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MCH Capacity-Building Models: A Summary

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— Executive Summary —

Nebraska, recognizing the Maternal and Child Health (MCH) population as a core component of the public health system, is exploring how to improve capacity across the state to better address the unique needs of this group. Capacity building may be particularly important in Nebraska, which ranks last among states in per capita government health spending (Nebraska Community Health Partners Stakeholders Group and Nebraska Health and Human Services System, 1999).

Many governmental, for-profit, not-for-profit, and other organizations and individuals have a stake in the health of Nebraska's maternal and child population. How might these diverse groups develop a strategy for greater participation, coordination, education, and collaboration to improve the health of women of childbearing age and the health of children? The purpose of this report, then, is to identify models of *types of intervention* (i.e., the *how*) and *organizational strategies* to deliver the intervention (i.e., the *who*).

🔗 *Types of Intervention*

The MCH capacity-building models identified in this report represent projects and processes that are being implemented across the country that might be adapted to strengthen the capacity of MCH stakeholders in Nebraska. We identified *three levels of intervention*:

1. **Individual development** – includes formal continuing or adult education targeted to working professionals, and informal opportunities for learning (networking, mentoring, and information sources).
2. **Community development** - emphasizes collaboration, community alliances, and sharing information. Other capacity-building strategies at this level include community assessment of services and needs, training of professionals and/or community residents, increased access to medical professionals in the community, and technical assistance in using data to improve MCH services.
3. **Statewide development** - includes strategic planning and visioning processes; initiating/supporting infrastructure development; networking, communication, and information dissemination; needs assessment; and accreditation and certification.

Many capacity-building initiatives simultaneously incorporate activities at several levels.

🔗 *Organizational Strategies*

We also examined *who* undertakes capacity-building efforts. We identified four basic organizational types that have successfully implemented MCH capacity building:

1. **Private not-for-profits** – may include those that deliver capacity building activities along with other MCH-related services, and those that are membership associations.
2. **Partnerships** – collaborations for the purpose of capacity building that may include representation of governmental, academic, and other organizations.
3. **Governmental bodies** - governmental (e.g., state or local government) or government-sanctioned bodies (e.g., authorities) that build capacity as a part of their pursuit of public welfare.

4. **Universities** – higher education institutions that deliver capacity-building activities, primarily through education and training activities.

🔗 *Capacity Building Best Practices*

The report concludes with “best practices” for mounting successful collaborative efforts and relates them to Nebraska’s MCH capacity building:

1. Capacity-building planning should build upon successful past collaborations and relationships.
2. A statewide conference or summit could initiate discussion with diverse stakeholders.
3. Capacity building will require financial or in-kind resources.
4. The strategy for capacity building should include short-term objectives for early success and support.

🔗 *Appendixes*

The report appendixes contain detailed information about the MCH capacity-building programs we reviewed and a listing of relevant online information sources.

— Introduction —

Maternal and Child Health (MCH), a core component of the public health service system, encompasses the provision of key services through a broad range of government, private, and not-for-profit organizations, partnerships, and professionals. Maternal and Child Health as typically defined within public health arenas, includes **infants, children, adolescents, and women**. The MCH population is particularly important in the public health system because they comprise a complex interdependence of conditions and outcomes that directly impact on the present and future of communities (Grason and Guyer, 1995).

Systems and services focusing on the needs of this large and diverse population implicate **numerous public, private, for-profit, and not-for-profit programs and professionals**. MCH programs and delivery systems are often viewed as categorical stand-alone programs (e.g., based on funding or populationally-defined categories such as pregnant teens, low-birth weight infants, or low-income women), rather than viewed as programs that are intertwined and share core interests. Any MCH capacity-building approach may be informed by the widely acknowledged three core functions of public health:

1. Assessment of information on the health of the community;
2. Comprehensive public health policy development; and,
3. Assurance that public health services are provided to the community.

Relatively new, but important additions to the MCH infrastructure in Nebraska are the 16 **multi-county health departments** created through funding made available through LB 692 (2001). Until then, local health departments served only 22 of Nebraska's 93 counties. Now, public health departments serve 92 of Nebraska's 93 counties. (Sioux County is currently choosing not to ally itself with a new health department.) These new health departments face daunting challenges in developing infrastructures and capacities. Even in those areas with longer public health legacies, there are challenges in developing networks and capacities around MCH.

There are many excellent programs and services in Nebraska serving MCH. These programs and services often operate in **isolation** from one another, however, providing few opportunities for collaboration, shared advocacy, coordination, and other capacity-building activities. The opportunity for capacity building may be particularly important in states like Nebraska, where funds for MCH and other public health activities are scarce: Nebraska ranks last among states in the amount of per capita government health spending (Nebraska Community Health Partners Stakeholders Group and Nebraska Health and Human Services System, 1999). **Capacity building** is desired both at the level of individual development opportunities, as well as building greater capacity and collaboration within Nebraska's human service systems and programs. An interest in building capacity across the state, and inclusive of the many governmental, not-for-profits, for-profits, individuals, communities, and other stakeholders, was spurred by Nebraskans attending the American Public Health Association Maternal Child Health Community Leadership Institute.¹

¹ The Leadership Institute, with funding from Colgate-Palmolive, facilitates collaboration among state maternal and child health directors, state American and Public Health Association affiliates, community, and civic leaders.

The Nebraska Department of Health and Human Services Office of Family Health contracted with the University of Nebraska Public Policy Center to identify, review, and summarize **models** that may serve as an informational resource on current and ongoing trends in MCH capacity building throughout the country.

— Report Approach and Components —

The MCH capacity-building models identified in this report represent **projects and processes** that are being implemented across the country and might be adapted to strengthen the capacity of MCH stakeholders in Nebraska. Information about the models was gathered primarily from reports, articles, personal communications, and materials available on the World Wide Web. The programs identified are not intended to serve as an exhaustive or definitive compilation of MCH capacity-building programs. Rather, they represent a snapshot of models currently being employed in the MCH and public health arenas to develop individual, community, and state level capacity.

The report begins by identifying an array of MCH **stakeholders** in Nebraska. We then provide an **overview** of the strategic trends found within models of **individual, community, and state** capacity building. We conclude with a discussion of **organizational models** for capacity building in Nebraska.

The Appendixes provide additional information about MCH capacity-building programs and resources. Appendix A contains **detailed information** about the MCH capacity-building programs we reviewed. Appendix B provides a list of a variety of public and private organizations' **websites** that provide information relevant to MCH.

– Stakeholders in Maternal and Child Health in Nebraska –

Many individual providers and organizations have, or are in a position to have, an impact on the health of women and children in Nebraska. When considering capacity-building activities, then, it is important to consider the array of people and organizations that may benefit from additional knowledge, support, and resources regarding MCH. Some of the stakeholders for MCH in Nebraska include:

- ▶ *Academic Entities* – major academic institutions, community colleges, and affiliated research centers.

- ▶ *Community Entities, Resources, and Players* – the persons and organizations within communities that provide services to women and children, including individuals, faith- and community-based organizations, and public and private organizations.

- ▶ *Local Government Actors* - branches of local government, including the public school system, the criminal justice system, and local public human services and health providers.

- ▶ *Point of Service Providers* - direct service providers for mothers and young children such as hospitals, local clinics, and shelters for battered and abused women.

- ▶ *Professional Associations* - statewide special interest organizations that have an interest in MCH.

- ▶ *Special/At-Risk Population Advocates* – advocates for ethnic and racial minorities, indigent families, women, and children.

▲ *State Government Agencies and Programs* – agencies that have an interest in maternal and child health and federal programs that are run by the state.

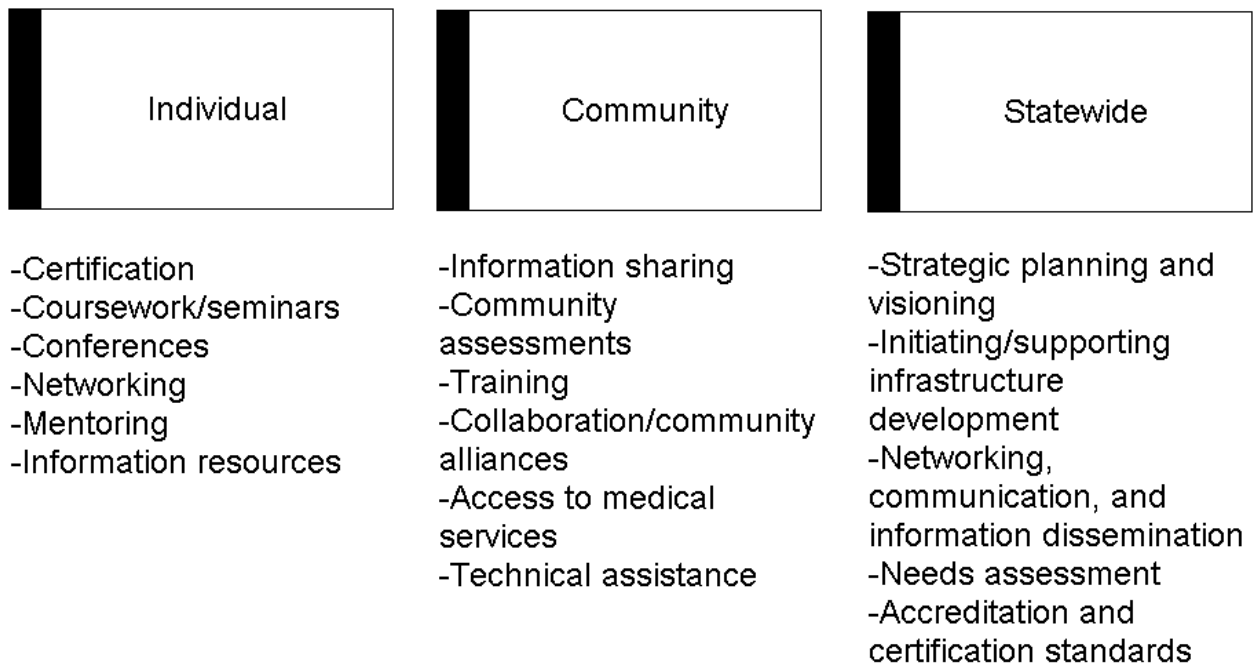
▲ *Tribes* - the various agencies (similar to those in local governments) associated with Native American tribes in Nebraska (i.e. the Omaha, Ponca, Santee Sioux, and Winnebago).

▲ *Non-Nebraska Partners* - organizations beyond the borders of Nebraska that contribute to quality MCH through professional preparation and development, funding, and research.

— Capacity-Building Approaches —

We have identified three approaches to capacity building – those that focus on **individual** development, those that organize efforts at the **community** level, and those that undertake **statewide** initiatives. These three approaches are illustrated in Figure 1, below, with various capacity-building activities classified by approach.²

Figure 1. Capacity-building approaches



Individual capacity-building activities reviewed include both formal and informal models of continuing education. Many capacity-building models embrace a *formal* structure that typically relies on academic institutions to provide structured, continuing education programs targeting working professionals. Some of these formal approaches also include less structured elements in their programs, such as networking and mentoring opportunities to enhance the educational process. Other models embrace a more *informal* learning structure

² It should be noted that although these three levels (i.e., individual, community, and state) are used to categorize the models reviewed, we have found that many capacity-building initiatives extend to at least one of the other levels. Thus, discussion of a single program will resurface in several contexts, illustrating how the activities of a number of the programs reviewed enhance capacity on the individual, community, and state levels concurrently.

that creates and makes available educational resources, which professionals independently access as they choose.

Community capacity-building models we identified include *information sharing*, conducting community-wide *assessments* of services and needs, facilitating *training* experiences in communities, *collaboration and cooperation* among community entities, increasing *access* to medical professionals in communities, and the provision of technical assistance for *data analyses* to communities. These themes reflect the basic philosophy of the community-centered approach to public health practice.

State capacity building can include many elements utilized by individual and community capacity-building models, but on a larger scale. *Infrastructure and network development* and *strategic planning* are typically accomplished as statewide activities, whether directed by state government agencies, academic institutions, or a formal statewide association of concerned organizations. Statewide *needs assessments* can help to inform these activities, as well as indicating the most useful foci for programs increasing individual and community capacities. State agencies can further support individual capacity-building programs through formal *accreditation and certification* requirements. Overall, state level capacity-building strategies can provide a consistent and cohesive structure to MCH capacity building.

— Individual Capacity-Building Models —

The Maternal and Child Health Bureau, Health Resources and Services Administration, and Department of Health and Human Services provide around \$35.8 million dollars per year to support programs nation-wide that train maternal and child health care professionals (Alexander, Petersen, Pass, Slay, and Chadwick, 2001). Many, but not all of these programs, focus on developing skills and knowledge that will enhance professionals' capacity as individuals, using a variety of strategies and targeting different professional audiences and needs.

A number of individual capacity-building programs utilize models based around *formal continuing or adult education* formats that target working professionals. Significant components of these formal continuing education programs include:

- Target audience
- Content of training
- Program interaction and duration
- Faculty

Other individual capacity-building programs rely on *informal opportunities* for learning. Sometimes, these informal opportunities supplement more formal components of programs. Other programs offer informal resources to individual professionals that stand alone, and involve little programmatic structure. Informal opportunities include:

- Networking
- Mentoring
- Information sources

Formal Continuing Education

Many of the individual capacity-building programs identified were based on a formal, continuing education model, typically organized around a university. The continuing education model targets working professionals desiring further education on a number of topics and through a variety of means. In these models, programs are typically highly structured around selected learning topics and goals for a stated duration, involve a substantial amount of interaction among participants and between participants and faculty members, often provide continuing education credits, and may charge tuition.

🔗 Target Audiences

A number of the capacity-building models distinguish between general types of program participants. One general distinction identified was between programs targeting individuals in formal leadership roles, versus those focusing on individuals who, although they may have some leadership responsibilities, are largely seeking to develop more general substantive public health or administration skills.

The Maternal and Child Health Leadership Skills Training Institute, based out of the University of Alabama, specifically targets directors of state Title V MCH and Children with Special Health Care Needs programs with intensive, in-person seminars on topics of use to senior level managers.

Programs that target lay practitioners often provide participants with a more general continuing education approach, basing their curriculum around overall needs of the current MCH and public health workforce, a significant percentage of which do not have formal graduate level degrees (Alexander et al.). A typical example of such a program would be the Rocky Mountain Maternal and Child Health Care Certificate Program, based out of the Arizona College of Public Health. The Rocky Mountain program targets working professionals in MCH and offers part-time, graduate level courses on a variety of practice-related topics. Academic credits are available, and tuition is charged. The immediate emphasis is not on developing senior level leaders, but on enhancing overall skills and knowledge of the general public health sciences that participants may not have received in a graduate degree program.

🔗 Content of Training

The curricula of training programs vary according to target audiences and programmatic goals. Some programs have curricula that exclusively focus on very specific and narrow topics. For instance, the Iowa Community Health Leadership Institute (a joint creation of the Iowa Association of Local Public Health Agencies and the Iowa Health System), and the University of Alabama's Leadership Skills Institute, discussed above, base their curricula around topics specific to the needs of their stated audience: senior level leaders and managers. Curricula thus focus on expert level knowledge of management systems, strategic planning and performance evaluation, and communication skills.

Another very specific, recurring curriculum among capacity-building programs promotes advanced education in data skills. The University of Rochester's MACH 2010 program exclusively focuses on enhancing data analysis capacities. Participants learn a variety of collection, analysis, and reporting methods over the course of approximately half a year. Similarly, the University of North Carolina Data Skills Online project focuses

exclusively on quantitative and qualitative data collection and analysis, developing questionnaires, surveillance, and other statistical and epidemiological topics. Although both programs focus on data skills, the duration and methods used in each program differ greatly, as discussed later.

A number of programs, particularly ones targeting lay practitioners, offer more general modules. Montana's Public Health Training Institute offers "Public Health 101" for participants. Participants in its Public Health Summer Institute also have a choice in selecting other general topics in two to three day seminars, including "Public Health Law and Policy," "Communicating the Public Health Message," and "The Ten Essential Ingredients for Environmental Health Practice." It has been suggested (Alexander et al., 2001) that broader curricula such as this may reflect the overall need to provide some form of general graduate level training to lay practitioners who, although they work in the maternal and child health field, lack formal training.

Program Interaction and Duration

Programs differ in terms of how participants interact with faculty and with other participants in the learning process, and for what duration interaction occurs. Consideration of target audience characteristics and their needs reflect the means by which capacity-building programming is presented to participants. Because the University of Alabama's MCH Leadership Institute targets state program directors and other senior level managers whose positions leave them a minimal amount of time for training, the Institute arranges intensive, 3-day, in-person seminars on a detailed topic. The in-person interaction facilitates discussion among participants, and draws upon their experiences as senior level managers to enhance the overall educational experience.

Many capacity-building programs employ a combination of in person and distance education methods. In these programs, participants are generally required to meet with faculty in an intensive series of seminars lasting several days, and then separate for a period of time where assignments are completed online or through other distance education mediums, followed again by in-person, concluding sessions. The length of time during which participants work separately varies from program to program. In Montana's Public Health Training Program, participants have a five-week term, during which they complete assignments long-distance, in between intensive in-person sessions with instructors and other participants. Academic credits are available following successful completion of the entire program. Participants in the University of Rochester's MACH 2010 program have close to seven months to independently complete seven modules on data-skills topics, during which two in-person sessions also are scheduled to occur.

Faculty

The majority of these programs involve the active participation of university level academics as program faculty. In many cases, individual universities themselves, such as the University of Rochester or Boston University, offer a capacity-building program. A consortium of universities developed the Rocky Mountain Certificate program around the common goal of pooling educational resources to provide training needs to working professionals in the region. Other programs may be housed and coordinated at non-university institutions, but still rely on university faculty to develop curricula or otherwise participate in activities. Such would be the case with the Iowa Community Health Leadership Institute. The Institute is the creation of an association of local public health agencies, hospitals, and other

professional entities, but it relies on faculty members and educational resources from the University of Iowa College of Public Health and other institutions to assist in developing program substance. Similarly, the Montana Public Health Training Institute is based at Montana's Office of Public Health System Improvement, but the Institute was created through a state contract with the University of Washington School of Public Health and Community Medicine, which currently provides faculty for the Institute's continuing education courses. Although the participation of university academics is common, they do not exclusively compose the faculty of all programs. Practice-based experts often serve alongside academics as faculty members in individual capacity-building programs.

Informal Opportunities

In some of the individual-capacity-building models investigated, programs supplemented formal forms of continuing education with informal opportunities for individual growth and capacity-enhancement through a variety of means. For example, opportunities to network and develop mentoring relationships are built into several programs that also feature more traditional, "formal" educational aspects (i.e. attending seminars, completing assignments, etc.). Other informal capacity-building opportunities exist completely independent of formal approaches, serving as information sources, usually online, that professionals may access on their own time without participating in a more structured or traditional academic program.

🔗 Networking

A number of programs aim to encourage the development of an informal network of contacts among participants following graduation from respective programs. For instance, the Iowa Community Health Leadership Institute, noted above, brings professionals together to develop public health leadership skills through a one-year learning process. Several in-person facilitated sessions are held to enhance learning skills in group problem-solving, conflict resolution, communication styles, and collaboration strategies, through an interactive process in which participants will learn from each other, and ideally develop into a network of lifelong learners and leaders in the state. Participants also work in teams, based on geographic proximity, and identify a "Community Improvement Project" in which participants collaborate together in examining and developing solutions to a selected community health issue. The Improvement Project encourages the development and fostering of a local network of partners, while simultaneously developing leadership skills among individual participants.

🔗 Mentoring

At least one of the programs investigated includes a mentoring component in its capacity-building program. In between intensive, in-person summer training sessions, participants in the Rocky Mountain Maternal and Child Health Care Certificate Program have a full year to complete a graduate level course online or through a partnering university. Between summers, participants complete an independent practicum project on a selected issue while working with one academic mentor and one practice-based mentor. The program selects the mentors, places them with participants, and also provides them with compensation.

Information Resources

In contrast to training in person, a number of resources are available for MCH/Public Health professionals to access completely independently, usually through the Internet. These resources can accommodate professionals seeking self-directed learning opportunities at a time of their choosing. Unlike other forms of distance education that require ongoing, albeit occasional, contact with faculty members or peers, and provide academic credit upon completion, these resources are truly informal in the sense that they often do not provide the individual with any accreditation or formal feedback. These are simply resources available for interested individuals to access at their convenience in order to better understand items of interest, often at little or no cost, and do not provide any form of accreditation.

For instance, the University of North Carolina’s Data Skills Online project, noted above, offers individuals a “toolbox” of online lessons in a variety of analytical and technical data-related topics. Completion of individual lessons is estimated at one to three hours per lesson, and instruction objectives, self-testing activities, and a glossary of terms, are provided with the lessons. There is no cost for using the online tools, and academic credits are not available following completion of any toolbox items. Another example is the informal information disseminated by CityMatCH, the national membership organization of city and county health department MCH programs and leaders from urban areas (population of 100,000 or more). CityMatCH utilizes its website, newsletter, fax networks and e-mails to relay information on pertinent MCH topics to professionals.

Other such resources may include CD-ROMs or video or PowerPoint presentations that also are geared toward the working professional seeking to supplement their understanding of a topic at their own pace, without the formalities of in-person or more structured forms of education that may require lengthy assignments or tuition.

— Community Capacity-Building Models —

Communities are “cornerstones of the process by which problems are defined and by which responses are generated, implemented, and evaluated” (Grason and Guyer, 1995, p. 1). In regards to the core functions of public health, a community-centered approach to public health practice focuses on sharing information and including community partners when identifying priorities and solutions to community MCH problems (Fauth and Pappas, n.d.). Communities in other states and regions have developed processes and systems to strengthen the capacity of their MCH stakeholders. MCH community capacity-building approaches that emerged from the programs reviewed include:

- Information sharing
- Community assessment of services and needs
- Training
- Collaboration/Community alliances
- Increased access to medical professionals in the community
- Technical assistance in using data to improve MCH services

Information Sharing

🔗 Among Health Care Professionals

The strategy of increasing information and sharing of available information is evident in many of the programs that aim to increase community capacity in maternal and child health care. Using information to increase capacity includes increasing knowledge regarding a specific health care issue, keeping up with new issues in maternal and child health care, and sharing information about best practices. One national example of an information-sharing project (that could be adapted to a community-based project) is CityMatCH. The project facilitates the exchange of community information between its members through an annual leadership conference, with newsletters, and with a lessons-learned publication.

🔗 Among Community Residents

The Faith Community Church Liaisons project of Arizona's African-American Faith Partnership (formerly known as the Neighborhood Healing Circles project) builds community capacity by increasing the availability of health care information to community residents from other residents, rather than from health care professionals. Churches participating in the partnership form internal health ministry teams from members of their congregations. The team members receive broad training in health related subjects specific to African-American and other minority communities, and share this information with area residents during home visits. The Church Liaisons project has more than doubled the number of churches participating in the partnership. The partners have also begun to look at additional topics, as well as health care, that may affect minorities in their area.

Another example of building community capacity for better child health by increasing community residents' health care knowledge is Smart Start, a public-private initiative. A statewide nonprofit organization provides oversight and allocates funds among local (nonprofit) partnerships that are in charge of Smart Start programs in North Carolina communities. The program provides education for parents regarding both parenting and health. Results have shown that child care in homes has improved, and children participating in the child care facilities that the program supports are more likely to have regular health care, better cognitive and language skills, and are less likely to have behavioral problems.

Community Assessment of Services and Needs

A second phase of the Faith Community Church Liaisons project in Phoenix is to gather information from the community's minority residents to assess their health services and needs. The Arizona Department of Health Services and Arizona State University are collaborating with the project to complete the assessment. The Faith Partnership plans to use the information as a community tool in long-term planning for improvements in community health as well as to provide the information to local and state legislative bodies.

The Yakima Valley Farm Workers Clinic also conducted a community assessment of services and needs as part of a project aiming to increase service capacity for Hispanic and Native American families in the Oregon and Washington State communities that the clinic serves. Providing community-based services for children with special health care needs is a goal of the capacity-building Yakima Valley program.

Training

The train-the-trainers approach to building capacity utilizes a small number of professionals who receive training and then take that knowledge back to their community to educate others who work in the health care field. This approach develops community-based health care providers' knowledge in a health care area in which the community would like to improve their MCH capacity.

For example, Pennsylvania initiated the Educating Physicians in their Communities (EPIC) public-private partnership in 1994. A group of 24 pediatricians was selected to receive training in areas such as early intervention services and the role of physicians working with families and care coordination. In turn, those physicians took their increased knowledge back to their communities and educated local health care providers in their regions. By 1998, approximately 500 health care providers had been trained through the program. Pennsylvania's demographic profile (but not absolute population numbers) is similar to Nebraska's in that there are two major metro areas in the state, many small communities in rural areas, and large areas with low population density. These characteristics influenced the design of the EPIC program (Grason, Aliza, Hutchins, Guyer, and Minkovitz, 1998). Although the initial EPIC program is no longer active, the train-the-trainers model served as a basis for developing a variation - the Educating Physicians in Community Integrated Care (EPIC IC) Medical Home Development project. The EPIC IC project trains primary care physicians and their office staff in the medical home approach to improving health services for children with special health care needs.

Collaboration/Alliances

CityMatCH increases community capacity by promoting collaboration among city and county health departments at the Annual Urban MCH Leadership Conference, resulting in better coordination of maternal and child health activities. Collaboration that is encouraged as part of the conference agenda is a more formal experience than the informal networking that is also likely to occur at the annual conference.

The Pennsylvania EPIC program's train-the-trainers model contributed to community capacity by establishing links between family practice physicians providing health care and early intervention service providers. These community-based alliances did not exist before the training program emphasized the pediatrician's role in early intervention.

The Faith Community Church Liaisons project of Arizona's African-American Faith Partnership connects churches, health care providers, and community organizations when ministry teams are formed and trained in health subjects. A part of their vision is that the project be based in the community, and the connections established among these various groups in the community help to build that community base and increase capacity for delivering health care.

Kansas University Medical Center and a Kansas City school district cooperate to provide greater access to medical services for school children under TeleKidcare. These partners increased community participation and awareness in their effort by asking the County Health Department, the Kansas Department of Health and Education, and local physicians to be part of the project.

Increased Access to Medical Professionals in the Community

Some communities increase their capacity in the MCH area by increasing access of medically underserved populations to medical professionals in their community. TeleKidcare developed from the Wyandotte County Community Health Partners pilot telemedicine program that made medical services available to school children in a Kansas City area characterized by low incomes and few physicians. Telemedicine equipment connected school nurses' offices to physicians' offices and allowed physicians to diagnose close to 200 children and fax over 140 prescriptions during the three-month pilot in the spring of 1998. One disadvantage associated with the program is that the start-up costs were high in terms of the participants' time.

In the fall of the pilot year, the telemedicine program was expanded to four additional schools not located in medically underserved areas. Plans were made to more than double the fifteen new sites added to TeleKidcare since the inception of the pilot program, bringing the number of sites to 32 by the fall of 2003. Telemedicine projects being developed will benefit from findings of a research team that is studying health-care related issues as a part of the TeleKidcare project.

Another example of increasing access of a specific group to medical professionals is seen in the Yakima Valley Farm Workers Clinic program that operates in some communities in the Pacific Northwest. In the fall of 2001, after interviewing Spanish-speaking parents whose children with special health care needs might be served at one of the clinics, the program identified possible changes to service delivery that might reduce the barriers to medical service for those families. Suggested changes included: hiring bilingual staff who are fluent in both English and Spanish and have the appropriate cultural competency skills; changing clinic hours; addressing transportation problems; altering the structure of parent support groups; coordinating with public schools; and providing greater outreach to the Spanish-speaking community. The Yakima Valley program has since extended this approach to Native American parents of children with special health care needs in order to reduce barriers to health care services in that community.

Technical Assistance

Communities may have data that could be utilized to make changes in MCH services, but may need technical assistance to be effective in using the data to affect MCH programs and policy development. Urban communities involved in the Urban MCH Data Use Institute, sponsored by CityMatCH, build community capacity by learning how to use data that relate to MCH.

The North Carolina Partnership for Children is a statewide nonprofit organization that provides technical assistance to local Smart Start partnerships in that state. Some communities receive grants for technical assistance to help develop their early education initiatives.

Informal Networking Approach

Informal networking may result in community MCH capacity building even when those involved have no formal agenda. The following example of informal networking was given at a June 2003 Nebraska conference. Some people working in health care in a Nebraska community felt that they would benefit from getting together to share ideas. A local church volunteered the use of a meeting room once a week and offered to provide coffee for anyone who wanted to meet. The informal group had no agenda or formal plans for action, but as a result of the casual meetings, the group was a catalyst for change in health care service provision in their community.

Community Capacity Building: A Nebraska Example

A Healthy Moms, Healthy Babies Consortium³ recently formed in southeast Nebraska includes representatives from a multi-county public health department in collaboration with five other agencies serving women and children. The Consortium, the first in the state, is an example of a model of community capacity building that incorporates many of the approaches discussed above. In recognition of the need for service coordination and consistency, the Consortium plans a formal assessment of MCH services and needs in its area. This information will be used to evaluate the need for adding new or adapting current MCH programs.

— Statewide Capacity-Building Models —

Statewide activities promoting MCH often provide infrastructure, planning, and monetary support to the individual and community level MCH capacity-building programs. States play a key role in MCH program initiation, resource allocation, and data collection and analysis. Other organizations, such as non-profits and universities, may also play important roles in statewide capacity building.

The three core functions of public health – assessment of information on the health of the community, comprehensive public health policy development, and assurance that public health services are provided to the community – can be planned and directed from the state level.

Statewide MCH capacity building involves the following types of activities:

- Strategic planning and visioning processes
- Initiating/supporting infrastructure development
- Networking, communication, and information dissemination
- Needs assessment
- Accreditation and certification

³ The National Healthy Mother, Healthy Babies Coalition (<http://www.hmhb.org/>) promotes a variety of community capacity building approaches, including: information sharing and education, educational materials and resources for providers, technical assistance, and networking.

Strategic Planning and Visioning Processes

Some Maternal and Child Health programs interested in policy and planning, such as the Michigan Council for Maternal and Child Health, have focused on coordinating statewide support among stakeholders in MCH for policy development and action implemented at the state legislative level. The Michigan Council for MCH develops a yearly policy agenda in partnership with consumers, consumer advocacy, and provider organizations. When feasible, the Michigan Council coordinates their advocacy activities with state government efforts. Many Michigan Council board members participate in government committee meetings when the state executive and legislative administrative environments are conducive to this participation. Over the past several years, Michigan Council board members were not able to participate in committee meetings, but this has since changed and the Michigan Council for MCH is now re-creating the internal advisory structures that were eliminated by the previous state administration.

The Maine Turning Point project has developed a multi-year strategic plan (as compared to the annual strategic plans of the Michigan Council for MCH). Maine Turning Point's Public Health Improvement Plan (PHIP) is based on a 1988 Institute of Medicine Report that outlines the role of the federal, state, and local governments in public health. The role of state government was particularly emphasized by the PHIP because of Maine's lack of a consistent sub-state system for delivery of public health services. Generally, four main strategies were identified by the working group to strengthen Maine's public health workforce: 1) Maine employers and public health professional organizations should adopt policies that improve access to public health training for their employees; 2) Maine should develop a life-long learning system on public health topics that is accessible statewide and is based upon explicit public health competencies; 3) public health training programs in Maine should be evaluated for effectiveness; and 4) the state should survey the active clinical workforce and use the data to project need. Many of these planned strategies are common to other state level MCH capacity-building programs, as discussed below.

Initiating/Supporting Infrastructure Development

State government agencies have played a key role in the genesis of a number of public health capacity-building programs by obtaining grants for such purposes (Turning Point in Maine and Montana; Nebraska also is a Turning Point state), passing legislation (Montana), or simply initiating discussions regarding the promotion of Maternal and Child Health issues (Michigan). Some of these programs retain close ties to the state and are at least partially funded by them. An exception to this is the Michigan Council for Maternal and Child Health, which has severed its funding ties to the state and acts solely as an advocacy group for MCH issues. The Michigan Council still cooperates with the state to develop MCH policy, however.

The Michigan Council for MCH developed out of discussions initiated by the state department of health, which wanted to create an advocacy group to promote MCH issues. Likewise, the Montana Public Health Training Institute arose out of a conference convened by a group of state and local public health officials concerned with the role of public health in state and national health care reform. As a result of this conference, a group of concerned local and state professionals formed the *Committee for the Improvement of Public Health in Montana*. The activities of this committee led to the Montana Public Health Improvement

Act in 1995, the formation of a task force to carry out the Act, and a subsequent Turning Point grant to fund development of the Montana Public Health Training Institute.

Academic institutions have also helped initiate state level capacity-building activities. Representatives from both academic and practice organizations that were concerned with the training and education of Nebraska's public health workforce formed the Nebraska Educational Alliance for Public Health Impact (NEAPHI), an alliance of organizations dedicated to improving Nebraska's public health infrastructure. NEAPHI serves as Nebraska's representative to the Upper Midwest Public Health Training Center (UMPHTC), which also covers Iowa and South Dakota.

Another example of an academic institution's involvement in public health is the Rural Health Education Network at the University of Nebraska Medical Center, which was instrumental in developing both the Central and Northern Nebraska Area Health Education Centers (AHECs). More centers are planned around the state. Both Nebraska AHECs focus on educating high school students about careers in health care and on providing continuing education for health care professionals.

Networking, Communication, and Information Dissemination

We found many examples of programs that promoted networking, but few examples of network building that formally attempt to involve a variety of stakeholders in an inclusive manner. An exception to this is the Michigan Council for Maternal and Child Health, discussed previously, which encourages collaborative advocacy strategies and initiatives. The Michigan Council is an organization of diverse partners, with consultant staff working closely with coalitions around the state. Providing technical support to organizations and smaller networks involved in MCH creates connections with and among these groups. The Michigan Council also helps coordinate policy agendas among MCH-concerned organizations in Michigan as part of their networking activities. Together, the Council's partners believe their collective effort has had more impact at the state level than they might otherwise have achieved individually.

The Montana Public Health Training Institute has identified different targets for different communication goals. They target community partners with information encouraging collaborative networks in order to reduce duplication of services and to expand efforts to reach target populations. They also target policy makers, community leaders, and the general public with a different goal in mind: increasing awareness of the range of public health responsibilities, programs, and priorities and their impact on the community.

Numerous strategies exist for formal training institutes to advertise their programs and information regarding public health issues. Brochures, websites, and e-mail are often used. The Maternal and Child Health Leadership Skills Training Institute, based at the University of Alabama-Birmingham, identifies directors and executive staff of programs and government agencies concerned with Maternal and Child Health and with Children with Special Health Care Needs. Invitations to attend the Institute's training seminars are sent directly to officials in many states.

Needs Assessment

A number of the programs that engage in multiple state level capacity-building activities conduct a statewide needs assessment. A needs assessment survey was a component in the formation of the Montana Public Health Training Institute. Similarly, the Maine Turning Point program recommended that the state of Maine survey the active clinical workforce and use the data to project need. This workforce needs assessment has prompted the University of New England to begin offering a graduate certificate in public health. Likewise, the Upper Midwest Public Health Training Center conducted a workforce needs assessment in its covered states to determine educational and training needs for those working in public health.

Accreditation and Certification

States can encourage public and personal health workers to become knowledgeable regarding Maternal and Child Health issues by formally recognizing certification offered by approved training programs. The Montana Public Health Training Institute intends its certification program to provide a minimum level of competency for employees within the state's public health system.

Other states are moving beyond encouraging certification to requiring certification. An additional component of these accreditation and certification programs is an evaluation component to ensure that such initiatives are resulting in the creation of a competent public and personal health care workforce. In Maine, at the recommendation of the Maine Turning Point project, the state is taking the responsibility for designing and identifying funds for such an evaluation.

— Organizational Models —

Capacity building, then, may target individuals, communities, and entire states. The goal of such capacity-building efforts is that organizations and professionals working with the MCH population have the opportunity to:

- develop individual knowledge, skills, competencies, and abilities;
- participate in community and state partnerships to improve leadership, quality of care, and problem-solving;
- assess and evaluate strategies through data sharing, networking, and communicating with representatives of other communities; and,
- promote the availability of services and efforts of many on behalf of the MCH community.

We have identified four basic organizational types that have successfully implemented MCH capacity building – **private not-for-profits**, **partnerships**, **governmental bodies**, and **universities**.

Private Not-for-Profit Organizations

Private, not-for-profit organizations have been the primary vehicle for MCH capacity building in a number of examples we identified. We found two examples of types of not-for-

profits: those that are primarily *membership associations* and those that are *MCH-related activity organizations* that have been established for the express purpose of promoting or delivering an MCH-related activity, but are not organizations that primarily draw their funding and/or support from members.

Membership Associations

Membership associations may provide MCH capacity building. These membership associations provide capacity building primarily to their members and may also promote the importance and visibility of MCH-related activities to the greater community through advocacy and/or lobbying.

One prime example of this type of association is the Michigan Council for Maternal and Child Health, established in 1983. Although the Michigan Council was developed through discussions, initiated by the state department of health, among stakeholders interested in creating an advocacy group to promote MCH issues, the Council is independent of any organizational or financial ties to the state. The Michigan Council receives approximately \$300,000 per year in support from its member organizations, including community groups, physicians, hospitals, and associations, but none from state government. The Michigan Council partners with consumers and consumer advocacy organizations in the policy development process. The Michigan Council has developed a reputation for promoting prevention programs within MCH and not as an advocate tied to a specific profession or association (i.e. local physicians or hospitals). They credit their strong marketing/advertising program with helping to consolidate support among community groups.

Another example, albeit a national example, of a membership association is CityMatCH, established in 1991, to promote communication and collaboration to improve the health of urban children and families. CityMatCH's \$1 – 1.2 million dollar annual budget is funded in part through cooperative agreements with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services and Centers for Disease Control and Prevention in Atlanta. The University of Nebraska Medical Center and the National March of Dimes Birth Defects Foundation provide additional support. Unlike the Michigan Council for MCH, CityMatCH does not charge a membership fee. CityMatCH has successfully increased its visibility and leadership as the voice of urban MCH nationally and promoted its many capacity-building activities, such as the Data Use Institute. CityMatCH membership includes health departments in 148 urban centers across the United States. The National Headquarters is located in Omaha, Nebraska, and is physically located at the University of Nebraska Medical Center. Two member health departments exist in Nebraska: Lincoln/Lancaster County Health Department in Lincoln and the Douglas County Health Department in Omaha.

MCH-Related Activity Organizations

We found numerous examples of not-for-profit organizations that have been created expressly for an MCH-related activity. A study of Turning Point grantees suggests that this type of organization may be uniquely able “to represent community needs and support community ownership for community public health activities” (Lewin Group, Inc., 2003, April, p. 12). We have categorized examples of these types of organizations as Skill Promotion Centers, Resource Centers, and Funding Conduits.

► *Skill promotion centers.* Across the nation, and in Nebraska, not-for-profit organizations have been established to provide access and funding to students interested in pursuing careers in MCH-related professions, primarily related to healthcare. Area Health Education Centers (AHECs) are one of a new breed of centers being developed. Nebraska currently has two AHECs whose mission it is to improve health care through the recruitment and training of healthcare professionals.

► *Resource centers.* Another category of MCH capacity-building not-for-profit organizations includes those established as resource centers to serve professionals and citizens. Many times these resource centers provide information through the Internet as well as at their office locations. Resource Centers may also provide direct services to clients, such as through a health clinic, as well as informational resources. Two examples are the Community Health Resource Center, established in 1995 by the Palo Alto Medical Foundation, and the Yakima Valley Farm Workers Clinic in Washington. Another example of this type of Resource Center may also include a model such as the Early Childhood Training Center in Omaha, Nebraska, which provides support, training, and consultation to staff who work with young children and their families. The Early Childhood Training Center receives support from the Nebraska Department of Education, Title I, and the Nebraska Health and Human Services System.

► *Funding conduits.* Not-for-profit organizations may provide capacity building by channeling funding resources to community organizations undertaking MCH-related activities. An impressive example of this type of organization is Smart Start in North Carolina. Smart Start was initiated in 1993 with a \$20 million state appropriation. The program matches every ten dollars it receives from the North Carolina General Assembly with one dollar from the private sector. The state's largest banks and top corporations have made significant contributions to Smart Start. The initiative has also received support from the David and Lucille Packard Foundation and the U.S. Department of Justice. Much of Smart Start's funding is targeted towards providing accessibility to child care and education through subsidies. However, Smart Start also has established the National Technical Assistance Center to share information, resources, and lessons learned with other states in the development of community-based early childhood initiatives. Although the scale of Smart Start is very large, it provides a viable model for how a not-for-profit organization may be able to pool public and private resources to provide services and capacity building.

Partnerships

There are a number of examples of partnerships that have been forged to build MCH capacity. Many times partnerships include formal representation of governmental, academic, and other organizations. An advantage of this type of relationship, particularly when contrasted to a governmental alternative is that it benefits "from working closely with governmental agencies without being restricted by government bureaucracy, political agendas, and funding limitations (Lewin Group, Inc., 2003, April, p. 10)." The Lewin Group (2003) further suggests that partnerships may provide an ideal organizational framework for communities to explore innovative solutions that otherwise may not be accommodated because they cross bureaucratic structures or lines of responsibility.

Two partnerships we examined were developed primarily to develop formal educational activities. Another partnership provides both formal and informal capacity

building. The final example relies entirely on building capacity through more informal training of paraprofessionals.

Formal Educational Partnerships

Both Iowa and Nebraska have established partnerships to expand the availability of formal training in public health. In Iowa, the Iowa Community Health Leadership Institute has sponsored a yearlong training program since 1998. The Institute is a partnership of the Iowa Association of Local Public Health Agencies, the Iowa Health System (an association of Iowa hospitals), and the Iowa Department of Public Health. The Institute is not formally associated with a school of public health. Its annual operating budget is approximately \$130,000 annually.

The Nebraska initiative, Nebraska Educational Alliance for Public Health Impact (NEAPHI), is exploring the education and training needs of Nebraska's public health workforce, including collaboration with the Upper Midwest Public Health Training Center based at the University of Iowa College of Public Health. NEAPHI relies primarily on "in-kind" operational support from its partnering organizations. It consists of approximately 30 representatives from a variety of academic and practice-based public health organizations in Nebraska. Members, however, do not necessarily officially represent the organization with whom they are affiliated.

Formal and Informal Capacity-Building Partnerships

Partnerships may undertake both formal and informal capacity-building activities. For example, the Maine Turning Point project supports communities in creating and sustaining the coordinated delivery of public health services through both formal and informal opportunities. Planning for the Turning Point project was convened by many partners, including the Maine Center for Public Health (private, not-for-profit), Medical Care Development (private, not-for-profit), and Maine Department of Human Services - Bureau of Health. Steering Committee members now represent public health, academia, business, legislators, healthy community coalitions, tribal health organizations, rural health organizations, minority communities, state agencies, family planning organizations, hospitals, health plans, and others. Four work groups were created representing some 175 Maine Turning Point partners. Most of the state's key public health stakeholders are involved with this project, which has annual operating costs of approximately \$100,000. The work of the partnership has resulted in the creation of a Master's of Public Health program at the University of New England and a partnership with Healthy Community coalitions to start a peer-mentoring program in which community leaders mentor each other in the creation of more community level public health programs in areas such as education and awareness. The Maine Center for Public Health now offers a number of education and training programs using innovative technologies, including videoconferencing and satellite broadcast. Maine Turning Point also has made extensive efforts to educate policymakers about public health through conferences and educational forums.

Paraprofessional Capacity Building

Partnerships may also be formed to train the natural helpers, or paraprofessionals, that already are present within the MCH population. One innovative, citywide approach, using the connections and resources of faith-based communities, is the African-American Faith Partnership "Faith Community Church Liaisons" project. The project began as a partnership comprising ministers from eleven African-American churches in South Phoenix, Arizona.

The churches (now expanded to 23) formed ministry teams within each congregation made up of members of the congregation. The members of the health ministry teams received extensive training on subjects such as: the history and theology of health; spiritual care; and the leading causes of death in the African-American community. Once trained, these ministry teams visit homes in the area and share this training with area residents. The project will conduct a needs assessment of the minority residents in South Phoenix, examining the utilization of services, perception of services, affordability of services, and other factors. The project hopes to use this information to create a long-term plan for improving the health of the community, as well as to share this information with local and state government bodies. The partnership has established alliances with community residents, church leaders, and community-based organizations. Funding for the project comes from the R.W. Johnson Foundation, Kellogg Foundation, and the Turning Point organization through a three-year grant.

The R.W. Johnson Foundation has, through its Faith in Action program, supported voluntary care efforts around the country. An evaluation of the Faith in Action grantees found that faith-based organizations are able to recruit volunteers for a wide variety of needs, and that strong leadership and a volunteer infrastructure (e.g., volunteer recruitment, training, supervision) is necessary (Pepper, Herrera, and Leviton, 2003).

Government

Government, particularly state government, may play a prominent role in promoting, delivering, and coordinating public health. It is not surprising, then, that we found a number of successful MCH capacity-building initiatives under the governmental or government-sanctioned bodies. We will turn, first, to examples from state government and then talk about other governmental entities.

State Government

The Montana Public Health Training Institute, based within Montana's Department of Health and Human Services, provides training opportunities for public health leaders and practitioners, teams of state and local government health employees, tribal health officials, policy makers, private and not-for-profit health organization staff members, and local board of health members. The University of Washington School of Public Health and Community Medicine helped develop the institute and provides contractual assistance. The Institute's operating costs are approximately \$200,000 annually. Funding comes from a Health Resources and Services Administration (HRSA) Workforce Development Grant through the Northwest Center for Public Health Practice, a Preventive Health Block grant from the Centers for Disease Control and Prevention (CDC), the Turning Point Initiative, and tuition fees.

Pennsylvania's human services agency launched a pediatrician-centered train-the-trainer approach to enhance the skills of community-based primary care providers and other health care personnel in developmental screening, collaborating with families, care coordination, and working within the managed care environment. During the first three-and-a-half years of the program's operation, the 24 participating pediatricians hosted over 40 local training sessions. The project administrators believe that at least 500 pediatricians and other providers received training during this period. The project cost approximately \$100,000 annually and was funded through state resources. This program is no longer active, but the

training model has been incorporated into the state's Educating Physicians in Community Integrated Care (EPIC IC) project.

In Vermont, over 1,000 providers have been trained through an initiative of the Vermont Department of Health. The approach is targeted toward providers working with parents from the prenatal stage through their children's early years, with the goal of actively involving parents in observing their children as unique individuals with a variety of skills and abilities. The 50 initial trainees were chosen from a pool of applicants who had been approved for the training by their employer organizations. Additional project activities have centered on creating a comprehensive set of parent educational materials, increasing the competency and efficacy of professionals conducting home visits, streamlining the assessment, monitoring and referral processes, and gathering information from parents that can be applied to increasing skills of home visiting professionals and making it an overall better experience. The training budget includes \$30,000 per year and the in-kind services of over 50 staff. Funding comes from a three-year grant from the Commonwealth Fund grant, the Vermont Child Care Services Division, and tuition.

Other Governmental or Government-Sanctioned Organizations

Some community-grounded organizations receive their authority as a governmental unit or quasi-governmental organization. An example would be a health "authority" established by the legislative or executive action of county governments, local health departments, or state government. A study of W.K. Kellogg's Turning Point grantees identified this type of government or government-sanctioned organization pattern of community organizing. This type of arrangement provides credibility, regulatory and legislative authority, and "formal links to local and state level policymakers" (Lewin Group, Inc., 2003, April, p. 7).

Universities

Universities have taken a lead role in MCH capacity building through a number of types of initiatives – delivering *certification programs*, delivering *self-directed resources*, and providing University expertise for *provision of services*.

Certification Programs

A number of universities are involved in delivering MCH certification programs through existing schools of public health. Examples include the Arizona College of Public Health Rocky Mountain Maternal and Child Health Certificate Program, Boston University Maternal and Child Health Certification Program, University of Alabama Maternal and Child Health Leadership Skills Training Institute, Upper Midwest Public Health Training Center, and University of Rochester's Maternal and Child Health Analytic Training for the Year 2010 (MACH 2010). Target audiences are typically staff of state or local agencies, including health departments, hospitals, HMOs, perinatal networks, Healthy Start Projects, community-based organizations, and others working with the MCH population. Only two universities provided us with annual operating costs: Arizona's program costs approximately \$150,000 annually and Boston University's program costs \$50,000 annually. Named funding sources for these programs include the Health Resources and Services Administration, the Health and Human Services Maternal Child Health Bureau, the Association of Teachers of Preventative Medicine, and tuition fees.

A notable initiative mentioned above is the Upper Midwest Public Health Training Center, based at the University of Iowa and covering Iowa, South Dakota, and Nebraska. The Center, through a five-year Health Resources and Services Administration grant, is: assessing the public health workforce and competency needs, assets, and educational programming to meet the needs of minority and underserved populations; delineating available resources; and developing a plan for addressing the identified gaps and developing/implementing new curricula and training programs.

Self-Directed Resources

The University of North Carolina’s Data Skills Online project provides on-line learning modules for training MCH professionals to apply analytic and technical skills in their day-to-day job responsibilities. From January 2001 to May 2002, 975 individuals had registered for at least one analytical or technology tool – on average, 60 new registrants per month. These registrants represented 49 US states and several foreign countries. During this period, all of the technology tool users responded that a tool had improved their knowledge, and 96% responded that a tool had improved their confidence in using the skills. Similarly, 97% of analytic tool users responded that a tool had improved their knowledge, and 90% responded that a tool had improved their confidence in using the skills. Annual operating costs of the North Carolina program include expenses for three staff members, consultants, field testers, computers, and necessary software. Funding for the development of the online tools project came from a Special Project of Regional and National Significance grant from the Maternal and Child Health Bureau. The Health Resources and Services Administration funds the Southeast Public Health Training Center, which administers the online tools project.

Provision Of Services

Many universities routinely provide expertise to improve and enhance the delivery of services. One project we found, however, did so within the context of capacity building through community awareness and participation. The TeleKidcare project, through the Kansas University (KU) Medical Center, provides medical care to children through a combination of school nurses, physicians, and other necessary parties. The physician can diagnose the children and fax a prescription (or call it in to the parent’s pharmacy of choice) using the telemedicine equipment. At the time of the pilot project, there was no specific state funding for TeleKidcare. Since the pilot project, however, TeleKidcare has been expanded to fifteen other sites throughout Kansas (and is scheduled to further expand to thirty-two sites by Fall 2003) through funding from the Kansas Children’s Initiative Fund. The telemedicine equipment used in the schools was paid for by the school districts, and the equipment in the doctor’s offices was paid for by the KU Medical Center. The second phase of the project received a grant from the National Telecommunications and Information Administration, which enabled the program to be expanded.

— Observations —

There is an emerging body of research on “best practices” in building and sustaining successful collaborative efforts. Below, we discuss and apply several best practices relevant to MCH capacity building in Nebraska.

Nebraska has a rich and long history of organizations working together to successfully address complex issues. Partners in MCH capacity building will likely profit

from the connections and competencies built through **prior experiences** in forming successful cooperative projects and initiatives (Promising Practices Network, 2001).

- To the extent feasible, MCH capacity-building planning should be designed to build upon successful past collaborations and relationships. Past and existing partnerships should be acknowledged and leveraged.

Effective statewide MCH capacity building is unlikely to be accomplished by a single organization. **Engagement** of many stakeholders is necessary (Farrow and Gardner, 1999). A **vision** of what capacity building will accomplish may help individuals and organizations understand how they may contribute (Promising Practices Network, 2001). The participation of all stakeholders will optimize buy-in and encourage a feeling of shared ownership. (Reynolds and Leahy, n.d.)

- Nebraska’s statewide stakeholders should represent urban, rural, traditional, and even non-traditional interests. A statewide conference or summit may be convened to start discussion around the provision of MCH services and to pull in stakeholders from across the state to vision the impact of capacity building, identify additional key partners, and plan initial steps.

Capacity building will take resources. **Investment** is necessary – either financial or in-kind – and must be sustainable (Promising Practices Network, 2001; Education and Human Services Consortium, 1991). However, there are likely cost-saving opportunities in adapting existing regional and national resources (Reynolds and Leahy, n.d.).

- Planning should include projecting resource needs. Resources may include financial as well as in-kind resources. There are a wide variety of materials and programs across the country from which Nebraska may adapt for our own needs. Distance-learning opportunities may address transportation barriers. Existing collaboratives and programs that currently serve Nebraska may provide needed resources.

A well-known axiom in planning is to achieve some sort of **success early** in the process. That is, at least some objectives or action steps should be achievable quickly.

- Lay out a plan of work that includes short- and long- term objectives. Short-term objectives enable collaboratives to experience early success and ensure that participants do not become overwhelmed by a lack of progress. Early success may also contribute to recruiting additional partners, support, and political will.

— Summary —

This report set out to identify, review, and summarize models of MCH capacity building being used in the United States that might provide information useful to Nebraska. The array of successful approaches developed to build MCH capacity, along with the many varieties of organizational models for MCH capacity building being implemented, suggest that various options may be successful in building capacity. In the Appendixes that follow, we provide more detailed information about the various programs we investigated (Appendix A: Selected Capacity-Building Programs) and provide an extensive resource list of

MCH-related sites for federal government agencies and resources, private organizations and projects, and university-based programs (Appendix B: Online Information Sources).

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Appendix A

Selected Capacity-Building Programs

— Introduction to Appendix A —

The program descriptions in Appendix A were compiled and written by Public Policy Center staff. Much of the information was collected from the programs' websites or printed materials, and is presented directly as stated in those websites or materials. Information was also obtained through personal correspondence via mail, email, or telephone conversations with program representatives.

After compiling the individual program descriptions, Public Policy Center staff contacted a representative from each of the programs via email and/or telephone, provided them with the description created, and requested that the program representative revise or update the program description.

Representatives from programs denoted with an asterisk * in the following list reviewed the Policy Center staff's program descriptions and provided any revisions or updates to those descriptions. To maintain consistency across summaries, Public Policy Center staff edited the information. The state where each program is administratively based is noted in parentheses.

African-American Faith Partnership Faith Community Church Liaisons* (Arizona)
Arizona College of Public Health Rocky Mountain Maternal and Child Health
Certificate Program* (Arizona)
Boston University MCH Certificate Program (Massachusetts)
Central Nebraska Area Health Education Center (CN-AHEC) (Nebraska)
CityMatCH* (Nebraska)
Community Health Resource Center* (California)
Educating Physicians In their Communities (EPIC) (Pennsylvania)
Iowa Community Health Leadership Institute* (Iowa)
Maine Turning Point Program* (Maine)
Michigan Council for Maternal and Child Health* (Michigan)
Montana Public Health Training Institute (Montana)
Nebraska Educational Alliance for Public Health Impact (NEAPHI)* (Nebraska)
Northern Nebraska Area Health Education Center (NN-AHEC) (Nebraska)
Smart Start* (North Carolina)
TeleKidcare* (Kansas)
University of Alabama Maternal and Child Health Leadership Skills
Training Institute (Alabama)
University of Minnesota School of Public Health Center for Public Health
Education and Outreach* (Minnesota)
University of North Carolina Data Skills Online* (North Carolina)
University of Rochester Maternal and Child Health Analytic Training for the Year 2010
(MACH 2010)* (New York)
Upper Midwest Public Health Training Center (UMPHTC) (Iowa)
Vermont Assuring Better Child health and Development (ABCD) Project* (Vermont)
Yakima Valley Farm Workers Clinic* (Washington)

African-American Faith Partnership Faith Community Church Liaisons

✓ **TITLE**

African-American Faith Partnership “Faith Community Church Liaisons” project (formerly called “Neighborhood Healing Circles” project)

✓ **MISSION**

The group works to coordinate predominantly African-American churches in providing health services to the areas it serves in South Phoenix and South Mountain Village, Arizona. The motto of the partnership is “bringing physical, mental, emotional, and spiritual health to our community.”

✓ **VISION**

- 1) To establish the project as community-based.
- 2) To involve African-American churches in the South Phoenix area.
- 3) To collect and analyze data on the health status of African-American residents of South Phoenix churches.

✓ **BACKGROUND**

The project began as a partnership comprised of ministers from eleven African-American churches in South Phoenix, Arizona. “Healing Circles,” initiated after meetings between the partnership and the Arizona Department of Health, were first funded in January 1998. The definition of the term “Healing Circles” begins with the relations formed by the ministry teams within each congregation, with a network of inter-church connections extending outward, forming intersecting circles, and incorporating links between existing health care providers and community organizations. The first ever African-American Legislative Day was held at the state capitol in Phoenix in February 2003. Health care was one of the primary issues addressed, and participants succeeded in getting support from the governor for health funding issues, particularly for minority populations.

✓ **START DATE**

1998

✓ **TARGET AUDIENCE**

Minority populations (mainly Hispanics, African-Americans, Asian-Americans, and Native Americans) in the South Phoenix area are targeted. This program is unique in that the target audience is not defined through geographical boundaries, but rather through the areas to which the individual churches provide services.

✓ **ACTIVITIES**

The Faith Partnership has two primary focal points. First, each of the individual churches in the project formed an internal health ministry team made up of members of the congregation. The members of the health ministry teams received extensive training on subjects such as: the history and theology of health, spiritual care, and information about the leading causes of death in the African-American community (i.e. HIV/AIDS, cardiovascular disease, cancer, diabetes, hypertension, etc.). Once trained, these ministry teams would visit homes in the area and share this training with area residents (the “Healing Circles” part of the partnership). Secondly, the project will conduct a needs assessment of the minority residents in South

Phoenix, examining the utilization of services, perception of services, affordability of services, and other factors. The project hopes to use this information to create a long-term plan for improving the health of the community, as well as to share this information with local and state legislative bodies.

☑ SUCCESSES/CHALLENGES

Since its inception, the partnership has expanded to twenty-three churches and has established an East Valley chapter to serve the minority populations in that part of Maricopa County. The partnership has expanded their original areas of interest to include issues such as environmental justice, domestic violence, and lung disease.

☑ ANNUAL OPERATING COSTS

Information not provided.

☑ FUNDING SOURCES

The R.W. Johnson Foundation, the Kellogg Foundation, and the Turning Point organization fund the partnership through a three-year grant. The funding sources for the partnership have become well established and will ensure the continuation of the program after the original three-year grant.

☑ SERVICE CHARGES/INCOME

There are no fees for any service.

☑ MARKETING/PROMOTION

Not applicable.

☑ ORGANIZATIONAL STRUCTURE

The Healing Circles' ministry teams operate within individual churches, which function under the Faith Partnership. The needs assessment is being carried out in collaboration with Arizona State University and the Arizona Department of Health Services.

☑ STAFFING

Staff includes an executive Director, an Executive Steering Committee (made up of representatives of participating churches, community organizations, and community residents who serve on a volunteer basis), and one clerical support person.

☑ PARTNERS

The partnership has established alliances with community residents, church leaders, and community-based organizations.

☑ FUTURE STRATEGIES

The partnership hopes to use the information generated by the needs assessment to create a long-term community health plan. Additionally, they will pass the information to the Arizona state government to facilitate an improvement in public health throughout the state.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

☑ CONTACT INFORMATION

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Arizona College of Public Health Rocky Mountain Maternal and Child Health Certificate Program

✓ **TITLE**

Arizona College of Public Health Rocky Mountain Maternal and Child Health Certificate Program

✓ **MISSION**

The mission of the Mel and Enid Zuckerman Arizona College of Public Health is to promote the health of individuals and communities with a special emphasis on diverse populations and the Southwest. The goal of the Certificate Program is to enhance the skills of the MCH professionals in the areas of scholarship, leadership, and partnership in MCH public health practice to better enable them to improve the health of their communities.

✓ **VISION**

The Mel and Enid Zuckerman Arizona College of Public Health strives to act with respect and integrity to continuously advance health and well-being for all through knowledge, collaboration, empowerment, advocacy and sustainability.

Fairness, trust, equity, social justice, excellence, innovation, commitment, collegiality, diversity, open communication, participation, consensus and enhancement are among the core values of the College of Public Health.

The College strives to foster an educational community that values innovation and excellence in teaching, creation and dissemination of knowledge, practice-based research, and research-based practice to address the health needs and interests of individuals and communities.

✓ **BACKGROUND**

The Arizona Board of Regents voted to create the College of Public Health in 2000 as a tri-state institution composed of elements of the University of Arizona, Arizona State, and Northern Arizona University. Beginning in 1993, the three institutions established a joint MPH program.

A development grant from HRSA was obtained by the University of New Mexico to start a Rocky Mountain MCH summer program based in Colorado, modeled after the epidemiology institutes of Johns Hopkins, Michigan and Minnesota. As a result, a consortium of schools developed based on memorandums of understanding.

✓ **START DATE**

While the College of Public Health started in 2000, the Rocky Mountain MCH Certificate program was established prior to the College organization, and has been running for 3 years.

✓ **TARGET AUDIENCE**

The certificate program targets bachelor degree level public health workers, especially those already in MCH practice in isolated areas from one of the four corner states (AZ, UT, NM, CO).

✓ ACTIVITIES

Participants take an intensive summer training program, then have one year to complete a 3 credit hour graduate course at a consortium university or via the Internet, as well as a 5 credit practicum. The participant teams up with an academic and a professional mentor for the practicum (both of whom are paid and identified by the program). The trainee then participates in the following years' intensive summer program, and gives a presentation on the completed practicum. One example of a previous practicum was making a North Dakota hospital more "baby friendly." There are a limited number of participants each year (10-20).

✓ SUCCESSES/CHALLENGES

The Consortium has been able to operate for 5 consecutive years. The biggest challenge is maintaining funding.

✓ ANNUAL OPERATING COSTS

The certificate program cost is about \$150,000 per year. The original HRSA development grant was \$30,000 to begin building up regional networks and to support the summer institute, which helped underwrite costs of planning meetings for the institute.

✓ FUNDING SOURCES

The program is almost completely funded by HRSA, with tuition making only a small contribution. They are currently looking into private and other government sources.

✓ SERVICE CHARGES/INCOME

The charge is \$150 per credit hour. Limited financial support is available.

✓ MARKETING/PROMOTION

Brochures and the Internet.

✓ ORGANIZATIONAL STRUCTURE

Informal.

✓ RELATIONSHIP WITH STATE

The program is coordinated through Arizona state universities.

✓ STAFFING

Staff for the Rocky Mountain program: Director; Program Coordinator; and Student Services Coordinator. Agreements are maintained with other universities to assist with coordination.

✓ ACCREDITATION/CERTIFICATION

Certificate and academic credits provided.

✓ PARTNERS

University of Utah, University of Colorado Health Sciences Center, Utah State University, University of New Mexico, Northern Arizona University and Regional Title V programs.

☑ FUTURE STRATEGIES

They hope to continue with the program. HRSA has provided the Arizona College of Public Health and University of Utah with two distance-learning grants to develop more online courses.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

☑ CONTACT INFORMATION

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<http://www.publichealth.arizona.edu>

— Boston University MCH Certification Program —

✓ TITLE

Boston University MCH Certification Program

✓ MISSION

- 1) To develop a new educational initiative in response to national and local demands for increased MCH workforce capacity.
- 2) To eliminate key financial and non-financial barriers to advanced MCH academic preparation.
- 3) To improve rates of recruitment and retention of students from minority communities, thus enhancing the quality of MCH services.

✓ VISION

The program is an attempt to encourage individuals who are already familiar with MCH programs, problems, and target communities to seek further training.

✓ BACKGROUND

Hoping to encourage mature students to commit to graduate level education, the program works to facilitate the integration of these students into the academic community. A bridge program model was implemented so that students can acquire new MCH knowledge and competencies within a structure that provides graduate level content, continuing education credit, and advanced standing toward a graduate degree.

✓ START DATE

1997

✓ TARGET AUDIENCE

The program is designed for clinicians, including but not limited to nurses, occupational therapists, nutritionists, and public health practitioners as a bridge to graduate programs in public health. All students with an undergraduate professional degree (RN, OT, RD, etc.) and work experience or evidence of interest in an MCH related field are eligible, as are those who have an undergraduate degree in a non-health related field and recent work experience in public health programs.

✓ ACTIVITIES

The program, which generally lasts for two semesters, includes a competency-based curriculum with skills workshops, leadership seminars, mentoring, small group activities, and an interactive teaching format.

✓ SUCCESSES/CHALLENGES

Program participants report an expansion of core public health knowledge (issues, policies, and strategies), enhanced self-confidence, and efficacy. In particular, the program attempts to address educational training needs for nontraditional students with community experience and a lower level of academic preparation. Additionally, it integrates continuing education with formal graduate education, reduces the financial and personal burden of training, and improves rates of recruitment and retention for minority students. Since the program works to attract nontraditional students and students with lower levels of academic preparation, the

program works to encourage students to question and digest the information taught and to apply it to the “larger picture.”

✓ ANNUAL OPERATING COSTS

The MCH Certificate Program is self-supporting in that tuition covers direct costs of approximately \$50,000 a year. In-kind support also is received from the university in the form of donated classroom space, some staff support for production of course readers, and reduced student fees.

✓ FUNDING SOURCES

The initial phase of development of the MCH Certificate Program was supported with Leadership Training funds from the Maternal Child Health Bureau (MCHB), with the intention that the program would eventually become self-sustaining and self-supporting. MCHB also provides two scholarships per year under the auspices of the Maternity Nurse Leadership Education Center at Boston University.

✓ SERVICE CHARGES/INCOME

Tuition for the 2000-2001 academic year was offered at a reduced rate of \$1600 per semester. Certificate program tuition represents less than half of the fee for comparable courses in the traditional MPH program at Boston University School of Public Health, so in a sense all students receive department funded “scholarships.”

✓ MARKETING/PROMOTION

Because the program’s classes take place once a week in the evening, they are able to attract nontraditional students and students with other daytime commitments.

✓ ORGANIZATIONAL STRUCTURE

The certificate program takes place at Boston University’s School of Public Health and is within the School’s structure.

✓ RELATIONSHIP WITH STATE

The MCH department receives grants from the U.S. Department of Health and Human Services.

✓ STAFFING

Faculty consists of a senior faculty member from the Department of Maternal and Child Health at the School of Public Health who serves as Director and has a prominent teaching role, and three junior instructors with adjunct faculty appointments. Although the entire MCH Certificate Program could be taught by a single individual on a half-time basis, they choose to present a variety of instructors in order to introduce students to teachers who are ethnically and experientially diverse.

✓ ACCREDITATION/CERTIFICATION

In addition to providing a certificate in the area of MCH, students who complete each semester are offered continuing education credits approved by the Massachusetts Nurses Association.

They are also eligible for advanced standing should they decide to matriculate in the MPH program with a concentration in MCH, if they complete courses with a grade of B or better.

Certificate program credits do not, however, reduce the total number of credits required for an MPH.

✓ PARTNERS

The Certificate Program works in conjunction with the MPH program, helping to integrate students into the life of the MCH department and occasionally sharing classes.

✓ FUTURE STRATEGIES

The staff would like to rework the program to meet the needs of rural public health practitioners, to adapt the program for distance learning, and to incorporate Internet technology more fully into the program.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

No.

✓ CONTACT INFORMATION

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— Central Nebraska Area Health Education Center —

✓ TITLE

Central Nebraska Area Health Education Center (CN-AHEC)

✓ MISSION

The Center's mission is to enhance access to quality health care in Central Nebraska, particularly primary and preventative care. The Central Nebraska AHEC will improve the supply and distribution of healthcare professionals through partnerships among healthcare, academic, and community providers.

✓ VISION

Information not provided.

✓ BACKGROUND

Nebraska AHECs began as a University of Nebraska Rural Health Education Network project, funded by the legislature beginning in 1990. AHECs are modeled after those in North Carolina, which were created in response to a federal workforce law in the 1970s.

✓ START DATE

September 1, 2001

✓ TARGET AUDIENCE

See "Activities" below.

✓ ACTIVITIES

The Central Nebraska AHEC currently is involved in two major activities. The first is a Robert Wood Johnson Foundation (RWJF) grant-funded project to improve communication between providers and Spanish-speaking clients. The short-term goal is to increase number of qualified and trained interpreters in the area. The long-term goal is to create more bilingual health care workers, by either recruiting bilingual individuals into health care or developing the language capacity of current health care workers. They are also working with Kaiser-Permanente in this project. The second activity involves developing a Health Science Curriculum Framework with the Nebraska Department of Education, Kearney and Grand Island public schools, area community colleges, and St. Francis Medical Center in Grand Island. The goal is to generate interest in health care careers among youth.

✓ SUCCESSES/CHALLENGES

A big challenge was starting from the ground and getting the organization functioning, including an accounting system, insurance, employees, etc.

Successes include implementation of the Health Sciences Project to pilot in two schools in the area (Grand Island and Kearney) to promote health careers at high school level. The Center is also being awarded the RWJF grant (Hablamos Juntos) with Year 1 as a development year. If successful, the Center will be awarded the remainder of the grant for Year 2 and 3.

☑ ANNUAL OPERATING COSTS

Approximate costs:

- Year 1 - \$402,588
- Year 2 - \$260,194
- Year 3 - \$344,160

☑ FUNDING SOURCES

The first one to three years is Health Resources and Services Administration funded. In addition, there is an RWJF grant (see above), a Nebraska Department of Education Grant partnered with Central Community College, and support from the Saint Francis Foundation for Health Sciences Project.

☑ SERVICE CHARGES/INCOME

Information not provided.

☑ MARKETING/PROMOTION

The Center utilizes the media (newspapers, radio stations, television stations) and development of its website (<http://www.cn-ahec.org>) to promote activities.

☑ ORGANIZATIONAL STRUCTURE

Information not provided.

☑ RELATIONSHIP WITH STATE

The Central Nebraska AHEC is independent of direct ties with the state, but is affiliated with the University of Nebraska Medical Center.

☑ STAFFING

Central Nebraska AHEC
Sarah Cunningham, Executive Director
Mary Roy, Administrative Assistant
Cindy Paustian, Education and Outreach Coordinator
Rosa Guia, Hablamos Juntos Project Assistant (RWJ Grant)
Roberto Valencia, Hablamos Juntos Project Coordinator (RWJ Grant)

☑ ACCREDITATION/CERTIFICATION

Information not provided.

☑ PARTNERS

The University of Nebraska Medical Center and project-related partners.

☑ FUTURE STRATEGIES

Continue with current projects.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

No.

☑ CONTACT INFORMATION

Sarah Alexander

Central Nebraska AHEC

<http://www.cn-ahec.org>

— CityMatCH —

✓ **TITLE**

CityMatCH

✓ **MISSION**

CityMatCH's mission is to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities.

✓ **VISION**

CityMatCH is grounded in the philosophy that all children and families deserve to be healthy and achieve their optimal growth and development in the physical, intellectual, social, emotional, and spiritual aspects of their lives. The responsibility for assuring this is shared by each individual and his or her family, the community, and government at the federal, state, and local levels. Children and families in urban areas have unique needs and deserve special attention. These needs must be effectively addressed in order for all children, and ultimately our society, to achieve full potential. Local public health agencies are a critical component of the collaborative effort that is needed to improve the health of children and families in urban areas.

✓ **BACKGROUND**

CityMatCH was designed to promote communication and collaboration to improve the health of urban children and families.

✓ **START DATE**

1991

✓ **TARGET AUDIENCE**

Membership in CityMatCH is available to city or county health departments having jurisdiction over one or more urban areas with populations of 100,000 or larger, and associate membership is offered to any person who has an interest in urban MCH affairs, but is not a local MCH director or designee.

✓ **ACTIVITIES**

- Annual Urban MCH Leadership Conference allows major city and county MCH leaders to exchange information about current local level programmatic efforts aimed at preventing disease and promoting health. It strengthens the capacity of urban health departments to meet the Year 2010 objectives related to MCH, and foster ongoing collaborative efforts among local, state, and federal public health leaders to maximize the coordination of MCH activities.
- Urban MCH Data Use Institute addresses skills development to enhance public health practices necessary in an era of change in health and human services delivery. The Urban MCH Data Use Institute is about data use: using data effectively in MCH programs and policy development, with skills building in the translation of data to action in urban communities. Designed as a year-long learning experience for a cohort of selected urban MCH data use teams, the model integrates the Institute with related capacity-building initiatives at CityMatCH, including the annual Urban MCH

- Leadership Conference associated data workshops, and new distance-learning technologies.
- Perinatal Periods of Risk (PPOR) Practice Collaborative National Initiative is demonstrating the community impact of using the PPOR approach, a newly validated community tool to address infant mortality. The PPOR Initiative aims to capture best practices and lessons learned, to develop and enhance supporting materials, to develop local practice expertise, and to capture this experience for use by other cities. Community teams from 14 U.S. cities are developing and revising prevention strategies for their communities' feto-infant mortality problem using the PPOR approach. These strategies are part of an intense systematic learning and demonstration Practice Collaborative with CityMatCH, CDC, the March of Dimes, and other national experts.
 - Perinatal HIV Urban Learning Cluster focuses on promoting the translation of research and data into effective practice in urban communities with the highest rates of perinatal HIV. The Urban Learning Cluster approach fosters strategic interchange among scientists and other content experts and action-oriented teams of policy-makers and practitioners from targeted communities. Coupled with targeted information dissemination, which provides CityMatCH member public health departments and other key partners with timely information about perinatal HIV prevention, CityMatCH is able to act as a clearinghouse and liaison of information among U.S. cities.
 - Rapid FAX Queries allow CityMatCH to survey members on "hot topics" via FAX communication. Data obtained through queries are used to give immediate input to national policy development.
 - Ask-A-Colleague Service improves peer-to-peer support among CityMatCH members. CityMatCH maintains a fax network that can be used by individual members to ask colleagues around the country specific questions related to MCH.
 - CityMatCH News Briefs is a bi-weekly e-mail summary news service to CityMatCH members and colleagues. Urban MCH policy and funding FAX "Alerts" are services provided by CityMatCH to provide members with time-sensitive information.
 - CityLights quarterly newsletter is published under our PIC cooperative agreement with MCHB/HRSA and is distributed by CityMatCH. Key regular features include recent data reports from our membership sites and national urban MCH partners, profiles of urban MCH programs "that work," regional news and invited articles from urban MCH program directors and leaders. It is also available on the CityMatCH website.
 - City-Specific Data reports consist of national comparative data regarding specific urban MCH issues, such as women's health, infant mortality, low birth weight, or late-entry prenatal care.
 - Urban MCH Resource Info is a collection of abstracts and contact information on current policy materials related to urban MCH issues.
 - Lessons Learned is an annual publication designed to facilitate easy access to selected urban public health practices. It promotes communication across urban communities about what works, what doesn't work and why. It is a compendium of contributed CityMatCH member health departments' profiles of their most successful MCH efforts.

✓ SUCCESSES/CHALLENGES

CityMatCH has successfully increased its visibility and leadership as the voice of urban MCH nationally and promoted its many capacity-building activities, such as the Data Use Institute. A challenge has been finding high-caliber public health professionals who possess specific training in Maternal and Child Health (MCH) in Nebraska. As students begin to complete the new Master of Public Health program offered jointly through UNMC/UNO, this is expected to change. Currently, CityMatCH assures a quality staff through intense, ongoing training and development.

✓ ANNUAL OPERATING COSTS

\$1-1.2 million

✓ FUNDING SOURCES

CityMatCH is funded in part through cooperative agreements with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services and Centers for Disease Control and Prevention in Atlanta. The University of Nebraska Medical Center and the National March of Dimes Birth Defects Foundation provide additional support.

✓ SERVICE CHARGES/INCOME

No membership fee is required.

✓ MARKETING/PROMOTION

CityMatCH utilizes targeted e-mail, mailings, exhibits, word of mouth, and direct phone calling.

✓ ORGANIZATIONAL STRUCTURE

CityMatCH is a freestanding national membership organization of city and county health departments' MCH programs and leaders representing urban communities in the United States. Currently, there are 148 members.

✓ RELATIONSHIP WITH STATE

CityMatCH is a national organization with member health departments in 148 urban centers across the United States. The National Headquarters is located in Omaha, Nebraska and physically located at the University of Nebraska Medical Center. Two member health departments exist in Nebraska: Lincoln/Lancaster County Health Department in Lincoln, and the Douglas County Health Department in Omaha, Nebraska.

✓ STAFFING

CityMatCH currently has a staff of 14 full-time positions and one part-time position.

✓ ACCREDITATION/CERTIFICATION

None.

✓ PARTNERS

CityMatCH "regular" membership is extended to city or county health departments having jurisdiction over one or more urban areas with populations of 100,000 or larger. In states where no urban area has a population greater than 100,000, one city or county health

department in that state will be granted membership. In addition, any person who has an interest in urban MCH affairs but is not a local MCH director or designee may become an associate member.

✓ FUTURE STRATEGIES

CityMatCH will work to continue providing cutting-edge services. In July 2003, CityMatCH initiated “*Emerging Issues in MCH*,” a monthly series of audio-conferences highlighting nontraditional MCH issues, such as integrating mental health in the public health setting, adolescent obesity, and oral health services in MCH. To that end, CityMatCH is partnering with the National Association of County and City Health Officials (NACCHO), and continues to pulse its members to ascertain their needs.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

✓ CONTACT INFORMATION

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— Community Health Resource Center —

✓ **TITLE**

Community Health Resource Center

✓ **MISSION**

The center's goal is to provide free health information to anyone in the community, as well as assistance in finding information on specific health and wellness issues, or medical questions.

✓ **VISION**

Information not provided.

✓ **BACKGROUND**

The Palo Alto Medical Foundation established the center as the Women's Health Resource Center in 1995. The foundation opened the center after assessing community need in finding health resources about diagnoses and procedures in an informal setting to complement doctor visits. The center focused on information needs of women because it is recognized that women make 70 percent of family medical decisions. A few years later, the name was changed to reflect the holistic approach of the Community Health Resource Center and to offer a resource to all members of the community. The center was so successful that a second site was opened recently in a satellite office. Both sites are physically linked to multi-specialty physician group. The center is not connected to the state in any way and it operates independent of other state-funded health awareness programs. The Palo Alto Medical Foundation is a large not-for-profit organization, and an affiliate of Sutter Health.

✓ **START DATE**

1995

✓ **TARGET AUDIENCE**

Open to the public.

✓ **ACTIVITIES**

The center engages in a range of activities primarily related to health education. It has a large library of books, as well as an extensive collection of CD-ROM references, videos, websites, handouts, and other resources. The medical group's physicians review all of the center's resources before they are made available to the public. The center manager/health educator maintains a communication link with the staff through e-mail, new physician orientation, and informal one-on-one conversations to apprise physicians of any additional resources acquired by the center, changes in the education curriculum, and upcoming center events. The center manager/educator holds monthly health-related lectures that are open to the community, and does community outreach at schools, community-based organizations, and companies, as well as being available for individual meetings by appointment and with individuals who walk in to the center with questions about a diagnosis, condition, or procedure. A quarterly publication entitled "To Your Health," covering timely health topics, circulates throughout the clinic and its satellites, and is mailed to community members on the mailing list.

✓ SUCCESSES/CHALLENGES

Through its extensive outreach activities, the center has raised awareness in the community that it serves regarding both specific health conditions and health resources available within the community. The director reports that physicians view the center as an extension of their practices, and community members and patients value its resources for their specific health questions. The center has served almost 24,000 people since its inception.

✓ ANNUAL OPERATING COSTS

Information not provided.

✓ FUNDING SOURCES

Most of the center's funds come from the Palo Alto Medical Foundation's Education Division. Private donations and corporate donations also make up a portion of the budget.

✓ SERVICE CHARGES/INCOME

There are no fees for any service.

✓ MARKETING/PROMOTION

The center is part of the Education Division, which has a standing box in one of the local newspapers for its classes, lectures, other educational events, and support groups. The center is also on the Palo Alto Medical Foundation web site, which results in frequent inquiries from individuals out of this area. A local agency includes the center's lecture series in its calendar of events.

✓ ORGANIZATIONAL STRUCTURE

The manager/health educator reports to the vice president of the Education Division, who reports directly to the President and CEO of the Foundation.

✓ RELATIONSHIP WITH STATE

The center is a private enterprise of the Palo Alto Medical Foundation and does not have a relationship with the state of California.

✓ STAFFING

The center has one full-time registered nurse (the manager/health educator) on staff, and seven volunteers with health-related backgrounds who serve as assistants.

✓ ACCREDITATION/CERTIFICATION

No

✓ PARTNERS

The center has numerous collaboration partners, including individual physicians, community-based agencies, and the area high schools. The center and several of its community-based partners host an annual "Mothers Symposium" that focuses on different aspects and challenges of motherhood. The director has also developed strong relationships with all medical, surgical, and specialty departments of the Palo Alto Medical Clinic and does a significant amount of education in these areas. She also works closely with the system's diabetes educators to coordinate activities, dissemination of information, and referrals.

☑ FUTURE STRATEGIES

The manager/health educator hopes to further develop the new satellite center, the Family Health Resource Center, as well as strengthen some of the centers' relationships with community agencies through the Palo Alto Medical Foundation.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

☑ CONTACT INFORMATION

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— Educating Physicians in their Communities —

✓ **TITLE**

Educating Physicians in their Communities (EPIC)*

✓ **MISSION**

The program sought to improve the health care of children by using a train-the-trainers approach to enhance the skills of community-based primary care providers and other health care personnel in developmental screening, collaborating with families, care coordination, and working within the managed care environment.

✓ **VISION**

The EPIC Program was designed as a public-private partnership to:

- develop a group of community pediatricians who can present medical education to the health care providers in their communities;
- provide practicing primary care physicians and other providers with quality, practical education in their own communities;
- improve the access and quality of health care for children with special health care needs and their families; and
- provide primary health care providers for children with linkages to the early childhood and early intervention service providers within their communities.

✓ **BACKGROUND**

Preliminary planning took place in 1991. Linkages and needs assessment information were culled from a Healthy Tomorrows project. A small advisory group was formed that was charged with the task of developing a format and content for physician training. After review by pediatricians and parents, the EPIC training content was reoriented to better address the concerns and practice styles of community pediatricians. EPIC was officially launched in 1994 with funding from the Early Intervention Technical Assistance contractor for the Part H early intervention program.

✓ **START DATE**

1994

✓ **TARGET AUDIENCE**

The program targeted community-based pediatricians, pediatricians who work with children with special health care needs, hospital nurses, office staff, nurse practitioners, and residency programs.

✓ **ACTIVITIES**

The EPIC Program was a public-private partnership designed to develop a cadre of community pediatricians who could present medical education to the health care providers in their communities. EPIC used a train-the-trainer approach to enhance the skills of community-based primary care providers and other health care personnel in developmental screening, collaborating with families, care coordination, and working within the managed care environment. The program also created both formal and informal linkages between participating pediatricians and local early intervention program interagency coordinating committees across the state. In 1994, 24 pediatricians were identified to participate in an intensive training session covering three core topics, and in contemporary practices

promoting adult learning and office-based change. The three topic areas included: early intervention services and community physicians (understanding what works in early intervention, the pediatrician's role, and improved methods for developmental surveillance); new roles for physicians (collaborating with families and care coordination); and coding, receiving reimbursement for these services, and working with managed care.

✓ SUCCESSES/CHALLENGES

The 24 Regional Education Coordinator pediatricians hosted over 40 local training sessions during the first three-and-a-half years of the program's operation. The project administrators believe that at least 500 pediatricians and other providers received training during this period.

Several coordinator pediatricians now receive requests for consultation on early intervention-related issues from physicians in and around their communities. There was evidence that new linkages were established with family practice physicians who did not previously interface with early intervention professionals in the community.

If EPIC reached a significant portion of its target audience, regrouping and strategizing might be necessary.

✓ ANNUAL OPERATING COSTS

Annual costs were approximately \$100,000, supporting materials development as well as honoraria and travel costs for the physician trainers.

✓ FUNDING SOURCES

Department of Human Resources.

✓ SERVICE CHARGES/INCOME

Information not provided.

✓ MARKETING/PROMOTION

Information not provided.

✓ ORGANIZATIONAL STRUCTURE

Director, Dr. Alan Kohrt, M.D.

✓ RELATIONSHIP WITH STATE

EPIC was part of Pennsylvania's human service agency, and funds to support the program were included in the state agency budget. EPIC was intended to dovetail with state agency functions and to help meet the needs of pediatricians and families.

✓ STAFFING

EPIC had a full-time director, Dr. Alan Kohrt, M.D. and a small office staff. Local committees designated representatives to coordinate and facilitate local EPIC presentations.

✓ ACCREDITATION/CERTIFICATION

EPIC offered continuing education credits that met criteria for state licensure to physicians attending EPIC presentations.

✓ PARTNERS

Collaborators included the early intervention agency and its contractors, academic pediatricians, faculty at the University of Pittsburgh, family advocate groups, and the state Title V Maternal and Child Health/Children with Special Health Care Needs programs.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

No.

✓ CONTACT INFORMATION

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*This program is no longer active, but the training model has been incorporated into Educating Physicians in Community Integrated Care (EPIC IC), which Dr. Kohrt directs.

— Iowa Community Health Leadership Institute —

✓ **TITLE**

Iowa Community Health Leadership Institute

✓ **MISSION**

The Institute's mission is to improve the health of Iowans through collaborative efforts using a new model of leadership development that draws on the assets of the represented systems. Additionally, the Institute works to establish a network of leaders that will promote the health and well being of communities across Iowa through partnerships between public and private health and community professionals.

✓ **VISION**

Improving the health status of Iowa through leadership development.

✓ **BACKGROUND**

The Iowa Community Health Leadership Institute is a joint project of the Iowa Association of Local Public Health Agencies and the Iowa Health System. This partnership was established in September of 1998 to provide a training ground for individuals committed to improving the health status of the communities in which they live. This outcome represents three years of planning among Iowa Health System affiliate staff members and the association agencies who originally came together with a vision. This vision was to improve the health of Iowans through a collaborative effort among the public health and non-profit healthcare systems using a new model of leadership development drawing on the expertise of the represented systems. The Institute represents a culmination of many hours of work by dedicated individuals committed to seeing the vision actualized.

✓ **START DATE**

1998

✓ **TARGET AUDIENCE**

Experienced professionals from healthcare, public health, non-profits, education, human service and government who are strongly motivated to develop their leadership skills, and who are committed to improving the health and quality of life of their community.

ACTIVITIES

✓ The program components and activities include a yearlong process with opportunities to enhance personal expertise in the areas of transformational leadership, networking, asset-based community development, and team building competencies. Guiding principles focus on experiential learning models that accelerate the education process, life-long learning, and partnerships that are based on respect and trust.

The program components and activities of the Iowa Community Health Leadership Institute include a yearlong process with opportunities to enhance personal leadership expertise in the selected competencies while building a learning community of scholars. Three face-to-face sessions will be held in September, January and May, with a final meeting the following September that includes a synthesis of learning, display of Community Improvement Projects, and a graduation ceremony. In addition to the program's four sessions, intercessions between each session provide for periods of study that include on-line facilitated sessions

with Institute faculty and scholars. An Institute chat room also is provided for a more informal distance-learning opportunity.

At the end of session one, participants will:

- Become familiar with various personality types and leadership styles.
- Become acquainted with other scholars and develop trust, explore communication and problem-solving techniques.
- Create a vision of a healthy community and expand understanding of systems that support it.
- Identify personal mastery skills such as stress management, conflict resolution and relaxation techniques to improve well being.
- Enhance understanding of ethical considerations in the many aspects of healthcare and life.

At the end of session two, participants will:

- Gain a shared understanding about asset-based community development and the community as a system.
- Use partnership and change models to gain insight into teams.
- Enhance facilitation skills and problem-solving methods within the group.
- Explore sustainability streams for community health initiatives.

At the end of session three, participants will:

- Identify the MODI (Management of Difference Inventory) tool as a map to creating highly collaborative, trusting relationships within your working team.
- Identify personal and societal issues in regards to diversity.
- Understand and build personal and community capacity to sustain community health initiatives.
- Explore ways to integrate the past year's experiences into strategic tools for positive community and personal change and continued learning as leaders.

In addition to curriculum and modules and as part of the applied learning model of the Institute, Scholars will design and implement a specific Community Improvement Project. This project promotes community change by examining a community health and/or quality of life issue, engages others in proposing a solution, and develops the scholar's own leadership potential. During the final September face-to-face session, scholars share their project summary in a display for members of the Institute and communities to view. The Community Improvement Project is designed as a team effort consisting of scholar teams based on geographical location selected prior to session one. However, applicants may not be able to find collaborators within their geographical location and/or may have other extenuating circumstances that do not allow for a group project. In these cases, the Institute may consider individual projects.

✓ SUCCESSES/CHALLENGES

Challenges include not being formally associated with a school of public health, and securing funding opportunities.

✓ ANNUAL OPERATING COSTS

Budget expenses of \$70,000.

✓ FUNDING SOURCES

Funded by the “Iowa Health System,” an association of Iowa hospitals.

✓ SERVICE CHARGES/INCOME

Tuition fee of \$2,500.

✓ MARKETING/PROMOTION

Year-round recruitment.

✓ ORGANIZATIONAL STRUCTURE

A Leadership Advisory Board advises the Institute staff.

✓ RELATIONSHIP WITH STATE

The Institute is a private organization, co-sponsored by the Iowa Health System (Association of Iowa hospitals), Iowa Association of Local Public Health Agencies, and Iowa Department of Public Health.

✓ STAFFING

Three staff members.

✓ ACCREDITATION/CERTIFICATION

There is an agreement with Des Moines University to share credits; nursing and social work continuing education units are also available.

✓ PARTNERS

Des Moines University, Wellmark, University of Iowa College of Public Health, Visiting Nurse Service agencies, Iowa Association of Local Public Health Agencies, Polk County Health Department (in Iowa), and the Iowa Department of Public Health.

✓ FUTURE STRATEGIES

Information not provided.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

✓ CONTACT INFORMATION

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—Maine Turning Point Program —

✓ TITLE

Maine Turning Point Program

✓ MISSION

The program works to support communities in creating and sustaining the coordinated delivery of public health services.

✓ VISION

Information not provided.

✓ BACKGROUND

Maine Turning Point began to develop in 1996 and 1997 in response to the creation of the Maine Center for Public Health and the anticipated availability of foundation funding. Leaders in the Maine Public Health Association, Medical Care Development, and other organizations recognized that in order to improve health status in Maine it was essential to focus some public health planning measures on how to assure provision of the 10 Essential Public Health Services in all parts of Maine. When the Robert Wood Johnson Foundation, along with the W. K. Kellogg Foundation, announced the availability of funding for state level grants and grants to local health departments, a number of organizations came together to develop an application. Unfortunately, this initial effort was not funded. A new announcement was published two years later, this time with funding only for statewide activities. Maine leaders put together a new application. The funded effort, which began in late 1999, was convened by the Maine Center for Public Health, Medical Care Development, and Maine DHS Bureau of Health. The first two project years were devoted to planning for an enhanced public health infrastructure; an implementation effort began in 2001.

✓ START DATE

Non-funded effort began in 1996-97; funded effort began in 1999.

✓ TARGET AUDIENCE

The audience for the entire project is all of Maine's population, through systemic change in the public health system. Turning Point planning has resulted in a University of New England graduate MPH program and a partnership with Healthy Community coalitions to start a peer-mentoring program in which community leaders mentor each other in the creation of more community level public health programs, such as education and awareness. The Maine Center for Public Health now offers a number of education and training programs using innovative technologies that include videoconferencing and satellite broadcast. Turning Point has also made extensive efforts to educate policymakers about public health through conferences and educational forums.

✓ ACTIVITIES

Discussions from 1999-2001 resulted in the creation of a 2003 Public Health Improvement Plan (PHIP). The Maine PHIP rests on a 1988 Institute of Medicine Report that outlines the role of the federal, state, and local governments in public health. The role of state government in the improvement plan was particularly emphasized because of Maine's lack of a consistent sub-state system for delivery of public health services. The PHIP was derived

from recommendations made by four working groups: Finance; Infrastructure; Public Health in the Context of Clinical Care; and Workforce and Training.

The Workforce and Training workgroup created a survey (PTNA – Public Health Training Needs Assessment) of individual public health workers based on a survey developed by the Northwest Center for Public Health Practice at the University of Washington.

Four main strategies were identified to strengthen Maine’s public health network:

- A. Maine employers and public health professional organizations should adopt policies that improve access to public health training for their employees.
- B. Maine should develop a life-long learning system on public health topics that is accessible statewide and is based upon explicit public health competencies.
- C. Public health training programs in Maine should be evaluated for effectiveness.
- D. The State should survey the active clinical workforce and use the data to project need.

Implementation measures for the four strategies include:

A: Maine employers and public health professional organizations should adopt policies that improve access to public health training for their employees.

Strategies:

- Review national consensus documents in order to adopt and promote a scheme of training curricula and competencies necessary for public health workers to provide essential health services.
- Identify, disseminate, and promote adoption of model personnel policies that will improve the competency of public health workers in Maine.
- Provide the technical equipment and expertise to make distance education feasible and accessible for public health service providers.

B: Maine should develop a life-long learning system on public health topics that is accessible statewide and is based upon explicit public health competencies.

Strategies:

- Convene a consensus forum for public health education and continuing education providers in Maine. Participants should identify and endorse curricula and course content components that will provide appropriate public health skills. Participants should also identify strategies for implementing curricula changes necessary at their institutions.
- Create a masters level program in Public Health (MPH) that is accessible (cost/location) to Maine residents.
- Create a public health certificate program that is accessible (cost/location) to Maine residents.
- Whenever possible, program-funding contracts should include resources to provide ongoing training in public health for the staff of grantee organizations.
- Identify and seek financing for public health training from federal, state, and private sources.
- Enhance the availability and use of distance-learning technology for public health training and education purposes.

- Explore the potential for a loan repayment program for MPH education similar to that now available for physician education.

C: Public health training programs in Maine should be evaluated for effectiveness.

Strategy:

- Design and identify funding for evaluating the quality of public health continuing education and other public health training programs in Maine.

D: The State should survey the active clinical workforce and use the data to project need.

Strategy:

- Monitor the active clinical workforce composition and use the data to project need.

Currently: The University of New England has recently implemented an MPH program in collaboration with the University of New Hampshire.

Turning Point has also, in partnership with Healthy Community groups, helped organize and sponsor a “peer-mentoring” program in which Healthy Community groups, at the local level, mentor and help individuals from other communities develop their own programs.

☑ SUCCESSES/CHALLENGES

In early 2003, the Maine Turning Point project released a comprehensive planning document that summarized plans for a system of regionalized public health authorities in the state. The recommendations emerged from a multiyear planning process, which attempted to address the lack of public health infrastructure in a state in which public health issues (high rates of chronic disease, environmental concerns, deleterious lifestyle behaviors) loom large.

☑ ANNUAL OPERATING COSTS

Approximately \$100,000.

☑ FUNDING SOURCES

Information not provided.

☑ SERVICE CHARGES/INCOME

Information not provided.

☑ MARKETING/PROMOTION

Information not provided.

☑ ORGANIZATIONAL STRUCTURE

A planning project convened by the Maine Center for Public Health (private, non-profit), Medical Care Development (private, non-profit), and Maine Department of Human Services-Bureau of Health (among many other partners).

☑ RELATIONSHIP WITH STATE

Information not provided.

✓ STAFFING

Project Director.

✓ ACCREDITATION/CERTIFICATION

Information not provided.

✓ PARTNERS

A steering Committee represents public health, academia, business, legislators, healthy community coalitions, tribal health organizations, rural health organizations, minority communities, state agencies, family planning organizations, hospitals, health plans, and others. Four work groups were created representing some 175 Maine Turning Point partners. Most of the state's key public health stakeholders are involved with this project. In the past two years, much work on capacity building has been accomplished with the Maine Network of Healthy Communities, which represents a number of healthy community coalitions around the state. Since Maine does not have a formal public health infrastructure, these stakeholders are central to include in Turning Point efforts.

✓ FUTURE STRATEGIES

Maine has recently passed legislation to develop a universal health system (Dirigo Health), to be implemented in 2008. Because there is much political attention to access, Turning Point is now concentrating efforts to include public health voices in this process. Our second focus is involvement in plans to merge the state departments of health (incorporating the Bureau of Health, or public health entity) and mental health departments. This may reconfigure our public health system and we are anxious that the Merger Council examine plans for a regionalized public health system. Our Merger Task Force is thus nominating public health participants in the state's process and we are developing our message to be communicated in the merger planning process.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

✓ CONTACT INFORMATION

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— Michigan Council for Maternal and Child Health —

✓ **TITLE**

Michigan Council for Maternal and Child Health (MCMCH)

✓ **MISSION**

When the Michigan Council for Maternal and Child Health was formed in 1983, its goal was simple -- to be a voice in the political process for those who too often had no voice. Commitment to the goal remains strong today.

MCMCH believes:

- Advocacy is most effective when practiced in a collaborative environment. The Michigan Council for MCH Board of Directors is an organization of diverse partners, with a consultant staff working closely with coalitions around the state so that our collective voices speak louder than we might as individuals.
- Maternal and child health includes more than medical services. Poverty, inadequate education, abuse and neglect -- all these are intimately connected with a child's ability to reach his or her full potential in life, and a mother or family's ability to provide a positive, nurturing environment.
- Any effort to improve the health of Michigan's mothers and kids must focus on the big picture and the future -- even as we are working on today's details.

In Michigan, and across the nation, health systems, services, and policies are changing -- often very rapidly. The Michigan Council for MCH ensures that its advocacy stays focused on what is best for families and children by:

- Developing positions on policies, programs and services in partnership with consumers and consumer advocacy organizations, and never in isolation.
- Participating in discussion on quality/outcome indicators, service standards, and patient/consumer satisfaction issues, especially in the transition to capitated managed care for Medicaid and Children's Special Health Care Services.
- Collaborating with groups such as the Consumer Health Care Coalition and Parent Leadership Program to involve consumers as partners in the policy development process.

✓ **VISION**

Information not provided.

✓ **BACKGROUND**

The Council developed out of discussions initiated by the state department of health between a variety of stakeholders interested in creating an advocacy group to promote MCH issues. They have since separated from the state and purposefully remain independent from any financial ties.

✓ **START DATE**

1983

✓ **TARGET AUDIENCE**

The Michigan Council for MCH relies on community organizations as a base of support.

✓ ACTIVITIES

The Michigan Council for MCH Board develops the advocacy agenda. Members of the Board, with input from all partners, annually develop/endorse key policy initiatives that become the Council's political agenda. The Board meets monthly 10 times a year and in those meetings develops and works to support the Policy agenda according to their interests. In this process partners in the state and local agencies get input informally to the policy process. When feasible, the Michigan Council coordinates external efforts with their internal processes. Many Board members actually participate in internal departmental committees when the administrative environment is conducive to it. For the last several years that was not possible. The new administration at the state is now again welcoming and the Michigan Council is joining the internal advisory structures that were eliminated by the previous administration. Cooperation is more effective when the strategic planning can be staffed from within the government and then have the external advocacy support those plans in the legislative forums.

✓ SUCCESSES/CHALLENGES

The Michigan Council has enjoyed a relatively good relationship with the state legislature and has earned its respect because the Michigan Council argues from the merits of their positions and advocacy rather than from a monetary gain perspective. They have developed a reputation for promoting prevention programs within MCH and not as an advocate tied to a specific profession or association (i.e. local physicians or hospitals) with an interest in personal gain. They have a very strong marketing/advertising program, which has helped to consolidate support among community groups.

✓ ANNUAL OPERATING COSTS

Information not provided.

✓ FUNDING SOURCES

\$300,000 a year in dues from members, including physicians, hospitals, and associations; none from state government.

✓ SERVICE CHARGES/INCOME

Collects support from member-contributors as its sole source of income.

✓ MARKETING/PROMOTION

Many connections are made by providing technical support in policy coordination to networks and organizations involved in MCH. This generates practical support from “natural allies” in child health, school health clinics, infant mortality, etc.

✓ ORGANIZATIONAL STRUCTURE

Private, non-profit 501(c)(4) status allows the Michigan Council to engage in lobbying activities.

✓ RELATIONSHIP WITH STATE

Independent from the state.

✓ STAFFING

Staff includes 2.6 FTE's and three part-time statewide consultants on retainer.

✓ ACCREDITATION/CERTIFICATION

Not applicable.

✓ PARTNERS

A number of state wide professional associations serve on the advisory board (14 Sustaining members, 3 Contributing members), as well as about 200 individuals and organizations on an “alert list.” The Michigan Council also is a leader and member of the Michigan Coalition of Children and Families, a group of about 70 statewide agencies that work together on the Children’s Agenda – a prevention oriented group.

The Board level partners as well as the community networks are allies in defining all of the issues addressed by the Michigan Council for MCH, in communicating community concerns to elective officials, in testifying when appropriate, in utilizing media strategies when appropriate, in building and sustaining legislative relationships on an ongoing basis, and in educating key legislative people on specific MCH programs over time.

✓ FUTURE STRATEGIES

Information not provided.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

✓ CONTACT INFORMATION

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— Montana Public Health Training Institute —

✓ **TITLE**

Montana Public Health Training Institute

✓ **MISSION**

Goals of the Institute include: improving public health workers' knowledge and understanding of the mission and goals of the public health system in relationship to the larger community; increasing communication and collaboration with community partners thereby reducing duplication and expanding efforts to reach target populations with services; increasing policy makers,' community leaders' and the public's awareness of the range of public health responsibilities, programs and priorities and their impact on the community; encouraging/enabling leaders to recognize emerging problems and mobilize the community into needed action; and resulting in development of a recognized certification program that becomes the minimum competency level for employees of the Montana public health system.

✓ **VISION**

Information not provided.

✓ **BACKGROUND**

Public health concerns prompted a group of state and local public health officials to convene a conference of local and state public health providers in February, 1994, to address the role that public health should play in state and national health care reform. The conference focused on describing public health in Montana, and resulted in an outline of core public health functions and services as they apply uniquely to Montana.

Following a recommendation from that conference, a group of concerned local and state professionals formed the *Committee for the Improvement of Public Health in Montana*. One of the charges to that committee was to conduct a survey of local public health agencies to determine their ability to perform the public health functions that were outlined during the conference. The survey results indicated that most local agencies had the ability to perform fewer than half of the functions fully, and those local agencies with the least resources had little or no ability to perform any of the functions.

Subsequently, Representative Bill Tash (Dillon) and Senator Mignon Waterman (Helena) jointly introduced the "Public Health Improvement Act" which was passed by the 1995 Montana Legislature. To carry out the Act, a Public Health Improvement Task Force was created in 1995 (appointed by the Governor).

Planning for the institute was initiated as part of a workforce development component of a 1997 Turning Point grant. Planning resulted in a Department of Public Health and Human Service contract with the University of Washington School of Public Health and Community Medicine in 1999 (Northwest Center for Public Health Practice), which helped develop the institute.

✓ **START DATE**

1999

✓ TARGET AUDIENCE

Public Health leaders and practitioners, teams of state and local government health employees, tribal health officials, policy makers, private and non-profit health organization staff members, and local board of health members.

✓ ACTIVITIES

The Institute offers two curriculums:

- 1) “Public Health 101” which focuses on “basic” Public Health skills and knowledge. Participants meet in person for 2 days, then separate for a 5-week term and complete assignments and interact through distance-learning medias. Participants then reconvene in person to complete the course.
- 2) Summer Institute: intensive, in-person seminar series. Choice of 2-day or 4-day classes.

✓ SUCCESSES/CHALLENGES

The biggest success has been the close working relationship with the University of Washington School of Public Health, as well as being creative in finding a variety of funding sources. Challenges include temporary funding sources and the continuing need to find more funds.

✓ ANNUAL OPERATING COSTS

Approximately \$200,000 not including the \$700,000 bio-terror grant, much of which goes to other sources outside the institute.

✓ FUNDING SOURCES

To run the institute and pay faculty: HRSA Workforce Development Grant through the Northwest Center for Public Health Practice, CDC Preventive Health Block grant, and the Turning Point Initiative.

✓ SERVICE CHARGES/INCOME

Tuition is charged for classes. For example, \$150 is the tuition for one 2-day intensive summer course.

✓ MARKETING/PROMOTION

Email, mailing brochures, etc.

✓ ORGANIZATIONAL STRUCTURE

The State Health Policy and Services Division created the Office of Public Health System Improvement, to consolidate public health improvement activities. The Institute falls within this office, which also serves as the coordinating point for the Robert Wood Johnson Foundation funded Turning Point initiative and bio-terror preparedness activities.

✓ RELATIONSHIP WITH STATE

Based within the Montana State Department of Health and Human Services.

✓ STAFFING

Training Institute Coordinator/Turning Point Manager, Distance Learning/Workforce Development Coordinator, Bio-terrorism training coordinator, Learning Management System Specialist (funded through the Bio-terror grant), half-time administrative support.

✓ ACCREDITATION/CERTIFICATION

Continuing education credits are available.

✓ PARTNERS

University of Washington School of Public Health.

✓ FUTURE STRATEGIES

Information not provided.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

No.

✓ CONTACT INFORMATION

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— Nebraska Educational Alliance for Public Health Impact —

✓ **TITLE**

Nebraska Educational Alliance for Public Health Impact (NEAPHI)

✓ **MISSION**

The primary purpose for NEAPHI is to bring representatives from educational institutions together with representatives of the public health practice community to identify the education and training needs of Nebraska's public health workforce and, in turn, to identify the educational resources that might be leveraged to address those needs.

✓ **VISION**

The long-term purpose is to build and sustain capacity in Nebraska to improve the public's health.

✓ **BACKGROUND**

NEAPHI was established in the summer of 2000 when representatives of numerous academic and practice organizations concerned with Nebraska's public health workforce training and education came together to explore joint interests. A federation of interested organizations was formed, agreeing to meet quarterly in pursuit of strategies to address this common concern. NEAPHI's membership has grown to 31 organizations and has several projects currently underway.

✓ **START DATE**

2000

✓ **TARGET AUDIENCE**

Individuals involved in the public health workforce.

✓ **ACTIVITIES**

NEAPHI's current projects can be divided into two categories: 1) Health Care Cash Fund financed projects for 2002-2005; and 2) projects involving collaboration with the HRSA Upper Midwest Public Health Training Center based at the University of Iowa College of Public Health.

Health Care Cash Fund Projects:

- 1) Educational Resources: Identify educational resources and assets that can be used to address workforce education/training needs statewide.
- 2) Statewide Summit: Plan and conduct statewide summit to establish a coordinated 3-year blueprint for action for public health education/training.
- 3) Leadership Institute: Research, plan, and implement the Nebraska Public Health Leadership Institute for training public health leaders in Nebraska.

Projects in conjunction with the Upper Midwest Public Health Training Center:

- 1) Nebraska Workforce Needs Assessment Survey: A survey of public health professionals across Nebraska to assess their education and training needs.
- 2) Public Health 101 Training Series: videotaped sessions of the 10 essential functions of public health for the continued education of public health workers.

- 3) Environmental Health Training: Continued development of environmental health training for public health professionals.

✓ SUCCESSES/CHALLENGES

NEAPHI has been successful in securing involvement in, and funding for, activities cited above. It has been a challenge to secure active and consistent involvement of representatives and members.

✓ ANNUAL OPERATING COSTS

Up to the present time, all have been voluntary/in kind.

✓ FUNDING SOURCES

Funds are provided by the Nebraska Health Care Cash Fund (grants awarded by the Nebraska Health and Human Services System) and tobacco settlement dollars allocated by the state legislature. Presently, there is a limited "health care cash fund" of \$100,000 over 3 years, which started in October 2002. A volunteer advisory board makes funding decisions for NEAPHI.

✓ SERVICE CHARGES/INCOME

Currently none.

✓ MARKETING/PROMOTION

NEAPHI is currently seeking means to distribute training/education media to interested parties (video tapes, CD-ROMs, etc.).

✓ ORGANIZATIONAL STRUCTURE

NEAPHI is composed of an oversight/leadership group, comprised of representatives of the Practice Community and the Academic Community. There are also three taskforces, each one charged with facilitating/developing the three Health Care Cash Fund projects: 1) a Statewide Summit Taskforce; 2) an Educational Resources Task Force; and 3) a Leadership Institute Task Force. There are also 2 support staff members who facilitate general administrative/coordination activities.

✓ RELATIONSHIP WITH STATE

Currently there is no official relationship with the state other than the fact that a number of the volunteer members happen to have positions with the state or other local government entities.

✓ STAFFING

There are currently 2 staff members who coordinate administrative activities and meetings: the University of Nebraska Omaha/University of Nebraska Medical Center MPH Program Coordinator; and an MPH graduate student assistant.

✓ ACCREDITATION/CERTIFICATION

No.

✓ PARTNERS

Membership in the three task forces is voluntary. Currently, it is undecided if members "officially represent" their respective organizations. There are some 30 or so members from a

variety of organizations both from the academic and practice communities in Nebraska. NEAPHI does have a partnership with the Upper Midwest Public Health Training Center (UMPHTC) based at the University of Iowa College of Public Health. NEAPHI serves as the Statewide Advisory Board, representing Nebraska, for the UMPHTC (which covers Iowa, Nebraska and South Dakota).

☑ FUTURE STRATEGIES

Implement results of statewide summit plan.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

☑ CONTACT INFORMATION

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— Northern Nebraska Area Health Education Center —

✓ TITLE

Northern Nebraska Area Health Education Center (NN-AHEC)

✓ MISSION

Northern Nebraska AHEC's mission is to promote, recruit, and retain health care professionals through partnerships between healthcare, educational, and community providers in northern Nebraska.

✓ VISION

Information not provided.

✓ BACKGROUND

Information not provided.

✓ START DATE

December 2002

✓ TARGET AUDIENCE

Currently, high school students interested in health care careers and public health professionals with an interest in continuing education are targeted.

✓ ACTIVITIES

The Center organized and sponsored a Career Day at Norfolk Junior High, bringing health care professionals together with students to learn about careers in health care and medicine through a hands-on approach.

Recently, the Center co-sponsored a bio-terrorism preparedness symposium with the Bio-terrorism Health Education Consortium in Norfolk, the objectives of which were to provide an overview of issues related to bio-terrorism, discuss needs of communities for disaster response, and facilitate local community planning and identify roles and responsibilities of community members for bio-terrorism response.

The NN-AHEC also sponsored a viewing site for the Cross Cultural Communication in Health Care: Building Organizational Capacity national broadcast in June of 2003.

✓ SUCCESSES/CHALLENGES

Information not provided.

✓ ANNUAL OPERATING COSTS

Information not provided.

✓ FUNDING SOURCES

Information not provided.

✓ SERVICE CHARGES/INCOME

Information not provided.

✓ MARKETING/PROMOTION

Information not provided.

✓ ORGANIZATIONAL STRUCTURE

Information not provided.

✓ RELATIONSHIP WITH STATE

Information not provided.

✓ STAFFING

Information not provided.

✓ ACCREDITATION/CERTIFICATION

Information not provided.

✓ PARTNERS

University of Nebraska Medical Center; Health Resources and Services Administration.

✓ FUTURE STRATEGIES

The Center will sponsor a series of Health Career Camps around the Northern Nebraska area to expose students to health care careers in 2003. The camps will target junior and senior high school students, and will include presentations, workshops and other activities.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

No.

✓ CONTACT INFORMATION

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— Smart Start —

✓ **TITLE**

Smart Start

✓ **MISSION**

To provide leadership to achieve the vision of Smart Start.

✓ **VISION**

- Programs and services are collaborative between state and community efforts and within local communities.
- Programs and services focus on accessibility and inclusion of children and families of all races, classes and cultures, and all needs.
- State and community efforts will build the state and community infrastructure needed to improve child care, make it more accessible and affordable for families, improve child health outcomes, and strengthen families.
- Proactive, cutting-edge and innovative approaches are utilized in programs and services.
- Smart Start's National Technical Assistance Center is a national leader in the development of early childhood initiatives.

✓ **BACKGROUND**

Smart Start legislation was ratified in 1993 with a \$20 million state appropriation. The legislation was spurred by North Carolina's high infant mortality rate, recognition that the state's child care standards were the worst in the nation, and very poor performance on SAT scores. In September 1993, North Carolina's Governor Hunt announced the selection of 12 pioneer Smart Start partnerships representing 18 counties. In July 1995, a performance audit ordered by the state legislature confirmed that Smart Start was a viable program and should continue to receive state funds, and in 1997, the program was expanded to serve all 100 counties in North Carolina.

✓ **START DATE**

1993

✓ **TARGET AUDIENCE**

Child care providers, teachers, parents, children.

✓ **ACTIVITIES**

Smart Start makes child care and education available to families by providing child care subsidies to working families, Head Start, and public preschools. Smart Start funds create additional spaces in child care, preschool, and infant/toddler care, and provide transportation services to make child care more accessible, especially during non-traditional hours. Smart Start also funds access to health services for young children and programs that promote strong families.

✓ **SUCSESSES/CHALLENGES**

Since Smart Start began, more than:

- 175,140 children have received child care subsidies so parents can work.
- 467,800 children have received preventive health screenings.

- 276,500 parents have received parenting and health education.
- 60,000 new child care spaces have been created.
- \$200 million in non-state funds have been raised.
- More than a dozen states have begun replication of Smart Start.

Studies by the Frank Porter Graham Child Development Center at UNC Chapel Hill show:

- The quality of child care in child care centers and homes has significantly improved.
- The education of child care teachers has dramatically improved.
- Children attending Smart Start-supported child care facilities have better cognitive and language skills and fewer behavioral problems than children not attending Smart Start-supported facilities.
- Children attending Smart Start-supported child care facilities are significantly more likely to have a regular source of health care.

Due to ongoing state budget deficits, Smart Start's budget was cut by \$7.7 million for FY 2004. This reality will force Smart Start to rely more heavily on private contributions in coming years.

☑ ANNUAL OPERATING COSTS

Smart Start's annual appropriation is approximately \$188 million for FY 2004. Of that amount, 8% is used to fund administrative costs.

☑ FUNDING SOURCES

Smart Start legislation mandates that the program match every ten dollars it receives from the North Carolina General Assembly with one dollar from the private sector. The state's largest banks and top corporations have made significant contributions to Smart Start. The initiative has also received support from the David and Lucille Packard Foundation and the U.S. Department of Justice.

☑ SERVICE CHARGES/INCOME

Smart Start earns income through sales of their publications and reports. The National Technical Assistance Center – a division of Smart Start – charges for consulting services and some technical assistance.

☑ MARKETING/PROMOTION

Not applicable.

☑ ORGANIZATIONAL STRUCTURE

Smart Start is a public-private initiative that provides early education funding and access to health services, makes child care more affordable, and offers family support for children and their families in North Carolina. Smart Start funds are administered at the local level through local nonprofit organizations called local partnerships. Each local partnership receives an allocation of Smart Start funding that is determined by the North Carolina Partnership for Children, the statewide non-profit that provides oversight and technical assistance for the local partnerships. At least 70% of Smart Start direct service funds are spent on child care and child care-related activities. Of that 70%, a minimum of 30% must be spent on child care subsidies. The remaining 30% of direct service funds are spent on health care and family support programs and services.

Smart Start's National Technical Assistance Center, a division of the North Carolina Partnership for Children established in 2001, shares information, resources, and lessons learned with other states in the development of community-based early childhood initiatives. Currently, 82 local partnerships are established throughout the state to administer funding and programs. Through funding from the Packard Foundation, the Carnegie Corporation of New York, and the Triad Foundation, a technical assistance grant is available to up to ten communities and states to fund participation in the intensive technical assistance program.

☑ RELATIONSHIP WITH STATE

Close relationship; major support comes from state funds. Smart Start enjoyed strong political support from North Carolina's Governor Hunt during the mid to late 1990s. He was very involved in crafting the first Smart Start legislation in 1993 and continued to raise millions of dollars from private donors for the program throughout his tenure as governor. The combination of ongoing state budget deficits and the current economic slowdown has reduced Smart Start's annual appropriation. Nevertheless, political support for the initiative remains high with current Governor Easley and legislative leaders protecting Smart Start from additional cuts.

☑ STAFFING

There are 52 full-time staff at the North Carolina Partnership for Children. Staffing within local partnerships varies based on the size of the organization and the number of programs it funds or manages.

☑ ACCREDITATION/CERTIFICATION

No.

☑ PARTNERS

Information not provided.

☑ FUTURE STRATEGIES

Smart Start will continue to build relationships in the private sector to fund additional components of its work.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

☑ CONTACT INFORMATION

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— TeleKidcare —

✓ TITLE

TeleKidcare (formerly Wyandotte County Community Health Partners)

✓ MISSION

The goal of this program is to provide urgent or acute care and behavioral health care to children in the urban Kansas City area through the use of telemedicine connections between local schools and the KU Pediatric Clinic and the KU Child Psychiatric Clinic.

✓ VISION

Information not provided.

✓ BACKGROUND

The general background for the project results from the fact that Wyandotte County, Kansas had: 1) a high physician-patient ratio and was considered a “Federal Health Profession Shortage Area”; and 2) 40% of the residents in the county were living at or below the poverty line and low-income areas are often medically underserved. This particular project came out of a 1996-1997 study from the Kansas University Medical Center (KUMC) about the improvement of health care for local residents. From the study, the idea of creating a pilot telemedicine program in select Kansas City schools was developed. The following steps occurred in the development of the pilot program:

- 1) Fostering community awareness and participation – The Kansas City school district and KUMC invited participation from agencies in the community, including the County Health Department, local physicians, and the Kansas Department of Health and Education.
- 2) Selecting equipment – Each of the four participating schools received PC-based videoconferencing units, video otoscopes, electronic stethoscopes, and fax machines, with a total cost for each school of about \$20,000. KUMC paid for equipment that was needed at the medical center.
- 3) Solving the legal and procedural difficulties – Strict protocols were developed for the delivery of medical treatment at the four schools. Other issues addressed included Medicaid reimbursement approval and the creation of appropriate patient consent forms.
- 4) Training – The school nurses at each of the four schools were trained on all aspects of the telemedicine program.

✓ START DATE

Planning for the pilot project began in the spring of 1997 and the pilot service started in the spring of 1998. A second phase of the project was started in the fall of 1998.

✓ TARGET AUDIENCE

Children in four inner-city elementary schools in the Kansas City area.

✓ ACTIVITIES

The pilot program provides medical care to children through a combination of school nurses, physicians, and other necessary parties. The physician can diagnose the children and fax a prescription (or call it in to the parent’s pharmacy of choice) using the telemedicine equipment.

✓ SUCCESSES/CHALLENGES

During the three-month pilot program:

- A total of 187 consultations were conducted.
- 212 diagnoses were made for the 187 consultations, with the most common diagnoses being ear, nose and throat problems (29%), mandatory school physicals and dermatology problems (40%), and other problems (32%). The latter category included psychiatric treatment, upper-respiratory problems, and eye problems.
- 142 prescriptions were written, with over-the-counter drugs recommended in 46 cases and referrals to other doctors (most commonly to dentists) made in 37 cases.

✓ ANNUAL OPERATION COSTS

Information not provided.

✓ FUNDING SOURCES

The telemedicine equipment used in the schools was paid for by the school districts, and the equipment in the doctor's offices was paid for by KUMC. The second phase of the project received a grant from the National Telecommunications and Information Administration, which enabled the program to be expanded.

✓ SERVICE CHARGES/INCOME

No charges for the medical services were mentioned.

✓ MARKETING/PROMOTION

Information not provided.

✓ ORGANIZATIONAL STRUCTURE

This study was conducted through the TeleMedicine Department at KUMC in cooperation with Kansas City, Kansas Unified School District 500.

✓ RELATIONSHIP WITH STATE

At the time of the pilot project, there was no specific state funding for TeleKidcare. Since the pilot project, however, TeleKidcare has been expanded to fifteen other sites throughout Kansas and is scheduled to further expand to thirty-two sites by Fall 2003, due to funding from the Kansas Children's Initiative Fund.

✓ STAFFING

Fourth year pediatric residents under the supervision of a Pediatric Resident Advisor conduct the sessions. Approximately six residents are involved each semester. There is one school nurse at each school.

✓ PROVIDES ACCREDITATION/ CERTIFICATION

Information not provided.

✓ PARTNERS

Local healthcare providers, local schools, Kansas University Medical Center, state and federal agencies.

✓ **FUTURE STRATEGIES**

The second part of the project began in the fall of 1998. The telemedicine service was expanded to include one high school, two elementary schools, one middle school, and one campus housing a middle school and an elementary school with a shared school nurse. Also, a research team was created to study health-care related issues in order to provide information to future telemedicine projects.

The researchers made the following conclusions from the first part of this project:

- 1) Telemedicine enabled underserved inner-city children to access health services.
- 2) There was a link between children's health and the ability to learn. Children who received medical care appeared to attend school more regularly and to participate more in class.
- 3) Telemedicine was quickly embraced by the community. The benefits of the pilot service were universally recognized.
- 4) Technology was quickly forgotten during the consultations and became transparent. Instead, patients and providers focused on receiving and delivering health care.
- 5) There was a significant start-up investment in people's time, rather than in the direct costs of implementing the system.
- 6) An effective and efficient telemedicine organizational infrastructure was crucial.
- 7) Dedicated school nurses and dedicated doctors facilitated effective telemedicine services.
- 8) The role of the school nurses was enhanced because they played a bigger part in identifying and referring children for physician consultation, providing the hands for the physician during the telemedicine encounter, and facilitated the follow-up services require.

✓ **INFORMATION REVIEWED BY PROGRAM STAFF**

Yes.

✓ **CONTACT INFORMATION**

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University of Alabama Maternal and Child Health Leadership Skills Training Institute

✓ **TITLE**

University of Alabama Maternal and Child Health Leadership Skills Training Institute

✓ **MISSION**

Information not provided.

✓ **VISION**

Information not provided.

✓ **BACKGROUND**

The Maternal and Child Health Leadership Skills Training Institute (formerly the Maternal and Child Health Continuing Education Institute to Increase Leadership Skills) was initiated in 1985 to respond to the needs of those in leadership positions of state Maternal and Child Health programs. The curriculum was developed as a response to the need for leadership training. Recognizing that most MCH leaders had extensive clinical training and experience and opportunities to enhance clinical expertise exist widely, the Institute chose to focus on skills such as communication, negotiation, grant writing, planning and advocacy. The Institute experiences strong continuing support from Health Resources and Services Administration as a funding source, but no direct political support other than from the Alabama Maternal and Child Health Partnership.

✓ **START DATE**

1984/1985. The Institute is a virtual center that moves between academic centers and is currently based at the University of Alabama.

✓ **TARGET AUDIENCE**

The Institute's target audience is management personnel in State Title V Maternal and Child Health and Children with Special Health Care Needs (CSHCN) programs in the United States. Specific participants include designated state directors of MCH and CSHCN activities.

✓ **ACTIVITIES**

Three to four Institute sessions are scheduled each year, with differing topics. Between the inception of the project in 1985 and October 2002, 2,157 State Title V staff from all 50 states as well as the District of Columbia, Puerto Rico and the Virgin Islands have been trained in 64 institute sessions. Specific areas of training include planning, needs assessment, evaluation, quality assurance, inter-agency collaboration, communication, negotiation, organizational behavior, conflict resolution, advocacy, budgets, funding, contracting, use of consultants and technical assistance, program and policy development, core public health functions, resource development, and cultural competence.

2003 sessions include 3-day seminars on Planning, Implementing, and Evaluating programs (leadership issues related to internal agency/program functions) and Systems (issues related to assuring the well being of MCH/CSHCN populations while working with other agencies). Ideally, the Institute offers a total of four seminars per year (two for each theme).

✓ SUCCESSES/CHALLENGES

The Institute has trained over 1600 individuals, including legislators and attorney generals, since its inception. The large training base can be accounted for by the frequent turnover in state government positions.

A big challenge, besides logistic management of the program nationwide, is identifying and “nurturing” good trainers. Good trainers are those skilled in adult education, not just continuing education, and well experienced in training individuals with as much expertise and experience as they have themselves, given that the target audience is upper level management and policy leaders. The community of trainers, about one third of whom are academics, has become well known to interested stakeholders because of the small number of training programs specifically focusing on MCH. As a result, good centers have identified and nurtured the same set of trainers over time. A challenge is to not duplicate the efforts of other training centers.

Another challenge is that the training is focused on education and skills building, but many participants are looking for technical assistance specific to their individual projects and situations. This is very difficult because it takes quite a bit of time to tailor technical assistance to specific projects and situations.

Distance learning has been very hard to do for a number of reasons. Generally, distance learning has been good for communicating lesson content. However, it is a poor medium for questions, demonstration activities, or any other activities that involve a degree of active participation. It is difficult to schedule as well, since trainers/instructors are often too busy to schedule a set time period for webcasts and it’s often hard to maintain a consistent pace and pick up where things last stopped. Distance education is a medium that offers little incentive to stay with a program over a long period. For these reasons, intensive, live interaction has been a preferred approach.

Generally, it’s important to offer an incentive for participants to stay involved. Offering credit or a certificate is one incentive. Requiring a considerable amount of tuition is another.

✓ ANNUAL OPERATING COSTS

Information not provided.

✓ FUNDING SOURCES

Health Resources and Services Administration funds the Institute with 5-year grants.

✓ SERVICE CHARGES/INCOME

The Institute collects no tuition from participants in its training sessions.

✓ MARKETING/PROMOTION

The Director contacts states directly and identifies MCH and CSHCN directors and their executive staff and invites them to participate in the training seminars.

✓ ORGANIZATIONAL STRUCTURE

A small administrative base located at the University of Alabama – Birmingham partners with trainers across the nation, who have become regular training staff.

✓ RELATIONSHIP WITH STATE

The Institute has very little if any relationship with a host state.

✓ STAFFING

Project Director, Project Coordinator, Technology Coordinator, Administrative Assistant.

✓ ACCREDITATION/CERTIFICATION

Information not provided.

✓ PARTNERS

The Alabama Maternal and Child Health Partnership is a key advisory partner that represents state MCH programs. Because the Institute's training program targets the state level, the Alabama Maternal and Child Health Partnership serves as a good source for determining capacity needs and knowing what is being done nationwide.

✓ FUTURE STRATEGIES

Information not provided.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

No.

✓ CONTACT INFORMATION

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University of Minnesota School of Public Health Center for Public Health Education and Outreach

✓ **TITLE**

University of Minnesota School of Public Health Center for Public Health Education and Outreach

Three directly applicable initiatives organized under the umbrella of the Midwest Center for Life-Long-Learning in Public Health are: 1) Public Health Institute; 2) Maternal Nutrition Intensive Course; and 3) Distance-based Academic and Continuing Education.

✓ **MISSION**

As a school-wide center, the Center for Public Health Education and Outreach was established to expand access to public health education/training and provide continuing education offerings for practicing public health professionals throughout their careers. The Center serves as an intersection between the University of Minnesota School of Public Health and the community, and provides an on-going presence and infrastructure to support education for public health professionals throughout the region.

The goal of the Center is to work with the community and the faculty of the School of Public Health to help develop and strengthen the public health workforce and prepare for future public health challenges through education. In addition to the Midwest Center for Life-Long-Learning in Public Health, the Center for Public Health Education and Outreach serves as the administrative home for Occupational Health and Safety Training as a National Institute for Occupational Safety and Health sponsored Education and Research Center and a National Institute of Environmental Health Sciences Worker Safety initiative; and for the University of Minnesota Center for Public Health Preparedness, an Association of Schools of Public Health/Centers for Disease Control and Prevention sponsored initiative.

✓ **VISION**

The purpose of the Midwest Center for Life-Long-Learning in Public Health is to strengthen the technical, scientific, managerial and leadership competence of the current and future public health workforce in the Midwest (Minnesota, Wisconsin, North Dakota). Emphasis is placed on developing the existing public health workforce as a foundation for improving the infrastructure of the public health systems in the Midwest and achieving the objectives of Healthy People 2010. The training programs apply distance/distributive-learning technologies and off-site courses to meet the learning needs of public health personnel in medically underserved populations and geographically removed areas.

✓ **BACKGROUND**

Midwest Center for Life-Long-Learning in Public Health – University of Minnesota School of Public Health and the Health Resources and Services Administration support the program. While not financially linked to the states in its service region, the Midwest Center for Life-Long-Learning in Public Health has developed collaborative working relationships to address gaps in competence, access, and capacity across the region. Experts from the departments of health in the region serve as faculty for some educational initiatives and/or participate as key informants in the development of curriculum.

✓ START DATE

Midwest Center for Life-Long-Learning in Public Health – 2001-present (the initiatives below are examples of but are not all the offerings provided under this center):

1. Public Health Institute – 2002.
2. Maternal Nutrition Intensive Course – Not a continual project.
3. Academic and Continuing Education through distance-based technology.

✓ TARGET AUDIENCE

1. Public Health Institute – Representatives from local, state and federal government agencies, community organizations, private sector, graduate students, generally anyone practicing or studying in the public health fields.
2. Maternal Nutrition Intensive Course – Designed for dietitians, nutritionists, certified nurse midwives, registered nurses and nurse practitioners, physicians, and public health professionals who serve pre-conceptual, pregnant, postpartum, and breastfeeding women.
3. Midwest Center for Life-Long-Learning in Public Health – Health and human service professionals.

✓ ACTIVITIES

1. Public Health Institute – Offers intensive courses spanning a 3-week period in late May-early June. Concentration areas include: public health preparedness, response and recovery; public health leadership; occupational safety and health; food safety and bio-security; agricultural safety and health and other courses developed to assist in the development of core and specialized public health competencies. The Institute is basically the media for offering education in an intensive, summer format.
2. Maternal Nutrition Intensive Course – 3-day intensive course/conference series focusing on the improvement of maternal and infant health through the delivery of risk-appropriate high-quality nutrition services. Online streaming video is also offered for a reduced fee.
3. With support from the Midwest Center for Life-Long-Learning in Public Health, academic certificates in the areas of core concepts have been developed and degree programs have been enhanced through distance education opportunities.

✓ SUCCESSES/CHALLENGES

Rapid growth and competing priorities for public health professionals are challenges.

✓ ANNUAL OPERATING COSTS

Information not provided.

✓ FUNDING SOURCES

The school leverages quality resources and experience across a variety of initiatives to better serve the community.

✓ SERVICE CHARGES/INCOME

Information not provided.

✓ MARKETING/PROMOTION

Via web, Association of Schools of Public Health websites, direct mail, promotion from Departments of Health in the Center’s service region.

✓ ORGANIZATIONAL STRUCTURE

The Associate Dean for Public Health Practice Education is administratively responsible for the Center. An Executive Board and Advisory Cooperative Board provide input and general direction regarding initiatives.

✓ RELATIONSHIP WITH STATE

1. Public Health Institute – University of Minnesota project.
2. Maternal Nutrition Intensive Course – University of Minnesota project.
3. Midwest Center for Life-Long-Learning in Public Health - University of Minnesota project in collaboration with the Health Departments of Minnesota, North Dakota, and Wisconsin.

✓ STAFFING

Principle Investigator, Distance Education Coordinator, Continuing Education Specialists, Grant Coordinator, Marketing Coordinator, Registrar, Program Associate, Technology Team Leader, and Administrative Assistants (partial support from University and grant initiatives).

✓ ACCREDITATION/CERTIFICATION

1. Public Health Institute – Continuing Education and Graduate credits are available. Options for completing or building on a degree or certificate are available.
2. Maternal Nutrition Intensive Course – Certificate of Attendance is awarded, and 17 CE hours are available.
3. Academic and Continuing Education through distance-based technology: academic and/or continuing education credit available.

✓ PARTNERS

The Midwest Center for Life-Long-Learning in Public Health works collaboratively with the Health Departments in Minnesota, North Dakota and Wisconsin, with professional associations, and with academic institutions nationally to accomplish its goals.

✓ FUTURE STRATEGIES

The Center hopes to expand distance-based initiatives and the collection and application of data regarding the development of workforce competency and capacity.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

✓ CONTACT INFORMATION

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— University of North Carolina Data Skills Online —

✓ **TITLE**

University of North Carolina (UNC) Data Skills Online (DSO)

✓ **MISSION**

Offer a set of analytical and technical tools that state and local Title V professionals may use for online, self-directed learning.

✓ **BACKGROUND**

Data Skills Online was developed in the Department of Maternal and Child Health (MCH) in the UNC Chapel Hill School of Public Health. Doctoral students, project staff, and consultants from other higher education institutions collaborated to develop the tools.

✓ **VISION**

Data Skills Online aims to increase the analytic and technical skills of MCH professionals, encourage use of these skills on the job, and therefore improve access to health care services for mothers and children.

✓ **START DATE**

2000 - 2002 (Grant period).

2001 - 2003 (Twenty-one Data Skills Online tools were released from January 2001 through March 2003).

April 2003 Southeast Public Health Training Center at the North Carolina Institute of Public Health took over administration of the tools.

✓ **TARGET AUDIENCE**

MCH professionals and local Title V professionals are the target audience.

✓ **ACTIVITIES**

Training MCH professionals to apply analytic and technical skills in their day-to-day job responsibilities, including:

- Working with population-based data.
- Developing and reporting on measures for the Title V Block Grant Application.
- Monitoring and evaluating progress on specific program activities.
- Developing strategies to meet the needs of the MCH population.

Each tool has clear learning objectives, MCH-specific examples and self-test activities, and a glossary of new terms. The time for tool completion varies from 1 to 3 hours, depending on the subject matter. Tools will be developed on an ongoing basis.

✓ **SUCSESSES/CHALLENGES**

From January 2001 to May 2002, 975 individuals had registered for at least one DSO tool – on average, 60 new registrants per month. These registrants represented 49 U.S. states and several foreign countries. The registrants' responses to questions from the end-of-tool survey were used to assess the impact of the tools on users' knowledge, confidence, skills, and practice.

From January 2001 to May 2002, 76 (100%) technology tool users responded that a tool had improved knowledge, and 72 (96%) responded that a tool had improved confidence in using the skills. Ninety-seven percent (474 out of 489) of analytic tool users responded that a tool had improved knowledge, and 435 out of 485 (90%) responded that a tool had improved confidence in using the skills.

It has been challenging to maintain an accessible website while incorporating complex elements such as charts, screen shots of images, graphics and multipart tables.

✓ ANNUAL OPERATING COSTS

Annual operating costs were \$150 for each of the two years (this is in addition to the cost of three staff, consultants, field testers, computers, and necessary software).

✓ FUNDING SOURCES

A Special Project of Regional and National Significance (SPRANS) grant from the Maternal and Child Health Bureau, Health Services and Resources Administration, U.S. Department of Health and Human Services funded the development of Data Skills Online tools. Health Resources and Services Administration funds the Southeast Public Health Training Center, which administers the tools.

✓ SERVICE CHARGES/INCOME

The tools are available online at no cost.

✓ MARKETING/PROMOTION

The project attempted to reach a geographically and professionally diverse professional audience composed of MCH public health program directors and professional staff. While the MCH area was a specific target, the DSO toolbox was also marketed among diverse e-mail lists, website links, search engines, and professional organization newsletters to attract users in many areas of public health. A marketing postcard with a detachable Rolodex card was created for mailings and distribution at national meetings. As another means of promoting the project and reaching maternal and child health professionals specifically, project staff presented information at several national conferences.

✓ ORGANIZATIONAL STRUCTURE

From 2000-2002 there were three staff members on the project. There was a Project Director, a Research and Information Coordinator, and a Project Coordinator.

✓ RELATIONSHIP WITH STATE

The project was housed at the University of North Carolina-Chapel Hill. Various state employees assisted in field-testing the Data Skills Online tools. The Microsoft Access tools were designed using sample state data from the North Carolina Teen Pregnancy Prevention Initiative (TPPI).

✓ STAFFING

Project coordinator, research and information coordinator, principal investigator, and a technical and research assistant.

✓ ACCREDITATION/CERTIFICATION

Users of the toolbox may print a certificate of completion after working through each tool.

✓ PARTNERS

Management Academy for Public Health participants were required to complete at least one of three Data Skills Online tools as part of their training. There were approximately 100 participants in 2001 and 200 participants in 2002.

In May 2001, Data Skills Online project staff convened a meeting in conjunction with the UNC Chapel Hill School of Social Work: the Public Health Social Work Bi-Regional Leadership Training Workshop. This workshop brought together 20 public health social workers from public health regions IV and VI. The 1½-day training in a computer laboratory provided participants with the opportunity to complete the Data Skills Online tool entitled, “Web Design” with in-person technical assistance.

In an effort to expand the reach of Data Skills Online tools, project staff entered into a collaborative effort with the UNC School of Public Health’s Public Health Leadership Program (PHLP) to develop a one credit, asynchronous course entitled “Data Skills for Leadership.” The Public Health Leadership Program is an academic unit dedicated to preparing leaders in public health practice and building linkages between professionals in academic and community based organizations. One of the objectives of the PHLP is to provide an integrated, practice-based curriculum using a variety of teaching approaches. The Public Health Leadership Program offers two distance-based Masters in Public Health degrees: one in Leadership and one in Occupational Health Nursing.

✓ FUTURE STRATEGIES

The NC Institute of Public Health is in the process of updating the tools to ensure all of the links work correctly, all tools are accessible, and that the content is up-to-date.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

✓ CONTACT INFORMATION

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University of Rochester Maternal and Child Health Analytic Training for the Year 2010

✔ **TITLE**

University of Rochester Maternal and Child Health Analytic Training for the Year 2010
(MACH 2010)

✔ **MISSION**

To facilitate state and local maternal and child health program staff to expand their use of data for planning and evaluation purposes through improving analytic capacity (knowledge and practice) and expanding access to analytic resources through in-person and electronic training.

Specifically, the goals of MACH 2010 are:

1. To increase knowledge of applied MCH analytic methods and demonstrated skills.
2. To increase awareness of methodological opportunities and limitations in conducting MCH analyses.
3. To promote knowledge and use of New York State and national MCH databases.
4. To increase knowledge and appropriate use of race and ethnicity data in MCH analyses.
5. To ensure adequate representation of a variety of organizations involved in public maternal and child health planning and care.
6. To increase knowledge and usage of EPI-INFO and the New York State data resources for program evaluation and planning purposes among participants.
7. To assist in the creation of "analytic homes" for agencies and organizations.

✔ **VISION**

To improve the health of mothers and children in New York State by helping agency-level personnel better utilize the data they collect. It is envisioned that students completing the MACH 2010 training program will serve as a data and information resource for their home agency and community.

✔ **BACKGROUND**

MACH 2010 grew out of a need for data driven analyses. The program's director identified that data was available through Healthy Start evaluations and work with the New York State Perinatal Data System and local health departments but no one knew how to use it. He responded to an RFP (Request for Proposals) issued by the Centers for Disease Control and Prevention that addressed the need for agency-level analytic training.

✔ **START DATE**

1999/2000.

✔ **TARGET AUDIENCE**

Qualified applicants would be staff of state or local agencies, including health departments, hospitals, HMOs, perinatal networks, Healthy Start Projects, community-based organizations, and others working in New York State. Applicants and their sponsoring agencies must demonstrate that they work, in whole or in part, with families, pregnant women, infants, or children. Approximately 30 applicants are accepted into the training

program each year. When selecting students, emphasis is placed on admitting the broadest possible representation of student interests, research areas, agency types, and state regions. Applicants need to be committed professionals with data responsibilities in their agencies that can invest the time in completing the training as required.

✓ ACTIVITIES

Participants will be expected to complete on-line readings and assignments on a monthly basis, and are also required to attend two, 2-day on-site sessions.

The trainings will provide a blend of basic methodological instruction together with practical, hands-on implementation of data analyses. Participants will work with relevant databases throughout their training, generating real, useful, and appropriate analyses of their own information. The focus of training will be on using Perinatal Data System data, but will also go beyond that by providing some instruction in implementing their own data collection and reporting efforts. The instructors will be drawn from in-state MCH data analysts, to include staff from the Division of Public Health Practice at the University of Rochester, the SUNY Institute of Maternal and Child Health in Syracuse, the Bureau of Women's Health at the New York State Department of Health, and other state and local agency experts. Further, we will work collaboratively with other national sites to share information, resources, and strategies.

MACH 2010 modules 1-5 have been translated into Spanish and have been used for a 3-day onsite training program in the Dominican Republic. These modules are also freely available from the MACH 2010 home page (link cited below).

A previous MACH 2010 program schedule is noted below:

February	Deadline for applications (February 22)
March	Intake interviews conducted
April	Login and passwords issued Review, and Module 1 and Module 2 are made available
May	Module 3 available
June	First conference/In-service
July	Module 4 available
August	Module 5 available
September	Module 6 available
October	Second conference/In-service Module 7 available
November/December	All modules completed, evaluations conducted, and exit interviews.

✓ SUCCESSES/CHALLENGES

Some of the participants, especially those working with local health departments, have had to leave the program prematurely due to the need to address unanticipated public health issues.

A few of the comments we have received include:

- The content was great! Again, info is very useful on my job. The assignments are also helpful in rethinking the way we do things. The topics were good for what we do. Computer skills were definitely improved and knowledge of resources expanded.
- Data analyzing skills - I really learned the skills-how to do the math. I can now calculate relative risk, p-values, economic benefit/efficiency reports etc and more.

- Learned statistical validation for common-sense approaches.
- Content was very helpful. Enjoyed specifically analyzing info that will help me propose programs and do strategic planning.
- My knowledge and understanding and appreciation of MCH analytic methods were increased through participation in this program.

A summary of the programs success:

- Of the students who completed the first MACH 2010 module more than 75% went on to successfully complete the course.
- Compared to both traditional teaching methodologies and other distance learning programs the MACH 2010 program's student attrition rate was quite low (<25%).
- Students unable to complete the MACH 2010 program typically left because of (a) changes in their job duties [particularly after Sept 11, 2002], or (b) change of place of employment [agency sponsorship is required for continuation in the program].
- There was a statistically significant ($p = 0.05$) increase in student test scores both across the course and within each MACH 2010 module.
- On average student test scores improved ~20% within each MACH 2010 module.

ANNUAL OPERATING COSTS

Currently no operational money is dedicated to the program.

FUNDING SOURCES

Funding from a 3-year grant from Centers for Disease Control and Prevention/Association of Teachers of Preventive Medicine.

SERVICE CHARGES/INCOME

No tuition is charged.

MARKETING/PROMOTION

Web based, mailings, and word of mouth.

ORGANIZATIONAL STRUCTURE

Two instructors and two teaching assistants (TAs) interfaced with students on a regular basis. Participants in the program completed assignments at the conclusion of each module, emailing them to their assigned TA. The TA reviewed the assignments, providing the participant with suggestions for improvement. This review process continued until the TA and participant were satisfied that the assignment was satisfactorily completed, at which time the participant emailed the assignment to his instructor.

RELATIONSHIP WITH STATE

None. The program is based at the University of Rochester and has no funding or ties to New York State except that many trainees are with government agencies. The program may seek to sell modules to other states, and intentionally seeks to remain independent from state ties.

STAFFING

Program Director, Instructor, Teaching Assistant, and Teaching Assistant/Technical Support.

☑ ACCREDITATION/CERTIFICATION

A MACH certificate was given to each participant who successfully completed the program. During the 3rd year of the program, CME (continuing medical education) credits and CE (continuing education) units were awarded to those who qualified.

☑ PARTNERS

None.

☑ FUTURE STRATEGIES

The marketability and repurposing of the program for use in other settings is being researched.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

☑ CONTACT INFORMATION

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— Upper Midwest Public Health Training Center —

✓ **TITLE**

Upper Midwest Public Health Training Center (based at the University of Iowa; covers Iowa, South Dakota, and Nebraska)

✓ **MISSION**

The purpose of the Upper Midwest Public Health Training Center is to establish a public health training center that serves professionals and students in public health and provides information on the latest public health techniques and practices (for Iowa, Nebraska and South Dakota).

✓ **VISION**

This virtual center's current goals focus on four areas: 1) infrastructure, 2) assessment, 3) planning and implementation, and 4) evaluation activities.

✓ **BACKGROUND**

The Health Resources and Services Administration lobbied schools of public health in the upper Midwest region to establish regional training centers. The ultimate objective is to align all states with a regional center. Both the University of Iowa and the University of Minnesota were chosen as bases for regional centers, based on location and their academic resources.

✓ **START DATE**

2000/2001

✓ **TARGET AUDIENCE**

Public health professionals, including those in clinical professions, allied health care, health education/promotion, environmental health, and students. Assessments have revealed different needs in different states, so target audience may differ by state.

It should be noted that this training center was one of the first to target primary care associations as both target audiences and partners, a trend many centers have also adopted.

✓ **ACTIVITIES**

This virtual center's current programs involve four general areas: 1) infrastructure, 2) assessment, 3) planning and implementation, and 4) evaluation. It will ideally reduce replication of workforce development activities in the three states involved, thus maximizing efficient use of resources, and strives to focus on collaborative projects to enhance public health services to medically underserved communities and to implement a model "Kids Into Health Careers" program.

Specific capacity-building activities include:

Assess the public health workforce and competency needs, assets and educational programming to meet the minority and underserved needs of the three-state region and delineate available resources.

- a. Assess competencies of public health workforce to identify their needs and assets.
- b. Inventory curriculum, resources, recruitment and educational opportunities in public health.

- c. Assess career choices, placement/recruitment of students from underserved areas, including minority populations.

Develop a plan for addressing the identified gaps within the UMPHTC and develop/implement new curricula and training programs.

- a. Develop accessible, integrated and comprehensive curricula and training programs.
- b. Develop a mechanism to increase the number of minority/disadvantaged persons represented in the public health workforce.
- c. Plan and develop continuing education utilizing a variety of modalities, including distance education, for the public health workforce.
- d. Develop a support system for students to learn about and choose health occupations.
- e. Support each state with developing systems responsive to the public health workforce goals identified in *Healthy People 2010* and *Healthy Iowans 2010*.
- f. Assure that current technology is utilized in education and training of future and existing public health workforce.
- g. Develop field-based learning experiences for students from traditional on-campus programs with adequate field supervision to maximize the value of these learning experiences.
- h. Develop mechanisms for sharing data, curriculum, assessment tools and lessons learned with other public health training centers and the public health community.
- i. Develop health system partnerships in underserved communities.
- j. Develop collaborative public health coalitions/networks to incorporate partner's resources and strengths into the regional strategy.

Assessment is nearing completion. Currently, gathering and compiling data from sources.

SUCSESSES/CHALLENGES

Information not provided.

ANNUAL OPERATING COSTS

Funded by Health Resources and Services Administration grant. Conducted self-assessment.

FUNDING SOURCES

Funds of \$250,000 for the first year came from a Health Resources and Services Administration 5-year grant.

SERVICE CHARGES/INCOME

None yet.

MARKETING/PROMOTION

Not applicable.

ORGANIZATIONAL STRUCTURE

Virtual center attached to the University of Iowa College of Public Health, funded by HRSA, with collaborative partnerships among many entities in the three state area.

RELATIONSHIP WITH STATE

Fitted with University of Iowa Center for Public Health Practice, a center aiming to link academics with practice. Departments of health from all three states have advisory roles as

equal partners. The Iowa department of health and the University of Iowa jointly fund the project coordinator position.

☑ STAFFING

Project Director (Iowa), Project Coordinator (Iowa), two Training Coordinators (in Nebraska and South Dakota).

☑ ACCREDITATION/CERTIFICATION

Not applicable.

☑ PARTNERS

The virtual training center has numerous partners (40+) in the three states – primary care outlets, academic, professional associations, and governmental.

☑ FUTURE STRATEGIES

Information not provided.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

No.

☑ CONTACT INFORMATION

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Vermont Assuring Better Child health and Development Project

✓ **TITLE**

Vermont Assuring Better Child health and Development (ABCD) Project – one of four states that is part of the Commonwealth Fund ABCD consortium

✓ **MISSION**

Using an ABCD grant, the Vermont Department of Health integrated and expanded existing programs into Healthy Babies, Kids & Families. The goal is to create one program serving all Medicaid children ages 0-5 that provides preventive services related to early childhood development. The program outcomes are to provide a broader range of services and support to more Medicaid families throughout the developmental continuum of 0-5 years, and to increase the state's ability to meet its public health and quality improvement goals related to maternal and child health in areas such as immunization, infant mortality, and service and emergency room use.

✓ **VISION**

To improve the health and well being of families receiving Medicaid services through a comprehensive system of care.

✓ **BACKGROUND**

The Healthy Babies program began in Vermont in 1994.

✓ **START DATE**

Approximately 2-3 years old. Commonwealth Grant Period: April 2000 – March 2003.

✓ **TARGET AUDIENCE**

Parents, pediatricians, and other health professionals working with children are the target audience.

✓ **ACTIVITIES**

Assuring Better Child health and Development is intended to help states improve early childhood development services through state Medicaid programs via a variety of programs.

Vermont's ABCD project has integrated two existing home visiting programs and expanded their scope to better serve families with Medicaid eligible children ages 0-5. The Healthy Babies, Kids & Families program resulted, which provides comprehensive preventive services related to early child development. Service options include home visiting with case management, phone consultation, targeted educational material that highlights child development, and group education for parents and care givers. The phone consultation is a new service.

Grant strategies and activities have centered on creating a comprehensive set of parent educational materials; increasing the competency and efficacy of professionals conducting home visits; streamlining the assessment, monitoring and referral processes; and gathering information from parents that can be applied to increasing skills of home visiting professionals and making it an overall better experience.

Vermont's ABCD plan emphasizes improving provider practice in early childhood development by using Dr. Barry Brazelton's "Touchpoints" training model. Over 900 practitioners in the state who work with families have been trained using this model. "Touchpoints" emphasizes partnerships between parents and professionals centering on key points in the development of young children. The approach is targeted for providers working with parents prenatally and through the early years, with the goal of actively involving parents in observing their babies as a unique individual with a variety of skills and abilities. Pediatric providers report that they find the tool useful in helping parents get to know their babies.

The [Brazelton Touchpoints Center](#) trained a leadership team consisting of the Deputy Secretary of the Agency for Human Services, a leading Human Services Pediatrician, the Assistant Director of Public Health Nursing for the Division of Community Public Health, a University of Vermont psychology professor, and a program director in the Child Care Services Division. The leadership team provided direction and supervision to the faculty who were also trained by the Brazelton Touchpoints Center.

Local training teams were then developed to cover the state. Each team was responsible for conducting five 16-20 hour classes in their region between May 2001 and April 2002. The 12 Vermont Department of Health District Offices provided logistical support for training space, invitations, and registrations. Faculty teams were responsible for planning trainings, recruiting families to interview, and submitting paperwork and billing for Continuing Education credits. The central office of the Vermont Department of Health handled oversight of the entire project, provided training material, faculty team packets and conducted the evaluation.

Touchpoints has been incorporated into all staff performance expectations and many District Offices have included a "Touchpoints moment" in staff meetings. A WIC (Women, Infants, and Children) nutritionist has developed an in-service, "Using Touchpoints in WIC." The Family Support Worker Competency Validation Tool incorporates Touchpoints principles as a validation item.

Vermont has enacted a comprehensive statewide initiative in a short time because of its small size, but also because the existing system of care and collaboration facilitated the process. Touchpoints has served as a unifying force to facilitate even better relationships among providers in this system. The interdisciplinary nature of Touchpoints training has helped workers at all levels to share a common approach in working with families.

\$25,000 per faculty level training was spent for each group of 25 providers in early care and education and 25 general health care providers. The 50 initial trainees were chosen from a pool of applicants who had been approved for the training by their agencies/organizations.

Collaborating partner agencies provided in-kind services of faculty time in the initial year of the training.

✓ SUCCESSES/CHALLENGES

In about 2 years, over 1,000 providers have been trained with Touchpoints. Training is ongoing, as well as developing reflective practice opportunities within agencies and within

collaborating partner groups. Related trainings in the areas of neonatal behavioral assessment and pregnancy and early postpartum antibody screening tests, which are based on Touchpoints principles, have also been offered to targeted providers. These approaches are targeted toward fostering early maternal-fetal attachment and parental understanding of newborn behavior.

The Touchpoints Initiative currently is offering two Touchpoints Institutes per year for Touchpoints trained providers to provide an opportunity to focus on the Touchpoints principles of practice. In addition, training is provided for new staff at least once per year in each region, north and south.

✓ ANNUAL OPERATING COSTS

Touchpoints Training Budget is \$30,000 per year plus the in-kind services of over 50 staff.

The cost per training with 3 paid faculty for 20 people is approximately \$5,000, depending upon facilities costs and whether food is included in the training costs (\$250 per participant for the 20-hour class). When in-kind services are used, costs are greatly reduced.

✓ FUNDING SOURCES

Funded as part of a three-year grant from the Commonwealth Fund Grant, with additional funds from the Vermont Child Care Services Division.

✓ SERVICE CHARGES/INCOME

After the completion of the Commonwealth Fund Grant, conference fees of \$35 are being charged and Touchpoints Training registration fees will be charged. Additional grant funding will be sought.

✓ MARKETING/PROMOTION

Local District Offices worked with their community partners to recruit initial trainees. Later, word of mouth and training fliers were used.

✓ ORGANIZATIONAL STRUCTURE

Located at the Vermont Department of Health and Child Care Services Division in the Agency of Human Services.

✓ RELATIONSHIP WITH STATE

Involvement and continued support from the (Deputy) Secretary of the Agency of Human Services; Commissioner of Health and Community Public Health Division Director; AAP-VT Chapter; Pediatric Department of the UVM School of Medicine; VT Childhood Improvement Project; and Deputy Commissioner of Social and Rehabilitative Services and Child Care Services.

✓ STAFFING

Administrative staff, Community Public Health Specialist, Program Director in Child Care Services, Training Coordinator, and administrative support staff.

✓ ACCREDITATION/CERTIFICATION

Continuing education credits are available.

✓ PARTNERS

Obstetric and Pediatric providers; home visitors; child care providers; Program staff - WIC; Head Start; Early Intervention (200-400).

✓ FUTURE STRATEGIES

Plan to continue implementation of the Healthy Babies, Kids & Families program's expanded menu of service options, as well as to continue provider training.

✓ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

✓ CONTACT INFORMATION

800-649-4357 - Phone

802-863-7333 - Phone

<http://www.healthyvermonters.info/cph/hbkf/hbkf.shtml>

— Yakima Valley Farm Workers Clinic —

✓ TITLE

Yakima Valley Farm Workers Clinic – Spanish Speaking Parents of Children with Special Health Care Needs

✓ MISSION

The mission of the Yakima Valley Farm Works Clinic, its Board of Directors, and its employees, is to improve the quality of life for farm workers, the under-served, and others as we work to strengthen the health of our communities. The clinic believes in the right of wellness for all in a comprehensive, preventative approach to health. The goal of the particular capacity-development project is to assure access to comprehensive, community-based, coordinated, and family-centered services for children with special health care needs and their families in central Washington and to promote the effectiveness and efficiency of community integrated services provided at Children’s Village (one of the Yakima Valley Farm Workers Clinic points of service).

✓ VISION

Information not provided.

✓ BACKGROUND

This project was implemented as a requirement of a Maternal-Child Health Bureau (MCHB) CISS/COG (Community Integrated Service Systems/Community Organization Grant) entitled “Capacity Development and Sustainability of Integrated Services for Children with Special Health Care Needs.”

✓ START DATE

2000/2001.

✓ TARGET AUDIENCE

Enhancing the clinic’s ability to better serve Spanish-speaking parents of children with special health care needs through conducting focus groups. However, there were other pieces/objectives to this project, including an examination of service capacity and implementation of strategies to increase capacity, as well as an examination of services for Native American families.

✓ ACTIVITIES

In an attempt to explore potential barriers to and solutions for Hispanic children and families seeking clinic services at Children’s Village, Yakima Valley staff completed key-informant interviews with three monolingual Spanish-speaking parents whose children access services at Children’s Village. Parents were recruited through Children’s Village Parent to Parent Program. A Hispanic registered nurse (RN), fluent in Spanish and trained to conduct these interviews, conducted the key-informant interviews. The interviewer completed interviews with parents from three families – two mothers and one father. All interviews occurred in October and November of 2001. All interviews were conducted in Spanish, audio taped, then transcribed in Spanish and translated into English.

In addition to the three interviews reported above, the examination of capacity for Hispanic and Native American families included a community assessment of services and needs (a needs assessment document) to identify area of concerns in serving Hispanic families.

✓ SUCCESSES/CHALLENGES

Through interviews, clinic staff obtained detailed feedback from participants on barriers to service for Spanish-speaking parents whose children access services at their clinic. As a result of the interviews, Yakima Valley Farm Workers Clinic may make changes/initiatives in staff linguistic and cultural competency, material development, and structure of parent support groups, as well as address issues related to transportation, hours of operation, coordination with public schools and general outreach to the Spanish-speaking community.

✓ ANNUAL OPERATING COSTS

There were minimal costs involved hiring a community RN to conduct interviews. The transcript analysis and other related duties were built into the internal budget of this capacity-development project funded by the Maternal-Child Health Bureau.

✓ FUNDING SOURCES

Information not provided.

✓ SERVICE CHARGES/INCOME

Information not provided.

✓ MARKETING/PROMOTION

Information not provided.

✓ ORGANIZATIONAL STRUCTURE

Information not provided.

✓ RELATIONSHIP WITH STATE

Information not provided.

✓ STAFFING

Hispanic RN fluent in Spanish who was hired by contract (minimal costs) to conduct the interviews. Internal staff did transcription and analysis.

✓ ACCREDITATION/CERTIFICATION

Information not provided.

✓ PARTNERS

Internal activity.

✓ FUTURE STRATEGIES

A similar project with Native American parents of children with special health care needs was successfully conducted. That analysis is complete and available upon request.

☑ INFORMATION REVIEWED BY PROGRAM STAFF

Yes.

☑ CONTACT INFORMATION

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Appendix B

Online Information Sources on MCH

FEDERAL GOVERNMENT AGENCIES AND RESOURCES

Administration for Children and Families

<http://www.acf.dhhs.gov/>

Bright Futures for Families

<http://www.brightfuturesforfamilies.org/>

Centers for Disease Control – National Maternal and Infant Health Survey

<http://www.cdc.gov/nchs/about/major/nmihs/abnmihs.htm>

Centers for Disease Control – National Center on Birth Defects and Developmental Disabilities

<http://www.cdc.gov/ncbddd/>

Childstats.gov

<http://childstats.gov/>

Fatherhood Initiative – USDHHS

<http://fatherhood.hhs.gov/index.shtml>

Head Start Information and Publication Center

<http://www.headstartinfo.org/>

Maternal and Child Health Bureau

<http://www.mchb.hrsa.gov/>

Maternal and Child Health Bureau – Women’s Health USA

<http://mchb.hrsa.gov/data/women.htm>

Maternal and Child Health Library: A Virtual Guide to MCH Information (from the National Center for Education in Maternal and Child Health)

<http://www.mchlibrary.info/>

Maternal and Child Health Information Research Center

<http://www.mchirc.net/CH-USA.htm>

Maternal and Child Health Policy Research Center

<http://mchpolicy.org/>

National Child Care Information Center

<http://nccic.org/>

National Children’s Center for Rural and Agricultural Health and safety

<http://research.marshfieldclinic.org/children/>

National Information Center for Children and Youth with Disabilities
<http://www.nichcy.org/>

National Institute of Child Health and Human Development
<http://www.nichd.nih.gov/>

National Women's Health Information Center
<http://www.4woman.gov/>

Office of Minority Health Resource Center
<http://www.omhrc.gov/>

Parenting Resources for the 21st Century
<http://www.parentingresources.ncjrs.org/>

Safe Youth – National Youth Violence Prevention Resource Center
<http://www.safeyouth.org/home.htm>

PRIVATE ORGANIZATIONS AND PROJECTS

Advocates for Youth
<http://www.advocatesforyouth.org/>

Annie E. Casey Foundation – Kids Count
<http://www.aecf.org/kidscount/>

Children's Defense Fund
<http://www.childrensdefense.org/>

Children's Health Environmental Coalition
<http://www.chechnet.org/>

Child Trends
<http://www.childtrends.org/HomePg.asp>

Child Welfare League of America
<http://www.cwla.org/>

Families USA
<http://www.familiesusa.org/site/PageServer>

Future of Children – The David and Lucile Packard Foundation
<http://www.futureofchildren.org/>

Kid's Health

<http://www.kidshealth.org/>

National Campaign to Prevent Teen Pregnancy

<http://www.teenpregnancy.org/Default.asp?bhcp=1>

National Center for Education in Maternal and Child Health

<http://www.ncemch.org/>

National Parent Teachers Association

<http://www.pta.org/>

National School Safety Center

<http://www.nssc1.org/>

Peristats – March of Dimes Birth Defects Foundation

<http://peristats.modimes.org/>

Planned Parenthood Federation of America

<http://www.plannedparenthood.org/>

Resource Center for Adolescent Pregnancy Prevention

<http://www.etr.org/recapp/>

Zero to Three: National Center for Infants, Toddlers, and Families

<http://www.zerotothree.org/>

UNIVERSITY-BASED PROGRAMS

Bright Futures (Georgetown University)

<http://www.brightfutures.org/>

Center for School Mental Health Assistance (University of Maryland)

<http://csmha.umaryland.edu/csmha2001/main.php3>

Children, Youth, and Families Education Research Network (University of Minnesota-Twin Cities)

<http://www.cyfernet.mes.umn.edu/>

Early Childhood Research Institute on Culturally and Linguistically Appropriate Services (University of Illinois-Urbana Champaign)

<http://clas.uiuc.edu/>

Harriet Lane Links (Pediatric Points of Interest) (John Hopkins University)

<http://derm.med.jhmi.edu/poi/>

Institute for Child Health Policy (University of Florida-Gainesville)

<http://www.ichp.edu/>

Maternal and Child Health Managed Care Resources (University of Illinois-Chicago)

http://www.uic.edu/sph/cade/mch_managed_care/

National Center for Cultural Competence (Georgetown University)

<http://www.georgetown.edu/research/gucdc/nccc/index.html>

Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health

(University of California-San Francisco)

<http://youth.ucsf.edu/policycenter/>

Women and Children's Health Policy Center (John Hopkins University)

<http://www.jhsph.edu/wchpc/>



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