAMS IDENTIFIED BY AUDITOR GENERAL AS BEING SIMILAR TO HEALTH START

PROGRAM TYPE	NAME OF PROGRAM	SERVES PREGNANT WOMEN	HEALTH SERVICES FOR CHILDREN	ELIGIBILITY	SERVICE SETTING	DOES PROGRAM USE LAY HEALTH WORKERS?	MISSION STATEMENT
NICP	NICP & Office for Children with Special Health Care Needs	No	Yes	96 hours postnatal in NICU for 72 hours	phone 10%; home 90%; WIC office 1%	No	To reduce the mortality and morbidity in NICP infants who are critically ill at birth, and other children with special health care need who develop physical and developmental delays, through a state wide system of coordinated care
NICP	Newborn Intensive Care Program (NICP)	No	Yes	infants are post graduate of 48 hour stay in NICU or can be referred in	home 100%	No	To reduce the mortality and morbidity of NICP infants who are critically ill at birth and other children with special health care needs who develop physical and developmental delays, through a statewide system of coordinated care
Parental Support	Project Thrive	No	No	targets families with medical evidence of mother's prenatal substance abuse & newborn is drug exposed	primarily home visiting	No	To enable families to safely provide care for high risk infants ...through intensive monitoring, education, support services, counseling & training. To prevent foster home placement for newborns
PROGRAM CLOSED	Prenatal Care Initiative	No	No			No	





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