

Building and Sustaining Partnerships Early Head Start and Healthy Start Programs Improving Outcomes for Children and Families

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Christina Benjamin: Good afternoon. I'm Christina Benjamin, Special Liaison to the Office of Head Start and the Early Head Start National Resource Center. Welcome to "Building And Sustaining Partnerships, Early Head Start and Healthy Start Programs: Improving Outcomes for Children and Families."

In this webcast, we'll be talking about successful collaborations between Early Head Start and Healthy Start programs across the country and how these partnerships support low income, pregnant women, infants, toddlers, and their families. This webcast is a follow up to an earlier one produced by Healthy Start in August, 2010, titled, "The Rewards of Collaboration: Healthy Start and Early Head Start in Action." A copy of this webcast can be found on the Maternal and Child Health Learning website. Details about how to access it are also available in the Viewers' Guide for this webcast.

In that earlier webcast, we highlighted some Early Head Start and Healthy Start programs that had outstanding collaborations in their communities. Today, we'll be hearing from other programs across the country about how they have built and sustained their own partnership efforts. We hope that by highlighting these successful collaborations, we might encourage you to develop similar efforts in your own communities. To help us kick off this webcast, we invited two federal representatives to join us: Amanda Bryans, director of the Education and Comprehensive Services Division at the Administration for Children and Families, Office of Head Start, and Dr. Hani Atrash, director of the division of Healthy Start in Perinatal Services and the Health Resources and Services Administration's Maternal and Child Health Bureau. Earlier, I had an opportunity to talk with Amanda and Hani about their agencies' missions and why they've developed this strong partnership. Let's take a look.

Thank you both for joining us to talk about the collaboration between Early Head Start and Healthy Start programs, and how we can support each other's work. We have a dual audience for the webcast. Some of our viewers are from Early Head Start and some of our viewers are from Healthy Start. They might not necessarily know very much about each other's programs, missions or services they provide. So, I thought I would ask you both to give a brief overview of your programs, just to make sure that all of our viewers have the same, basic understanding. Amanda, let's start with you. Could you please give us a brief overview of Early Head Start?

Amanda: Thank you, Christina. On behalf of Yvette Sanchez Fuentes, the director of the office of Head Start, I want to express our excitement about the ongoing collaboration with our partners at Healthy Start. The Early Head Start program was created by Congress in 1995 to serve the needs of children under the age of three, and pregnant women. The program was created in response to research that demonstrated that the first three years of life are a period of tremendous growth, and that babies' health and development are directly influenced by the quality of care they receive and the relationships that they have with their families and caregivers.

Early Head Start is a child development and family support program. The mission of Early Head Start is to promote healthy prenatal outcomes for pregnant women, to enhance the development of very young children, and to promote healthy family functioning. Early Head Start serves approximately 110,000 children under the age of three, and more than 16,000 pregnant women, through 1,028 programs in all 50 states, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands. These programs offer their services through center-based, home-based, and family child care options, as well as, through combination program options. Regardless of the specific program setting, the work that we do in Early Head Start is grounded in a belief that strong and nurturing relationships provide a supportive framework, in which infants and young children grow and thrive.

Christina: Thanks, Amanda. Hani, could you please give us an overview of Healthy Start and its mission?

Hani: Thank you, Christina. Like Amanda, I'd like to express how happy I am to be here today, and, on behalf of HRSA administrator, Dr. Mary Wakefield, to confirm Healthy Start's commitment to working in partnership with Early Head Start programs. Healthy Start is an initiative mandated in the Public Health Service Act, to eliminate health disparities and address factors associated with infant mortality and poor perinatal outcomes, through grants to project areas with high annual rates of infant mortality. Healthy Start began in 1991 with grants to 15 communities with infant mortality rates from 1.5 to 2.5 times the national average.

Today, there are 104 Healthy Start projects, serving populations in 179 communities and 39 states, Washington, D.C., and Puerto Rico. Approximately 38 - 40,000 women receive case management services from our programs, and 640,000 community participants receive public health information and education. All Healthy Start grantees are required to provide certain core services to women and their families during pregnancy and for two years after pregnancy. These core services include direct outreach and client recruitment, case management, health education, interconceptional care, which is care focused on improving a woman's health and reducing her risk factors from the end of one pregnancy

to the beginning of the next pregnancy, and depression screenings and referrals for women during their pregnancy through two years after pregnancy. Healthy Start grantees have great flexibility in how they deliver their services. However, they share some characteristics that are proven to increase success. For example, all Healthy Start programs are community driven. They use peer outreach workers, home visiting, and other techniques that insure their efforts are relevant and sensitive to the particular needs of the women and families in the communities they serve. They are also service focused. They provide medical and supportive care, help with food, safety, housing, and other basic human needs. And empower at-risk women to advocate for themselves and their families.

Christina: Thank you, Hani. And partnerships are an important part of Healthy Start program. Isn't that right?

Hani: Yes. Every Healthy Start grantee is required to have a community-based consortium of individuals and organizations, including women and families served by the program and agencies responsible for administering block grant programs under Title V of the Social Security Act. These consortia also typically include public health departments, hospitals, social service agencies, members of the faith and business communities, and other programs that support at-risk pregnant women and their families, which, of course, would include Early Head Start. Healthy Start projects also are required to develop and implement a comprehensive local health system action plan to improve the quality and the effectiveness of services, to meet the needs of pregnant and parenting women and their families.

Christina: Thank you, Hani. And, Amanda, partnerships are a key part of Early Head Start programs as well. Could you please tell us about that?

Amanda: Yes, yes. Partnership building is included in the Head Start Program Performance Standards, the standards that all Head Start and Early Head Start grantees must implement as a condition of their grant funding. Program Performance Standard 1304.41A1 states that grantees must take an active role in community planning, communication, cooperation, and the sharing of information. The goal of these partnerships is to make sure that there is maximum support for families who need it the most. So, partnerships are really built in to the work that we do.

Christina: Thank you, Amanda. Could you both please talk about why this partnership between Early Head Start and Healthy Start was established, and what your agencies hope to accomplish? Hani, would you like to start?

Hani: Sure. Thank you, Christina. Clearly, Healthy Start and Early Head Start are two very different programs with equally important, but unique, goals, objectives, target outcomes, and program requirements. We both have our own strengths, but we operate in many of the same communities, offering services to women, infants, and families with the highest level of need. Our programs started meeting together regularly in 2009 to share information about our services and discuss how we can help promote partnerships between Early Head Start and Healthy Start across the country. Not surprisingly, we found that many Early Head Start and Healthy Start programs were already working together, through both formal and informal service agreements, to support high-risk mothers and infants in their communities. It is essential for programs to leverage local resources in order to be most efficient and effective in meeting the critical needs of at-risk women and families in their communities. One organization cannot do everything by itself. You need to focus on what you do best and bring that to the table to serve the needs of the families.

Christina: Thank you, Hani. Amanda, is there anything you would like to add?

Amanda: As Hani said, both programs have their own strengths. Healthy Start programs are the experts in their communities on maternal and child health, particularly, on issues related to infant mortality, low birth weight, and racial disparities in perinatal outcomes. And Early Head Start programs have that strong child development piece. They provide comprehensive services that support the healthy growth and development of infants and toddlers, from healthy sleep and nutrition, to supporting babies' social and emotional development. By working together, the two programs can have a huge, collective impact on very young children and families. That's why Hani and I are excited to hear from the program panelists today. They've been doing some wonderful work in their communities to support pregnant women and babies and are real role models for collaboration. I think that other programs watching will get some great ideas from them and will hopefully be inspired to set up similar collaborative efforts in their own communities.

Christina: Amanda and Hani, thank you both. I think that conversation really demonstrates a commitment to partnerships between Early Head Start and Healthy Start programs at the national level by both organizations. Now, I'm joined by panelists representing two local Early Head Start and Healthy Start collaborations: One in Gadsden County, Florida, and another in Pittsburgh, Pennsylvania. First, representing Florida, I'd like to introduce Rebecca Pruet, the former director of Florida State University Early Head Start and current assistant in research at the university's Center for Prevention and Early Intervention Policy. Next, also representing Florida, we have Dr. Maurine Jones, executive director and CEO for the Center for Health Equity Incorporated, which runs the Gadsden Women to Women Project, a federal Healthy Start program. From Pennsylvania, I'd like to introduce Cheryl Squire Flint, executive director of Healthy Start Incorporated in Pittsburgh. And our fourth panelist is also from Pittsburgh,

Deborah Gallagher, Early Head Start director at the Council of Three Rivers American Indian Center.
Thank you all for joining us.

Before we begin our conversation, I want to be sure to call our viewers' attention to the Viewers' Guide, which was developed to accompany today's webcast. If you haven't had the opportunity to download it, I would encourage you to do so. You can use the link on your browser, which you'll find located under the word, "resources," on the right side of your screen. Also, if you're not able to watch today's webcast in its entirety, don't worry; an archived version will be posted on the Head Start Early Childhood Learning and Knowledge Center, the ECLKC, where you can view it, at any time.

Now, let's start off with a little background about your programs. I'll begin with our team from Pittsburgh. Cheryl, can you tell us a little bit about your Healthy Start program and the community that you serve?

Cheryl Squire Flint: Yes. Our program in Allegheny County is one of the original 15 projects. Pennsylvania had the dubious distinction of being the only state that qualified to have two projects from Pennsylvania. We're a case management medical, psycho-social model that targets African Americans. At any given time throughout the process, we are providing case management services to 750 women. It's on a rotating basis. The program targets females who live in the area, from childbearing age to 44. The objective of our program is to provide services as it relates to breast feeding, case management in-home, done by a multidisciplinary team, comprised of nurses, social workers, and outreach workers, help in identifying and navigating systems of health and human services. We do postpartum screenings and referrals for both males and females, because we believe that if the mother is healthy and the father is healthy, the outcomes for the child are better and they are better prepared to enter life and have a good quality of life.

We have a 24-hour help line that is manned and anyone in the county can access that information and be connected to resources, again, that overall help them. We have a health education curriculum that does mailings each month that go out to over 5,000 individuals. For providers who are in our network, they are able and encouraged to share that information. So, while we say it's 5,000 that go out, we actually probably reach many, many more individuals with messages that are pertinent to their outcome and health. We give assessments, we do risk assessments, but I think what's the most important thing is the ability to be able to collect the data that we have and to share that information and to meet valuable objectives that improve what we're doing and support what we've done, and shows us where we need to be able to make changes. We monitor immunizations age appropriately, which, again, we haven't always, as a county, been on top of that. We're able to see that it's improving and that children are being raised in homes where they are healthy and ready to progress onto life.

Christina: Thank you so much, Cheryl. Debbie, as the Early Head Start representative from the Pittsburgh area, can you give us a little bit of background about your organization and the children and families that your program serves?

Deborah Gallagher: Well, the Council of Three Rivers American Indian Center Early Head Start program is one of the four Early Head Start programs in Allegheny County. Our program services families in the south Pittsburgh communities across the river from the city and northeast Allegheny County. We have 70 children--22 of them are in home-based services; forty-eight of them are in-home based services, sorry, and 22 are in-childcare services. Ninety percent of those children and families live at or below the poverty level, some in housing communities. We service...15 percent of our children have an IFSP or-- which means they have a special need of some sort. And we also have a large population--about 12 percent of our population is immigrant population from Nepal, Bhutan, or Somalia.

So, that is a new service that we're providing, some interpretation services as well. "Kindergarten readiness begins at birth," is a tagline that we have in Allegheny County. And it absolutely happens before that. We have quality child development services that we provide to the children and families. We do developmental assessments, ongoing screenings, vision screenings, hearing screenings, comprehensive medical follow through--from every well baby check-up to every immunization that they have, as well as mental health services and referrals. We do referrals for adult education and literacy, because kindergarten readiness begins with the mother and child relationship, and reading is a big part of that. Job skills training for family self-sufficiency, as well as assistance for families in obtaining income support that they may need, health insurance that they may need, and meeting any other basic need. Because, also, school readiness begins with the family having the basic needs to move that child forward, as it grows.

Christina: Thanks, Debbie. And can you and Cheryl tell us a little bit more about how your partnership began? Did it develop in response to a particular need in your community or an issue that you wanted to address?

Deborah: Well, our partnership goes back over 20 years. It began when the community discovered that there was a large infant mortality rate in the Allegheny County, Pittsburgh area. I ran a family support center 20 years ago--this was way before Early Head Start was even funded. And we were one of the first programs to go to the local consortia meetings with Healthy Start, as they began from a grassroots up.

After we received the Early Head Start grant in 2000, it was just a natural partnership to continue working with Healthy Start because infant mortality had gone down, and we wanted to keep it low.

Cheryl: One of the main things was the Healthy Start program took a different approach. And they wanted community involvement. It was going to be a bottom-up approach. That is to say, often when programs came, they had the infrastructure and the strategic planning built in. This was different. The Healthy Start program said that consumers, those recipients of services, would have to have involvement at every level of the planning and project. And a special effort was put forth in Pittsburgh to be able to get their input. And their input came. And they identified the resources that they felt would be needed. And, of course, school--being ready for school, having healthy children, getting that early childhood development, learning about what was important, as it related to milestones; so, they named programs that traditionally might not have been included. The job of what the people who were planning it--I like to call them visionaries and trailblazers, because they listened and they heard and they made it happen. And so, when we say 20 years; it's actually been longer than that. But there was an effort set by the community: If you're coming in, we're going to take ownership of this program and we are known now as a community driven model that is participant-based and functions under their monitoring and guiding and direction.

Christina: Thank you both. And now, let's hear from our Florida panelists. Becky, could you please tell us a little bit about your Early Head Start program and how you serve families in that particular community?

Rebecca Pruettt: Okay. We serve Gadsden County, Florida, which is--many people think about Florida when they think of beaches and suntans and sunsets, et cetera. And we serve a small, rural county in northern Florida, which is just to the northwest of Tallahassee, our state capital. So, our area--our service area is more like rural south Georgia. It is a very--it's an agricultural region. Formerly, it--the agriculture there, the main crop was shade tobacco, and shade tobacco was grown to roll cigars. And the tobacco was shipped to Tampa, actually, to roll cigars. But, now, it is an agricultural area with small crop farming. It's a fairly unique county in Florida, in that the population is a majority of African American--about 58 percent of our population is African American. The rest of our population we serve are white and Hispanic. The program started approximately in '96, we were funded. And we applied for Early Head Start funding during Wave 2, to continue our services that we had started under Healthy Start. Florida State University being the grantee of a Healthy--a federal Healthy Start program; and we applied for the Early Head Start grant to continue and expand our services that had begun in Healthy Start. We're funded to serve 68 children and families and expectant women.

We...throughout any given program year, we usually serve between 15 to 20 expectant women. Our eligibility is based upon, of course, the federal poverty guidelines. And we have a number of children enrolled in our program who are also served with--through the part C early intervention program for our state. We are a...both...we...prior to this year, we offered our services through the home-based model and a center-based model through a community child care partnership, of which, unfortunately, we had to end last year with some unforeseen circumstances. But we are now looking for an additional child care partnership. But for this current year, we are an all home-based services program. We use the partners for a healthy baby curriculum, which is a home visiting curriculum that was developed through our program. We, of course, offer prenatal and postpartum education services and support, parenting education and, of course, parent and child activities, child development and ongoing assessment, health, nutrition, dental, and mental health services. And we provide, of course, linkages and referrals to other agencies in the community.

Our program is primarily focused on child development and school readiness. And in our program, we have the motto of, "school readiness actually starts in the womb." I heard Debbie speak of their program motto, but we believe it really does. It starts in the womb, and helping our families prepare for the birth of their child and that relationship building begins at that point.

Christina: Thank you so much, Becky. And Maurine, can you please share with us a little bit of background about your Healthy Start program?

Dr. Maurine Jones: Yes. As Becky said, the federal Healthy Start program was awarded in 1995 to the Center for Prevention. And then the Center for Health Equity, actually took over that program in 2000. And so we're no longer affiliated with the university, although we collaborate, of course. The goals of the program are targeting the--targeting the poor birth outcomes of African-American families--women and their children, and to reduce the number of infant deaths, to improve the overall health of African-American women before they get pregnant. And then also, one of the charges--important, critical charges that we have--is to look at the system of care and to, in fact, collaborate with other providers in the community, which we do.

We provide services to pregnant and nonpregnant women, although our focus, primarily, in Gadsden County, based on the needs of the community and what we saw as some of the gaps, said that we should focus on interconceptional care. So, that's our main focus, although we do serve pregnant women as well. The services that we provide are provided through case management and care coordination. Just as Cheryl was saying, we provide outreach; we provide education; we provide education through--in the home, through case management, but also in small group--peer support groups throughout the community and the schools and in churches and so on.

We also provide nutrition assessment and nursing assessment. This is so that we make sure that we link our consumers with a medical home. If they're not--if they have no prenatal care, we make sure they have prenatal care. And once they have the baby, we want to make sure that they are linked with a primary care provider, so that we can start talking about the importance of well women care and preventive care. And we also provide mental health screening and counseling. The other services that we provide, include physical activity. We have, actually, a physical educator that goes out in to the community and does Zumba training. And, then also does one-on-one training with our clients who want to get healthier by losing weight, for example.

Christina: Great. Thank you so much, Maurine. And your collaboration is a little bit unusual, because it includes four different organizations. Could you please tell us about that?

Rebecca: Yes. Our home visiting partnership does include the other home visiting partners' programs in Gadsden County. These include, not only our federally funded programs of Early Head Start and Healthy Start, but we also have a Healthy Families program, as well as, a state Healthy Start program. This was an initiative started in Florida around 25 years ago under the leadership of then-governor, Lawton Chiles. And we're very proud of our partnership between all of our local partners in Gadsden County. And I know there's--there's sometimes some confusion...you will hear us refer to federal Healthy Start and state Healthy Start and Maurine will tell you a little bit more about the difference in those programs.

Maurine: Yes. As I mentioned, the federal Healthy Start program provides some prenatal care to women--about 30 women--pregnant women are served. The rest, 187 to 200, are nonpregnant women--either before pregnancy--either prenatal, I mean interconceptional or preconceptional--sorry. The state program is funded through the Title V program office and serves all 67 counties with 32 coalitions representing them. And so, again, they have primarily prenatal care services and postpartum care. They do prenatal and infant screening--universal screening. And so that is a very important collaborative for us, is the state Healthy Start program. They also have--their program also has some--of the similar kinds of services that we're talking about, in terms of education, mental health services, and so on. But, in our community, because it's the state Healthy Start and the federal Healthy Start program, we refer to the federal Healthy Start program as the Gadsden Women to Women Project, to differentiate the two.

Christina: Thank you so much for that additional clarification. Now, let's talk about how your partnership works on a regular basis. And we're going to go back to Cheryl and Debbie. Could you give us some specific activities that you collaborate on together?

Cheryl: Well, I think we're pretty unique in Allegheny County through our consortium. Our consortiums-- there are six of them. They have a minimum of 18, a maximum of 23. And they are chosen, again, by the people in that region as to who sits on that consortium. And it's based upon the needs of the community and what they feel the services are that best benefit those families who live there. Debbie happens to be the chair of Region 4, the south side. And the consortium, as Dr. Atrash mentioned earlier, is a mandated component. Every Healthy Start program has to have a consortium. A consortium is defined as a group of individuals who work on behalf of the community in a collective fashion. Debbie, do you want to tell them about the consortium and the role that we have carved out that is done in Region IV?

Deborah: Okay. Our consortium meets every other month and we bring back to the board of directors and Healthy Start what the community is feeling about services that have been received, have not been received, would like to see more of, would like to see less of, or would like to try a new initiative. We have a number of projects that we have worked on over the years. One we just finished last Thursday, was a Healthy Start educational event, which we termed a "baby shower." Because if we term it an educational event, it's not quite so well attended. You entitle it a baby shower with a literacy focus, and everybody comes. I spoke about the milestones of infants and toddlers and their reading life, from the fact that they're going to start chewing a book, to start ripping the pages, to turning the pages, to actually mimicking what their parents are reading to them. We had a librarian speak about how reading to a child can de-stress the child and actually de-stress the parent. And then we had a person from the Pittsburgh Association for the Education of Young Child speak about raising readers and what books they should go to the library and use with their children in the libraries, bring home from the libraries-- or if they're fortunate enough to be able to purchase a book, which books are good for that avenue. Additionally, Healthy Start has, every year, provided the Pittsburgh communities and the consortias with an opportunity for training. It's called their annual symposium and it is coming up on May 4th or 5th-- 6th? Okay, I lost track of my days. And this year, it is on relationships. And relationships that women have. And relationships with friends, relationships with significant others or spouses, relationships with people in the community and relationships with their children. And it is an absolutely fantastic event to send our Early Head Start staff to, to learn about from the speakers that come in, but also to network with all of the Healthy Start staff and the other community staff that are within the area. And the topics for these yearly symposiums are driven by the consortia. There is also a leadership training that they do every year that we take part in, and that is held in December. So, we--as they call them consumers, we call them families, they get to go and get some leadership training so that they can become advocates for themselves and, more importantly, advocates for their children. And become involved in the community.

Cheryl: We're particularly excited about this year's topic, because you often heard about going to your girlfriend and being able to tell them everything--not necessarily your mom, your aunt, your grandmother, but the girlfriend. And our participants came to us echoing that that connection is no longer there. There are numerous reasons why that bond that had been developed over years has deteriorated to the point where the network that was so entrenched and established, has gone.

And that they needed and wanted to talk, and that they didn't want local because views are inbred. They wanted to hear from other people whether they were experiencing the same thing. And as we started to go out and identify panelists, we began to learn that, indeed, that's a national trend. And it has to do with decisions that we are making, based upon some choices and behaviors that we have adopted. Friends now become competitors and it's usually about relationships that have been long term. And that's what we're going to discuss. But, more importantly, we've developed a relationship with the community where they feel comfortable in our life skills classes that we have, telling us that this is a problem and we want you to help us with it.

Christina: Thank you so much, Cheryl. I'd like to talk a little bit more about communication. Going back to Maurine and Becky, what have you found to be helpful in your communications system, to sustain and continue your partnerships?

Maurine: One of the things that we've talked about a little bit earlier is that forming these relationships is a long term thing--and it may begin informally. But what we found is that, in order to maintain that kind of relationship, we started having more formal meetings, regularly scheduled once a month--every third Thursday of the month--so that people had it on their calendars and they could prioritize it for that. So, we always have very, very good attendance. We also make sure that we keep an agenda and we send it out in advance to make sure--there's a template that people add what they want to add that is important for their particular program at the time. Although the--this meeting looks at system issues as well, so--that really impact all of us--but it's important to have an agenda. And then we also keep minutes because we actually--this is a very good meeting. Everyone really enjoys this meeting because we get so much done, accomplished. And so we like to make sure that we have the minutes, and we send the minutes out in advance of the next meeting, so that we all remember what we said we were going to do. Because, we usually have some task or, you know, strategy for what we want to do to address particular system issues. So, that really keeps us all informed about what we want to do, how we want to do it, when we want to do it and who's going to be involved--which of our agencies will be involved in that.

Rebecca: I think one of the most important things that we've done as our community management team, is we developed a matrix of services that is included, I believe, in the viewers' packets. But this matrix of services lays out--it's a side by side comparison of all of the various home visiting programs in our community and it's been a wonderful tool to--for both our community members to see where we may have--where we can identify gaps in services in the community--but also similarities and just a little bit the difference in our targeting of which types of families that we may want, that are referred to, say, our Healthy Families program or to Early Head Start. And our--our matrix has helped, also, our staff, to understand. Because, our home visitors are all out in the community and they may meet each other coming and going and it's helped our--our home-based staff actually learn more about the other

programs in the community and making referrals specifically on--to help with--with issues--specific issues that one program may not be able to address all the issues that a family might--the needs that the family might have. So, that's been a--that's been a good working tool for our collaborative group.

Christina: Thank you, both. Maurine and Becky, do you have any other meetings as well, in addition to your regularly scheduled monthly meetings?

Maurine: Yes. In fact, the project managers meet monthly as well and that's where they do case staffing. It's very important for us to really understand what the population that we're serving--the high risk population--is getting exactly what they need, based on their risk assessment. In some cases, we might find that a family has multiple risks and so that might require that more than one of our agencies be in the home to provide case management services. And so what we developed, as a result, was a tool. And, again, I think we have that tool available in the packet for the audience as well--that identifies the consumer--identifies what those risks are for the consumer and for her family. And then, based on that, if this family has a premature baby, we want to make sure that Early Head Start is in there because we want to look at the attachment between the mom and the baby. They may have some very serious mental health issues we want--that maybe the federal Healthy Start project would take on, as well as the health of the mother to make sure that she doesn't have a subsequent birth before 18 months. So, that tool has been very good for us to make sure that we're not duplicating services and really overlapping the services where we need to with this different strengths and different programs.

Christina: Thank you so much, Becky and Maurine. Moving on to Cheryl and Debbie, which types of communication systems and processes do you have in place that support your collaboration together?

Cheryl: We have quarterly meetings. There was a need to get all of the home visitors in a coordinated fashion and we all developed what's called a home visiting network. And they hold quarterly meetings. It's been in operation for--since about 1997. Again, another rich history trying to develop and then tweak, you know, what we're doing and see what works and what doesn't. We also have a communication, as we all develop what would be our risk assessments or plans of care. We have a referral system that's developed, and before they leave, we have what are called weekly case reviews where discussion is gone out among the multidisciplinary team to determine what are the best referrals for this particular family. And then our staff is talking with any other of the home visiting staffs and updating them on what care we have viewed in our initial intake and assessment that this family is going to need. And, when necessary, case conferences take place--and definitely before the person--the family child has reached age two, there's the referral process and the discussion as to why this particular agency was chosen and what the ongoing needs we view to be are. That's one of the ways.

Deborah: As Cheryl was saying, we have a home visiting network. And one of the projects of the home visiting network was a refrigerator magnet, which is a pocket refrigerator magnet that all of the home visiting staff that go in and out of a person's home can put their business cards in. Or, if they don't have a business card, they can put their name and address, phone number, contact information. Because we have found some of our needier families, who need multiple services coming in and out of the home for whatever reasons at the time, know the worker walking in the door, know the name, know what they're there for, know what to work on, but have no clue as to what agency they are from. So, when the next agency walks in the door and wants to know who else has been in there so that they can coordinate, basically through the home visiting network, they say: "Oh, it's so and so," but I don't know where they're from. So, we try to relieve that by having the refrigerator magnet. We only piloted it since October. We will get the results at our next home visiting meeting in June, because in March, we were going to send in the data to see how well that worked. So, that's one way we're trying to communicate with each other. Another way is through the case conferences. There--an example of that was we had a grandmother that moved in to our south side service area, who had just received custody of her 4 children--grandchildren. And unfortunately, this grandma was not prepared. It was a very sudden relocation of the children, as they normally are, and they went from about three weeks all the way up to six years old. She needed food; she needed beds; she needed clothing; she needed school; she needed to know what to do, because I'm a grandma and I know that things have changed since I was a mother. So, she needed to be updated on the latest of how you raise a baby and when--what you feed them now and how you put them to bed--and it's not on their tummies anymore. So, those were some of the things that we worked on. But Healthy Start and Early Head Start were both in the house at the same time, working together deciding who could do what, when they could do it, and how we could do it and how we could work together. Another example of that is with the mental health services. Early Head Starts are required to have mental health contracts, but sometimes the services there aren't as good as we would like them to be, because the contractor isn't available when we need them. But if we call the social worker at Healthy Start, we can probably get a home visit scheduled a little faster than with our mental health consultant, just because of timing. So, that is a great collaboration that we have there as well. We really work hard so that we don't duplicate services or--there's nothing worse than going--having two people in the house doing the same thing at the same time. So, we want to make sure that we're coordinating and that we--we talk with each other about what's going on.

Christina: Thank you, both. Now just, you know, take a moment and think back to when you first began your collaboration and partnership. How did that start out and, you know, what were some of the initial activities that you worked together on?

Deborah: Well, as the Early Head Start grantee back in 2000, when we first got our funds, we were a staff of five. We've grown to a staff of 10--so, we've grown over the years. But one of the things that we did not have was a nurse. So, we went to Healthy Start and said, how can we work this out?

And so we approached it from the fact that Healthy Start had the nurse; they had the expertise at the time, they had the funds, and we worked together. So, the home visitor and the nurse worked together, until such time we had some quality improvement money that came along that we were able to finance our own nurse. But it was an absolutely great partnership when we started it out. And as we have grown, we have also been able to work on other aspects of working together--particularly, with the social work and with a project with Dr. Wisner, when she was at the University of Pittsburgh, on the depression and perinatal depression of parents.

Cheryl: I think--I'll go back to talking about the vision that the implementers and the board had, as to the services that were needed and what would be a part of our infrastructure. We believe getting a child until the age of two is critical in getting them ready to be able to go to school. And the natural fit, the similarity as to outcomes that we're looking for, are the same. But ultimately it comes about, what is this child going to need to be able to have a quality of life? And our programs mirror that and so the natural fit is there and there is a commitment to make it work. We believe it's all about the relationships and the communication and we've built that in and we make it work and it's worked for 22 years.

Christina: Thank you, so much, for sharing about how your initial collaborations began. Becky and Maurine, how about you? What are some challenges that you have had to overcome in your collaborations?

Rebecca: Well I think, as far as challenges, when you're in a rural community with less resources, you have a lot of--of need to work together. You know, they say necessity is the mother of invention. Well, in Gadsden County, where there are fewer resources, as we worked together and looked at the gaps in the services in our community, we were able to really see how each of our programs could begin to fill in the gaps. And I think that our monthly meetings and just developing that level of trust, really, initially was a challenge, but the other challenge that I think programs that have--in collaboration--is the fact that you always need to anticipate change. And when there may be a change in leadership in one of your programs, that that sometimes can present challenges to the partners that have been working together for a number of years when they don't have that history of where we've been and what our vision is of where we want to go in our partnership. I think, again, the formalized meetings and documenting what we're doing is very, very important, so that new leaders coming in can see how--see our history of how we've solved some local problems together, in looking at the local system of care. And--but whenever you have a change in leadership and those dynamics of your communication and developing trusting relationships, I do believe, you know, that is something that you really have to consciously work on in a partnership.

Maurine: I think that one of the first things that we found, and many communities find this, is that, with programs, there's some turf guarding. And so that is a difficult issue to overcome. And I think what we found, certainly what I found, was that if--if I--and I was very sincerely interested in what the other programs were doing. What are their concerns? What are their goals? What are some of their restrictions? Because, if there is something that you would like to do, but another program is restricted in some way...if you don't really fully understand that, then that can really cause some friction. And so you have to be very mindful of what the other program's responsibilities, roles are--and so that you can figure out how to dovetail those programs together to make them more--more effectively, more efficiently. You know, it's not...it can be an intimidating process to begin, but it is well worth the work. It does take time; it does take patience; it does take understanding; but, it is certainly worth the effort.

Christina: Thank you, so much, Becky and Maurine. Now, turning back to Cheryl and Debbie, what other advice do you have or suggestions would you have to give programs that are considering beginning or initiating a collaboration, based on your experience?

Cheryl: When Debbie and I discussed, I talked about open communication and putting out there, from the beginning, what your plan is. And making sure that you're willing to compromise, but truly understanding that what the objectives and outcomes that you're looking for.

Deborah: And it helps to have a partnership where their leadership believes strongly in collaboration. Because you, as a leader need to be setting the tone by going to the meetings yourself, by knowing who the leaderships are and who the other staff are. At the agency, I'm blessed to be able to know the whole agency because, as part of the consortium, I'm also on the Healthy Start board of directors, so that I can speak to my staff and say, "well you need to call this person to take care of this," because that is their role. And I think it's important that you understand the inner workings of the other agencies--because you cannot do it all yourself. If you set the tone from the top, your staff will not view it as territorial. And that's one of the worst things, you know? When they say that there's another home visiting agency in there, you look at it as an opportunity of what they can help you do and collaborate. With Healthy Start, there is so much that they can help us do. And, you know, you just have to set the tone and provide the training and connections, so that they understand that it's a positive for them in the growth of their professional career, plus for the growth of the children and the families, who are the most important.

Christina: Thank you. What about having a memorandum of understanding? Cheryl and Debbie, I know that you've worked successfully with--for many years--without having that. Maurine and Becky, do you have something similar to a memorandum of understanding or a memorandum of agreement?

Maurine: Yes, we do and I will say that that too, takes quite a while to get to that point. Because the memorandum of agreement is really a written documentation of the years you have spent building relationships and figuring out how you're going to work together successfully. And it's a good tool to have, particularly, when you are looking at other funding sources and opportunities and they want to see that document of collaboration. So, in that way, it's an excellent tool. But it's just the beginning, really. As I've said, from there, once you set that in writing, then everybody has agreed to it; there's a consensus; everyone has signed that memorandum of agreement, and then you begin to really create other kinds of instruments that allow you to work together more effectively. And we talked about two of them--our matrix that outlines each of our programs and what we do, how we're the same, how we're different, as well as the tool that we use for co-managing clients. Those kinds of things come, I think, in the evolution of the relationship. So, it's a good thing to have.

Rebecca: I think one thing that we should also point out is, as Debbie said, that leaders in the community set the tone for your collaborative partnerships and how your staff --how your direct service staff interact with each other. One of the other things that we've done in our community, and you mentioned, Debbie, training--we've done a lot of joint training, across our home visiting programs. Luckily, the federally funded programs are Healthy Start and Early Head Start, usually have a little more funding to do training and bring training in to the community and--and that is a great way to collaborate and have your front line staff meet each other, in a more--an informal way, and really to begin to learn a lot more about each other's programs and develop some camaraderie and respect across programs in the community. So, that does a lot to break down some of those--those barriers or that territorial--the turf guarding that sometimes you might see in a community. So, we've had some wonderful experiences in our joint training activities.

Christina: Thank you, so much. Let's talk about some of the program changes that may occur, due to turnover in organizational leadership, staff and families. Debbie and Cheryl, can you give us some insights or perspectives on how you can sustain a partnership, you know, amongst those different changes?

Deborah: Well, one of the ways that I, as a leader--and, mind you, I've been doing this for 20 years, so--but eventually, I will retire. So, I want to make it in to the plan for my successor of who I've collaborated with and what we've done. So, we have performance standards, which have been mentioned several times on this show. And as part of the performance standards, we are required to have a work plan. And the work plan coordinates with the performance standards and states what we need to do. Now, there is this cute performance standard that says that you will engage in the community and you will partner in the community. And on my work plan, we list who our partners are in the community. So, when the predecessor comes in and they have a book that already states who we're partnering with, how we're partnering, and what we do--if it's written down, it will happen.

We also have a succession plan. I think part of the success of Allegheny County is, there is very little change over. In our 20 year-plus history, there have been really two executive directors. So, the consistency is there; the acceptance of what the organizational structure is; the consortia is mandated; the partners are laid out according to the community, and all you have to do is follow the plan.

Christina: Great. Thank you, so much. Becky and Maurine, what advice do you have to offer to our viewers about how to sustain a collaboration over time?

Maurine: Well, I think we've kind of touched on some of the significant points of making sure you understand it's a relationship. And I think a commitment and a reiteration of the importance of not maintaining the silos, but rather, integrating your system so that you're working together, that you are leveraging the limited resources that you have--particularly, if you're in a rural community. So, that's very, very, very critical. And, again, people are a little tentative about their funding, but I find that, particularly with the trainings, we can provide, as Becky said we have more funding sometimes. So, one of the things that we like to do is share it with all of the community--all of the programs in our community, so that they understand how we really do all have very good staff well trained professional staff, but we also all have individual strengths--and they need to understand that. So that's a very, very good part of collaboration and it makes an example of why we need to sustain it.

Rebecca: And just to reiterate, it truly is--it, you know, I know we say a lot in Early Head Start, that--how much we emphasize relationships. Relationships between moms and dads and their babies and their toddlers--and also about the relationships between our staff and the families that we serve. But, in the same vein, it's all about the relationships that we have within the community, and the partnerships--the relationship is what sustains the partnership over the years. That's pretty much it in a nutshell, I think.

Christina: Thank you, both. And I think this is an excellent note to close on, because, of course, it's all about relationships--our relationships between babies and families, babies and their caregivers, caregivers and families, as well as organizations in the community who are working together to help ensure that pregnant woman are healthy, as well as, the babies and families are able to grow together and also thrive. I would like to thank all of you for joining our panel today. Cheryl, Debbie, Maurine, and Becky. And I would also like to thank Amanda Bryans and Dr. Hani Atrash for their federal welcome. And, of course, thank you, our viewers, for joining us today. As always, we welcome your feedback.

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