Chicago Sun-Times
June 18, 1994, SATURDAY, Late Sports Final Edition

SECTION: NEWS; Pg. 1
LENGTH: 669 words
HEADLINE: Clinton Backs Plan to Demolish CHA Projects
SOURCE: JIM KLEPITSCH
BYLINE: By Maudlyne Ihejirika
BODY:

Dense, segregated enclaves of poverty such as Robert Taylor Homes should come down, the president of the United States told the Chicago Sun-Times Friday.

In a visit to the world's largest public housing complex, President Clinton endorsed for the first time Chicago Housing Authority Chairman Vincent Lane's $ 2.8 billion plan to begin demolishing and replacing developments such as Taylor.

Lane hopes to raise the $ 2.8 billion through private investments if Congress approves legislation that would permit his agency to borrow $ 750 million from the federal government.

He hopes to use the money to replace much of the city's public housing stock with mixed-income housing that pairs welfare and working families. He also wants to build smaller housing developments scattered more equitably throughout the city and buy housing for welfare families in suburban communities.

Clinton said he will push for the landmark legislation incorporating Lane's plans, currently stalled in Congress.

"I'm for it. We're for it," Clinton said in a brief, informal interview with the Sun-Times. "(Housing and Urban Development) Secretary (Henry) Cisneros has got a whole plan to restructure the way public housing works. It is a way to make it better.

"Smaller units and mixed housing -- opening public housing units for people of all incomes so that you can really re-create a representative community, I think that's a good thing. We believe it ought to be done around the country."

Clinton cited violence in Chicago's public housing in pushing for his administration's anti-crime initiatives, as he did in April.

"This community is like any small town in America," he told about 300 CHA residents gathered at a basketball court at Taylor.

"There's no real difference, except that you have been asked to live in a place where there is too much violence, too many drugs, and not enough things

for our young people to say 'yes' to. You can't just tell them to say 'no' all the time."

For several months, Clinton has featured the Taylor complex in speeches to show what is wrong with public housing. However, in the past he has stopped short of endorsing Lane's plan.

The president, in his address to residents Friday, failed to mention the housing bill. He told residents he would remember their unfaltering spirit in the face of adversity "when we fight for the crime bill, when we fight to reform the welfare system, when we fight for empowerment zones to bring investments and jobs to these communities, when we fight to give you a chance."

Clinton, however, told the Sun-Times later that he includes the housing bill when he speaks of giving public housing residents "a chance."

Cisneros said Friday that Clinton signed off early on Lane's plan, which has caused controversy here with its goal of giving public housing residents options to live wherever they choose throughout the metropolitan area.

"These folks deserve a chance to have a really full life. They deserve better opportunities," Clinton said. "We've got a lot of work to do. I want the people out here to know that I'm pulling for them. I think we're going to do quite well in terms of getting some capital in here if we pass all the legislation."

The housing bill would permit housing authorities to divert up to 50 percent of their HUD funds -- previously reserved for upgrading aging buildings -- to demolition and replacement. That provision has garnered congressional support.

But a provision seeking permission for authorities to borrow billions of dollars from the federal government to undertake large-scale replacement has not.

The plan was undercut when Clinton's budget office insisted that loans be backed by city or state guarantees, and Mayor Daley and the City Council balked.

Lane, who has been working with HUD to find an alternative, said Clinton's support was a good omen: "Of course, this gives me a boost," he said. "The president thinks we're headed in the right direction."

1994, Chicago Sun-Times

GRAPHIC: President Clinton hugs Tiffany Hudson, who is graduating from Beethoven School, as Housing and Urban Development Secretary Henry Cisneros applauds Friday outside Robert Taylor Homes. Tiffany presented Clinton with a "peace quilt" made by students at the school.

Chicago Sun-Times

June 19, 1994, SUNDAY, Late Sports Final Edition

SECTION: SUNDAY NEWS; Pg. 5
LENGTH: 578 words
HEADLINE: Clinton Vows He'll Support New CHA Plan
BYLINE: By Maudlyne Ihejirika
BODY:

A day after visiting Chicago's Robert Taylor Homes, President Clinton on Saturday featured the huge public housing development in his weekly radio address to the nation.

"No issue poses the need to come together more to deal with the problems that we face than does the cancer of crime and violence that is eating away at the bonds that unite us as a people," Clinton said. "I saw it again this week when I visited a housing project in Chicago called Robert Taylor Homes.

"I went there once three years ago. So I'm pretty familiar with all the wonderful people who live there, the good things they're trying to do, and the terrible problems they face from violence and guns and drugs."

Clinton said he chose Taylor for his first visit to public housing since taking office because the South Side development suffers from ailments that he says his crime bill can cure.

"I went there because it's a good place to emphasize to all Americans that we have begun a nationwide effort to drive the guns, the gangs and the drugs from public housing and from all neighborhoods where Americans feel terrorized," Clinton said.

"Unless we do something about crime, we can't be really free in this country. We can't exercise the opportunities that are there for us."

Clinton visited Taylor on Friday, and while he said he found the spirit of Taylor residents rejuvenating, he also said there was a better way for people to live than in the dense, segregated enclave of poverty that is the largest public housing development in the world.

Taylor and developments like it should come down, Clinton told the Chicago Sun-Times, endorsing for the first time Chicago Housing Authority Chairman Vincent Lane's $ 2.8 billion plan to begin demolishing and replacing public housing here.

Lane hopes to raise the $ 2.8 billion through private investments if Congress

approves legislation that would permit his agency to borrow $ 750 million from the federal government.

Lane hopes to use the money to replace much of the city's public housing stock with mixed-income housing that pairs welfare and working families.

Lane also wants to build smaller housing developments scattered more equitably throughout the city, and buy housing for welfare families in suburban communities.

Clinton said Friday he will push for the Housing and Urban Development Department's landmark legislation incorporating Lane's plans. The legislation currently is stalled in Congress.

"I'm for it. We're for it," Clinton said in a brief interview with the Sun-Times. "(HUD) Secretary (Henry) Cisneros has got a whole plan to restructure the way public housing works. It is a way to make it better.

"Smaller units and mixed housing -- opening public housing units for people of all incomes so that you can really re-create a representative community, I think that's a good thing. We believe it ought to be done around the country."

Before meeting with Taylor residents on Friday, the president toured a weapons room in a CHA police station that holds 1,400 guns taken from gang members and others on CHA property. He said in his Saturday radio address that the room speaks to a need to ban assault weapons.

"I saw hundreds, I mean hundreds of those assault weapons in one little police cubicle in Robert Taylor Homes," he said. "We have got to take these weapons of killing away from people who are putting the police at a disadvantage and terrorizing our children and our neighborhoods."

THE WHITE HOUSE

WASHINGTON

June 15, 1994

MEMORANDUM TO THE PRESIDENT

FROM: ANN WALKER

RE: ROBERT TAYLOR HOMES: HISTORICAL OVERVIEW

The Robert Taylor Homes, under the administration of the Chicago Housing Authority (CHA), remains the world's largest low-income housing project. Its history reflects both past and present realities of racial discrimination in public housing and outdated philosophies concerning the nature of public housing in the United States.

The project was completed in 1962 and was ironically named for Robert Taylor, the first African-American to serve as chairman of Chicago's public housing authority (1943-50). Taylor, who died in 1957, staunchly opposed the high-rise concept for low-income public housing. His plan was to build low-rise garden housing that families could take pride in maintaining. The late Dorothy Taylor, his widow, said of the Taylor Homes project in 1993, "he'd be unhappy, he'd tear them down and build low-rise housing."

As a housing project, the Homes conformed to various federal and local goals for public housing. In awarding the money for the project, the Public Housing Authority (PHA), then the federal equivalent of HUD, wanted to insure that no public housing rivaled private housing in terms of cost per unit. Thus, the PHA provided the equivalent of 20 percent less money to build public housing units than an average private unit. The Chicago Housing Authority, faced with the prospect of needing to build large amounts of housing with limited funds, decided on the cheaper high-rise option despite warnings that such housing was inappropriate or even dangerous for families with large numbers of children.

Racial discrimination also plays a large part in the formulation of the Taylor Homes. As early as 1955 in the Administration of Mayor Richard Daley, high-rise public housing was advocated for Chicago's South Side area as a means of containing the city's black population in its so-called "black belt." Because they could accommodate large numbers of people in a relatively small land area (the Taylor homes could house about 28,000 people on 95 acres), high-rise housing complexes fulfilled this purpose. Despite prior attempts by the CHA to spread new low-income public housing into neighborhoods throughout the city, several aldermen granted city council the right to review and approve housing sites of the Authority despite its independent status. There was also a state law requiring the same of the Authority. Mayor Daley accelerated the pace of the high-rise building program on the South

Side throughout his Administration, and the Taylor Homes were but one of the 22 high-rise projects carried out under his Administration. When the Taylor Homes were completed at a cost of $70 million, 28 new sixteen-story buildings stood on Chicago's South Side. Alvin Rose, then head of the Authority, acknowledged the racial implications of the project at the time, saying "any public housing project built on the South Side, apart from Hyde Park, is bound to be all-Negro."

With a large amount of established housing like the Robert Taylor Homes on the South Side, Housing Authority officials now had a means to continue its isolation of poor blacks into specified areas of Chicago. Although this plan was blatant discrimination, support for it was high since its alternative meant that the CHA would spread low-income housing, and blacks, throughout the city into low-rise and/or single-unit dwellings.

In the 1960s, national and local civil rights leaders sought an end to Chicago's high-rise building program because they recognized the damaging consequences that segregated public housing had for blacks. This issue was in fact a keystone of the Chicago civil rights movement. The Robert Taylor Homes, along with its predecessor the Cabrini-Green Homes, became one of Chicago's last high-rise projects. Mayor Daley and Martin Luther King, Jr. reached a "summit agreement" in 1966 on discontinuing the building of high-rise public housing. Three years later, Congress limited all public housing to three stories or lower in design.

The course of the Taylor Homes and other similar housing from the 1970s into the 1980s follows a downward trend toward deterioration. Although the Chicago Housing Authority, under court order, began to follow mandates toward spreading low-rise housing throughout the City, the cost of maintaining the high-rise projects became prohibitive given increasingly limited federal and local funds for public housing. The design of the projects also contribute to their destruction. As families continue to move out of the buildings, upper floors are sealed off, unmaintained elevator shafts become dangerous for small children, street gangs and drug dealers find it easy to occupy vacant apartments and floors, and vandalism and destruction of the building become easier.

The CHA does not have the space to evacuate completely all of the Taylor Homes or its other currently maintained high-rise projects at present, not does it have the money to renovate them. According to recent media reports, there seems to be some community and political support for completely levelling the Taylor Homes and starting all over again.*

* Chicago Urban League favors demolition of Taylor Homes in 4/24/94 *Chicago Sun-Times*, Professor Ed Marciniak of the Institute of Urban Life at Loyola University and the Leadership Council of Metropolitan Open Communities favor demolition of high-rise projects and relocation to scattered site housing in 11/26/93 *Chicago Tribune*. Both Mayor Daley and Chairman Lane of the CHA have not given an opinion on whether the high-rise projects should be demolished.

The President of the United States
Robert Taylor Homes
Chicago, Illinois
June 17, 1985

Thank you, [resident]. I've always felt that if you really want to know what needs to be done in public housing, you ought to listen to the people who live there. Three years ago, before I even ran for President, I came here to Robert Taylor Homes with Vince Lane and I have never forgotten the affection I saw for him that day.

You ought to be proud of people like Chairman Vince Lane, and Mayor Daley and Secretary Cisneros, because they don't spend their time talking down to people in public housing. They spend their time trying to lift our people up.

I ran for President because I wanted to lift people up. To restore the bonds between our government and our people. To renew the sense that, together, we can help others make their lives better for themselves.

Everything I'm doing in Washington -- from the things Sec. Cisneros mentioned, to other work like welfare reform, job training, health care, our community investment strategy and community service -- everything is aimed at giving people more opportunity to take responsibility for the direction of their lives and life in their community.

I came here today because I wanted to show the rest of the country that there are plenty of decent, law-abiding people here at Robert Taylor Homes, and at other public housing in Chicago: Stateway Gardens, Ida B. Wells, Cabrini-Green, and others. There are plenty of people who just want to live in peace and who are desperate for someone to help them take control over their lives.

I know you're eager to do whatever you can. You've done a lot already, through your tenant patrols, your B.I.T.E. teams, and the youth programs that help make a community stable and secure. And I know you're counting on our help. Vince Lane and Mayor Daley are doing their part. Sec. Cisneros and I are doing our part, too. Everyone in America today has got to take responsibility for bringing our communities back together.

When I spoke to some of you by phone two months ago, I made it clear that I see the problem of crime in your community as a national crisis that demands nothing less than an emergency response and a wholesale change in how we go about making communities safe.

That is why the most important thing we can do right now is help people like Congressman Bobby Rush and Senator Carol Mosely Braun pass the Crime Bill, the most comprehensive anti-crime program in American history. This Crime Bill gives decent people like you the tools to join together, to join with us. As you've shown us here already, people are stronger as a team than they are alone.

The Crime Bill will put 100,000 more police in our communities, punish more criminals for what they do to people, and help prevent crime by giving young people summer jobs, and alternative activities that teach self-esteem, respect for others, and an appreciation for work at an early age.

Everybody needs someone they can rely upon, someone they can look up to, someplace where they feel they can belong: a family, a church, a job. These things give structure to our lives. But, let's face it, crime and drugs and violence now fill the vacuum where some of these things used to be. So, all of us have got to work to change that.

I want to help you change that, because I believe that nobody in America deserves to live in a place where bullets fly through the window. Nobody deserves to live in a place that's unsafe and rundown, where drug dealers chase the security guards away. None of you students deserve to live in a place where you have to dodge gunfire coming home from school, where you pray that some gang leader won't try to turn you against your family.

People don't deserve to live in places like that. They deserve to live in a home -- where their dignity and safety are respected.

That's why we found a way to continue the Chicago Housing Authority's sweeps. I know this was controversial, but we did it without stepping on anybody's constitutional rights. We are going to do everything we can under the Constitution to put public policy back on the side of public safety.

I wish all of the intelligent people out there who care deeply about civil liberties would see how hard it is to reinforce civility in public housing and the liberty of people who live here. It is hard to raise children in a place like Robert Taylor Homes. It is hard to be a child, or an adult for that matter, and live among bloodshed and terror every day. Gangsters aren't the only ones with rights. The people of this community have rights, too.

You have right to live in safety; the right to use the playground; the right to go to the store without walking in the line of gunfire; the right to sit by an open window; the right to tuck your baby into a safe bed instead of the bathtub where she won't get shot. The residents of Robert Taylor Homes have the right to live in peace.

And a community has the right to hold people accountable for their actions. We've got to stop making excuses for bad behavior. We will never solve our crime problem or our housing problem until people in this country start raising their expectations of one another, just as so many of you have rightfully come to expect more from life in this community.

What I ask of America today is to think about what kind of communities we want our children to raise their children in tomorrow. That's what Sec. Cisneros has done when he talks about giving people the option of moving out of these high rises and into a real working neighborhood, where people live closer to jobs and economic activity, alongside neighbors who work, where more people take care of their own places. We can build a better future for ourselves if we just keep working together.

The problems we see here didn't happen overnight. They were decades in the making. They may take decades to correct. There are no quick fixes; there are no easy answers; but Vince Lane and Sec. Cisneros have already pointed to a better way. It will take determination and patience to get us there. But we must do all we can to help lift each other up. For each of us has a responsibility to make things better, and all of us must try.

U.S. Newswire
June 20, 1994

SECTION: NATIONAL DESK
LENGTH: 1720 words
HEADLINE: Radio Address by President Clinton to Nation on Saturday, June 18
CONTACT: White House Press Office, 202-456-2100
DATELINE: WASHINGTON, June 18

BODY:
Following is a text of a radio address by President Clinton to the nation on Saturday, June 18:

Robert Taylor Homes
Chicago, Illinois

THE PRESIDENT: Good morning. For a year and a half now, I and my administration have worked very hard to do the right thing by ordinary Americans -- to restore the values of community, opportunity and responsibility that have always strengthened our country. Thanks to you, we're getting the job done on many fronts.

We've reduced the deficit dramatically. We're going to have three years of deficit reduction for the first time since Harry Truman was President. We've expanded trade and increased investment in our people's education and training and in new technologies. All of this has produced steady growth in our economy. There are now 3.4 million new jobs in the economy in the last 16, 17 months -- more than in the previous four years combined.

Meanwhile, we've worked hard to give more of our children a better education, more of our workers a chance to meet the changing demands of the job market. This week we offered a plan to end welfare as we know it, a plan that will encourage personal responsibility and help strengthen our families through tougher child support, more education and training and an absolute requirement to go to work after a period of time.

We've broken seven years of gridlock to pass the Family and Medical Leave Law, to give working families the security of knowing they won't lose their jobs if they have to take time off from work for a child's birth or a sick parent. Seven years of gridlock to pass the Brady Bill to help keep more of our citizens and police officers alive by keeping guns out of the hands of people with dangerous criminal or mental health records.

And then our efforts to reform health care, to provide health care to all Americans -- for the first time ever, a committee of Congress has recommended private health insurance for every American family. We're trying to break 60 years of gridlock and stranglehold by special interest on health care.

Now, each of these accomplishments is important in its own right. But all of them take on an even greater meaning when we see them as part of

our larger mission. That mission is to make it possible for all Americans, without regard to their race, their gender, their income, the region of the country from which they come, to be able to make better lives for themselves -- to face the future with all of its changes with the enthusiasm and confidence that they should have.

Our goal is not to hand anyone anything, but to improve the economy, offer opportunities, strengthen families and communities so that people can assume the responsibility to make a better life for themselves.

No issue poses the need to come together more to deal with the problems that we face than does the cancer of crime and violence that is eating away at the bonds that unite us as a people. I saw it again this week when I visited a housing project in Chicago called Robert Taylor Homes.

I went there once three years ago, so I'm pretty familiar with all the wonderful people who live there, the good things they're trying to do, and the terrible problems they face from violence and guns and drugs. I went there because it's a good place to emphasize to all Americans that we have begun a nationwide effort to drive the guns, the gangs, and the drugs from public housing and from all neighborhoods where Americans feel terrorized. I wanted to underscore how important it is to empower our people to take back their homes, their streets and their schools wherever they live.

Unless we do something about crime, we can't be really free in this country; we can't exercise the opportunities that are there for us; and our children can't inherit the American Dream.

Now, our administration and the Congress must do our job on crime so that the American people can do their job in the communities where they live. We have waited five long years, through partisan and political gridlock, for a crime bill that will address the growing crisis. That's long enough. The crime bill, which has now passed both Houses of Congress, but which must be reconciled into one bill and passed one more time, does provide us with the tools we need to help prevent and punish crime.

Congress is on the verge of adopting this crime bill. It contains almost all the elements of the anticrime plan I've been promoting ever since I started running for President. Now it's time to pass the bill -- to stop talking, to stop posturing, and pass the bill.

The crime bill will put 100,000 more police officers on the street. They'll be visible. They'll know the children and the neighbors. They'll give our communities the power to keep themselves safer. Properly trained and properly deployed, 100,000 more police officers on our street will lower the crime rate and increase security.

The bill will enforce our sense of safety in many other ways. We did what many said couldn't be done, including in this bill a ban on assault weapons. I saw hundreds -- I mean hundreds -- of those assault

weapons in one little police cubicle in the office in Robert Taylor Homes just on Friday. We have got to take these weapons of killing away from people who are putting the police at a disadvantage and terrorizing our children and our neighborhoods.

This bill will provide for capital punishment for anyone who kills a law enforcement officer. It will give serious repeat offenders what they have earned -- a life sentence, by making three strikes and you're out the law of the land. It will make it illegal for teenagers to possess handguns unless they're under the supervision of a responsible adult. It will make our schools safer by giving the most dangerous school neighborhoods in the country more resources to provide for safe schools.

But providing more police and tougher punishment isn't enough. We have to deter crime where it starts. This proposal also gives people something to say yes to. It provides jobs for thousands of young people from high-crime neighborhoods, particularly those who stay in school, off drugs and out of trouble. It gives funds to keep schools open after hours. It adds support for boys and girls clubs, for community activities like midnight basketball. It builds better partnerships between our police and our young people.

An investment in a child is not only a contribution to America's future, it's a real stroke in the war against crime. Those on the front lines of crime, our police officers, have witnessed firsthand the explosion in youth crime and violence, and they know this is true.

A coalition representing more than half a million law enforcement officers nationwide has just written to me and said, "We support the inclusion in the crime bill of substantial funds for prevention programs. They can help make a difference."

Here at the Robert Taylor Homes on Friday I saw young people wearing tee-shirts for peer groups, for Adopt A Grandparent's program, for antidrug programs, for midnight basketball programs. I met adults working in tenant patrols. All these prevention programs are unleashing the grass-roots energy of responsible residents who understand that they, too, have a duty to try to do something about crime. They're young, they're old, they're middle-aged, they want to take their streets, their neighborhoods, their communities back. And we owe it to them to support them. We can only do it if we keep the prevention component of the crime bill.

Now is the most crucial time to make sure your congressmen know you want action on the crime bill. There has been enough talk. We have broken years of gridlock to get the bill through both houses of Congress. But unless it comes to my desk and I sign it, all this effort will have been for nothing. We can give the families of this country the chance to control their own neighborhoods, to raise their children in safety and security. That's what real freedom requires. We can't give up until we've got it.

Thanks for listening.

AP Online
June 17, 1994; Friday 15:51 Eastern Time

SECTION: Domestic, non-Washington, general news item
LENGTH: 571 words
HEADLINE: Clinton Visits Chicago Project
DATELINE: CHICAGO
BODY:

The streets were swept clean and the basketball courts freshly painted to welcome President Clinton to the Robert Taylor Homes, the high-rises that stretch across the South Side in a chain of despair.

"We can make life better here," Clinton promised residents of the nation's largest public housing project.

But people who live in the crumbling towers greeted the visit with a cynicism that grows like the crab grass in the vacant lots of this most violent of Chicago Housing Authority developments.

"They can fix this up for the president," said Jerry Davis, who has lived here all his 33 years. "Why can't they fix it up for us?"

City workers spent hours in the hot sun this week picking broken glass from vacant lots, spreading wood chips across a playground and putting Plexiglas in window frames at Beethoven Elementary School, next to Clinton's speaking site.

On Friday, police cars outnumbered other vehicles on nearby State Street.

"There's all this security here now," said resident Michael Causey. "When the drug dealers are selling by my front door, there's no security."

The Robert Taylor homes stretch across two rugged South Side miles: 28 buildings, each 16 stories high. Only 4.3 percent of the 12,320 residents hold jobs.

Police say the Black Disciples and Gangster Disciples consider the development their personal turf. In one weekend alone this spring, police received 324 complaints of gunfire in and around the development.

Residents say the violent streets have been calmer since an April 15 visit from Housing Secretary Henry Cisneros, beefed-up security and new recreation programs but not calm enough.

"Hey, move everybody out of here," said Dara Gardner, hustling her two toddlers along the hot blacktop outside her home. "Once they start shooting,

you're afraid to take the kids to school."

Students were scrubbed and smiling Friday as they headed for their first chance to see a president. These were street-wise youngsters, 6- and 7-year-olds who blithely held their arms above their heads as they walked through metal detectors to class, their lunches searched by Chicago police.

Federal officials previously had promised an estimated $29 million for better security, housing improvements and recreational outlets for Chicago's public housing residents. Clinton promised Friday not to forget the Robert Taylor Homes.

But some questioned if the visit spells real change for this beaten-down neighborhood.

The Rev. B. Herbert Martin, whose church stands in the shadow of the high-rises, said Thursday that Clinton should have arrived a day earlier to "see some real stuff instead of all this prepared stuff."

He was referring to the 40 people standing outside his Progressive Community Church, awaiting the monthly government handout of surplus apple juice, corn meal, butter and rice.

"I hate this day," Martin said. "These elderly people standing in the 95-degree weather life should not be so hard for them in America in their last days."

Martin says he's seen more heartache than he cares to recall in his 12 years at the church. Although optimistic about the impact of Clinton's visit, Martin is also a realist.

"He'll spend an hour among the poorest of the poor. ... Maybe it will stimulate a little hope in the minds of the kids," Martin said. "But what does he leave behind? What's left at the end of the day?"

TABLE PARTICIPANTS

1. The First Lady
2. Secretary Cisneros
3. Sister Sheila Lyne, Commissioner, Chicago Dept of Health
4. Loys Holland, Grand Boulevard Clinic Facility Manager
5. Jackie Jones, Infant and Toddler Center Manager
6. M. Gayle Hart, HIPPY Program Manager
7. Willie White, Girls Athletic Program Manager
8. Delores Shoemate, Public Health Social Worker
9. Elsie Burton, Healthy Moms/Healthy Kids Program Manager
10. Mary Carpenter, Resident
11. Lorraine Barnes, Resident
12. Gene Wells, Resident
13. Daisy Reed, Resident
14. Veronica Tabb, 10 yrs old
15. Tashee Brown, 9 yrs old

Rangel

Collins

Cook County Commissioner
Danny Davis

Congressman Bobby Rush

Gutierez

Jesse Jackson, Jr.

Alderwoman Dorothy Tillman

1747

Katie pager
333-9126

8/25/96

TO: Sara, Julie, Patti, Jen, Nicole, Pat, Roshann, Site/Press Advance Team members on these events

FR: Sarah Farnsworth
RE: Robert Taylor Holmes visit/discussion, Copernicus Visit on Tuesday

==========

Attached is information on the Robert Taylor Holmes visit and discussion on Wednesday and the Copernicus Visit on Tuesday for comments, questions, discussions, spare reading, etc...

I'd like to have a meeting about the discussion format and participants late Monday when/if everyone is together. Attached is a ROUGH list of the participants. Sara is getting the elected officials update. Jen is talking to Jackie Keene about the other participants, but I think we should have a larger discussion about who's at the table, who's in the observer section, etc.

With regard to Tuesday, there is a lot of set up elements that are being confirmed on Monday.

Review the attached and let me know questions, concerns....

Thanks - Happy Convention Week!

DRAFT 1 a/o 8/25; SF

DROP BY PASIEKA BAKERY
Tuesday, August 27, 1996
1:05 p.m.-1:15 p.m.
Pool Press

PASIEKA BAKERY
3056 N. Milwaukee Avenue
Diane Pasieka, owner
312-278-5190
h: 847-825-3563

FORMAT:

Monday	Contact Bakery about drop by - press pool, owner.
12:45 p.m.	Rod Blagojezich arrives at Bakery. *Whitney Williams to meet.*
1:05 p.m.	**THE FIRST LADY** arrives in front of the Bakery. Brief hold to allow time for the pool to position in the Bakery. Whitney to direct. Sidewalk Greeter: Rod Blagojezich (need phonetic), Running for 5th District Seat **THE FIRST LADY** and Rod Blagojezich enter Bakery. Owner present.
1:15 p.m.	**THE FIRST LADY** departs via motorcade to the Copenicus Center. Rod Blagojezich to join her in the motorcade. Staff note: tbd staff person w/Rod Blagojezich to ride in staff van.

NOTES:
Site Advance: Whitney Williams
Sarah to contact bakery owner on Monday.
Travelling party: hold in motorcade or on sidewalk
No holding room or restroom facilities.
No unilateral press area at this time.

Additional Contacts:
Deanna Bennas 539-9773
Carol Ronen 539-9773

DRAFT 1 a/o 8/25; SF

VISIT/REMARKS TO COPERNICUS CENTER
Tuesday, August 27, 1996
1:30 p.m.-1:55 p.m.
Open Press/Approx. 250 ticketed guests

Contacts:
Copernicus Seniors Center
3160 N. Milwaukee
Luke Fitzgerald, Regional Director, Chicago Dept on Aging (Director of Center)
312-744-6681 fax: 312-744-6696 (H: 312-973-6499)

Elizabeth Miller, Congmn Gephard's office- need number
Deanna Bennas 312-539-9773
Site Advance: Tracy Collins (set up), Michael Shalinski (audience)
Press Advance: Dave Bayless, Wendy Aarons

10:15 a.m. (T)	Staging, lighting, audio, pipe and drape vendors arrive for set up. Contact: Tracy Collins
11:30 a.m.-12:30 p.m	Lunch in Center
tbd	Security Sweep
12:45 p.m.	Doors open for admittance of ticketed guests. Contact: M. Shalinski D. Bennas to coordinate two staffers checking tickets at door. Natalie to coordinate seating of guests. <u>Audience: (Contact: M. Shalinski, E. Miller)</u> - 30 WH Tickets - xx Copernicus Center tickets -xx Rep Gephardt -xx Rep Gutierrex <u>Reserved seats:</u> Approx. 20 for tbd
12:50 p.m.	The following arrive and hold in <u>Room 2</u> - Rep. Gephardt - Rep. Luis Gutierrez - Rep. Robert Torricelli - TBD Senior who will intro HRC
1:20 p.m.	**THE FIRST LADY** arrives with Rod Blagojevich at the Center and is greeted by: - Luke Fitzgerald, Director of the Center, Regional Director, Dept of Aging

THE FIRST LADY proceeds to Room 2 to greet Representatives.

1:25 p.m. **THE FIRST LADY**, Rep. Gephardt, Rep. Gutierrez, Rep. Torricelli, Candidate Blagojevich, and tbd Senior Citizen proceed on stage. (TBD announcement)

Draft Speaking Program:
- Rep. Gephardt delivers remarks and intros tbd Senior.
- TBD Senior delivers remarks and intros HRC
- **THE FIRST LADY** delivers remarks and departs. (No ropeline)
- Program continues

1:55 p.m. **THE FIRST LADY** departs.

SET UP NOTES:
Stage: Vendor/budget item (T. Collins, E. Miller)
Press Risers: E. Miller, stanchion/rope off press areas
Audio/Podium: PA, mult on main and cutaway risers, podium (tbd if center one can be used). (T. Collins, D. Bayless)
Backdrop/Visual: Blue pipe and drape along back wall (budget item/T. Collins) w/"Families First" Banner, Polish and US Flags (T. Collins) (E. Miller providing banner)
Room Set Up: Stage for speaking participants, audience seated theatre style w/center aisle, cutaway riser at door for easy entrance/dept.
Guest check in: Ticketed event; tickets checked at door.
Press check in: D. Bayless coordinating outside center
Holding Room: Pool Room (w/pool tables); no phone available in room. Facility offices located at opposite side of site w/phones, fax and restroom.
Additional Contacts: D. Weinberg (Rep Torricelli's office) 312-509-0999
WH tickets: M. Dgiacobe to coordinate w/Michael and Elizabeth (30 seats)
Senior Speaker: Nicole Rabner to coordinate w/D. Weinberg in Rep Torricelli's office and Luke Fitzgerald at Center

NEED:
- Diagram site (T. Collins)
- Budget/vendor update (T. Collins)
- Ticketing update (M. Shalinski)
- Press check in/arrangements update (D Bayless)
- Speaker/remarks/acknowledgements (Nicole)

DRAFT 3
a/o 8/25/96; SF

VISIT TO ROBERT TAYLOR HOLMES CLINIC & SCHOOL
Wednesday, August 28, 1996

VISIT TO THE CLINIC
4410 S. State Street
Contact: Loys Holland, Interim Administrator, Chicago Dept. Of Health
312-747-3505 (Manager of Clinic)

FORMAT:
3:05 p.m. HRC arrives at the front of the Clinic on State Street.

Greeters:
- Loys Holland, Interim Administrator, Chicago Dept of Health
- Sister Sheila Lyne, Commissioner of Public Health, City of Chicago
- Secretary Cisneros
- Congressman Charlie Rangel (t)

HRC begins tour of clinic on the First Floor led by Loys Holland. There will be two tour groups. The halls are very small and narrow. The tour will proceed through the clinic, to the playroom and out the front door. The Clinic normally closes at 4pm. There are no classes scheduled on the second floor in the administrative offices.

Tour Group One
- HRC
- Sister Sheila
- Sec Cisneros
- Cong. Rangel
- Led by Loys Holland

Tour Group Two
- Melanne Verveer
- Congressional Members
(TBD)
- Led by tbd

Staff: Kelly Craighead, Pat Halley, Neel Lattimore
Advance: Whitney Williams

3:35 p.m. Upon conclusion of tour, **THE FIRST LADY** proceeds to the Helen McCorkle School across the street.

CLINIC NOTES
Holding Room: Clinic Staff Room
Phone Number:
Fax Number:
Restroom in holding room.
Closed Press - Neel may take one camera inside to follow HRC. George Shelton to meet press at mcade arrival point and escort into school.
Travelling Party: Members of the travelling party not manifested on the tour groups should proceed directly to the school.

Draft 3
a/o 8/254; SF

DISCUSSION AT THE SCHOOL
HELEN J. MCCORKLE SCHOOL
Lunch Room
4421 S. State Street
312-535-1530
Contacts: Jerry Johnson, Principal
Jackie Keene, Assistant Commissioner, Chicago Dept of Health
312-747-9882 fax: 312-747-9739
home: 312-445-8651
3:45 p.m.-4:30 p.m.
Expanded Pool Press

FORMAT:

Tuesday afternoon Site set up. Site Advance: Vanessa James
Press Advance: Gretchen Michael, George Shelton

NOTE: Sound, lighting vendors arrive; table set up; visual set up in room w/ childrens art work. (Vanessa)

tbd Discussion participants (refer to separate list) arrive at the front entrance of the school and are checked in. Check in staff: xxx

3:00 p.m. **The First Lady** arrives at the clinic for tour - refer to clinic layout.

3:45 p.m. **THE FIRST LADY** proceeds to the school where she is greeted inside by:

- Jerry Johnson, Principal of Helen McCorkle School
- Jackie Keene, Assistant Commissioner, Chicago Dept of Health

Jerry Johnson and Jackie Keene escort **THE FIRST LADY** to the Lunch Room.

THE FIRST LADY greets discussion participants seated at the table and the observers seated to the side. NOTE: Press is in the room at this time.

DISCUSSION BEGINS: *draft format*
- **Sister Sheila Lyne** delivers remarks and introduces Loys Holland.
- **Loys Holland** introduces the program directors seated around the table, delivers remarks and introduces **THE FIRST LADY.** 7 minute overview intros
- **THE FIRST LADY** delivers remarks.
- TBD format - Jen Klein

Discussion Facilitator: xxx

4:30 p.m. Upon conclusion of discussion, **THE FIRST LADY** departs Lunch Room at rear door and greets School and Clinic staff located behind ropeline. (Approx. 60 staff). Photographer - who?

STAFF GREETING
- Principal to provide list of School Staff.
- Loys to provide list of Clinci Staff.
Contact: Whitney Williams to get lists and coordinate arrival of staff.

NOTE: Travelling press is escorted to motorcade at this time.

THE FIRST LADY departs via motorcade.

NOTES:
Holding Room: There isn't an office or classroom accessible near the discussion room, but the auditorium nearby will be clear for briefing if requested. There is no nearby restroom.
Table Set Up: TBD if its a U-shaped or hollow square shape. Depends on number of participants at table. Jen Klein to determine seating order. The tables are from the school - 6' laquered tables. The tables will be plain, without cloths. The school will provide the tables and the chairs.
Sound/PA: There will be 4-5 table mics on the table. There will be back up hand held mics. Gretchen Michael coordinating w/the vendor. Light PA in the room. One mult on main riser for press. Discussion will be recorded.
Lighting: Vendor paid for by C/G. (G. Michael contact)
Temperature: Portable/floor air conditioner. (V. James contact for vendor) budget item
Press/ Risers: Vendor/budget item for risers and stanchions (G. Michael contact)
Beverages: Budget item/drafts to V. James. (G. Shelton to assist)
Visual: V. James selecting childrens art work/murals from school and clinic; paper covering glass windows at entrance and along wall.
Staffing:
- Guest check in at sidewalk:
- Work w/participants in Lunch Room: Nicole, Jen
- Room set up: Vanessa
- Press set up: Gretchen
- Press arrival/check in/movements: George
- Seating plan/program format: Jen
- Troubleshooters: xxx

MONDAY EVENING: Discuss w/Jen, Nicole, Sara G., Patti, Melanne, Neel....

✓ Lanyd Simon M-B
X Durbin
Gutierrez
Collins
EH Norton

ROBERT TAYLOR HOLMES DISCUSSION PARTICIPANTS
Draft 1 a/o 8/24/96; SF
Contact: Jen Klein

PARTICIPANT	TABLE/PROGRAM	STATUS/NOTES
FLOTUS	Table	
Sec. Cisneros	Table	Arriving 2:45pm to Clinic
~~Mayor Daley~~	~~Table~~	TBD
Sister Sheila Lyne, Commissioner	Table	Meeting at Clinic
Jackie Keene	~~Table~~ Observer	Meeting at School
Loys Holland, Facility ~~Manager~~	Table	Meeting at School
Jackie Jones, Daycare	Table	Meeting at School
Elsie Burton, Healthy Moms/Healthy Kids	Table	Meeting at School
Gayle Hert, HIPPY	Table	Meeting at School
~~Eula Dean, WIC~~	~~Table~~	~~Meeting at School~~
Delores ~~Shomak~~ Shoemate, Social Services 538-9811 ext 269	Table	Meeting at School
Dr. Johnson, Principal, Helen J. McCorkle School	Observer	Greet HRC upon arrival
Melanne Verveer	Observer	Accompany HRC on tour
Jennifer Klein	Observer	Proceed to School
Kathy Burgess	Observer	Meet at school
Paul Verlas, Superintendant of Schools	Observer	TBD awaiting feedback from Bill Daley
Mildred Dennis, President of Tallor B	Observer	TBD per Bill Daley
Matty McCoy, President of Taylor A	Observer	TBD per Bill Daley

Berina Toney - Head of Robert Taylor Initiative

Will Carol school

David Wilson, President of Building	Observer	TBD per Bill Daley
Congmn Rangel		TBD per Leg Affrs
TBD other Congressional Members (approx. 4)	Observers (save 4 seats)	TBD per Leg Affrs
Hazel Barclay (suggested by K. Burgess)	Observer (save 1 seat)	TBD based on space
Program participant	TBD	Jennifer Klein
Program participant- job placement	Table	Jennifer Klein
Program participant- employee	Table	Jennifer Klein
Program participant Family	Table and observer seats	Jennifer Klein
Edwin Eisendrath	tbd	Sara Grote to determine

After discussion, HRC will greet staff from the School and the Clinic in the hall as she departs the back of the school. Approx. 60 participants behind a ropeline.
Lists to be provided by the Principal and Loys -Whitney Williams contact.

Sheraton Chicago
HOTEL & TOWERS
CITYFRONT CENTER
ITT Sheraton

Bill Daley 1624

Elected officials

for R. Taylor

301 EAST NORTH WATER STREET, CHICAGO, IL 60611
PHONE: (312) 464-1000 FAX: (312) 464-9140

cc: CPS + Cisneros Subject to Change/update

8/26/96

FIRST LADY HILLARY RODHAM CLINTON'S VISIT
ROBERT TAYLOR INITIATIVE

Formal Salutation = First Lady Hillary Rodham Clinton

Informal Salutation = Mrs. Clinton

Possible Escort = Secretary Henry Cisneros
Possible Escort = Mrs. Richard Daley
Possible Escort = Mayor Richard M. Daley

Clinic greeting and tour = Commissioner Sheila Lyne, RSM and Loys Holland

School greeting and direction to conference = Principal Jerry Johnson and Jackie Kean

Conference Participants = First Lady Hillary Rodham Clinton
Her Escort (s)
Sr. Sheila
Loys Holland
Willye White
Gayle Hart
Jackie Jones
Delores Shoemate
Elsie Burton
4-5 program participants

Observers = Jerry Johnson
Jackie Kean
Tim Hadac
Bill Card

Mrs. Clinton is scheduled to arrive at the front door of 4410 South State at 3 PM on Wednesday, August 28, 1996. There will be bicycle racks set up to control onlookers positioning. She will take a tour of the clinic (the east half of the ground floor of the 4410 building). She will, after knocking, visit doctors in consultation with patients. If patients do not wish to be disturbed, their wishes will be observed. She will talk freely with clinic staff and patients. There will be no photography. She will be accompanied by multiple secret service agents. Only staff whose names, birth dates and social security numbers have cleared with the secret service will be allowed into the clinic. Only patients known to the clinic staff and having appointments will be allowed into the clinic.

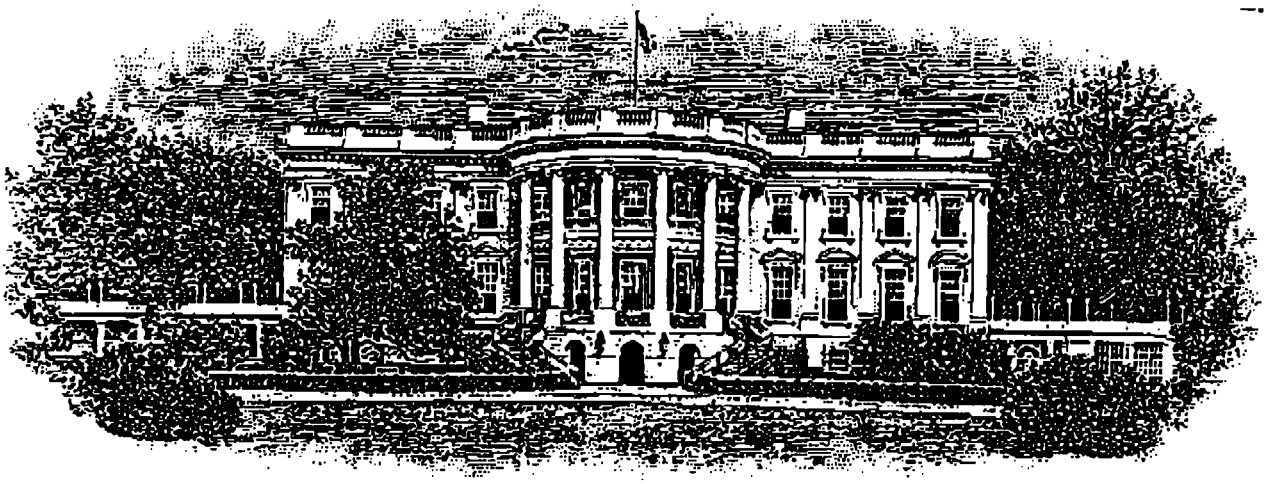
If 4410 staff, who are not involved in the clinic directly, wish to see the First Lady, they can assemble after the conference (approximately 4 PM) inside the back door of McCorkle school. Their names must be included in the staff listing given to the secret service.

Mrs. Clinton will leave the clinic via the front door. She will proceed to her car. She will be driven to the back door of McCorkle school. She will be led directly to the lunch room. The conference participants will already be assembled around a large table in the lunch room. The 20 or so press traveling with Mrs. Clinton will have a section covering two edges of the room. There will be an observers section off to the side.

Commissioner Lyne will begin with a welcome and brief remarks. Loys Holland will follow with a 5-8 minute summary of the Robert Taylor Initiative and its various programs. It is anticipated that the First Lady will respond with questions that all participants are welcome to answer. We are told that Mrs. Clinton is interested in our success stories, in stories about our experiences, both from program directors and participants in the programs. Name tags will be provided for conference participants to aid the conversation.

Liquid refreshments will be available at the school for conference participants. The lunch room is not air conditioned and the press lights are expected to create a very warm environment. Someone is looking into portable air conditioning, so be prepared for hot or cold.

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Jen Klein

FAX NUMBER: (312) 425-1797

TELEPHONE NUMBER:

FROM: Sandy Bublick-May

TELEPHONE NUMBER:

PAGES (INCLUDING COVER):

COMMENTS: Per our conversation

The # of uninsured kids is 10 million --HHS will call me with a source for this figure tomorrow am

Fact Sheet

ADMINISTRATION FOR CHILDREN AND FAMILIES

OFFICE OF FAMILY ASSISTANCE

Job Opportunities and Basic Skills Training (JOBS) Program

The Family Support Act of 1988 created JOBS, a comprehensive welfare-to-work program. JOBS provides recipients of Aid to Families with Dependent Children (AFDC) with the opportunity to take part in job training, work, and education-related activities that lead to economic self-sufficiency. JOBS also provides welfare recipients with necessary support services, such as transportation and child care. Responsibility for the JOBS program rests with the state welfare agency. However, in some areas, JOBS is under the administration of an Indian tribe or Alaska Native organization.

The Primary Goal of JOBS -- Self-Sufficiency

The ultimate purpose of JOBS is to improve a family's ability to become and remain self-sufficient. It targets resources to those AFDC recipients most at risk for long-term welfare dependency, especially young, never-married mothers and teenaged parents who did not complete high school. It also focuses on AFDC recipients who have been on welfare a long time.

Fundamental Shift in Welfare Policy

Passage of the Family Support Act and the establishment of JOBS reflect a rethinking of the welfare system. It no longer merely provides cash assistance to meet the basic needs, but now encourages economically disadvantaged people and families to gain skills that allow them to move permanently into the economic mainstream, while cash assistance is considered transitional.

The system places primary responsibility for JOBS implementation and accountability with the state welfare agency. Welfare agencies are required to provide job training and employment and education-related services as well as transitional cash assistance. New relationships among welfare agencies and other state and local agencies, community-based organizations, educational institutions, and public interest groups demonstrate this shift in welfare policy.

Department of Health and Human Services
Administration for Children and Families
370 L'Enfant Promenade, S.W., Washington, D.C. 20447
Phone: (202) 401-9215 \\ June 1995

Program Flexibility

The Family Support Act allows each state considerable flexibility to design its own JOBS program. It specifies certain program requirements, such as participation rates, but allows each state to define its own program goals and objectives. The Act allows each state to tailor its JOBS program to meet the needs of its recipients while assuring that each state provides an array of services and activities. While the Administration for Children and Families (ACF) sets program goals and provides funding, states determine the appropriate types of services to offer welfare clients to overcome employment obstacles.

A state must offer educational programs, job skills training, job readiness activities, and job placement and development services. It also must choose two or more of the following activities: job search, on-the-job training, work supplementation, and community work experience or other work experience.

Making it Easier for Families to Participate in JOBS

The Family Support Act provides that AFDC recipients receive child care and supportive services, such as transportation, that are necessary for participation in JOBS.

States may fund child care through vouchers, direct payments, or other types of financing. It may be provided by relatives, neighbors, family day care providers, independent contractors, or day care centers. AFDC recipients who lose eligibility because of earnings may receive one year of transitional child care and up to one year of medical assistance.

The Link Between JOBS and Child Support

The Family Support Act strengthens the link between AFDC and effective child support enforcement. It requires state welfare agencies to furnish JOBS, AFDC, and child support services in an integrated way. An underlying theme of this legislation is that both parents, whether or not they are living together, must be involved in financially supporting their children. In many cases, AFDC families can become self-sufficient by coupling child support payments with the custodial parent's earned income.

Encouraging Extensive Coordination and Partnerships

The Administration for Children and Families has a strong leadership role in uniting programs that serve vulnerable families. ACF promotes integration among the AFDC, JOBS, and Child Support Enforcement programs. It encourages active dialogue among organizations that provide employment services, job training, education, child support enforcement, child care, and other community services. ACF also supports collaboration with the business community to increase job training and work opportunities for JOBS participants.

State has a work supplementation program from any requirement of this part relating to work requirements, except during periods in which such individual is employed under such work supplementation program.

(f) COMMUNITY WORK EXPERIENCE PROGRAM.—(1)(A) Any State may establish a community work experience program in accordance with this subsection. The purpose of the community work experience program is to provide experience and training for individuals not otherwise able to obtain employment, in order to assist them to move into regular employment. Community work experience programs shall be designed to improve the employability of participants through actual work experience and training and to enable individuals employed under community work experience programs to move promptly into regular public or private employment. The facilities of the State public employment offices may be utilized to find employment opportunities for recipients under this program. Community work experience programs shall be limited to projects which serve a useful public purpose in fields such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, and day care. To the extent possible, the prior training, experience, and skills of a recipient shall be used in making appropriate work experience assignments.

(B)(i) A State that elects to establish a community work experience program under this subsection shall operate such program so that each participant (as determined by the State) either works or undergoes training (or both) with the maximum number of hours that any such individual may be required to work in any month being a number equal to the amount of the aid to families with dependent children payable with respect to the family of which such individual is a member under the State plan approved under this part, divided by the greater of the Federal minimum wage or the applicable State minimum wage (and the portion of a recipient's aid for which the State is reimbursed by a child support collection shall not be taken into account in determining the number of hours that such individual may be required to work).

(ii) After an individual has been assigned to a position in a community work experience program under this subsection for 9 months, such individual may not be required to continue in that assignment unless the maximum number of hours of participation is no greater than (I) the amount of the aid to families with dependent children payable with respect to the family of which such individual is a member under the State plan approved under this part (excluding any portion of such aid for which the State is reimbursed by a child support payment), divided by (II) the higher of (a) the Federal minimum wage or the applicable State minimum wage, whichever is greater, or (b) the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(C) Nothing contained in this subsection shall be construed as authorizing the payment of aid to families with dependent children as compensation for work performed, nor shall a participant be entitled to a salary or to any other work or training expense provided under any other provision of law by reason of his participation in a program under this subsection.

Personal Responsibility & Work Opp. Act of 1996 (PL-104-193)

"(D) NUMBER OF PERSONS THAT MAY BE TREATED AS ENGAGED IN WORK BY VIRTUE OF PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES OR BEING A TEEN HEAD OF HOUSEHOLD WHO MAINTAINS SATISFACTORY SCHOOL ATTENDANCE.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 20 percent of individuals in all families and in 2-parent families may be determined to be engaged in work in the State for a month by reason of participation in vocational educational training or deemed to be engaged in work by reason of subparagraph (C) of this paragraph.

"(d) WORK ACTIVITIES DEFINED.—As used in this section, the term 'work activities' means—

"(1) unsubsidized employment;

"(2) subsidized private sector employment;

"(3) subsidized public sector employment;

"(4) work experience (including work associated with the refurbishing of publicly assisted housing) if sufficient private sector employment is not available;

"(5) on-the-job training;

"(6) job search and job readiness assistance;

"(7) community service programs;

"(8) vocational educational training (not to exceed 12 months with respect to any individual);

"(9) job skills training directly related to employment;

"(10) education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency;

"(11) satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate; and

"(12) the provision of child care services to an individual who is participating in a community service program.

City of Chicago
Richard M. Daley, Mayor

Department of Public Health

Sheila Lyne, RSM
Commissioner

333 South State Street
Chicago, Illinois 60604
(312) 747-9884
(312) 747-9888 (24 hours)
(312) 744-2960 (TT/TDD)

TELEFAX TRANSMITTAL

DATE: 8-21-96

TO: Jennifer Klein

AGENCY: 1st Ladies Office

FAX# (202) 456-9412 2878

NUMBER OF PAGES TRANSMITTED
(INCLUDING COVER SHEET): 32

****
****

FROM: Jackie Kraw

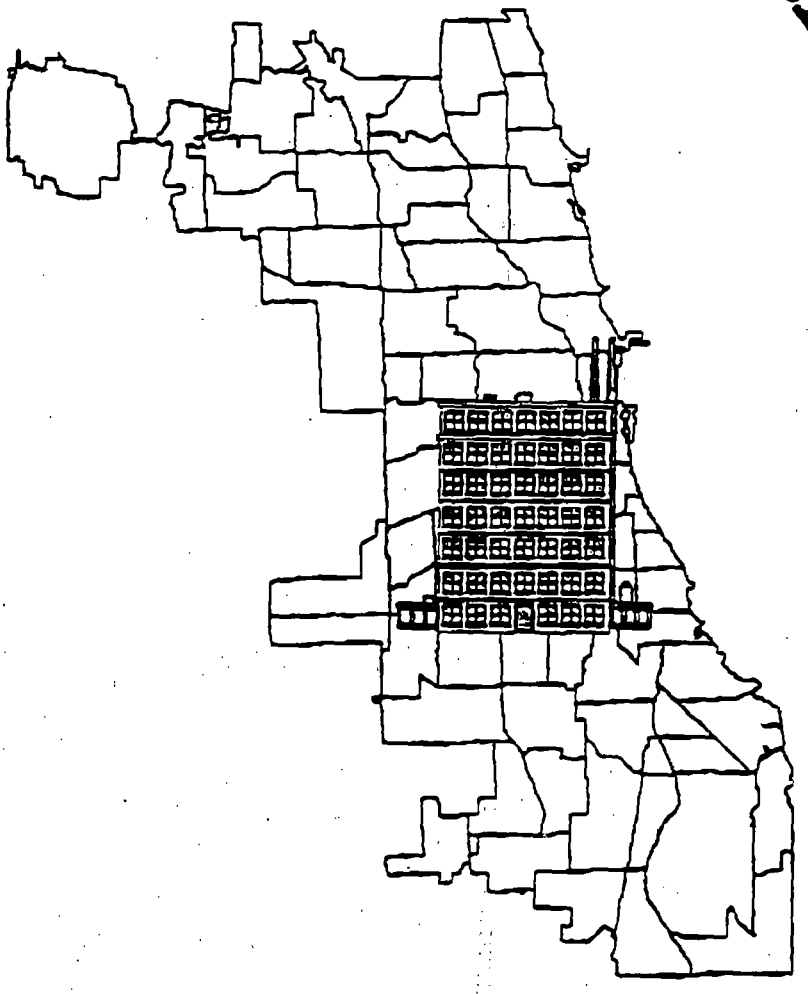
AGENCY: Chicago Dept of Public Health

FAX# (312) - 747-9739

TELEPHONE NUMBER: (312) 747-9882

COMMENTS: If you want more, just call - Thanks

The Robert Taylor Initiative



Working Paper

Chicago Department of Public Health
August 1995

The Robert Taylor Initiative
Working Paper

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I. INTRODUCTION

Origin of the Robert Taylor Initiative: The *Robert Taylor Initiative* is a direct outgrowth of the Chicago Department of Public Health's (CDPH) mission and strategic priorities. The primary mission of CDPH is to assure conditions in which Chicago residents can be physically and mentally healthy, with an emphasis on health promotion and disease prevention. This emphasis on prevention requires that the Department's interventions are comprehensive in scope and expand beyond traditional programs. Indeed, a hallmark of the public health approach is prevention and the need to address problems within the context in which they occur. Thus, effective prevention programs, such as those that comprise the *Robert Taylor Initiative*, must recognize that the behaviors which contribute to the high rates of morbidity and mortality experienced in Chicago's communities are often influenced by socioeconomic status, demographics and cultural norms. Meeting the mission also requires that the Department's services are effective and accessible. Programs that are not demonstrated to be effective or are not geographically and otherwise accessible, result in little more than wasted resources.

Acknowledging all that is entailed in achieving its mission, the Department's *Robert Taylor Initiative* strives to bring a continuum of services into a defined high need community and to engage area residents not only as clients but also as providers of these programs. The *Initiative's* effectiveness is derived from integrating a variety of services, targeted to individuals and families, into the everyday life of the community.

The Department's mission is one of several factors considered in the Department's strategic planning process. This process was initiated in 1991 for the purpose of assessing organizational capacity, establishing priorities, and allocating resources. The process involved more than 50 members of the Department's staff of nearly 1,900 persons. Following an assessment of critical issues facing the Department, participants selected eleven strategic issues which covered both programmatic and management performance areas. While the identified issues are being addressed throughout CDPH programs and activities, five of these priorities, and the spirit behind the Department's mission, are perhaps best exemplified through the *Robert Taylor Initiative*. These five areas are:

- Design and implementation of comprehensive prevention programs which integrate disciplines and are proactive.
- Improving the effectiveness of efforts to reduce infant mortality and improve overall maternal and child health.
- Assuring access to primary care services;
- Assuring comprehensive and holistic mental health services which are integrated with other programs.
- Effectively addressing substance abuse and alcoholism.

Finally, it has been the Chicago Department of Public Health's experience that for a program to be implementable, it must be developed through the broad-based participation of committed organizations and individuals. Thus the *Robert Taylor Initiative* is about partnerships. The *Initiative* involves partnerships between residents, and city, state and federal agencies. Included among the partners are the Chicago Housing Authority; Chicago Park Services; Chicago Public Schools; the Chicago Department of Human Services; the Mayor's Office of Employment and Training; the Illinois Departments of Public Aid and Children and Family Services; and formal and non-formal residents advisory groups, such as the Facility Health Board and the Robert Taylor Network of Services.

The *Robert Taylor Initiative* Working Paper is a work in progress intended to serve several purposes. The Paper provides a context for the *Robert Taylor Initiative;* it identifies and links a broad range of needs to a comprehensive package of services. As the Robert Taylor effort is largely defined by the individual program components which together comprise the *Initiative*, it is by necessity flexible and adaptive to changing needs and resources. It is imperative that new programs are developed within the context of this existing framework.

This Paper is also intended to provide a foundation for ongoing planning and program development. It captures an ongoing and dynamic planning process at a single point in time. Thus, it should serve as a baseline document for continuous assessment, rather than a definitive statement regarding needs and services. It is anticipated that both the gaps and resources identified in this report will be seriously considered as new components are developed and as revisions are made to any existing program elements.

This Working Paper is intended to facilitate coordination. The *Initiative* is designed to provide a continuum of services to project area residents throughout the course of their lives. Assuring that this is achieved, in an effective and cost-efficient manner, requires that significant emphasis be placed on coordination. Towards this end, the Paper describes mechanisms through which coordination occurs.

Finally, this Paper is intended as a mechanism for promoting the *Initiative*. The *Initiative* represents an innovative approach to meeting the needs of one of Chicago's highest risk communities. While much of the *Initiative's* success will be derived from the resources leveraged through program coordination, significant support is still needed. Thus, it is envisioned that this document will be useful in garnering both public and philanthropic support for the *Initiative*.

Document Organization: The *Robert Taylor Initiative* Working Paper is organized into four main sections, including this *Introduction*. Section II, the *Statement of Need*, presents a snapshot of conditions facing residents of the five selected buildings of the Robert Taylor Housing Development. This section focuses on socioeconomic, demographic, and morbidity and mortality indicators, and considers the barriers to care facing project area residents. Section III, the *Program Approach*, presents the overarching goals and underlying principles of the *Robert Taylor Initiative*, and describes the program components which comprise this endeavor. Where available, program budgets are also included. Finally, the report concludes with Section IV, addressing issues of *Coordination and Evaluation*.

II. STATEMENT OF NEED

A. Background and Overview

To best understand the Chicago Department of Public Health's (CDPH) approach to health planning for the area targeted by the *Robert Taylor Initiative*, it is necessary to first understand the characteristics of the city as a whole. With a population of nearly 2.8 million people, Chicago is the third largest city in the United States. Spanning nearly 230 square miles, the city is divided into 77 formally-designated community areas, originally delineated by factors such as local identification with the area, and natural and artificial barriers.

The single word which probably best describes Chicago is diversity, a characteristic which is reflected in a variety of demographic, socioeconomic, and health indicators. Ethnically, the city's population is 38.6% African American, 37.9% White, 19.6% Hispanic and 3.5% Asian American. Within community areas, however, the population distribution by race and ethnicity is more homogenous. For example, African Americans tend to live in communities on the city's south and west sides while Hispanics reside predominantly in the central west portion of the city and on the far southeast side. Chicago's overall population, according to the U.S. Census, has declined by 7.4% since 1980. This ten-year period saw the number of African American residents decrease by nearly 10% and a decline of the white population by just over 19% . The significantly smaller Hispanic and Asian populations both increased during that same period by 29% and 39% respectively.

The city's diversity is also reflected in the socioeconomic status of its residents. Chicago's median household income of $26,301, for example, ranges from just over $5,000 in the Oakland community to over $51,000 in Forest Glen. And while nearly 22% of Chicagoans have incomes which fall below 100% of the federally-defined poverty level, this figure ranges from a low of 1.3% in Forest Glen to over 72% in Oakland. Of Chicago's 2.8 million residents, 100,000 are estimated to reside in public housing units. Current estimates from the Chicago Coalition for the Homeless suggest that as many as 60,000 people are homeless annually.

Chicago's Grand Boulevard community is located approximately four miles south of the downtown business district, in the south central region of the city. Grand Boulevard is bordered on the west side by the CRI&P Railroad, and on the east by Cottage Grove. The community extends north to Pershing Road and runs south to 51st street. Named for the broad tree-lined street which runs through the center of the community, now known as Martin Luther King, Jr. Drive. Grand Boulevard was originally the home of wealthy white families and transitioned by the mid 1920's to a population that was 95% African American. During this era, Grand Boulevard, known as "the Harlem of Chicago," became a crux of African American culture and entertainment, winning world renown for its proliferation of black entertainers and writers such as Sarah Vaughn, Joe Williams, Nat Cole, Leontyne Price and Richard Wright.[1]

Today, in stark contrast to its cultural hey-day, Grand Boulevard represents one of Chicago's neediest communities. In a CDPH assessment of the 77 Chicago community areas ranked according to 29 socioeconomic and health indicators, Grand Boulevard ranks in the worst 10

community areas for 26 of the indicators, and in the bottom five community areas for 20 of the 29 indicators.

According to the 1990 Census, in the ten year span from 1980 to 1990, the population of Grand Boulevard decreased by 33%, three times the rate of the total decrease in the African American population of Chicago, and nearly fivefold the overall city decrease of 7.4%. This dramatic population decrease may largely be due to deteriorating housing, rising unemployment and the departure of business from inner city areas.

A total of 35,897 people are estimated to reside in Grand Boulevard; 99% of these residents are African American. Here, socioeconomics reveal a disproportionate impoverishment: over 65% of Grand Boulevard residents live below poverty level, three times the citywide rate of 21.6%. An analysis of the community by age reveals higher concentrations of the very young and the very old than comparable city rates. Of the 12,275 households in Grand Boulevard, 80% are headed by women, with 78% receiving some form of Public Aid. Nearly half of the residents over 65 years of age live alone, compared to less than one third citywide.

Robert Taylor Homes. Comprising one of the most densely concentrated public housing developments, Grand Boulevard contains nearly all of the 28 buildings of the Robert Taylor Homes, one of the country's largest public housing developments. Originally constructed in 1962, the Robert Taylor highrise buildings occupy the western corridor of Grand Boulevard, housing an approximate 12,320 people[2]. Despite historical efforts to improve the quality of life in public housing, many public housing developments remain areas where residents are isolated by poverty and inferior living conditions, contributing to elevated concentrations of morbidity, mortality and crime.

Despite the recent decrease in the Grand Boulevard population, many residents continue to live in overcrowded conditions. Nearly half, 46%, of the households in Grand Boulevard are comprised of three or more occupants, and 12.5% of all housing units have an occupancy greater than one person per room. From a public health perspective, overcrowded living conditions are a risk factor for a variety of health problems, among them substance abuse and tuberculosis.

Despite its prevalence, overcrowding is not a result of public housing occupancy at capacity, but as recently underscored in the takeover of Chicago Housing Authority (CHA) by the federal government, is a symptom of a neglected and problematic system providing inferior services to the poorest of Chicago residents. It was recently revealed that the CHA's waiting list for Section 8 housing extended past a decade, with units remaining vacant considerably longer than federal standards. According to 1992 CHA figures, 21% of the Robert Taylor Homes' units stood vacant while many residents contended with overcrowded and deteriorating conditions. Abandoned and deteriorating housing units serve as opportune locales for drug trafficking and unauthorized habitation, and increase the potential for environmental hazards such as unintentional injuries, fires, and infestation. In addition, the emotional and psychological hazards must be considered as residents contend with the daily stress and defeat associated with dwelling in substandard conditions.

B. Description of Project Area

The CDPH has chosen a segment of the Robert Taylor Homes as the focus of the *Robert Taylor Initiative*. The five buildings which comprise Census Tract 3806: 4352, 4410, 4444 South State and 4429 and 4331 South Federal, exemplify the characteristic need within this community and provide a measurable population for *Initiative* interventions. Within these five buildings, according to the 1990 Census, live a total of 418 families.

The health and well-being of the residents of the project area are reflected in their overall quality of life. Though the concept is evasive to quantitative measurement, an examination of various demographic, socioeconomic and health indicators present a portrait of the overall social, environmental and interpersonal conditions in which the population resides. Collectively, these measures denote quality of life.

(1) Demographics

According to the 1990 Census, there were 1,856 people residing in the project area. More recent counts by the Chicago Housing Authority cite an increase in this population by 32%, for a total of 2,462 residents as of December, 1994. This increase could be due to population growth or to an undercounting by the 1990 Census. Census data will be used in the following for comparisons to the Grand Boulevard community and to the city as a whole. Where possible, the most recent counts will be used.

The demographics of the project area are similar to those of the larger Grand Boulevard community, yet present an even greater severity of need. According to the 1990 Census, ninety-nine percent of the residents are African American, with Hispanics and Whites constituting the remaining 1%. Sixty percent of the residents are female, nearly half of whom are of childbearing age. The targeted population is younger than the greater Grand Boulevard population and the city as a whole. Within the five targeted buildings, 53% of residents are younger than 15 years old, well over Grand Boulevard's 32%, and nearly two and a half times the Chicago rate for this age group. Within the project area, 20.8% of the children are less than 5 years of age, twice the rate of the larger Grand Boulevard community and nearly three times the city rate of 7.8%.

The high proportions of young children in this community indicate the necessity of strong support systems from the adults they are dependent upon, and the overall community in which they reside. With one fifth of the population below the age of five, it is not surprising to find lower chronic disease morbidity and mortality, and a greater capacity for the development of communicable and vaccine preventable disease. Most significantly, the extremely high concentration of children in this area presents an exceptional opportunity for effective prevention interventions, allowing these estimated 1,304 children the occasion to grow into healthy, productive adults.

Population Distribution by Age and Geographic Area (1990 U.S. Census)			
Age Distribution	**Project Area**	**Grand Boulevard**	**Chicago**
< 5 years	20.8%	11.1%	7.8%
5-14 years	32.0%	20.5%	14.0%
15-24 years	18.5%	15.5%	15.7%
25-44 years	21.0%	24.3%	33.2%
45-64 years	6.3%	14.3%	17.4%
65-74 years	1.2%	7.3%	6.9%
75+ years	0.2%	7.0%	5.0%

(2) Socioeconomic Indicators

In October, 1994, the CDPH published the *Community Area Health Inventory*, a two-volume report presenting data on Chicago's community areas using various social, demographic, and health measures. *Volume I* presents the various measures arranged by community area, and *Volume II* uses the same measures as Volume I and ranks them by community area. According to this report, Grand Boulevard ranks in the bottom five worst community areas for seven of eight socioeconomic indicators. Narrowing the focus to the project area, it is apparent that the people who live in the targeted Robert Taylor Homes fare worse on all accounts than residents of the larger community.

The 1989 median household income in the project area is $5,452, and constitutes barely three quarters of the median household income of the larger Grand Boulevard area, which at $7,146 is ranked the fourth lowest of the 77 Chicago community areas. This project area measure is less than one-fourth of the citywide figure of $26,301. Nearly all of the project area residents, 86%, live below poverty level. This is significantly higher than the larger Grand Boulevard community, where 64.7% of residents live below poverty level, and four times greater than the city as a whole.

A large percentage of the project area residents living in poverty are children. Within the targeted population, 59.5% of the residents below poverty level are children under the age of 18. This compares to 49% in the Grand Boulevard community and 40% citywide. Eighty-five percent of children living below poverty level for these five targeted buildings are in families with only one parent: the overwhelming majority are from female-headed households where typically there is only one source of income.

Educational Achievement: Accompanying the project area's brutal impoverishment are associated indicators that further illustrate the economic destitution within this community. Educational attainment is closely linked to residents' access to employment and advancement.

In the targeted Robert Taylor Homes, only 34.6% of adults over 25 years of age are high school graduates, and none hold degrees at an Associate level or beyond. Comparatively, 45.4% of Grand Boulevard residents 25 years or older possess a high school diploma, with 8% holding higher degrees; and citywide, the percentage climbs to 66.4% high school graduates, with 24% of city residents holding higher degrees.

The Chicago Department of Human Services' Head Start Program developed indices to measure the developmental progress of children in the context of their community. These indices provide interesting indications of the developmental health of children in the project area.

To assess the *Total Quality of Educational Attainment*, the 1994 Head Start index cross examines median reading scores of children in early elementary school, the number of youth 16-19 who are not high school graduates and not currently enrolled in school, and the number of adults, 25 and older who have not reached or completed school. By percentages of residents with a lack of educational attainment, Grand Boulevard ranks second worst in the city.

Employment Rates: The disparities in educational achievement predictably play out in employment rates within the project area. Within the five targeted Robert Taylor Homes, 65.9% of the residents 16 and older and in the labor force are unemployed. This rate is nearly twice that of the larger Grand Boulevard rate of 34.1%, and nearly six times the citywide rate, which by national standards is considered high at 11.3%.

The following table provides a comparison of socioeconomic measures for the five targeted Robert Taylor homes, Grand Boulevard, and Chicago:

Socioeconomics by Geographic Area, 1990 Census

Measure	Project Area	Grand Boulevard	Chicago
Total population	1,856	35,897	2,783,726
1989 Median Household Income	$5,452	$7,146	$26,301
Population Below 100% Poverty Level	87.5%	64.7%	21.6%
Children < 18 in Poverty	93.4%	82.9%	33.6%
Population Unemployed	65.9%	34.1%	11.3%

(3) Health Status Indicators

Socioeconomic status is closely linked with health outcomes. In the Grand Boulevard community this is apparent in figures of morbidity, mortality, and maternal and child health. Through examination of these health indicators within the targeted area, the significant need for services explicitly emerges. Due to the fluctuations in numbers of cases, to ensure statistical reliability, the following measures are calculated using average annual cases for 1991-1993.

(a) Reportable Conditions

Due to the small size of the project area, it is difficult to calculate meaningful rates for disease incidence. Given the project area's similarity to the greater Grand Boulevard community, the incidence rates of reportable diseases in Grand Boulevard are used as surrogate measures for comparison to Chicago. Considering the severity of need revealed in the socioeconomic indicators, the disease incidence for the project area may in fact be worse than Grand Boulevard.

Within Grand Boulevard, the three-year rates per 100,000 residents of reportable diseases are higher on all counts than comparable rates for the city of Chicago. While constituting only 1.3% of Chicago's total population, Grand Boulevard accounts for over 4% of the total reported syphilis and gonorrhea cases, 1.6% of the total reported AIDS Cases, and over 3% of tuberculosis cases. The Grand Boulevard rates for syphilis and gonorrhea are well over three times the rates for the city as a whole. The following table documents the disproportionate morbidity rates in the targeted community.

Reportable Conditions by Geographic Area, 1991-1993 (rates per 100,000)

Reportable Condition	Chicago	Grand Boulevard
Syphilis	59	203
Gonorrhea	681	2,244
AIDS	55	69
Tuberculosis	28	70

Over thirty-two percent of annual births in Grand Boulevard are to women below the age of twenty. This high percentage of teenage births indicates the potential risk for the spread of sexually transmitted diseases amongst the sexually active youth in Grand Boulevard. As well as the immediate effect on community members, sexually transmitted diseases may impact the future health of a community. For example, sexually transmitted diseases in women may be a precursor for pelvic inflammatory disease, cervical cancer and adverse birth outcomes. As noted above, the prevalence of sexually transmitted diseases is high in the Grand Boulevard community. In conjunction with the high percentage of the project area below the age of 15 years, these rates present a stark prospect for the children of the project area who are just entering adolescence.

High incidence of sexually transmitted diseases may indicate a lack of access to preventive health education, care and treatment; difficulty incorporating the use of prevention strategies; and may be associated with substance use and sex-trading for drugs. These problems have been shown to benefit from intervention activities, and indicate the urgent need for accessible medical and preventive services within this community.

(b) Mortality

The small size of the project area makes it difficult to calculate reliable mortality rates. As illustrated above, by 1990 Census counts, one fifth of the targeted population is below age five, with over half below age 15. Thus, the number of disease-related deaths in this area is small, as disease-related mortalities develop with increasing age. Given the relatively poorer socioeconomic and living conditions of the project area, there may exist a potential for increased mortality rates as this population ages. Due to the absence of reliable rates from the project area, mortality rates for Grand Boulevard are used in the following comparison to the citywide mortality rates. The death rates are adjusted to the 1940 United States standard population, to remove apparent differences which are due only to differences in the age distribution of the population. The rates are calculated per 100,000 population.

The Grand Boulevard community has the third highest age-adjusted mortality rate in Chicago. The Grand Boulevard rate is almost twice the city rate, at 1,329 deaths per 100,000 annually. Citywide, the mortality rate is 700 deaths per 100,000. The leading causes of death in this community include: heart disease, cancer, homicide and unintentional injury. For ten out of eleven mortality indicators, Grand Boulevard ranks in the top twenty of 77 communities for the highest mortality rates, ranking second highest for heart disease, pneumonia and influenza, and unintentional injury mortality; third highest for homicide; and fourth highest for all cancer, liver disease and cirrhosis mortality rates.

The mortality rates for chronic diseases indicate the general health of the community as well as issues of access to health care. For example, factors contributing to mortality from heart disease include health and environmental problems such as: poor nutrition, insufficient exercise, smoking and other substance use, untreated hypertension, high levels of community stress and lack of access to effective health care. The following chronic disease mortality rates provide additional information on the health status and access to services of the community.

Heart Disease: The Grand Boulevard heart disease mortality rate ranked second highest in the city at 343 per 100,000, nearly 75% higher than the overall city rate of 198 per 100,000.

Cancer: Mortality rates for all forms of cancer in the Grand Boulevard community area are fourth highest in the city. The rate for Grand Boulevard is 243 per 100,000, 55% higher than the city rate of 157 per 100,000. Although Grand Boulevard constitutes only 1.3% of the city's population, it accounts for 2.1% of all Chicago's cases of cervical cancer, and 2.4% of all cervical cancer mortalities.

Homicide: One of the highest mortality rates in the Grand Boulevard community is the rate of death due to homicide. In this community, 33 deaths resulted on average annually from homicide in 1991-1993, yielding a rate of 106 per 100,000, over three times the city rate of 35 per 100,000.

Although the population of the project area is only 5% of the Grand Boulevard community, during the years 1991-1993, 3.3 average deaths per year occurred in the project area as a result of homicide, ten percent of the total Grand Boulevard homicide deaths.

Pneumonia and Influenza: Grand Boulevard has the second highest mortality rate for pneumonia and influenza of the 77 community areas. For the years 1991-1993, the mortality rate for these conditions in Grand Boulevard was 57 per 100,000, nearly three times the overall Chicago rate of 20 per 100,000.

Chronic Liver Disease and Cirrhosis: Grand Boulevard's mortality rate for chronic liver disease and cirrhosis is the fourth highest of the 77 community areas in the city, at 43 per 100,000, and is nearly two and a half times greater than the overall city rate of 18 per 100,000.

The disproportionately high mortality rates in Grand Boulevard compared to the city of Chicago are reflected in the following table.

Average Annual Cause of Death, 1991-1993 (number and rate per 100,000)

	Grand Boulevard		Chicago	
	Number	Rate	Number	Rate
All Causes	636	1,329	27,979	700
Heart Disease	190	343	9,124	198
Cancer, all causes	123	243	6,108	157
Homicide	33	106	938	35
Pneumonia and Influenza	30	57	1,022	20
Stroke	29	54	1,552	32
Diabetes Mellitus	13	45	699	17
Unintentional Injury	28	82	1,033	34
Chronic Liver Disease and Cirrhosis	13	43	531	18
HIV Infection	13	28	817	29

(c) Maternal and Child Health Indicators

Prenatal Care: Inadequate prenatal care is considered a contributor to low birthweight births and maternal and infant health. Adequate prenatal care is defined as care initiated during the first trimester of pregnancy, and consistently followed through to delivery. The adequacy of prenatal care is often measured by the modified Kessner Index which categorizes care as adequate, intermediate or inadequate based upon the timing of entry into prenatal care, the total number of visits and the length of gestation. According to the Kessner Index, 26% of women from the project area giving birth in 1993 received inadequate prenatal care. This is higher than the overall Grand Boulevard rate of 21.6%, and over twice the citywide rate of 11.8%.

Measures comparing the proportion of women with no prenatal care for Chicago and each community area for the years 1989 to 1993 reveal that citywide, 3.5% of women received no prenatal care. In Grand Boulevard this proportion rises to 8.7%, the highest of all 77 community areas.

Data examining receipt of prenatal care by age groups indicate a relationship between the lack of prenatal care and age. For the years 1989 through 1993, the proportion of women who received no prenatal care for Chicago decreases as age increases. Conversely, for Grand Boulevard and the project area, the proportion of women who received no prenatal care increases with age. For the age groups 25-34, and 35 and older, more than 12% from each group received no prenatal care. The citywide percentage for these groups is 2.95% and 2.55% consecutively.

Reasons for the failure to access adequate prenatal care span a broad variety of availability and accessibility factors. Some of these have been identified through an assessment of maternal and child health needs conducted by the CDPH in early 1994. Participants in the assessment cited absence of patient resources including child care, transportation, lack of finances; long waiting times; fear of being tested for drugs; problems getting appointments; and the belief that care was not necessary as barriers to prenatal care.

Live Births: Grand Boulevard has the highest fertility rate of all 77 Chicago community areas, with an average of 152.5 live births per 1,000 women of childbearing age annually for 1991-1993. This figure is 75% higher than the overall Chicago fertility rate of 87. The average number of live births annually for the years 1991-1993 in the project area is 147, accounting for 12% of the total births in Grand Boulevard for this period.

A significant finding from the CDPH Maternal and Child Health Needs Assessment was that among the participating women accessing CDPH clinics for care, 75% of the pregnancies were unintended. The assessment indicates that intendedness of pregnancy may have an important relationship to birth outcomes, impacting maternal, prenatal and infant health.

Teen Births: Within these targeted Robert Taylor Homes, 32.4% of annual births are to teenage mothers. This is nearly twice the citywide rate of 18.8%. Of the 408 teen births in Grand Boulevard for 1993, nearly 14%, 56 births, were to girls 15 years old and younger. Teens under the age of 15 are at high risk for delivering a low birthweight infant. Teen mothers are also at risk for a variety of health and social problems, including repeat pregnancies, school drop-out, and unemployment. Teenage pregnancy may be symptomatic of a lack of access to health and educational information, and may indicate the existence of barriers preventing successful access to family planning services.

Low Birthweight: Low birthweight is a risk factor for infant mortality and for many morbidities in infants including neurological damage and developmental impairment. In addition, low birthweight presents an economic and emotional burden on the family and society. Babies born weighing less than 2500 grams are considered to be of low birthweight. In addition to the conditions mentioned above, low birthweight babies are at risk for other health and developmental problems which can be identified in children when they reach an institutional

setting, such as pre-school or Head Start programs. Within the project area, 16.7% of babies are born below acceptable weight. Chicago has an overall low birthweight rate of 10.9%.

Data for the years 1989 to 1993 indicate a relationship between lack of adequate prenatal care and low birthweight. When examining the proportions of low birthweight by prenatal care, the proportion of low birthweight births is highest for women who received no prenatal care. For the city as a whole, nearly 28% of women receiving no prenatal care gave birth to low birthweight babies. For the project area, this proportion is even more alarming: 34% of women receiving no prenatal care had babies with low birthweight.

Infant Mortality Rates: Infant mortality rates also indicate the general health of mothers and children in the community area, supplementing other maternal and child health measures. For the period of 1991-1993, within the five targeted Robert Taylor Homes, the infant mortality rate per 1,000 births is an elevated 22.6, from the Chicago rate of 14.

Four identified risk factors which directly relate to infant mortality are: low birthweight, maternal substance abuse, neglect, and preventable complications. The root problems of infant mortality lay in both social conditions and health care problems. Lack of knowledge may be either a direct or indirect contributing factor for these identified risk factors.

Infant mortality rates are also impacted by a lack of prenatal care. For the years 1989 to 1993, the infant mortality rate for Grand Boulevard women who received no prenatal care was 74.1 per 1,000 births, about four times higher than for women receiving prenatal care. The numbers for the project area are too small for reliable analysis, however, the Grand Boulevard rate provides a good proxy measure. Citywide, the infant mortality rate for women with no prenatal care was 49.6 per 1,000 births, more than four times higher than the rate for women who received prenatal care. According to the CDPH Epidemiology Program, infant mortality rates of 50 and 74 are comparable to rates for Third World countries. Certainly this is indication of the urgent need to identify women who are not receiving prenatal care, and ensuring that care is accessed in the future.

Birth Outcomes by Project Area, Grand Boulevard and Chicago (1991-1993)

Birth Measure	Project Area	Grand Boulevard	Chicago
% Teen Births	32.4%	32.4%	18.8%
% Low Birthweight	16.7%	18.2%	10.9%
No Prenatal Care % Low Birthweight	25.9%	34.0%	27.8%
Infant Mortality Rate	22.6	24.3	14.0
No Prenatal Care Infant Mortality Rate	NA	74.1	49.6

Maternal Substance Abuse: Maternal substance use is implicated in low birthweight babies and infant mortality rates. Reports of tobacco and alcohol use during pregnancy are documented on birth certificates based on information provided by the mother. It is believed that self-reporting of substance use behaviors are not fully reliable and that smoking and drinking behavior are likely underreported.

As reflected in the following table, for the period 1991-1993, the proportion of mothers in the project area who reported smoking and drinking during pregnancy was more than twice the figure for Chicago as a whole.

Maternal Substance Use During Pregnancy by Geographic Area (1991-1993)

% Women Reporting Use	Grand Boulevard	Chicago
Smoking	25.0	12.3
Drinking	3.7	1.7

As previously noted, in addition to directly impacting on the health of one's infant, the fear of being identified as a substance user also impacts women's decision to access prenatal care.

Vaccine Preventable Diseases: During the years 1989-1990, Chicago experienced an outbreak of measles during which 2,857 cases were reported, resulting in 8 deaths. The outbreak underscored the extent of the poor immunization status of Chicago's preschool population and prompted significant changes in the Department of Health's approach to childhood vaccinations. The heightened commitment resulted in a nearly three-fold increase in the number of doses of vaccine administered by the Department through its mobile vaccination program and expanded vaccination services to WIC outposts and other sites where children at risk can be found.

In 1994, the CDPH performed a study of 19-35 month-old children to assess current immunization coverage, compare current coverage to the distribution of cases in the 1989 measles outbreak, and to examine coverage in children who reside in public housing where CDPH has intervention programs. Study results revealed that although vaccination coverage improved in Chicago over the past eight years, the coverage for African American children and for children residing in public housing is significantly lower than the rest of the city. Among the study recommendations was the targeting of public housing for outreach and community intervention.[3] This illustrates significant implications for the children of the project area who comprise a notably young African American population residing in public housing.

In accordance with these findings, the Maternal and Child Health Needs Assessment found that only 77% of children from the surveyed population had all their necessary immunizations. This increased risk of contracting vaccine preventable diseases among the project area children may be indicative of a lack of access to preventive health care and follow-up, a lack of parental involvement in children's health care, and a failure to educate parents about the importance of regular childhood immunizations.

Child Development: The developmental health of Chicago's children is directly related to the social and environmental conditions in which they live. Within the project area, the socioeconomic destitution and the deteriorating living conditions of the estimated 1,304 children below the age of 15, present specific developmental challenges.

Grand Boulevard has the sixth lowest second grade median reading scores of the 77 community areas. Ranging from a high of 3.66 to 2.16, Grand Boulevard has a score of 2.26. The citywide score is 2.60.[4]

To assess the *Total Quality of Health* of Chicago's children, the Chicago Department of Human Services' Head Start index cross examines the infant mortality rate, the percentage of births to teenage mothers, and the percentage of babies born with low birthweight. According to percentages of resident children with poor quality of health, Grand Boulevard ranks fifth in severity of need for the 77 community areas.

(d) Violence

Measures of violence within the community indicate the chronic stress and poor quality of life that afflict residents of this area. Issues of unemployment, discrimination, poverty, neglect and a lack of police presence are identified contributors to violence in Chicago's communities. The presence of gangs and accompanying turf issues create a daily stress on residents of the Robert Taylor Homes who fear gang-related violence. As indicated above, the homicide rate in the Grand Boulevard community is over three times higher than the overall city rate. While the homicide rate provides a vivid portrayal of the impact of violence in the community, homicide represents only a fraction of the toll intentional injuries have taken on community residents. It has been estimated that for every injury death, there are 26 injury-related hospitalizations and 1,000 emergency room visits. During the years 1991-1993 the project area experienced on the average, 3.3 homicide deaths per year. Applying the above calculations to the project area, we can estimate that there were an average of 89 injury-related hospitalizations and 3,000 emergency room visits for intentional injuries annually during 1991-1993. This equals 1.2 emergency room visits per person for each of the 2,462 residents of the project area.

Certainly the presence of violence in the community has a profound impact on its children and their ensuing behavior as adults. According to interviews of 1,053 children on Chicago's south side, by age 11, 80% had witnessed someone being beat up either at home or in the street. One of three children had seen someone being shot or stabbed and one in four had witnessed a killing. Violence within the home, a growing concern for all of Chicago's residents, must also be considered for its contribution to the devastation within the project area. Numerous studies with young children have found that living in a home where violence occurs increases the likelihood of subsequent violent behavior.

In March 1995, the CDPH reported on the prevalence of domestic violence in women who used CDPH clinics for health services. Though shocking, their results were comparable to national statistics on women and domestic violence. The CDPH study found that of the 1,404 women between the ages of 15 to 44, who participated in the study, 47% had been the victim of physical, verbal or sexual abuse in their lifetime. Twenty-six percent of the respondents

reported that the abuse took place within the last year and 10% reported abuse within the last month. Eleven percent stated that they were currently afraid of an intimate partner.

The most common type of abuse reported was physical. 34% of the women reported physical abuse. Twenty-one percent reported some form of abuse during pregnancy. More than 90% of the reported physical abuse was committed by a present or past intimate partner. 73% of the abusers were either a boyfriend or husband.[5] In addition to being a frequent witness to the abuse of their mothers, children who live in homes where domestic violence takes place are believed to also be targets of abuse.

Although long-term data are not yet available, Police District Two, which includes Grand Boulevard, has a high arrest rate for domestic violence battery over the span of one month. During the period of June 20 through July 21, 1994, Chicago Police Department District Two data reveal an arrest rate of 50.1 per 100,000 residents due to domestic violence battery, the third highest monthly rate in the city. Due to the complexities involved in reporting and prosecuting domestic violence battery, arrest rates are considered an underrepresentation of the actual numbers of incidents. Although not conclusive, this elevated arrest rate provides some insight into the severity of domestic violence as a public health problem for residents of the project area.

(e) Substance Abuse

As with other health indicators, substance abuse related morbidities and mortalities are directly related to low socioeconomic status and the characteristic community need and devastation in impoverished areas. According to the Communities Empowered to Prevent Alcohol and Drug Abuse (CEPADA) 1991 Needs Assessment, identified risk factors for substance abuse related death and illness include numbers of persons living alone or in single parent households; the availability of affordable and adequate housing, including the extent of vacant units which offer increased potential for activities related to illegal drug use; educational characteristics such as achievement, attendance, and drop-out rates; and resource availability and service delivery. As illustrated previously, the project area fares poorly on the above factors, with the bulk of children living below poverty status in single-parent households, inferior housing conditions, poor educational achievement and high unemployment rates.

CEPADA public health indicators for substance abuse-related problems include overall mortality rates, age-adjusted mortality rates, and the percent of deaths attributable to various alcohol-related conditions including: homicide, chronic liver disease and cirrhosis, and some cancers. Mortality rates used in the following are calculated per 100,000 population.

The mortality rate for liver disease and cirrhosis of the liver in Grand Boulevard was 43 per 100,000 for 1991-1993, nearly two and a half times greater than the city rate of 18 per 100,000. Lung cancer mortalities in Grand Boulevard were sixth highest in the city for this time period, and at 69 per 100,000 were 60% higher than the city rate of 43 per 100,000. The rate of diagnosed AIDS cases in Grand Boulevard for 1992 and 1993 attributable to injection drug use was 39 per 10,000, nearly twice the city rate of 20 per 10,000.

Public housing developments are prime locales for gang-related drug buying and selling. Thus, in February 1995, the Chicago Police Department began a strategic operation targeting the illicit drug trade in the Chicago Housing Authority complexes. In just five months of operation, an estimated 6,000 drug buyers and sellers were arrested.

(4) Available Resources

An assessment of existing resources must consider not only the number of existing service providers located near the project area, but must also include a variety of other factors influencing access. These include the limitations on existing services, the nature of the service delivery system, patient resources, and other cultural and systemic barriers. Following is a discussion of non-CDPH service providers near the project area.

(a) Overview of Existing Non-CDPH Providers

A list of existing area services is attached in Appendix A. Five Non-CDPH ambulatory care facilities exist in close proximity to the project area. Four clinics, Daniel Hale Williams, Komed Health Center, South State Family Health Center, and the Center for Successful Child Development offer primary health and preventive services for adults and children. The DuSable Adolescent Health Center offers primary and preventive health services to students enrolled in DuSable High School. There are two hospitals located near the project area: Cook County-Provident, and Humana Michael Reese. In addition to these health care services, Chicago Urban League provides the Grand Boulevard community with Heathy Start case management services through linkage agreements with local care providers. There are six local agencies that provide child development services for children ages three and above. Two substance abuse service agencies provide referral, outpatient care and prevention. Two crisis centers are available, Firman House which serves adults and families, and Belfort House which serves adolescents.

Despite the apparent availability of services near the project area, limitations on these services impede their accessibility to project area residents. Given the high proportion of young children in the project area, infant and toddler services are in great demand. The shortened hours available for pediatric visits at Daniel Hale Williams and Komed Health Center present difficulties for mothers. Although the walk-in clinic at the Center for Successful Child Development is open to residents of the project area, the Infant and Toddler Services are limited to the residents of other Robert Taylor buildings, and project area residents must access other services. Likewise, the DuSable Adolescent Health Center is available for residents who attend DuSable High School, but the elevated high school drop out rate in this area indicates the inability of many residents to access these services. In conjunction with the low number of placements available at Belfort House, there is a strong need for services targeted at teens, particularly out of school teens in the project area.

Although child development services exist for children ages 3-5, no local agency provides services for infants up to age three. This lack of infant care is a frequently cited reason for high school dropout and unemployment, and presents additional barriers to the mobility of young mothers and their ability to endure waiting times for appointments.

(b) Barriers to Care

Fragmentation of Services: The fracture of service delivery across multiple service sites is a major barrier to the ability of project area residents to receive services. It is likely that families of the project area have a variety of service providers from different agencies, addressing separate but overlapping needs. A family from the project area may use different agencies for the receipt of services for prenatal and maternal health, child health, adult male health, Public Aid, job or educational skills building and placement, parenting and child development instruction, social services, mental health services and substance abuse services. Without careful coordination and linkages between service providers, care may suffer gaps in information and consistency. There may be inefficient duplication of services, frustrating both providers and patients, and the result may be the fracture of the family into categories of social and health problems which are treated individually, lacking integration into overall family care.

The receipt of services at multiple sites may also cause a breakdown in provider communication networks, presenting barriers to successful receipt of care. For example, a family who uses different providers for maternal, child and adult male health may not benefit from shared information amongst providers. It may be very difficult for providers to appraise the overall family history in situations where care is split across agencies. It is common for families who do not have a consistent relationship with a primary provider to use emergency room care for acute problems that might have been prevented with comprehensive primary care. According to the CDPH Maternal and Child Health Needs Assessment, mothers from the six neediest community areas, who accessed CDPH clinics, used the emergency room more than any other care provider when children were sick (36%). Frequent emergency room care may not be reported to the primary provider, and care received by families who rely upon frequent emergency room visits may suffer from missing information, unnecessary diagnostics, duplication of services, and a lack of follow up.

Lack of Health and Service Information: The lack of a system to disseminate service information to providers and residents presents a major barrier to care in the project area. Unaware of available resources, residents may travel unnecessary distances to receive services or may forgo services completely. Service providers report that it is common for parents to lack basic health information and to be unaware of the need for consistent child developmental and health screenings. Residents may also fear that the utilization of programs that provide food and job resources may endanger support from Public Aid. Even though many social services are designed to work in conjunction with Public Aid, they may be perceived as a threat and therefore not accessed.

Social Isolation: Social isolation operates in the larger Robert Taylor community through the geographic isolation of the Robert Taylor Homes from the rest of the city, and through the national stigma of the Robert Taylor Homes as one of the most depressed developments in the country. As one service provider in the area stated, "Robert Taylor residents start out defeated." Although the focus of countless media articles, documentaries, television news specials and data gathering, residents of the Robert Taylor Homes have felt little reward in the form of social improvements. Within the Robert Taylor Homes exists a complex social network

with strong community boundaries which residents are frequently reluctant to cross in pursuit of social services.

Although frequently isolated from one another within these perceived community borders, there is nonetheless a powerful community influence amongst residents, marked by informal communication channels between friends and families, and defined community norms. The various buildings of the Robert Taylor Homes are controlled and policed by rival gangs, who are largely responsible for setting the norms for resident interactions. Though this population faces daily threats and challenges incomprehensible to most outsiders, there is frequently reported a sense of pride and strength in the ability of residents to survive and raise families in the face of such adversity.

Fear of Crime: Residents are isolated from each other by the fear of violence and the necessity of conforming to territorial boundaries set by the gangs and drug dealers who inhabit and dominate the buildings. The prevalence of violent activity inhibits provider access to the Robert Taylor Homes. Multiple reports cite the fear among police, paramedics and fire fighters that prevent their entry into the Robert Taylor Homes. In an effort to contend with the refusal of emergency workers to enter the Robert Taylor Homes, the Chicago Housing Authority houses a First Aid Care Team (FACT) of paramedics and emergency medical technicians which respond to 911 calls from within the Robert Taylor Homes. Operated by Hull House First Aid, the FACT teams are the first to respond to emergencies, working with City agencies to expedite care.

The fear of being victim to violence also impedes access to services for individuals who reside in the project area. The CDPH social worker stationed in the Robert Taylor Homes reported that often women are so afraid of being a victim of violence that they rarely leave the floor of their building. Single women raising families with young children are especially vulnerable to violence. Outdoor play spaces for children are vulnerable to drug dealing and gunfire. Because the various buildings are controlled by rival gangs, residents are limited in their ability to access buildings. This is especially true for men of the project area as gangs often compete for their membership. For men who are perceived to be from rival territory, even if they hold no gang affiliation, a cross into hostile territory may result in harassment, injury or death. Job skill training programs that teach participants to become home visitors are not viable options for men of the project area for this reason.

Patient Resources: As indicated earlier, the majority of the women and children in the project area are receiving some form of Public Aid. Eligibility guidelines make it difficult for single, able-bodied men to receive benefits. Although the eligibility guidelines are intended to assist with the welfare and health of families, the restrictions may have an adverse effect upon the cohesiveness of the family and it's ability to hold together in times of financial difficulty. Service providers report that mothers fear the presence of their male partners and children's fathers will sever their needed financial and medical support. The implications are severe: men are leaving the home, or living surreptitiously in unauthorized, unreported arrangements. If men do not have medical insurance and cannot pay sliding scale fees for service, they must be seen at health centers or county facilities which provide free care. This may involve traveling great distances on public transportation, or forgoing care completely. If fathers need to bring children for care and receive care themselves, they face enormous time and transportation barriers. In

Chicago it is estimated that every two miles traveled by public transportation takes nearly 30 minutes. For residents who must access services outside the community, transportation presents a major barrier. Money for transportation is also a barrier. Service providers in the project area report that the amount and complexity of paperwork necessary to receive free tokens for patients from the Chicago Transit Authority presents a major obstacle.

Finally, residents who lack sufficient resources often do not have telephones in their homes. Without ready access to telephones, residents must rely upon the use of public pay phones, or travel to service agencies where phones are available. As well as the obvious difficulty this presents for scheduling, the inability to reach clients by telephone may adversely affect follow up and continuity of care.

Other Barriers: In addition to the above limitations and obstacles, several related barriers exist for residents of the project area who seek medical and social services. Child care presents a major barrier to families of the project area as do lengthy waiting times. With multiple providers located at different sites, combined with transportation and distance barriers, additional waiting times may mean that residents spend several hours in receipt of care. Cultural and language barriers must also be considered as possible barriers to care. With a high percentage of youth and teenagers, and a high proportion of teen pregnancies in the project area, it is possible that more care may need to be taken to ensure that health information is fully understood and integrated into the patient's life in an accessible way. Teens may require more time than other patients in order to effectively educate them about health issues. The current gap in services in the project area for teenagers, particularly out of school teens, indicates that they have few options to benefit from specific targeted health information.

1. Chicago Fact Book Consortium, Local Community Fact Book, Chicago Metropolitan Area, University of Illinois, Chicago, 1984, pp.103-106

2. Chicago Housing Authority figures published in 1992

3. Chicago Department of Health Communicable Disease Division, 1994 Vaccination Coverage in the City of Chicago: Results of a Household Cluster Survey

4. City of Chicago Department of Human Services Head Start Community Needs Assessment, 1994.

5. Chicago Department of Health Epidemiology Program, Prevalence of Domestic Violence Among Women Attending CDOH Clinics, March 1995

III. PROGRAM APPROACH

A. Program Overview

Theoretical Basis: An extensive body of literature exists which examines factors contributing to the effectiveness of programs designed to promote health and prevent disease. From this literature, several common elements have emerged that, when combined, will likely increase the effectiveness of prevention efforts:

- Intervention begins early;
- Involvement is long-term, with case management and follow-up;
- Emphasis is placed on quality of service rather than the numbers served;
- The delivery of comprehensive, wrap-around services is assured;
- Programs are integrated for the provision of seamless care;
- Services are targeted to those at high risk;
- Participants are reached within their own environment;
- Individuals are acknowledged and served as members of larger family and community systems, and;
- Programs remain sensitive and responsive to participants' need.

Based on this information, in 1993 CDPH leadership gathered leaders from other service providers and residents of five buildings of the Robert Taylor Homes to consider the development of a comprehensive prevention program. Guided by the elements identified above, the assembled stakeholders committed to the development of an accessible, integrated service delivery model targeting a measurable, high-risk population and incorporating a stringent evaluation of outcomes.

Program Hypothesis and Strategy: The *Robert Taylor Initiative* is based on the hypothesis that if families receive all needed health and human services through an accessible, integrated service delivery model which empowers the family to meet their identified goals, then multi-generational experiences of poor health and related outcomes will be broken. Thus, the strategy for the *Initiative* is to develop and maintain a comprehensive, evaluatable, prevention model of health care serving at least two generations of family members and engaging them to take an active role in the development and pursuit of family and community goals.

Program Goal: The overall goal of the *Initiative* is to develop partnerships to provide families with the comprehensive, seamless service provision that they need to become socially and economically self-sufficient in reaching their own goals.

Through this approach the *Initiative* will:

- Assist families in improving their health status by responding to the needs of each family member in a holistic manner, recognizing each member's interaction in the larger family system, and;

- Assist families in altering the preventable root causes that contribute to poor health.

Guiding Principles: In order to achieve these goals, the *Initiative* operations are guided by several underlying principles:

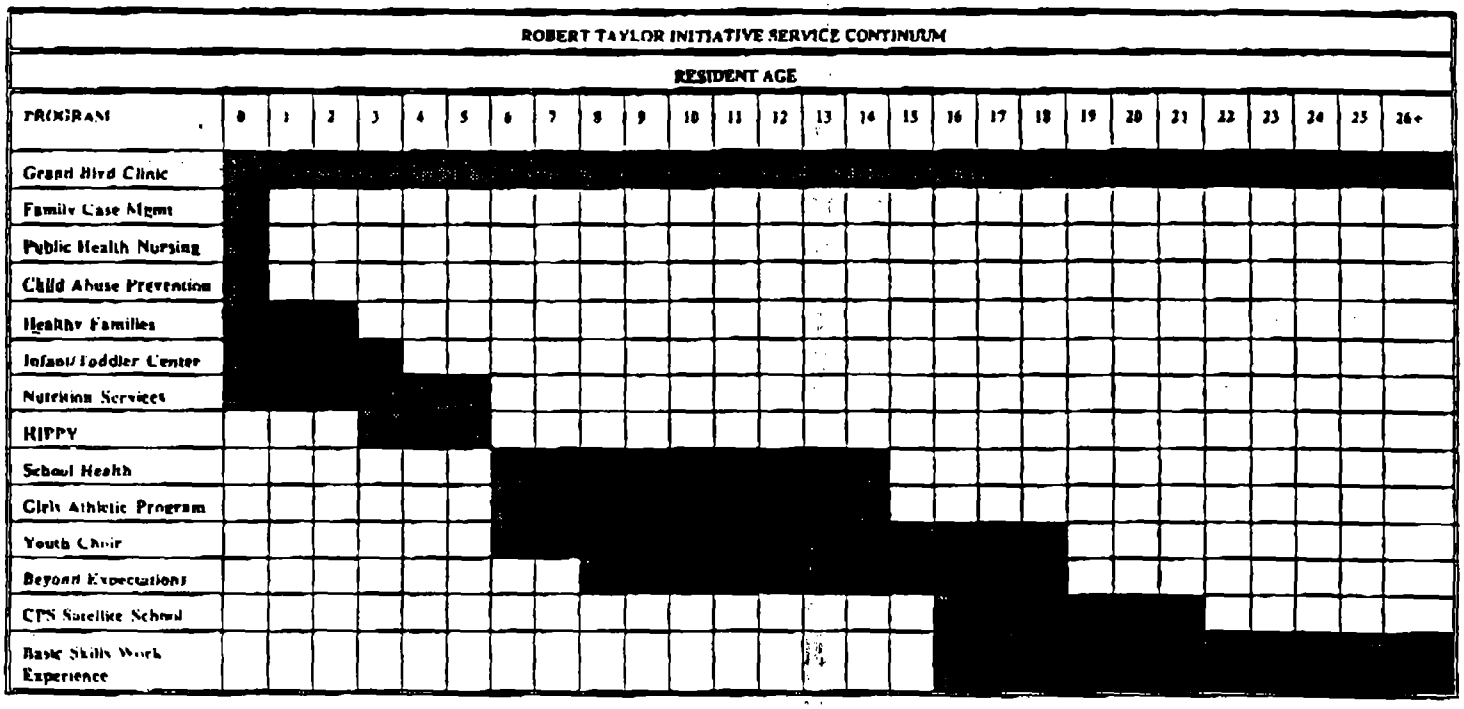
- Approach families holistically, targeting at least two generations: the parent and the child;
- Involve potential participants in the planning, implementation, and evaluation of program components;
- Acknowledge and build upon the existing strengths of families, and;
- Promote self-sufficiency through social empowerment, rather than dependence on social systems.

Program Components: The *Robert Taylor Initiative* consists of a variety of components, summarized below and discussed in detail in subsequent pages. The *Initiative* is based out of the Robert Taylor residential building at 4410 South State Street, which houses various program components. The *Initiative* provides linkages with three area schools and develops partnerships with local service agencies. Outreach workers work with residents of the targeted Robert Taylor Homes to provide information and recruitment for services. *Initiative* components in the aggregate are designed to serve project area residents throughout all ages of their lives as reflected in the table on the following page.

- *CDPH Grand Boulevard Clinic*, providing full maternal and child health care services, TB screening, and incorporating the CDPH nursing staff Year 2001 objectives;
- *Behavioral Health Services*, including social services, substance abuse and mental health prevention and treatment, and violence prevention;
- *Nutritional Services*, providing preventive and therapeutic nutrition interventions, including, but not limited to, the WIC program, patient counseling, and nutrition education;
- *Chicago Family Case Management*, providing case management and service coordination to pregnant women, new mothers, and infants;
- *Healthy Families America Project*, which provides case management for social and health services for families with children from infancy to three years of age;
- *The Child Abuse Prevention Project*, providing step-down care and extended hospital stays in an effort to educate new mothers on child development and care skills;
- *Healthy Living Infant and Toddler Center*, providing developmentally appropriate child care for children from 0-3 years old;

- *Home Instruction Program for Preschool Youngsters*, providing school readiness and parent support for preschool children;
- *Comprehensive School Health Program*, linking two local elementary schools to the CDPH Grand Boulevard Clinic and local health services;
- *Robert Taylor Girls Athletic Program*, a grassroots program incorporating athletics as a tool to assist the holistic development of girls ages 6 to 14 years;
- *Chicago Public Schools Satellite High School*, an individualized performance-based diploma satellite program, which provides actual high school diplomas and job readiness to students with poor records of achievement in traditional public high schools;
- *Basic Skills Work Experience Program*, providing educational and job readiness skills to young adults ages 16 to 21, and adults 22 to 55 years of age;
- *Beyond Expectations*, a violence prevention program, using adult mentors to guide children ages 8 to 18 through non-violent options for growth and development;
- *Ambassadors for Peace: The Community Youth Choir*, providing musical performance skills to area youth in an effort to provide non-violent alternatives.

In addition to the above programmatic components, the *Initiative* will provide on-site Public Aid assistance and enrollment, on-site assistance and management from the Department of Child and Family Services, and linkages to local child care and Head Start programs.



Program Objectives: The various program components are designed to work collaboratively in the provision of an integrated, seamless system of care for residents of the project area. The components are in varying stages of development, ranging from planning to fully operational. When fully implemented, all *Initiative* components will contribute to the attainment of the specified outcomes and the accomplishment of the overarching program goals. The level of specificity of the objectives varies by program component, reflecting the varying stages of program development. It is anticipated that objectives will be further refined and stated in measurable and time-framed terms as the individual programs evolve. In general, however, it is anticipated that progress will be made towards the following broader objectives organized into four categories.

(a) *Individual Health*

A greater number of residents from the project area will:

- Have improved self-image, perceiving themselves as valuable members of their family and community;
- Have more control of their individual health;
- Be more knowledgeable of health information and resources;
- Access regular screenings for the detection of chronic diseases;
- Access screening and treatment as needed for sexually transmitted diseases;
- Receive early treatment and/or management for health problems;
- Attain the education and training necessary to secure employment adequate to maintain independence, and;
- Find meaningful employment if ready and able to work.

(b) *Reproductive Health*

- More women in the project area between the ages of 15 to 44 will demonstrate informed decision-making about family planning;
- More women from the project area between the ages of 15 to 44 will successfully access their chosen birth control method;
- Fewer pregnancies will be unintended, and;
- More women from the project area will birth healthy babies:
  - with adequate birth weight,
  - with minimal defects,
  - with all defects detected and treated,
  - who are substance free.

(c) *Family Health*

- More family members will relate to each other and their community without violence;
- More parents will successfully access day care services when desired;
- More parents will be knowledgeable of healthy child development;
- More families will develop support networks within the community, and;
- More parents will spend quality time with their children on a daily basis.

(d) *Child Health and Development*

A greater number of children from the project area will:

- Be appropriately immunized;
- Receive regular well child care from a licensed provider;
- Enter school developmentally ready;
- Receive at least one complete EPSDT screen by age six, with all findings remediated;
- Receive annual vision and dental care;
- Receive psychosocial and mental health care and intervention, and;
- Progress according to appropriate physical and educational developmental markers.

Section Organization: This section includes descriptions of all CDPH program components currently being implemented or planned for the *Robert Taylor Initiative*. Each description includes an overview of the individual program, program objectives, and a program budget. It should be noted that program components are in various stages of development and there is consequently some variance in the amount of information presented for each of these elements. For most of the budgets, the figures represent the proportion of the costs attributed to serving the residents of the five targeted buildings. In most cases, the programs are open to residents from all of the buildings as well as the larger Grand Boulevard community. The budgets reflect the amount of support that is needed to deliver each program. For some programs, the needed resources have already been identified; for others support is still needed.

IV. COORDINATION AND EVALUATION

The *Robert Taylor Initiative* is more than just a compilation of individual programs: it is defined by the integration and coordination of program components in a concerted effort to meet an overall goal. Inherent in that goal is the provision of a service continuum across at least two generations, the parent and the child. The complexity and ambitiousness of the *Initiative* require that coordination among program components is strong, and that programs are proven effective through stringent evaluation methods.

A. Coordination

In order to meet the *Initiative's* aim of assisting families towards self-sufficiency through the provision of accessible, integrated, seamless service; it is crucial that mechanisms which assure coordination on multiple levels are incorporated into *Initiative* operations. The *Initiative* and its many components must be well integrated with existing community service providers; organization among the components must be strong; and each component must possess efficient internal channels of communication and service delivery. Of particular concern is the continuum of service delivery across various client age groups. Because the *Initiative* targets families across at least two generations through a patchwork of programs with specific enrollment guidelines, it is necessary that the internal channels of connection be streamlined to assist client passage through *Initiative* operations. A variety of opportunities for efficient service coordination exist through meetings with program managers, front-line staff, project area residents, and other stakeholders.

The *Robert Taylor Initiative* Committee meets to facilitate external linkages and service coordination within the project area. The Committee consists of representation of all *Initiative* stakeholders: leadership from CDPH, external partners and service providers and *Initiative* clients. The Committee is convened by the Commissioner of Health and includes members from CDPH, Chicago Housing Authority, Chicago Park Services, Chicago Public Schools, Chicago Department of Human Services, the Mayor's Office of Employment and Training, Neighborhood Services, the Chicago Department on Aging, and the Robert Taylor Local Advisory Councils. The Committee meets periodically to discuss major strategic issues involving long-term planning such as space, funding, and necessary adaptations to changing resources.

To ensure coordination across *Initiative* components, a Program Managers' Committee will be convened and chaired by the *Robert Taylor Initiative* project manager. The Committee will comprise those staff which oversee the major programs contributing to the *Initiative*.
This committee will meet monthly to discuss issues regarding specific programs, resolve issues identified by frontline staff, and refine coordination across *Initiative* components.

Regular staff meetings will be held by each component for the purpose of collegial support and collaboration, program and *Initiative* updates, and educational and skills-building in-services. These regular meetings of front-line staff will also assist in promoting staff involvement in *Initiative* strategic planning, incorporating valuable information from providers who work daily with the project area residents.

Residents from the project area have the opportunity to meet and discuss the *Initiative* during regular Local Advisory Council (LAC) meetings, organized in conjunction with the Chicago Housing Authority. Representatives from the LAC are able to report back to the *Robert Taylor Initiative* Committee through the regular meetings held every three months. The Commissioner of Health also meets bi-monthly with the Women's Issues Advisory Council, a group of residents from the Robert Taylor Homes with investment in improving the health of women and families. Feedback from the Women's Issues Advisory Council will be incorporated in the regular Committee meetings.

B. Evaluation

Purpose: As previously stated, the goal of the *Robert Taylor Initiative* is to develop and maintain a comprehensive, evaluatable, prevention model of health care, focusing on breaking multigenerational experiences of poor health by empowering families and providing all needed health and human services in an accessible, integrated service delivery model. In order to assess the progress towards attainment of this goal and the *Initiative* objectives, CDPH has developed a preliminary evaluation plan. Because the *Initiative* consists of multiple components, the evaluation plan is by necessity flexible, incorporating a comprehensive, multi-dimensional approach which involves both traditional and innovative methods.

Evaluation of the *Robert Taylor Initiative* has two primary purposes:

(1) to assess the relative success of the program components and the Initiative in meeting stated objectives, and;

(2) to identify potential sources of improvement in the *Initiative's* operations.

Challenges to Evaluation: In developing plans to evaluate the *Initiative*, there are several challenges which must be considered. These relate to a variety of factors including the numerous components which define the *Initiative*, as well as the complexity and required integration of program activities. The evaluation plan must effectively address the following issues:

(1) As mentioned in the *Statement of Need*, due to the small size of the project area (a single census tract), it is difficult to calculate meaningful rates for many indicators of morbidity and mortality. For example, between 1991-1993, there were an annual average of 25 cases each of AIDS and tuberculosis reported for the entire Grand Boulevard community. With 20 census tracts comprising the community, this represents an average of 1.25 cases per tract. Thus, evaluation must focus on a limited number of select indicators and consider proxy measures for several outcomes.

(2) Evaluation must also take into account the fact that the individual program components often have different tracking and reporting requirements. These requirements are most commonly imposed by outside funders and are seldom open to negotiation.

(3) Evaluation should, to the extent possible, consider the contributions of each program component towards attainment of the *Initiative's* objectives. If the *Initiative's* goals and objectives are to be attained in the most effective and cost-efficient manner, it is necessary to assess the contributions of each program component. This assessment requires that each program implement and maintain careful tracking of program processes and activities, effects upon the target populations, and changes in measurable outcome indicators.

(4) Evaluation must be long-term in nature so that (a) where needed, data collection systems can be developed, and (b) adequate time exists to assess the long-term impact of the interventions. In many cases, such as violence and child abuse, meaningful data simply don't exist. Thus, a necessary first step of evaluation is to put into place the systems needed to obtain desired data. Another factor concerns the time required to truly assess the impact of early intervention programs. While many of the *Initiative's* programs are delivered to persons at relatively young ages, it is anticipated that the benefits will be derived throughout their lives. Thus, in order to fully evaluate the effectiveness of programs targeting infants, children and youth, time must be taken to follow these persons through adolescence and adulthood.

(5) It is likely that the delivery of the many individual components under a single *Initiative* will provide benefits merely through their synergistic effect with one another. Such an effect does not lend itself easily to evaluation.

(6) Funding for evaluation is limited. Programs can only be evaluated as resources become available.

Approach: Participants in the *Initiative*, the residents of the five targeted Robert Taylor Homes, provide a measurable population from which evaluation measures can be based. The evaluation will utilize two comparison techniques. First, evaluation will consider historical comparisons, that is it will consider changes for the intervention group over time. The second technique will be a control group comparison. Through this approach, the residents of the five buildings will be compared to the residents of the other buildings which constitute the Robert Taylor Homes.

An optimal evaluation plan would include the simultaneous, ongoing assessment of each individual program component with a long-term plan (no less than 10 years) to assess broader outcomes. Such an approach would include coding of participants to determine which services from the available service continuum, individuals within the project area receive. Because the resources are not currently available to support such an approach, evaluation will occur in stages and as opportunities are presented. Evaluation can be conducted more informally or "passively" using data which currently exist and are being collected as part of the routine operations of several programs, such as Nutrition Services and the Grand Boulevard Clinic. More formal or "active" evaluations are also being conducted in areas where data are not currently available and the development of data collection systems is a necessary first step. Such is the case with the HIPPY program, which is being evaluated by the CDPH Epidemiology Program, and Beyond Expectations, which is a demonstration project with a rigorous evaluation component. And most recently, at the request of a potential funder, a formal evaluation plan was developed for the Comprehensive School Health Program. Towards this end, CDPH has engaged a University of

Illinois researcher experienced at evaluating social programs. This researcher will work closely with the CDPH Epidemiology Program in carrying out the School Health evaluation. It is anticipated that in time, evaluation activities will be expanded to include a cost-benefit analysis.

To most effectively determine the success of the *Initiative* and the impact of the individual program components, evaluations should consider process, program, and outcome measures. Process evaluation will focus on how the *Initiative* and its various components are being carried out relative to the original intent. Process evaluation will answer the question, "did CDPH do what it said it was going to do regarding the Initiative?"

The value in process evaluation is the ability to continuously obtain feedback on *Initiative* functions throughout operations; information on service delivery, accessibility, appropriateness, and consumer and staff perceptions can be gathered. If coordination among the *Initiative's* programs is flawed, the process evaluation should reveal these deficiencies, and allow for revision while programs remain operational. Sources of information for process evaluation include: patient records, client tracking information, focus groups, observational reports, and staff and client interviews. Identified process measures might include, but are not limited to:

- the numbers and characteristics of participants in each program component,
- program enrollment and attrition rates,
- the length of individual programs and interventions,
- the characteristics of the individuals delivering the programs, and
- mechanisms for program coordination

Program evaluation should assess the overall effectiveness of program components, alone and in the aggregate, to affect changes in consumer attitudes, behaviors, and other characteristics which should lead to changes in desired outcome measures. Outcome evaluation would subsequently focus on changes or improvements in morbidity, mortality, and other health status and related indicators among project area residents. Consistent with the broader *Initiative* objectives, this evaluation would look specifically at achievements in the areas of individual, reproductive, family and child health.

As previously noted, the small size of the project area limits the availability of several data elements. Variables that occur too infrequently to use include: AIDS, most sexually transmitted diseases, tuberculosis, infant mortality, any types of cancer and any cause of death, including even homicide. However, several variables measure more frequently occurring events and are thus suitable for evaluation. These include, but are not limited to:

- prenatal care
- maternal smoking
- maternal weight gain
- teen births
- unintended pregnancies
- low birth weight
- gonorrhea
- immunization coverage
- development skills

- educational attainment
- employment rates

Conclusion: While the preliminary design for the evaluation of the *Robert Taylor Initiative* establishes the underlying structure and identifies measures that will provide a reliable assessment of the achievements and outcomes of the *Initiative*: ongoing strategic development is necessary to effectively evaluate the complex and ambitious operations that comprise the *Initiative*. A stringent evaluation which considers process, program and outcome measures will provide information on the relative success of program components individually and in the aggregate; determine the extent to which achievements can be attributed to this model of service delivery; and will identify areas where *Initiative* operations can be refined. Though this endeavor presents many challenges, the conclusions resulting from a comprehensive evaluation of the *Robert Taylor Initiative* will provide invaluable information concerning service delivery to comparable high-need populations.