

MCH/ CSHCN Directors Webcast, February 12th, 2004

PETER VAN DYCK: Good afternoon. Welcome to the MCH webcast coming to you from HRSA in Rockville, Maryland. This is the latest in a series of monthly interactive webcasts for MCH and CSHCN directors. I'm Peter van Dyck, HRSA associate administrator for Maternal and Child Health Bureau. The integrated health services and state demonstration program will be featured today. This program begins fiscal year 2000 out of the recognition that, number one, women's healthcare is fragmented, two, in many states Title V programs already focus on and provide a variety of services for women beyond pregnancy-related care and three, Title V agencies are noted for their skillful work with others to improve the system. Currently there are 12 grantees funded under this initiative and the grantees with us today, Maryland and Indiana, represent two unique approaches to infrastructure development. And we will be hearing from each of these grantees on site today.

Maryland's involves expanding comprehensive women's health services at the county level first and then expanding statewide. Indiana women's prison is beginning with a correctional system and coordinating with family planning and other programs to strengthen the network of services to incarcerated women when they're released from prison. What we intend for you to learn today is how you can strengthen women's health through coordination across programs and benefit from the lessons learned by these two projects. It's timely since the

bureau is currently offering funding for up to three more of these grants. The application deadline is April 16. HRSA application number is 04-063. And more information is available, as always at the HRSA grants website www.HRSA.gov. I hope you enjoy the webcast. I'll turn you over now to Chris DeGraw for technical details today.

CHRIS DEGRAW: Thank you, Peter. Just a few comments about the technical aspects of our presentation today. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You don't need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. We encourage you to ask the speakers questions at any time during the presentation. Type your question in the white message window on the right of the interface, select question for speaker and hit send. It would help if you could identify if it's a question for a particular speaker, please identify that speaker. Please include your state or organization in your message so that we know where you're participating from. The questions will be relayed onto the speakers periodically throughout the broadcast. If we don't have an opportunity to respond during the broadcast we'll email you afterwards. We encourage you to submit questions at any time during the broadcast.

On the left of the interface is the video window. Adjust the volume of the audio

using the volume control sliders access by clicking on the loudspeaker icon. Those of you who selected accessibility features will see text captioning underneath the video window. At the end of the broadcast the interface will close and you'll be able to respond to some questions. We would appreciate it if you do so. We're always ask for your suggestions for future webcasts so you can include that in your evaluation form. Now I would like to turn the broadcast over to Lisa King. She's a women's health specialist at the Maternal and Child Health Bureau and she'll be moderating the program part of this webcast.

LISA KING: Welcome, everyone. I'm Lisa King and I'm the women's health specialist for the Maternal and Child Health Bureau. Today you're going to hear from first Dr. Diana Cheng who is the medical director with the Maryland Department of Health and Mental Hygiene and she'll be talking about her project, the women Women Enjoying Life Longer Project or the WELL project. After Diana you'll here from Janet Schadee from the Indiana Women's Prison. Her presentation is entitled, a working model of integration and collaboration of MCH programs within a women's prison. I think you'll find her project very interesting, too. Thank you for tuning in and first up is Diana.

DIANA CHENG: Thank you. I'm delighted to be here this morning to discuss our women's health project in Maryland. What I'm going to be doing in the next 15 or 20 minutes is really describing the women's health project known, as Lisa said, as the women enjoying life longer, WELL for show. What this project is, it works

on building an infrastructure for women's health in Maryland and translating it into actual programs. When we said we're the pilot -- we put up the title program and that first slide is the partnership of title 10 and Title V. It seems to be a natural partnership. When you think of it the Maryland family planning program and the women's health services part of Title V targets the same population. It targets the reproductive population age of women and women with difficulty with access to healthcare. The next slide is kind of busy but it shows what the title X family planning does in terms of services. It goes way beyond contraception, history and physical exams, breast exams, blood pressure and hemoglobin tests. Genetic screens in terms of checking for we did HIV counseling on every woman and testing if desired and check for -- it's already a fairly comprehensive program but what we thought we would do is really add additional services to this already great program. What we did was thought about what services we wanted to add.

We were guided by three main principals. This is what guided the whole WELL project. The first principle is there was a gap between health services, family planning services and health services needed. What I mean by that we would see a woman coming to family planning. They were smoking, maybe domestic violence problems or they had a nutrition problem. What happened is even though we gave them the birth control through family planning they would come back year after year with the same problems so we wanted to do something to help facilitate their healthcare. The second guiding principle that we were looking at was that women of reproductive age need comprehensive health services that

promote physical and emotional wellness beyond reproductive health. Even if these women did not have medical problems beyond needing contraception we really felt that every woman had a basic need for counseling in terms of nutrition and physical activity. In terms of getting the basic screening that the U.S. public health service recommends and we really wanted to tell women and make them aware of all these other healthcare needs. The third principle is that premature death, chronic and acute disability can be prevented by targeting the risk factors earlier in life. It's one of the key reasons why we picked the family planning program. We're seeing women at a fairly young age. We see women generally between the ages of 10 and 50 but we even see women below the age of 10. And I think this is a very critical fact that if we actually interconvenience at these early ages. Really the counseling and the prevention of osteoporosis occurs when the women are teens and earlier in getting enough calcium in their diets and enough physical activity. After we selected the family planning program for where we wanted to do the women's health services, we further selected which sites we wanted to go to.

The next slide is a map of Maryland and what is shaded is Baltimore County. We decided to really pilot these projects in the eastern part of Baltimore county and picked three sites on the eastern side. You'll see the sites, they're very different. The first one is eastern family resource center, a community center that is on the grounds of a large community hospital. They're right across the border of Baltimore city. The second site is Essex health center. It's part of a strip mall and

serves the population in eastern Baltimore county. The third site is a health center. That site is right across the street from an elementary school and in a large residential area. At these three sites I think we see about 1700 women each year and I have to say since the program started that number has really been increasing. I think it started out at about 1200 when we started the WELL program and now we have 1700 women a year that we see.

The demographics of the kind of populations we're serving at these three places. We see that by poverty level 98% of the women there are at or below federal poverty levels. Only 2% are above federal poverty levels. It's a very low-income area. When we looked at the means of payment of these women, we see that 80% are uninsured. They have no health insurance, and only 13% have medical assistance. 6% are private and the interesting thing about the women who have private health insurance is that a lot of these women were uninsured when they came to us and then even though they got their own private health insurance still continue to come to us. 1% is other. Looking at the demographics by race, we see that 58% are white, 32% are black and about 10% are Asian and other, and it's worthy to note that 7% are Hispanic. Really under 60% are white and almost over 40% are other races. When we look at the demographics by age we see that 33% are teens. 43% are in their 20's. 18% are in their 30's and 6% are in their 40's. I think this older group is really increasing year by year as well.

The first thing that we did when we started the project is we wanted to do a

community needs assessment. By a community needs assessment I really mean a really local community needs assessment right in the eastern Baltimore county where we would be seeing patients. We worked with a university to help education department to do this. One of the things they did is they interviewed providers and clients who were in the area or would go to the health center and they asked them about what they wanted or didn't want in women's health services. They also did a resource guide of the services that were available in Baltimore county in their area that they live in. And they also did an evaluation tool.

One part was just filling out a very broad women's health test and seeing how women did on it. What do women know about women's health? I'm going to describe a little bit of this view in more detail. On the next slide you'll see their healthcare service needs from both the interviews with the providers and the clients were very, very similar in what they thought was a priority. Both the clients and providers wanted nutrition and exercise as part of their service needs. They wanted vision and dental care, general healthcare, mental healthcare, alcohol and drug abuse, counseling about violence, smoking cessation, and medication.

The clients wanted some help with legal and social services and support groups and the providers thought there was need for transportation, insurance coverage and childcare. At the same time in this next slide what we also did as well for the state was we did a women's health data book. We looked at the status of women

in the state in terms of maternal mortalities, in terms of what women die of. What women have as chronic diseases and we really looked at that as the state as a whole and kind of combined the two community assessments together. On the next slide you'll see that we also worked on our resource guide for eastern Baltimore County. The university helped us with this. She went to the area and talked to all the organizations and services and got their listings and got their phone numbers and it was a wide variety of services. Anything from dentistry to flu shots and on the slide you'll see that. For each listing she has four descriptive icons. One is who should come for the service, the second one is what services are being offered, the third is the cost of the services, and then who provides the services is the one with the clipboard.

And you can see this as a typical example. I think this one is from possibly a shelter for adolescents. You can see this caters to adolescents 12 to 18, and provides shelter services for them. It's at no cost and that caseworkers and interpreter services are available there. It's a really nice guide for people who live in that community and for providers to provide referral services for their women and patients. The next part was the test. This was a general women's health test that we concocted. What it was was we asked women who came to the clinic 20 questions about general women's health. And you can see some of the results here. Some were surprising. The majority of women, I would say greatly over 50%, did not know that heart disease was the number one cause of death. We've seen this a lot in the news these days, too, but they thought breast cancer was

the number one cause of death and it's not true. Most women didn't know that hepatitis B is a sexually transmitted disease. They didn't know a bottle of beer has the same alcohol content as a glass of wine. They didn't know that fruits were a good source of calcium and they didn't know that depression occurs before menses than after. Most women thought it occurred after menstrual cycles. This is just about six of the questions but it was a 20 question test.

On the next slide you'll see that we graphed the results of the test and women really did not do very well. They all had practically a failing average on the test and there were only two questions that they got above 60% on. The majority of don't know the answers to these basic questions to women health and things we would want women to know about. On the next slide you'll see what the infrastructure for the WELL project is. For that part we really have two separate sets of infrastructures. We had a state level infrastructure and that was composed of all the different programs at the state health department that had to do with women's health. It was a very internal committee and it had members from really a wide variety of programs such as aids administration, chronic diseases, domestic violence. Primary care, mental hygiene, Medicaid, health education, alcohol and drug abuse, cancer registry. We came together and focused on women's health. It was an excellent committee just to see what we had in common in terms of women's health. To counter balance this we also had a Baltimore county task force directed to the WELL project. It was basically just the same grouping of Baltimore county health departments but it also had

community organizations in the eastern Baltimore county area.

The Franklin square hospital or bay view hospital and had women who go to the clinic and they were participating on the task force. They had the local domestic violence shelter there, family practitioners. It was a nice group of programs that we really could refer to or could refer to us in terms of women's health. Between these two programs we fashioned our priorities for women's health in the WELL project. I have to say that the program is really very client centered, as it should be. We interview the clients in terms of what they wanted, we established the Baltimore county task force and four of those numbers are clients who are part of the clinic system. We have a lot of health center events and we really ask the patients who go there what they want in terms of events. The health programs are fashioned after them and the clinical guidelines are made with them in mind completely. So with the guidance of the steering committee with the task force, with the community needs assessment and our own state data book we really established some priorities and goals for the WELL project.

And the next slide you'll see some of the programs that we decided to add to the well project and add to family planning programs. I'm going to read off just a few of them and then I'll be explaining them more in detail. One is smoking cessation, TMDD, depression treatment, screening and referral for alcohol abuse, drug abuse, domestic violence, depression, general medical screening. We do adult immunization, counseling for menopause. We do cholesterol levels and diabetes

screening and needs assessment as part of the ongoing goals. I'm going to take these through a little bit at a time. In the general counseling part which is the major part of the Title X family planning program not every woman gets a one-to-one counselor screening before they see a clinician.

We already do HIV counseling, and other things. Every woman gets nutrition counseling talking about her diet, about obesity, about what obesity does to a lot of chronic health conditions and talk about physical activity for every single woman and how important it is to her general health. For women who are out there we do menopause counseling as well. We ordered a lot of pamphlets and brochures to help women have materials to bring home with them. These materials are anything from breast cancer to cholesterol levels to thyroid screenings. We also have promotional items on the lower left side. These are items that we think really help drive the point home. We have a shopping list for women to take to the grocery store with them and it just is really highlights calcium as being one of the things they should be looking for. We have rulers with calcium on them and we have our favorite is the stress and to remind women about the calcium and a lactose intolerance sheet as well.

Here again on the left side you'll see the part that we already had in the title X program such as cervical cancer screening, screening for sickle cell. Smoking. What we've added is domestic violence screening, depression screening, substance abuse screening and general medical screening. Now we're doing

cholesterol levels on women who are 20 and over and repeating them every five years according to the U.S. public health service guidelines. We do thyroid screening for women 35 and over and diabetes screening for women at high risk. One of the sample questions we do for domestic violence screening and every woman at her annual exam will fill this out. It is an excellent screen for abuse and violence. The next slide shows some screening cards we developed for the family planning project and basically the screening cards are really nice because they really have drawn from the CDC program and the U.S. public health service program and we've taken every decade of life for women and tell them what they should or shouldn't be doing and screen for during each decade. We give these out during family family clinics. It's an invaluable tool to them to know what they should be screened for. The next part is treatment options. What we've done is added a lot of treatment options to the family planning program.

We now do smoking cessation so that all women get counseled about smoking. They get nicotine patches as well. We used to see so many women in our family planning sites who wanted to stop smoking but couldn't afford to go through the nicotine patches or gum or just didn't have the facilitation to go through the program. Now we have a health education counselor really being with them and going through the program and really helping them out with that. I think they really are bonding to the nicotine patches. They've been going very, very quickly. We also screen for pre-menstrual disorder and depression. And we go out to that. We write them prescriptions. We find so many women in our clinic really

have severe PM,S and postpartum depression or general depression. It's something that -- it's twice as common in women as men. I think the screening is really helping a lot of awareness of depression and antidepressants can really be very helpful.

The other program we've added is immunization. In that program we already were doing RUBELLA immunizations. We have a very high risk population that we see in family planning and we also see them fairly often and a lot of times with the hepatitis B it's a three-shot program. A lot of women get lost in the shuffle. They'll come back for the second or third shot. This is an ideal place to offer the immunization. That's been very popular as well. We also started tetanus immunizations. That's something women should have every ten years. We've given out a lot of them already to our populations. On the next slide you'll see one of the things that we really enjoy -- enjoy doing in the clinic. This is a record we give to women. When they come in we record to them their pap smear result. The cholesterol levels so they can take that home with them and know what the next level, whether it's gone up or down. It's a nice comparison for them to have. I really wish private practitioners did this more.

This part is just one page of the report or history that we give them. It's actually about six sides all together in a passport kind of envelope and nice for the women to have. They put it in their pocket books and bring it with them each time they come to the clinic. One of the other fraction we didn't want to ignore was the

clinic staff themselves doing the family planning program. You have to realize here that the family planning staff was already working so hard and doing so much in terms of getting family planning to the clients and here we're asking them to add women's health services as well. What we did was we basically had a monthly program for them where they saw or heard lectures about different presentations on women's health. We did depression, substance abuse, physical activity, general medical guidelines, osteoporosis. I think it was a very helpful way for them to get on board with a lot of these women's health issues and also learn how to counsel women about these. So it was a nice time for the staff to come together and learn about this. I really enjoyed it. I have to say that same test that we gave to the -- our patients at the start of the program we also gave to our staff after they finished this series, too. They all did very well on this.

On the next slide another part we did as the women's health program. One of the nicest things about working in women's health is the number of collaborators you can have to work together on a project. On this project we worked with the Maryland science center. I'm not sure if any of you saw this but a few years ago in 1999 there was a traveling women's health Exhibit that really went cross-country and started by the national academy of science, the Maryland science center was the lead agency on it and they really got together a lot of unique, creative women's health exhibits and we had them work with us on some womens health posters that we held all over the clinic and distributed to schools and other organizations and other clinics across the state. These are two of the

posters that you'll be seeing on the right side is just one that we have for leading killers of women and we have a woman with a heart and EKG pattern and on the left side the other cultures do menopause and how it's different in other parts of the world. Other posters include topics on osteoporosis, nutrition, the ideal image of women through time now in the time of some of the artists in the Renaissance and middle ages it was a much more well-developed women. What we have now is someone who is thin and more athletic. We also have posters on smoking and I think we're going to be giving out more pamphlets and posters in the future as well. They developed a risk wheel for us. It's the risk of unintended pregnancy and the risks of unprotected sex. Basically it's like a Las Vegas wheel and we actually sent to Las Vegas to have it made. After you spin the wheel it ends on either HIV, pregnancy or safe and read the caption that goes with it so it's very educational and fun as well. It was exciting use doing those projects with them.

On our next slide what we did was a community was we had an open house where we actually had all our services together and it took place a few months ago in October. We invited people in the community. Women that came to the clinic. A lot of organizations in the community. Private practitioners, the hospital staff and we also involved, before we had the open house, one of the local high schools and they actually drew a mural for us on women's health. It was getting all these organizations involved, which has been really very rewarding We also did some renovations in the center so that has been part of this whole -- it's kind of this project where everyone in different facets have come together to work on

women's health. I'm going to summarize everything, encapsulating women's health and saying that it's still a title X family planning program project and basically the foundation is in contraception and pre-conception health and reproductive health. What we've done is taken that core and added other services to it.

Preventive medical services including screening and immunizations. We've added health education in terms of physical activity. We have a treatment things with the smoking cessation and mental health screening and treatment and we've added, I think this is the most important piece, a very nice link to referral sites. We've made a lot of contacts and networks and feel free about referring our women who need it to other places in the county. And I think that the infrastructure that we've established in women's health really helped propel this whole unit along. So in summary I think that it's been a very successful program. I think we'll have more data in five or six months when we actually get the data from the last year of the program and how it's been working. I think they enjoyed having extra women's health services saving them a lot of access issues and a lot of time and very convenient. They already know the staff and enjoy working with it. I think the -- both the task force and the Maryland state steering committee have really come together in terms of really being on the same table with women's health. Thank you. I think I'm going to before taking questions turn the discussion over the Janet now and talk about her women's health program in Indiana.

JANET SCHADEE: Thank you very much, Diana. I wanted to say hello to everyone from Indiana and also thank MCHC very much for giving us the unique opportunity to be able to use this grant funding to strengthen our collaborations and integration of services. I previously worked with the Indiana State Department of Health in the Maternal and Child Health Bureau. I had some working knowledge of what was needed. We also are providing multiple services within the prison. If it hadn't have been for the integration of services for Indiana I don't believe this program could have been successfully completed. The program is unique. It's working in collaboration within MCH but in the Indiana state women's prison which is a unique opportunity for us to Exhibit how the program and services that MCH provides can be encapsulated within a prison system. If you would like to contact me the first slide my Internet site is there. On the second slide you can see that it's a unique program. We are the only and first adult female prison within Indiana, the first in the whole United States. We were established in 1873. We're the only female facility still within the confines of that original site as you can see on that first picture. The women in early 1900 there are over 1700 women and girls housed in adult correctional facilities in Indiana. It's to manage in a safe and secure and healthy environment that encourages rehabilitation through quality programming while ensuring protection of public staff and offenders.

This is our population. It is a unique program of services within the Indiana

Women's Prison. We have about 450 women within our facility. We are ranging in ages from 15 to 84. Our facility includes -- we have ten dogs on the I can program. I also have multiple women in multiple programs within the system. The background for females that enter into a female institution are multiple but they're also very similar to what Diana was talking about for those attending family planning clinics. The incarceration rate within the United States has -- for females has escalated at over 300%. Far faster than the male populations within prisons. We know that over 80% report significant mental illness diagnosis. Many with dual diagnosis issues, the special needs populations are escalated.

Unfortunately within our state the mental health institutions have been closed and so now we're finding that prisons have become the mental health institutions for many of our low income populations. 2% of the population have less than a 9th grade education. Over 75% record substance abuse issues and we probably in the last six months I would say that's closer to 90%. Over 85% of the women are victims of abuse since childhood. Most of them from infancy on. Most do not ever seek preventive healthcare services for themselves or children nor have they sought it, their mothers didn't seek it for them as children, either. You're looking at how do we connect them, how do we teach them to be able to reach the services that they are needing.

Most report very high risk behaviors for exposure to HIV and hepatitis B. The last six months hepatitis C population has been at over 60% of our women entering into the prison system. So we know that we have a very, very, very high risk

population but we know that the picture is no different than those that you're seeing out in the community. So we hope that within a prison we can attempt to reach your populations that you're trying to serve in a very controlled environment and teach them to be able to use the systems outside the prison once they get out and also their family members. We know also that many of these women come to us with multiple unplanned pregnancies in the past and obviously who have close to 80 women a year that enter into the prison pregnant that we're dealing with in our program. And as we say over 80% of the women have children and/or are pregnant. The Indiana Women's Prison looks at it in a different manner than Department of corrections programs do. Many look at the women as a place to lock them up and throw away the key.

We hope very much in the MCH programs you will look at the very issues within the Department of corrections for women's health issues as a critical need. We have to say that if it weren't for Maternal and Child Health Bureau commitment knocking at the doors of the prisons asking questions to bring programs in I wouldn't be there today. There is a -- from the Indiana maternal child health program to service the women and their children. We know within the prison we need to have separate housing units and zones. These zones have very specific trained staff around, supervisors and the women's prison is unique in that fact the custody, the operational staff, administration and those of us who aren't even DOC employees are allowed to work together. There is not a custody control of issues within the prison. We work as a team together to service these women.

We know that operational procedures must be different within each population because we do have very special needs populations within our prison.

Specifically the issues around special needs, around illness, around pregnancy, around youthful incarceration. We house all of those within the Indiana Women's Prison. Therefore those within the special needs program do not have the same adult policies for punishment. They would have time out versus possibly being locked up for their belligerence or inappropriate actions.

We look hard at individualizing the services and keep these women safe within their programs. We know that we need to look at 50% nurturing and 50% structure within a prison. I think many of us as parents look at this, this is basically you're attempting to represent these women and teach them how they can learn to better themselves. We try very hard to teach them to give back to others and to respect others and we find that due to the fact that we have the teamwork approach for custody for the staff issues and administration, all that rolls into a role model in respect for those women. We know that we create sleeping bags. We have for the homeless shelters. We have many inner city home projects that we're working with. We have a project down in Honduras where we're having the women make clothing and toys for these -- the children that are in orphanages in Honduras. All ways we can help them get back into community. We place a lot of responsibility on the offenders for programs. We bring in 140 different volunteers weekly into the prison not only just through the women's health initiative but also through church initiatives and other counseling

support.

So at that point we know that we can't bring the programs in nor can we bring the children in if we don't give responsibility to the offenders to keep it a safe place. It's not just the custody staff that can do that. These women know that if they're going to be allowed to participate in our programs that they must keep the prison a safe place. I have to say being in public health for over 30 years being in a women's prison it's the safest environment I have worked in. We have zero tolerance. Our superintendent of the prison believes in not allowing four letter words to be words in any way, shape or form and there is punishment in regards to that. We try to teach them appropriate language. We know the use of profanity will be the next step to violence. With that level of intolerance we're able to control the prison population in a much safer manner. The staff, as I said, we work as a team. We all wear our "how can I help" buttons and that's something that coming from the outside in has been a very useful tool to be able to get facilitation. One of the objectives of my grant was to develop a case management system for the families and their offenders. This program within the Indiana women's prison was the fact we had a family program within the prison.

One of the main highlights of the family program is that we have a summer camp. Literally the kids come in 8:00 to 5:00 Monday through Friday a week in July and the mothers and the children create wonderful crafts and activities. They actually help build an arc which will be used on an educational program for the women.

We have a weather station on there. It's giving the children and their mothers time to interact because oftentimes these mothers have been on drugs and inappropriate behavior before and therefore their children have not seen them as real parents. Now we're giving them the opportunity to do that. The family does represent a promise by the mothers to their children that they'll work hard to work together. Our main objective was to develop towards this grant an interagency infrastructure and integrate preventive health education within the Indiana Women's Prison as well as create community services. Oftentimes these women have no idea which programs to go to. We've given them unique names. Put them in locations which may not be on bus lines or they're within rural communities where they can't access appropriate services. So we see all those things that MCH has been charged to address and we hope that we can help link these women in a more excellent manner.

Through the next slide you'll look at what does it take to do integration of services? I could go on probably for two hours in regards to all of this but that we need programming, we need resources, collaboration, case management and assessment. It takes all of this to get a system working within another infrastructure. We know that there are multiple programs for maternal child health systems. We're trying to bring those together in the prison and maintain that. Resources are a huge avenue. By using people to come in we can use our dollars in a more appropriate manner. Many programs have refused grant funding out in the community and they're looking for classroom space or actual

people to serve and so we've been able to open our doors to the prison and be able to bring those programs within our prisons for free cost to us but that then those programs are able to access the needs of the populations that they need. Collaboration is a huge piece. On the next slide when we talk about collaboration, why does it work within the prison? Part of it is because we have a very collective population. Easy access to a very high population of women and children for program services. They aren't leaving tomorrow. They will open the door. It's not like you're taking a home visit and the offender, family is not there. You can work with these women at all times and most of the time once we start working with the women the families then realize this is something that they, too, need to work on. We're still working with women that left the prison three and four years ago because the families continue to call us and ask, we're having trouble with our bills. Our kids got kicked off of the health program. How do we get back on? We're able to facilitate and help them. So as I say, it's, you know, we have access to high-risk population and we work very hard to keep them connected.

We also have a safe environment within the prison system so we feel we have no problem with bringing outside case management workers for foster care issues or any public health initiatives that may want to come in and do an educational program. We know that we can protect our staff and those that come in. So we're able to do. Sensitivity of the prison staff to assist and coordinate service within the prison is a must. We hope that you'll be able to communicate with your prison system. Start that process of communication if you haven't already. I traveled to

several states, New Mexico for one and talked to other states in Connecticut and so on and have shared information on what we're doing within the prisons and hope we can help you find ways to open the doors and bring your programs within the prison. It takes a lot of communication back and forth to be able to do that. We hope that also with this collaboration we've been able to provide vital health statistics around women and children and be able to meet MCH performance measures better. We know that we have -- we're developing a case management system so our tracking ability for long-term outcomes will be great. We're able to access these women probably over 60% of them after they leave the prison are still maintaining contact with us in some fashion to be able to link back. Many times they're calling us and sharing their successes, which we're very, very glad to hear. And we can then work with their families and continue to strengthen all of this into the maternal child health program. It wouldn't work if we didn't have -- both within the state. Within our communities. And trying to change all the system to be able to meet the needs of these families. And I applaud Indiana's programs because they do work very hard with us and that has helped.

For example, with community and prisons working together on the next slide you'll see the training up children in the way they should go. Our first lady, she was our first lady at the time of summer camp. Our governor passed away this fall, unfortunately. And we have another governor but Judy is staying a friend of the prison and working very closely with us and helps us in our venture towards reaching to these children and it has brought multiple educational programs

within the prison for children's camp and other times. The collaboration of key stakeholders in communities -- state and community stakeholders is very important. We in the grant designed an advisory board which, as I asked those to come forward to help, we noticed that the numbers became overwhelming so we realized we must break it down into subcommittees. With those members we have three legislators. We became a subcommittee of the Office of Women's Health advisory board at the State Department of Health and they've been instrumental in helping us find key stakeholders as well as in the MCH programs. There are multiple state agencies that have comfort and many, many health professionals. Fortunately information technology consultants to help us maintain the large volume of information that we are gathering at this time. So with our Division of activities what we did was we broke down the collaboration into database development, evaluation teams, curriculum. Mental health and transition subcommittees and published policy infrastructure. The published policy and infrastructure. We had many women delivered into our healthy families program initially looked at if the woman was not in the home we were unable to link them into a healthy families programs within our state.

When we talked to the state's program directors of that, they recognized this was obviously one of their most high risk family groups and it's become one of the first priorities in healthy families. If the mother is incarcerated they'll work with the caregiving family. We work hard trying to find a safe placement for those children and they've changed their policies to be able to meet the needs of these women.

Funding sources are a continuing struggle for us because we are totally grant funded. I have six staff currently in the program and I maintain all of those staff along with all their other initiatives, educational and supplies, etcetera, through grant funds. It's a continuous search for that. And I'm always in an attempt to do that. The Department of corrections does not feel that our program is one that they can warrant the funds due to the fact that their dollars are actually restricted by 75% decrease in funding from the state last year for the Department of corrections.

All they have is money for beds and basic services for the women. It's imperative that outside monies are used to keep the appropriate programming going for these women. We know that HRSA has been there for us to be able to provide funding. We use the funding from our family social services administration, through domestic violence dollars and impact dollars. We're able to receive funding from the Department of Health. Both SSA and our initial funding for five years and we're very grateful for their continued support. We are able to now receive funding through services and supplies through title X. Also March of Dimes. Indiana network. Many local churches are helping us as well as teen agencies and community hospitals having services either being educational programs or actual grant funding being made available to us.

Our goal -- one of the first goals was to develop the comprehensive case manager package. Identifying in helping women and children. We are into the

final beta testing for this program and have case management teams now being developed. We have multiple areas where we can do offender information, searchable screens for demographics, child information, growth history and discharge planning forms so that we're able to communicate then back to the community programs to provide -- we're unique and a family information program and the children's center was built five years ago with funding through -- but women actually built all the furniture and so on. This room is actually within the Indiana Women's Prison which is unique. We're the only program in the United States that actually brings children into a maximum security prison within our entire confines. As we look at the goals I will go through these quickly because we've reviewed many of these in the past and I know Diana has talked about the services that need to happen for these women. We are looking at education, nutrition, post-partum and prenatal care. Family planning being offered through funding through the state board of health at this point. And also cooperation with a local hospital here.

We -- we utilize the many wrap around services. Substance abuse the key issue. I think that they have a lot farther to go in that and we're working hard at trying to strengthen that connection and treatment services. The children's issues are Paramount. We have the family preservation program going. We're attempting to link the families into necessary programs through special education, school cooperation, through all the medical services. Early intervention. Mental healthcare connections and trying hard to address mental health issues for those

families. I think that we've integrated our community programs. We have programs from the outside providing -- that come into the prison around survival skills and parenting exercise. Counseling, smoking cessation and a very good domestic violence program through the healthy start funding. And teach the women how to deal with it as they go out and then that counselor follows many of them out into the community. We know as we teach that we can all learn, care and share with one another.

Through coordination and cooperation as keys to survival. Coordination of services is Paramount in our existence. And that's probably what keeps me the busiest throughout this program is to keep universities informed and educated on our need for services. They come in and help us. We also educate the students on, as they get into the field. We know the State Department of Health is Paramount in our assistance helping families. United way, head start has priority enrollment for incarcerated families. We have multiple funds and we hope that you within the MCH programs will be able to help identify within the prisons this kind of collaboration that can happen because oftentimes the Department of corrections staff are totally unaware also of the services and we ask that you can go into the prisons, talk to them and share and get a win/win situation together for these mothers because we know that if we address the women's issues around their families, that we have much less violence. We know that for a fact that the violence has decreased in the last five years that we've brought the family preservation program into the prison and we ask that others take the time

to maybe make that attempt to reach into the prisons also from your state program. We hope in closing that as we've collaborated and coordinated, that there will be safe arms that wrap around all and help them to grow in healthy ways. Women are coming home to you. They will be your neighbors. Many women that are not there for life. They're there for other purposes. And while they're there we hope we can teach them to come back and be your healthy neighbors. We thank you very much and I will turn it back to Lisa.

LISA KING: Well, thank you, Janet and Diana for your great presentations. I don't know how much longer we have. Just a few moments for a couple of questions.

CHRIS DEGRAW: Just a reminder, if you have any questions, now is the time to enter them into the website. We do have one question. This one is directed toward Diana Cheng from Maryland. It comes from the New York Title V program. The question is, how are you evaluating the WELL project specifically what are your evaluation questions?

DIANA CHENG: One of our evaluation sources is that women's health test that we spoke about earlier and we administer a 20-question test to the women before the program started. By the end of the program that these women will do better on the test. It's just to increase awareness of women's health in terms of the screening that stuff done, things like that. Another evaluation piece is the number of women who access the services and we're keeping tabs on that, too,

how many women are actually getting -- it's all voluntary. The women's health services. It's how many women are doing this smoking cessation, how many women are getting tetanus immunizations, things like that. I think it's the two pieces that we're really looking at.

CHRIS DEGRAW: At this point we don't have any other questions. We'll give you a moment to present them if you do have any. I would like to thank both of our speakers and also like to thank you for participating in this webcast. I would like to thank the Center for Advancement of Distance Education from the University of Illinois for making all this technology work. Today's webcast and all of our information on the webcasts will be archived and available within a couple of days on the website www.MCHcom.com. We want to make it as responsive to your information needs as possible. If you have suggestions for topics you would like addressed on future webcasts or have comments in general, please email them to us at info@MCHcom.com. Thank you, we look forward to seeing all of you at the AMCHP meeting later this month and your participation in future webcasts. Thank you very much.