Community-Based And State Partnerships

Two North Carolina Success Stories

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Minority Infant Mortality Reduction Program (MIMR)

Note: this program is now called Healthy Beginnings

In 1994, the North Carolina General Assembly provided funding to address disparity between white and minority infant mortality and low birthweight rates. A year later, the MIMR program began by offering planning grants to local community-based organizations. These grants (up to $10,000 each for three to six months) brought people together to talk about the issues and plan what to do in their communities. Currently there are 14 projects funded for $700,000 per year, with an average award of $50,000 a year for three years. Some of the original projects have been refunded, some have not reapplied and some have not received additional funds.

Program Features

- Services: Healthy Beginnings's programs emphasize support, one-on-one counseling and education with outreach to hard-to-reach populations a priority. But just because you build it (i.e., good services) doesn't mean they will come. Consequently transportation and in-home visits are key to success.

- Partnerships: These community-based organizations—faith organizations, civic groups and nonprofits—have built partnerships with local health departments and community health centers. Each grantee is required to develop a community advisory board that includes community members, lay health advisors, outreach workers and consumers of services.

- Capacity building: Grantees were asked to address how they could put something in place that, if the grant funding went away, there would still be benefit to the community. In response, the programs have a strong focus on infrastructure development with state support for training, technical assistance and skill-building workshops. In building community capacity, trust is essential. Technical assistance is critical. Relationship building is necessary. And at the core is a strong program director.

Lessons Learned

- Financial Give and Take: One of the first needs was for technical assistance to build the capacity of community-based organizations to work with state agencies (and vice versa). The state's process is to reimburse for work done. The fact is that these projects needed a minimal amount of income coming in first to be able to do the work. We met with state agencies to come up with a system to give the grantees advances. It was give and take on both sides. The community programs had to learn to work with the state and the state had to learn how to work with community-based organizations; each one has different challenges.

- Listen and Learn: It is important to get out of the office to listen and learn about the communities and about the participants. One-on-one counseling with program

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participants, support and education has been most effective in the programs' success. Hand in hand is the importance of providing social/emotional support to the participants. We must never forget there are people out there who just want someone to talk to and who may not have anyone to share an issue with. One of the most productive ways to reach out is to utilize people who reflect the community and who mirror the families they serve.

- Relationship-building is Critical: Strong local and state leadership makes partnerships effective. Positive working relationships between project directors, outreach workers and health institutions influence success.

- Funding Challenges: The current funding level is insufficient to support the level of need in communities to address infant mortality issues. The programs started out with the same level of funding they have today. They need more.

North Carolina Healthy Start Baby Love Plus

Healthy Start Baby Love Plus is a program truly designed to address perinatal health disparities and to reduce infant morbidity and mortality. Its priorities are to increase access to services, strengthen the relationship between provider and consumer, and increase awareness of the issues.

The Eastern project began in 1997; Triad came next in 1999, followed by Northeastern which began planning in 1999 and implementation in 2000. In 2003 these projects covered 14 counties with funding ranging from $500,000 to $900,000 per year.

Building on the state's successful Baby Love program (prenatal care, care coordination and case management) and using the lessons learned from the Healthy Beginnings project, a new model program was conceived: Healthy Start Baby Love Plus. This program, like all others funded by federal Healthy Start, has specific models of intervention which have evolved over the years. All of North Carolina's Baby Love projects are required to have a regional consortium, outreach, health education and training and care coordination.

Program Features

- Regional Consortiums: Each consortium provides overall guidance to the projects. It is involved in developing the grant proposal and, before a program submits an application for federal funds, the consortium chairs have to approve it. The regional consortiums advocate consumer involvement, with a goal of having 51% of the membership be consumers of services. To obtain this level of involvement and to promote equality with the provider members, the consumers are reimbursed something for their time—such as $15 per meeting, child care and a nutritious meal.

- Outreach: In developing outreach, the success of the existing Maternal Outreach Workers (MOW) program, which was designed to be 25% outreach and 75% direct service/care coordination support, was considered. Unfortunately the MOWs had very little time for outreach because they were so consumed with direct patient care. The Healthy Start Baby Love Plus program wanted to change things by focusing on outreach, not caseload. Community Health Advocates (CHAs)—women within the community who understood the participants' needs —were hired. In many cases these women have been able to develop trusting relationships because before they became CHAs they could have been program participants themselves. They already understood the issues and concerns. The CHAs were able to build the bridge between community and agencies.

- Health Education and Training: The Eastern Healthy Start Baby Love Plus site focuses on improving outcomes in African American families by training lay health advisors such as beauticians on maternal and child health issues. The Triad project also focuses on African Americans and works with faith-based entities and church organizations to train the laity and their spouses on health issues. A new focus is on smoking cessation and AIDS/HIV training. The Northeast project focuses on African American and American Indian families and recently had a family leadership retreat for American Indian families.

- Care Coordination: Care coordination for pregnant women now extends two years post-partum. A woman is followed during her pregnancy; after the birth an "enhanced care coordinator" goes into the home to assess mother and baby for any additional care coordination. An added benefit to the two-year contact with care coordinators is more time to address birth spacing with the participants.

- Other Components: Through ongoing evaluation, the services and components continue to evolve to address the needs of the participants. The programs are now building relationships with male-friendly agencies to help expand fatherhood involvement. The Northeast project hopes to hire a clinical social worker to assist with family violence issues, and depression screening is being integrated into the services. And when it comes to education, the annual training institute and children's enrichment center exceeds expectations.

At the heart of the Healthy Start Baby Love Plus program is the belief that the community, guided by a consortium of individuals and organizations, can best design and implement services that families in their community need. As a result Baby Love Plus is credited for innovation in service delivery, community commitment to the program, personal responsibility demonstrated by expectant parents, increased access to services and resources, integration of a comprehensive package of health and social services, and multi-agency and community-based organizational participation. In short, Baby Love Plus in North Carolina is a success.

Yes We Can: Participants Taking Ownership

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The mission of the Nurturing Umbrella Program is to provide education, nurturance and transportation for a demographically targeted population of minority women, ages 18-34 years in Cumberland County. These women were selected because they lived in an area with a high incidence of infant morbidity or mortality. This faith-based community program received a planning grant through the North Carolina Minority Infant Mortality Program (Healthy Beginnings) in 1998 and an Implementation Grant in 1999.

Program Objectives

The program has three interrelated objectives:

- Decrease the rate of late access to prenatal care
- Decrease the incidence of low birthweight and premature deliveries
- Prevent and decrease the incidence of child abuse and neglect and domestic violence

More specifically, we set out to:

- Enroll pregnant minority women in prenatal care during their first trimester
- Provide prenatal education, support and transportation services, and continue services post-partum
- Continue services until the infant is 12 months old
- Decrease minority infant morbidity and mortality in the first year of life

Program Services

- Home Visitation: One-on-one contact and opportunity to offer education and support services in a participant's home has been a major component of our success. Recognizing that each family is unique and special, services are personalized to each participant and we help participants develop their own goals.

- A "Special Delivery": Within 24 hours of delivery, every participant receives a gift basket filled with necessary infant and post-partum care items. If a mother begins the program after the baby is born, we customize a basket to the mother's and baby's needs.

- Transportation: Getting women to clinic appointments was one of the biggest barriers we were able to overcome. We receive in-kind transportation services from Lewis Chapel Baptist Church. Participants help establish and enforce the rules for transportation use. They take responsibility for scheduling their rides when they make their clinic appointments. If they are a no-show, they lose the privilege for a while.

- Group activities: "Family Night Out" is a popular monthly family group activity. It started out as "Mommy's Tea Time" but was changed by the participants to support and encourage father participation (grandparents too). Each month we offer education and information sessions (including nutrition and financial management). And we make certain that all participants receive certificates to show the Department of Social Services that they are getting some kind of training. We are able to offer a nutritious,

Don't assume. Ask participants how your program can meet their needs.

catered meal and child care through in-kind services and volunteers.

- Housing referral and assistance: We have a valued partnership with the Cumberland County Housing Authority (CHA). In fact our monthly night out is in a CHA building. Participants are assisted with obtaining public or other affordable housing and are provided furnishings from community and church volunteers.

- Mentorship: Our mentorship program is a part of our program because the staff of two who do home visits can't do everything. Volunteer mentors offer one-on-one support, encouragement and role modeling (this helps empower the women in the program). We developed policies and procedures and an orientation manual for our volunteers. We also train mentors to reinforce education.

Community Involvement

One of the most important parts of the program is the advisory board, which meets every two months. The board consists of a multidisciplinary team of participants, health and human services professionals, clergy and concerned citizens. Program participants are a vital and integral part of the Board. The participants advise on how services are meeting their needs and can be improved (our most important measure). We also have nurtured relationships between important referral sources, i.e., the county's Maternal Care Coordinator, Department of Social Services, Mental Health, Housing Authority, WIC Office and our participants.

Measuring Outcomes

It is important to be able to measure outcomes. In our first year (FY 1999-00) the program participants had 21 deliveries, all full term! The average birthweight was a healthy 7.14 pounds. Our second year brought us a set of twins and a set of triplets. We had 17 full term deliveries, with a healthy average birthweight of 7 pounds. The triplets checked in at 3.43 pounds. In our third year, there were 16 full term pregnancies with an average birthweight of 7.14 pounds. Sadly, we experienced one death due to cardiac anomalies and had four preterm deliveries which averaged 3.83 pounds.

Lessons Learned

Collaboration is the key to our program's success from mentors to referral agencies, from staff to volunteers, from participants to providers. Hand-in-hand with collaboration is the need for community involvement and participant involvement. We need community support in order to do as many things as we can. We need participant involvement for success too. The program has to be important to the participants, it can't be forced on them. Participants know and understand their own needs (they should be asked how the program can meet their needs). Participant ownership should be encouraged and supported.

It also is very important to reward success. Whether it is an 8 pound baby or a big preemie, if someone schedules transportation or attends classes, or if a child does well in school … it is recognized and people receive something. It may be something as practical as cleaning supplies or as special as a gold star ... we reward the success.