# Healthy Start Federal Final Impact Report

## I. Overview of Racial, Ethnic Disparity Focused on by Project

The focus of the St. Petersburg/Pinellas HS Project (St. Pete/Pinellas H.S. FED Project) conducted in Pinellas County, Florida was to target 21,329 **African American** women of childbearing age, their children and their families and provide services to reduce the perinatal health racial disparity and decrease poor birth outcomes experienced by African Americans. The initial community needs assessment of the data identified several large and persistent gaps in all perinatal health indicators between its Black and White populations. The initial assessment revealed that a black infant born in Pinellas County was 2.6 times more likely to die before his/her first birthday, over 2 times more likely to be born low birth weight and 2.3 times more likely to be born very low birth weight than its white counterpart. The assessment also revealed that despite a well-developed perinatal care system, the Pinellas County 1996-1998 three-year average Black infant mortality was 16.8. The project proposed to improve the community perinatal health service system by enhancing the existing Florida HS services.

In order to focus on reducing the high disparities in perinatal health that existed in Pinellas County, the St. Pete/Pinellas H.S. FED Project served at risk African American **pregnant women** county-wide, and provided services to both the **mother and infant through the infant's second year of life**. The project focus included helping to promote longer **interconceptional** periods and support healthy behaviors.

The major goals for the project by 6/01/2005 were:
1) To improve the Black perinatal health outcomes including infant mortality, low birth weight, very low birth weight, preterm delivery, and small for gestational age; 2) To enhance growth and development and promote health of African American infants; 3) To promote longer periods and preventative health behaviors in African American women; and 4) To enhance the local perinatal system of care in order to reduce disparities in health.

## II. Project Implementation

Provided below is a description of how the Project implemented each service intervention including how each approach was decided upon, components of each intervention and the resources or events that either facilitated or detracted from successful implementation.

### Outreach and Client Recruitment

A. **Approach -** The outreach and client recruitment approach was decided upon through a consumer driven set of focus groups and meetings. The groups identified finding, identifying, enrolling, and retaining perinatal/interconceptional women and their infants with high risk factors who were not already accessing the comprehensive system of care or accessing it late as the primary focus. The consumers helped outline strategies that would find and assist women to seek

early prenatal care to optimize the chance of giving birth to a healthy newborn. The rationale for this approach was taken based on the importance of getting buy in from the community and consumers of services to best meet their needs during the Consortium activities and meetings of the Collaborative Management Team.

B. **Components -** The components of the outreach and recruitment strategies included Healthy Start screening at provider offices and hospitals, street outreach and door-to-door canvassing, community based outreach, center-based outreach, and referrals. The resources needed to implement outreach and recruitment strategies were contracted staff including a part-time social worker at Bayfront Hospital and three part-time and one full-time Outreach Worker/Health Promoter with neighborhood centered and grass-root community based agencies strategically located in the African American communities of Safety Harbor, Greenwood, Tarpon Springs and St. Petersburg. A pre-service training was offered to all new project staff to familiarize them with creative and diverse culturally competent outreach strategies. On-going training sessions for outreach and case management staff focused on specific training needs identified through surveys and feedback to enhance the skills of staff. Training was open to health promoters from Closing the Gap programs who were interested in improving their knowledge regarding the perinatal health and social needs of the target population. Changes to outreach and recruitment strategies were made in CY 2004 that increased contracted staffing to 3 full-time and 1 part-time Outreach Worker/Health Promoters. Outreach Workers/Health Promoters received additional training in locating and identifying high-risk women of childbearing age to offer pregnancy testing and confidential HIV testing. Outreach also expanded to non-traditional areas and required non-traditional work hours. These areas included laundromats, beauty salons, community centers, low-income housing complexes, social organizations, street locations, parks, bars, jails, homeless shelters, domestic violence centers, soup kitchens, substance abuse treatment centers and mental health facilities. The rationale for making these changes was due to outreach efforts not providing the expected recruitment to HS services and the data showing that there were still at risk women in the Project area who were not entering prenatal care in their first trimester. Another change that took place in outreach and recruitment was the discontinuation of the regularly scheduled nursing services of triage, pregnancy tests and family planning at the center based outreach site of Bethel Community Baptist Church. The rationale for this change was the low participation from women in the community to partake in the services. Instead the nurse provided services on a consultation basis in addition to nursing assessments on all HS participants.

**C. Resources -** Resources or events that facilitated the implementation of outreach and recruitment can be found in the above Components section. Resources or events that detracted from successful initiation and implementation of outreach and recruitment included the limited human resources within a large county-wide project area to conduct Street Outreach and Door-to-Door Canvassing outreach activities. This limitation of human resource staff resulted in the lower than

expected recruitment into HS services. The decision in 2004 to expand outreach to 3 full-time workers and 1 part-time worker was a result of this finding. Low participation from women in the community to partake in the nursing services offered at the Bethel Community Baptist Church site resulted in the discontinuation of this regularly scheduled service and was changed to an as needed basis.

**Case Management**

A. **Approach -** The case management approach was decided upon through an integration with the Pinellas County Healthy Start "Umbrella" which houses existing home visiting/case management/family support programs. The rationale for the approach taken was to avoid duplication of services. The addition of two teams allowed HS to serve more intensively an estimated 550 African American families per year that were not already targeted by Healthy Families Pinellas, one of the programs that serves geographically targeted populations. The project also served women who experienced a fetal loss or an infant death as they were not eligible for any other program. Case management (CM) was designed to address the needs expressed by pregnant women and parenting women and their infants (0-2 years old) through screening, risk assessment and risk-appropriate care including referral, monitoring, facilitation and follow-up on utilization of needed services in a coordinated, culturally competent approach. Access and utilization of quality prenatal, delivery, and postpartum care was a priority for pregnant women. For infants, the priority was access and utilization of appropriate quality well-baby care and primary care services. For mothers and women, the priority was access and utilization of women's health education and interconceptional care including postpartum depression and referral if necessary.

**Components -** The components of the home based case management strategies included central registration, an initial contact, initial assessment, screening for domestic violence, and depression, in-home education and counseling and referrals. An Individual Plan of Care/IPC was completed from needs/risk factors identified through Initial Contact and Initial Assessment for all Healthy Start Participants and was re-evaluated/updated at each subsequent program participant home visit. A Family Support Plan was developed for families that required a higher level of care (Level Med/High and Level High). Participants were assigned a level of care based on the needs and risks identified. This level determined the frequency of visits from case management staff. The frequency of home visits ranged from 1 time every 3 months (Level Low) to weekly and bi-weekly (Level Med/High and Level High). Other components of case management strategies included providing services to program participants to support and supplement existing resources and CM activities. These services consisted of in-home parenting education, substance abuse assessment and referral to outside agencies; developmental screening, tracking of immunizations and well-baby visits for infants; referral and tracking of well woman visits; nutritional counseling beyond WIC services, psychosocial counseling, dental

services for pregnant participants, smoking cessation counseling, breastfeeding counseling, car seat education, HIV education, father's services, doula, nursing assessment and consultation, family planning counseling and services, peer support groups and referrals to outside agencies and resources as needed. The resources needed to implement case management were two multidisciplinary, multi-agency teams sites located at the Pinellas County Health Department and Bethel Community Baptist Church. The multidisciplinary staff that were divided amongst these two teams included Family Support Workers ( 7 FTEs), Human Service Counselors (2 FTEs), a Social Service Counselor (1 FTE), a Nursing Consultant (2 FTE), a substance abuse specialist (0.5 FTE), a Father's Services Consultant (1 FTE), a Mental Health Consultant (1 FTE), a Doula/CB Educator (1 FTE), a nutritionist (0.5 FTE), a Field Supervisor (1 FTE), a Clerical Staff (1 FTE) and a Community Health Nurse Supervisor (1 FTE). Documentation and tracking of services provided by case management staff was done in the participant's record as well as using the paperless encounter in the HCMS system (See Appendix P-1 for Encounter Form, P-2 for CM Leveling Form, P-3 for Edinburgh Postpartum Depression Screen). Quality Assurance was performed through quarterly record reviews in which 10 % of active charts were audited. Participant Satisfaction Surveys were conducted annually (See Appendix P-12). Multi-disciplinary staff meetings were conducted monthly, and supervisors met with staff to review cases on a weekly basis. An intense pre-service training was provided for all incoming staff and at least 48 hours of ongoing training was provided to case management staff on an annual basis.

Changes that occurred over the Project period in case management were the addition/modification of paperless encounter codes including a Healthy Start Encounter Code added on 10/1/03 for the purposes of encountering time spent in providing interconceptional education and counseling. Codes for risk factors, referrals made and services received were also modified. The rationale for these changes was to better capture HRSA data requirements and services provided by the grant. In CY 2003, the in-kind nutritionist consultant services became more office based and the nursing services were consolidated to one nursing position instead of two. The rationale for the change for the nutritionist was due to time constraints. The consolidation to one nursing position was due to North County not generating enough nursing referrals. In CY 2004 there were several other changes to CM that occurred. The nurse began conducting assessments on the majority of new prenatal and infant participants. The rationale for making this change was in response to the HRSA requirement to capture several new medical risk factors on prenatal, interconceptional, and infant participants. The nurse was assigned to capture the required screening information and provide counseling for these medical risk factors. In CY 2004, the contracted mental health agency changed from Family Services Center to Directions for Mental Health due to the ability to bill for Medicaid services in the home. In June 2004, the mental health counselor position transitioned to part-time (0.5 FTE) in the Healthy Start Federal Project and part-time (0.5 FTE) in the State Healthy Start program. The rationale for the change was to continue financial support for the position and provide a

broader client base for the mental health counselor to conduct home visits. A dental hygienist (0.05 FTE) was added to provide dental services for pregnant program participants. The rationale for this change was to provide services to pregnant women who were exhibiting signs of periodontal infection, a risk factor for preterm labor, and to provide cleanings and basic dental services to pregnant women who did not have a dental provider. The two Human Service Counselors at the St. Petersburg CM site became the assessment workers for all new prenatal, interconceptional and infant referrals to HS FED and the Family Support workers and other CM staff performed the ongoing case management. The rationale for this change was to optimize the use of the two staff members' advanced level assessment skills from their social work training to perform the initial contact and initial assessment components of case management. Lastly, in CY 2004, there was a period when Somali Bantu refugee families were served by the Project in CM. Language and cultural differences created barriers for accessing of services. Culturally competency issues were addressed by Project staff attending special trainings within the community to learn about the Somali Bantu culture and needs and attending the Refugee Task Force meetings in Tampa, FL. Interpreting services were made available to Project staff through telephone interpreter lines and local interpreters in the community.

**Resources –** Resources or events that facilitated the implementation of case management can be found in the above Components section. A resource or event that detracted temporarily from successful initiation of the case management strategy of psychosocial counseling was the delay in finding a mental health counselor who could provide culturally sensitive mental health services in participants' homes. The mental health counselor position was vacant for 5 months, which created a disruption in home-based psychosocial services. In March of 2004, a masters prepared African American counselor was hired which eliminated this barrier to service. Another resource that detracted from successful initiation of case management services for interconceptional women were the post-partum women who lost their Medicaid eligibility 8 weeks following their deliveries. Not having insurance coverage made it difficult for women to seek medical services during her interconceptional period. The Family Planning Waiver was reinitiated in CY 2004 which extended Medicaid benefits toward family planning services for up to 2 years after a woman's last Medicaid covered delivery. This waiver helped to alleviate some of the detraction but does not provide insurance coverage for non-family planning related medical needs such as managing an existing chronic disease (e.g. asthma). Interconceptional women who did not have insurance to cover primary care and medical needs were referred by case management to providers and Community Health Centers providing health care services on a sliding fee scale. Women who had a chronic disease or medical need identified were also referred to the nurse consultant for follow-up.

## Health Education

A. **Approach -** The Health Education and Training approach was decided through consumer focused Parent Questionnaires, Women's Health Questionnaires and Peer Support Group participant requests. These were used to identify areas of perinatal health topics in which information and education were targeted. The community identified topics pertaining to physical and life skills that would improve their personal and family health outcomes. The HE team was also the Outreach staff. Through their outreach efforts they promoted the HE component. The rationale for the approach taken was based on utilizing the information and input from the community to design HE programs specifically for the targeted communities.

**Components -** The components of Health Education and Training were Peer Support Groups, health education classes, childbirth classes, Doula services, health fairs and community awareness activities. Resources (including personnel) needed to implement the Healthy Start Federal Health Education and Training component included seven staff members. A Health Education Coordinator (1 FTE), 1-part-time Secretary (0.5 FTE), a Childbirth/Doula Educator (1 FTE) and four Outreach/Health Promotion staff (3 – 0.5 FTE, 1 FTE) located in four targeted neighborhoods in Pinellas County providing services in 7 identified high-risk communities. Changes that occurred to Health Education and Training over the project period were the transitioning in CY 2004 of two PT case management staff to FT outreach staff which resulted in having 3 FTE and 1 - 0.5 FTE Outreach/Health Promoters. The rationale for making these changes was to allow more time for outreach and education in the targeted communities.

**Resources -** Resources or events that facilitated successful initiation and implementation of Health Education and Training included the cooperation of local area community agencies and staff providing space and teachers for PSGs, classes, health fairs and events free of charge. Also, the housing, furniture, phones and supervision of Health Education staff members provided by their individual agency facilitated the implementation of Health Education and Training. This at times became a resource that also detracted from successful initiation and implementation of Health Education and Training because staff identified with their agency and not the HSF project. Other resources or events that detracted from initiation and implementation were the lack of funding for incentives and the purchase of HE materials. These barriers were overcome by finding resources on the internet such as free health education materials, publications, information and resources from government and other health related sites. 4women.gov was a great resource for the Project's women's health campaign.

## Interconceptional Care

A. **Approach -** The Interconceptional Care approach was decided through a PPOR analysis of Pinellas County's fetal and infant deaths from 1998 – 2000 which

indicated that the greatest opportunity for improving maternal and child health was in preventing prematurity and very low birth weight births. These conditions were most affected by the health of the woman prior to conception. The Fetal Infant Mortality Review (FIMR) supported these PPOR findings. The Project began its Interconceptional Education and Counseling component using the Florida State University, Center for Prevention and Intervention Policy's interconceptional care curriculum, "Partners for a Healthy Mother," as a guide during home visiting to educate the women regarding her personal needs. The rationale for the approach taken was based on the Project not having its own curriculum at the time but still needing to provide the education and counseling. As the Project evolved it joined efforts with the other HS Umbrella Home Visiting programs in producing a culturally sensitive local curriculum. The local curriculum developed consisted of the Women's Health Questionnaire to identify risk factors for future poor perinatal outcomes, 10 brochures on the topics of 1) Women's Health, 2) Maternal Infection, 3) Nutrition, 4) Chronic Health Problems, 5) Stress and Mental Health, 6) Access to Health Care, 7) Baby Spacing, 8) Physical Activity, 9) Substance Abuse/Smoking, and 10) Environmental Risk Factors and the creation of new codes on the Encounter Form to capture the education given, referrals made and services received.

B. **Components -** The components of Interconceptional Care were case management, health education and outreach. Interconceptional Care in the case management component involved the case manager performing home visits and assessing and reassessing the interconceptional woman for health and social conditions, risk-taking health behaviors, medical conditions, psychological conditions, environmental conditions, barriers to family planning, primary health care, and dental care. Based on the risk assessment the case manager would provide the necessary 1-on-1 Interconceptional Education in the home, make appropriate referrals to Project consultants (nurse, mental health counselor, women's intervention specialist, dental hygienist) and/or community resources and follow-up with referral sources to find out if services were received. The case manager also provided parenting education and tracked the immunizations and medical home of the infants as part of interconceptional care. The two primary interconceptional goals for home visitors was to ensure the interconceptional case managed woman received at least one comprehensive primary/preventive health care visit before closure at the child's second birthday and to assist the interconceptional case managed woman to achieve recommended baby spacing. For the health education component, interconceptional education was provided through Peer Support Group sessions, newsletters, community presentations and at health fairs and events. For the outreach component interconceptional messages were distributed during street outreach and door-to-door canvassing, community based outreach, center-based outreach and was expanded in CY 2004 to include Outreach Workers conducting pregnancy testing. The resources (including personnel) needed to implement Interconceptional Care in case management were 11 case management staff (9 – FTE, 2- 0.5 FTE), 2 consultants including nurses (2 – FTE), nutritionist (part time/PinCHD), substance abuse

specialist (0.5 FTE), mental health counselor (1 FTE) a field supervisor (1 FTE), and a Community Health Nursing Supervisor (1 FTE). The resources needed for interconceptional care in health education and outreach were 4 Outreach/Health promoters (1–FTE, 3–0.5 FTE), a Health Education Coordinator (1 FTE), and a Secretary (1- 0.5 FTE). Resources included the housing, furniture, phones and supervision of staff members by their individual agency. Changes that occurred to interconceptional care over the project period for the case management component was a decrease in resources for CY 2004 in the number of Case Managers from 11 (9 FTE, 2 – 0.5 FTE) to 9 (9 FTE) and a decrease in the MH Counselor position in June 2004 from 1 FTE to 0.5 FTE. The case management interconceptional curriculum also expanded to include the Women's Health Questionnaire (See Appendix P-4), 10 interconceptional topic brochures (See Appendix P-5) and the new codes to capture information given, referrals made and services received. Changes made to the interconceptional component of health education and outreach included an increase in CY 2004 in the number of Outreach/Health promoters from 1 full-time and 3 part-time to 3 full-time and 1 part-time. The outreach/health education curriculum also expanded to include the Women's Health Questionnaire and 10 interconceptional topic brochures. The rationale for making these changes was to allow more time for outreach and education in the targeted communities and also to provide a more tailored interconceptional risk assessment and curriculum for the Program and Community Participants. The rationale for the change to the Mental Health Counselor position was to continue financial support for the position and provide a broader client base for the mental health counselor to conduct home visits. In CY 2004, the contracted mental health agency also changed from Family Services Center to Directions for Mental Health due to the ability to bill for Medicaid services in the home.

B. **Resources -** Resources or events that facilitated successful initiation and implementation of Interconceptional Care was the Community Health Division Workgroup that developed the Women's Health Questionnaire, 10 Interconceptional Brochures, and established the new Encounter codes. The workgroup consisted of team members from all of the Healthy Start Umbrella home visiting programs including HS FED. A resource that detracted from successful implementation of interconceptional care were the post-partum women who lost their Medicaid eligibility 8 weeks following their deliveries. Not having insurance coverage made it difficult for women to seek medical services during her interconceptional period. To overcome this barrier the Family Planning Waiver that was reinitiated in CY 2004 which extended Medicaid benefits toward family planning services for up to 2 years after a woman's last Medicaid covered delivery. This waiver helped to alleviate some of the detraction from interconceptional care but did not provide insurance coverage for non-family planning related medical needs such as managing an existing chronic disease like asthma. Interconceptional women who did not have insurance to cover primary care and medical needs were referred by case management, health education and outreach to providers and Community Health Centers providing health care

services on a sliding fee scale. Women who had a chronic disease or medical need identified were also referred to the nurse consultant to follow-up.

**Perinatal Depression**

A. **Approach -** The Perinatal Depression approach was decided upon after the Community Needs Assessment for the current grant identified that a mental health (MH) services gap existed in the County. An increasing need for MH services and a service gap in the MH system (waiting list and emergencies where patients were too often released within 24 hours with no resolution) were reported in the Safe Start Initiative Community Assessment (2001). MH and Family Counseling agencies also had eligibility/funding limitations on services. To overcome these barriers to MH services, a mental health counselor was hired to provide mental health services in program participants' homes or in their office at the Health Department to program participants identified at risk for depression or mental health issues. The Beck Inventory Screening was used initially by the Project to screen women for depression. The screening tool was later changed to the Edinburgh Postpartum Depression Screen (EPDS). Besides overcoming identified MH service gap in the community needs assessment, the rationale for the approach taken to provide in home mental health services was to decrease waiting times, reduce transportation needs and provide a more comfortable environment for the program participants to get the services they needed. The rationale for the switch to the EPDS tool was because it was recommended to attendees of the 2001 Healthy Start Grantee Meeting as a simple, reliable, self-administered tool to use for depression screening.

B. **Components -** The components of Perinatal Depression were screening, education, referral, and service provided. The Edinburgh Postpartum Depression Scale was used to screen prenatal, postpartum, and interconceptional CM program participants (PPs). The screen was completed as part of the PP's initial assessment, in the second month after the infant's birth during the postpartum period and could be re-administered anytime symptoms became evident during ongoing care coordination. "Depression and African Americans" (See Appendix E-1) was a pamphlet used to educate PPs during their home visits with case managers. Additionally the nurse consultant provided printed information on postpartum depression to PPs from the 4women.gov Dept. of Health and Human Services website. The referral process to mental health services took place if a PP scored a 12 or higher on the EPDS screening or if the PP was experiencing high stress or other mental health issues. The Mental Health Counselor would receive the referral and then contact the woman to conduct a psychosocial assessment. Once the assessment was completed the Mental Health Counselor would provide in-home counseling services if appropriate and the PP agreed to her services. An effort to educate the community about the signs and symptoms of perinatal depression was also done through Peer Support Groups, community presentations, health fairs and events. The resources (including personnel) needed to implement the case management components of Perinatal Depression were 11 CM, 1 Nurse

Consultant, 1 MH Counselor, and 2 Supervisors. The EDPS, depression pamphlets, print outs and brochures were the tools used to screen and educate PPs. The resources needed to implement the community health education component of Perinatal Depression were 4 Outreach/Health promoters (1- FTE, 3- 0.5 FTE), 1 Health Education Coordinator (1 FTE) and 1 Secretary (0.5 FTE) along with the pamphlets, brochures, newsletters, presentations and fliers used to teach about perinatal depression. Changes that occurred to Perinatal Depression over the project period were the switch in CY 2002 from the Beck Inventory Screening tool to the Edinburgh Postpartum Depression Screening tool. In CY 2004, the contracted agency that provided the mental health services changed from Family Service Centers to Directions for Mental Health. In CY 2004 the number of case managers decreased from 11 to 9 and the Mental Health Counselor position went from full-time with HS FED to part-time with the HS FED Project and part-time with the State HS program. The rationale for making the screening tool change was due to recommendations to use the EPDS given at the 2001 Healthy Start Grantee meeting. The rationale for changing the contracted agency providing the mental health services was due to need to contract with an agency that could process Medicaid reimbursement and provide in-home services. The rationale for decreasing the number of CMs was due to the need to transition 2 of the 0.5 FTE case managers to outreach to conduct more aggressive outreach activities and testing. The rationale for decreasing the MH Counselor from full-time to part time was to continue financial support for the position and provide a broader client base for the mental health counselor to conduct home visits.

C. **Resources –** A resource that facilitated successful initiation and implementation of Perinatal Depression Screening was the third party reimbursement collected from Medicaid by contracted agency for prenatal PPs who received mental health services from those agencies. Another resource that facilitated successful implementation for perinatal depression was having a culturally sensitive Mental Health Counselor willing to provide in home MH services. A resource that detracted from the implementation of Perinatal Depression was the loss of Medicaid coverage by Postpartum PPs 8 weeks after the delivery of their infants. Another resource that detracted temporarily from implementation of Perinatal Depression was the delay in finding a mental health counselor who could provide culturally sensitive mental health services in participants' homes. The mental health counselor position was vacant for 5 months, which created a disruption in home-based psychosocial services. The Medicaid insurance coverage barrier was overcome by the Project providing a set amount of money to the contracted agency to cover mental health services provided for PPs not covered by Medicaid. The temporary vacancy of the MH Counselor position barrier was overcome by referring PPs in that vacancy period to existing MH providers at the contracted agency or to other agencies in the community. In March of 2004, a masters prepared African American counselor was hired which eliminated this barrier to providing in home mental health services.

**Local Health System Action Plan**

A. **Approach –** The current Local Health System Action Plan was implemented in 2002. The Local Health System Action Plan approach was decided through efforts outlined in both local and state strategic plans (now revised) including the Florida Title V MCH Block Grant – FY 2001, the HS Coalition of Pinellas, Inc. Service Delivery Plan 2000 – 2003, the PATRICIA Community Action Plan 2001 – 2002 and proposed advisory body, and the Pinellas County Health Department's Strategic Plan 2000 – 2004. The Local Health System Action Plan was updated as community needs were reassessed and the local and state strategic plans were updated. The rationale for the approach taken was based on the Project's efforts to contribute to improving the current system of perinatal care through linkage with state health office staff, the Healthy Start Coalition Pinellas, Inc, the activities of PATRICIA, and the Pinellas County Health Department.

B. **Components -** The components of the Local Health System Action Plan were the linkages to the State Title V plan, the HS Coalition Service Delivery Plan, the PATRICIA Community Action Plan and the PinCHD Strategic Plan. For the State Title V Plan 10 priority areas were determined every year. The latest priorities outlined in the 2004 State Plan were improving pregnancy outcomes, access to care for maternal and child health populations, and MCH health data capacity, preventing the incidence of disabilities, decreasing infant mortality rate, particularly the non-white rate, low birth weight rate, and the number of people who are uninsured, and reducing incidence of infections during pregnancy, teen pregnancy and subsequent teen births, and infant and child morbidity and mortality. The local HS Coalition Service Delivery Plan was updated every 3 years. The latest 2003 – 2006 Service Delivery Plan targeted populations and areas of special interest. Target populations included women at risk for preterm delivery, women with previous fetal or infant loss, women with a HS score of four or higher, and HS children birth to two at risk of developmental problems. Key areas of special interest were the Perinatal Periods of Risk (PPOR) analysis, screening rates, improving client-provider relations, family planning, substance abuse/smoking cessation, nutrition, access to health care and maternal infections including dental services and teen pregnancy prevention. The PATRICIA Community Action Plan established 3 goals: 1) Analyze data regarding consumer perception of health and social service systems sensitivity to providing services to customers based on ethnicity, age and other variables of diversity; 2) Raise the awareness among the four major stakeholders: PATRICIA members, health care providers, broader community and policy makers about racial disparities in infant mortality; and 3) Sustainability. The Project with the involvement of the PATRICIA prioritized three needs identified in the LHSAP which included 1) reducing the gap in perinatal health disparity by improving access to care for the maternal and child health population, 2) improving the mother's interconceptional health status, and 3) increasing consumer involvement in the activities of the PATRICIA. The PinCHD's strategic issues were prioritized into three primary areas: Promoting Healthy Behaviors, Reducing

Racial and Ethnic Health Disparities, and Public Health Preparedness. Staff were cross-trained on issues related improving over all health of the community including benefits of physical activity, reducing unhealthy behaviors, nutrition, and diabetes. The PinCHD was awarded a STEPS for HEALTHIER US grant and is participating on a national level to improve the community's health. The resources (including personnel) needed to implement Local Health System Action Plan were the membership of the local HS Coalition and Project Consortium PATRICIA, the State Title V officer, health care providers, PinCHD management and staff and HS FED Project management and staff. Changes that occurred to the Local Health System Action Plan over the project period were the PATRICIA becoming a separate entity from the HS Coalition and an increased focus on interconceptional education and counseling at the local and state level. An interconceptional education and counseling (ICE) chapter was added in CY 2004 to the State HS guidelines and funding through the Title V grant was allocated for ICE activities. Perinatal depression screening of the Project was adopted locally by other HS Umbrella programs and is being considered at the State level to be incorporated into the HS Guidelines. The rationale for making these changes was the grant funding through the local HS Coalition ended in CY 2002 and the Project began providing funding for the Consortium. The rationale for increasing the focus on interconceptional education and counseling was due to County PPOR and FIMR analysis results which indicated that the greatest opportunity for improving maternal and child health lied in preventing prematurity and very low birth weight births. The rationale for expanding perinatal depression screening to other PinCHD MCH home visiting programs and the State level consideration of the screening was due to the demonstrated success of the Project utilizing the screen to make referrals and get mental health services for the PPs in need.

C. **Resources –** The resources or events that facilitated successful initiation and implementation of the Local Health System Action Plan was the Pinellas County Health Department creating a Pinellas Healthy Start Umbrella (integrated system of case management) that provided services to a variety of at-risk populations through state HS and other sources including Healthy Families, School Teen Parent Program, YWCA Teen Pregnancy Program, Family Continuity & Sheriff's Office, and Early Intervention Program Part H. These collaborative groups worked towards all goals of the Local Health System Action Plan. Staff were represented at meetings held by Pinellas Healthy Start Coalition, state workgroups, PPOR workgroups, PATRICIA and HS FED Project. There was also the reinstatement in CY 2004 of the Medicaid Family Planning Waiver which provided insurance coverage for family planning services to interconceptional women within 2 years of their last Medicaid covered delivery. Ongoing communication and collaboration between the Project and the state and local Title V agencies was another valuable resource. The resources or events that detracted from successful initiation and implementation of the LHSAP included *the transition of the PATRICIA when funding ended from the Allegany Franciscan Foundation. *State rules and legislation for Healthy Start

needed to be revised to include focus on preconceptional and interconceptional health care. *Disparities in perinatal health outcomes continued to exist. State data showed trends of an increasing infant mortality rate and generated concern for the number of very low birth weight babies born. *Pinellas County is a peninsula located on the central West Coast of Florida. The geography of the county may be a barrier to low-income residents who struggle to access non-neighborhood-based services. *A local study of low birth weight infants in Pinellas County described differences in the demographic characteristics of mothers delivered low birth weight infants by North County and South County residence. *According to the St. Petersburg Chamber of Commerce (1997), many residents were employed by small businesses. Since many small businesses and service industries do not provide affordable insurance, healthcare for working poor was a major issue. *Changes in malpractice coverage for prenatal care providers threatened to reduce the number of providers in Pinellas County. *The loss of funding and the inability to compensate with private donations may lead Planned Parenthood to raise the clinic costs to teens even higher in years to come. *The STOP program lost its funding to serve over 200 teens a year providing counseling and individual assistance in adolescent risk behavior such as smoking, teen pregnancy and substance abuse. *Lastly the communication among the partnership and participation on the PATRICIA detracted from implementation of LHSAP. Consensus building was somewhat isolated within individual groups. Partners had different priorities and agendas when participating in meetings. These barriers were overcome by the Project funding the PATRICIA Consortium, the State adding a new chapter to the state rules and regulations for Healthy Start to include interconceptional education and counseling, the formation of an Infant Mortality Workgroup of local and state Healthy Start and CHD representatives under the leadership of the Department of Health (DOH), the Project partnering with Community Health Care Centers who provided primary services on a sliding scale fee, the PinCHD applying and being awarded the HRSA Healthy Start Eliminating Disparities in Perinatal Health grant for CY 2005 – CY 2008 to focus on providing core services and cores systems efforts to the AA geographic areas with the highest IMR in the County instead of all AA communities in the county, and the Project strengthening a partnership with the YWCA that has a well developed teen pregnancy program. Lastly by the end of the Project the collaboration between partners strengthened and resulted in a highly successful “Bringin in Da Spirit” event which attracted providers, consumers and the community to learn about local resources for perinatal health with a focus on AA midwifery and its history and current status in Pinellas County.

**Consortium**

A. **Approach -** The Consortium approach was decided through trial and error. The initial approach or structure, of the Consortium as one large body meeting monthly, was changed to a tiered approach which permitted more substantive involvement on the consumer level (See Appendix E-2). The tiered approach

consisted of three tiers:1) the PATRICIA Advisory Committees (PAC)s that were developed at each of the nine program service sites; 2) three PAC Sectors , North Sector, Mid Sector and South Sector (each sector was decided based on geographical location in the county and shared issues and concerns); and 3) the PATRICIA Consortium which was comprised of elected representatives from each site, consumers from area of service, service providers and community organizations and groups both public and private. The rationale for the approach taken was based on the distance between the partners located in various cities throughout the county, the logistics of arranging transportation and the length of travel time to a centralized meeting location.

B. **Components -** The components of the Consortium were PATRICIA Advisory Committees (PAC), PAC Sector, and the PATRICIA Consortium. The PAC's were made up of consumers from the nine program delivery sites. This group met monthly to discuss issues regarding service delivery at their specific sites, share ideas and receive information from project staff and gain consensus on decisions related to the project and service delivery. The Sectors were comprised of 2-3 sites that were geographically connected. Representatives from each PAC attended the quarterly Sector meetings to discuss shared concerns and successes and to build a sense of connectedness between the program delivery sites. This was also intended to be a step in preparing consumers for participation in the larger consortium. The resources needed to implement the Consortium were the Consortium Consultant, Peer Recruiter, Federal Healthy Start staff and budget allocations from the Allegany Foundation grant through February 2003 and from the Project during March 2003 – May 2005. Changes that occurred to the Consortium over the project period were the development of the Consumer Advisory Committee which was a combination of the PAC and Sectors and the number of meetings per year were decreased from monthly to biannual with monthly meetings of the Consumer Advisory Committee. Another change that occurred in CY 2004 was adding a paid Consumer Coordination/Peer Recruiter in addition to the Consultant. The rationale for making these changes was to increase consumer and community participation.

C. **Resources -** Resources or events that facilitated successful initiation and implementation of the Consortium were orientations designed specifically to attract consumers from the service area, development of consumer handbook to provide community and consumers with information regarding the consortium, purpose and objectives, federal mandates, glossary of acronyms, parliamentary procedure, and by-laws, etc., presentations throughout the services area to engage the community, the Peer Recruiter, community visibility via such events as health fairs, conferences, and community forums. Resources or events that detracted from successful initiation and implementation of the Consortium were lack of understanding by Federal staff of the role of the Consortium in the project which resulted in lack of support and participation in the recruitment of consumers, insufficient monies to support Consortium and related activities and geographical distance between HS sites. These barriers were overcome by providing inservice

training to staff regarding the Consortium, creating a staff incentive program for recruitment of consumers and developing the tiered approach and the Consumer Advisory Committee to address the lack of consumer participation due to travel constraints. The issue of insufficient funding of Consortium was never adequately addressed.

D. For Consortium, the following additional elements were addressed:

1) **Establishment -** The Consortium was established by a diverse group of concerned citizens who began studying and analyzing the existing racial disparities in infant mortality rates in June 1999. The PATRICIA Group (Pinellas African Americans Targeted Reduction in Infant mortality using a Community Intervention Approach) initially operated as a community-based initiative with the support of the Health Start Coalition of Pinellas, Inc. PATRICIA included representatives of the African American community, experts in maternal and child health, managed care organizations, elected officials, social service providers, physicians, corporate representatives, members of the faith community, public school personnel and private citizens. The vision of the group was to mobilize the community to eliminate racial disparities in infant mortality. The mission of the group was to foster community mobilization and the organization of resources to develop effective programs to achieve the vision. Barriers that emerged in the Consortium's establishment were the relationship with the HS Coalition and the perception of staff that the Consortium was a Coalition activity rather than an integral part of the Federal Project. These barriers were addressed by the transitioning of the PATRICIA from the HS Coalition to the Pinellas County Health Department to serve solely as the Consortium to the Healthy Start Federal Project.

2) **Characteristics -** The working structure of the Consortium which was in place for the majority of the implementation was the PATRICIA Consortium, the Consortium Chairperson and the Consortium Consultant whose role was to facilitate the transition of the PATRICIA and to perform duties including planning and coordinating activities to facilitate a county-wide grassroots initiative **to focus on the disparities in infant mortality in Pinellas County**. The PATRICIA Advisory Committees (PACs), later renamed Consumer Advisory Committees, and the Peer Recruiter were added later. The PAC's were made up of consumers from the nine program delivery sites. This group met monthly to discuss issues regarding service delivery at their specific sites, share ideas and receive information from project staff and gain consensus on decisions related to the project and service delivery. The Peer Recruiter position was developed to provide a very personal approach to consumer recruitment. The Recruiter served as a direct link between the project and the consumer. Based on the most recent information submitted to HRSA in the grant reapplication in April 2004, the composition by race of the Consortium was 83% African American, 15% White and 2% Latino. The composition by

gender of the Consortium was 88% female and 12% male. The types of representation (consumer, provider, government, or other) were 8% Consumer, 42% Provider, 27% government, 11% private agency or organization (non-CBO), 8% Community Based Organization (CBO), 4% community participant. The size of the consortium was 48 members. The percent of active participants was 74%.

3) **Activities -** The activities this collaborative had utilized to assess ongoing needs were regular reports by project staff and analyzing of data, reports and budgets by consortium consultant. The activities utilized by this collaborative to identify resources were a Resource Development Committee shared with the Collaborative Management Team of the Federal Project and a two-day sustainability workshop facilitated by Mario Drummonds of the Central Harlem Healthy Start Project. The activities utilized by this collaborative to establish priorities for allocation of resources were monthly PATRICIA meeting discussions, Consortium Chairperson meetings with Project Manager on an ongoing basis, and the Consortium Chairperson participating in monthly CMT meetings. The activities utilized by this collaborative to monitor implementation were monthly updates given to the Consortium and CMT by Project Manager and Evaluator. The relationship this collaborative had with other consortia/collaborative serving the same population was that the Consortium consultant participated/served and worked collaboratively with other agencies/organizations/efforts serving the same or similar populations and/or addressing similar issues.

4) **Strengths -** The community's major strengths which have enhanced consortium development were strong, well developed communities of color.

5) **Weaknesses -** The weaknesses and/or barriers which had to be addressed in order for the consortium to move forward were the distance between the communities served and the differences in issues to be addressed.

6) **Resident/Consumer Participation -** The activities/strategies that were employed to increase resident and consumer participation were the development of a Consumer/community orientation, a consumer handbook and the consumer interest survey, staff incentive for consumer recruitment, informational sessions and PowerPoint presentations conducted throughout the county. These activities/strategies were developed over time and are still being used. They are modified as needed.

7) **Consumer Input -** Consumer input in the decision-making process was obtained by focus groups, participation in surveys and sharing information during regularly scheduled meetings.

8) **Utilization of Consumer Suggestions -** Suggestions made by the consumers were utilized by careful and serious consideration of said suggestions and implementing suggestions or some agreed upon modification of suggestion.

**Collaboration and Coordination with State Title V and Other Agencies**

A. **Approach -** The Collaboration and Coordination with State Title V and Other Agencies approach was decided through the innovative leadership of the Florida Department of Health (DOH) state Title V Director and the Deputy Secretary for Children's Medical Services (CMS) in building a strong infrastructure and service delivery system for MCH services. The department built a system of locally based providers, families and coalitions with informal as well as formal mechanisms for providing input into the status of health services delivery for families and children. These included the county health departments, HS Coalitions, CMS regional offices, MCH and CMS staff, and various consumer representatives. The State Title V MCH Director is a full partner in the Florida Federal HS Partnership combining the State efforts and the now 5 local federal HS initiatives. The rationale for the approach taken was based on an allocation methodology developed at the state level where MCH block grant funds were distributed by DOH to local HS Coalition to support the building of infrastructure and the provision of services to the MCH population. The Pinellas HS coalition very early on in 1993 developed a request for proposal for the provision of the majority of HS Services. The PinCHD was the successful applicant and has held the role of the lead agency for Pinellas County HS Services since then. As a result, the PinCHD is the main provider of Title V MCH services at the local level. The MCH block grants are used locally for the implementation of the Florida HS Services to enhance the provision of medical care covered by Medicaid.

B. **Components -** The components of the Collaboration and Coordination with State Title V and Other Agencies were a travel team sponsored by the Association of Maternal and Child Health Programs (AMCPH), the Florida Federal HS Partnership, the Pinellas County HS Services, the Collaborative Partners of the HS FED Project, and the local HS Coalition.

The AMCHP sponsored travel team consisted of Florida Title V Director, representatives from Florida's DOH Office of Infant, Maternal, and Child Reproductive Health, Federal Healthy Start Projects, Florida Healthy Start Coalitions, health care community, faith-based organizations, public health networks, community-based organizations, and health care consumers to participate in an Action Learning Lab to provide training to assist state and local MCH public health programs in addressing racial and ethnic disparities in birth outcomes. The HS FED Project Director participated on the travel team to the national Action Learning Lab meetings. A home team was developed to share the

knowledge and insights that were gained from the training and assisted in implementing the core strategies developed by the team during their trainings.

The Florida Federal Partnership between State and the 5 local HS initiatives included the participation of the State Title V MCH Director. The ongoing partnership activities included: 1) facilitating a more culturally competent, friendly medical environment for providing prenatal care and HS services through sponsorship of an in-depth training in cultural sensitivity and competence; 2) continuing to participate on state workgroups to revise the State HS screening tools to be more culturally competent and to revise the assessment used in State HS called "Tell Me About Yourself," to add questions relating to depression, domestic violence, stress, oral health and douching and other high risk behaviors; 3) continuing to enhance the state's Health Clinic Management System to facilitate the collection of relevant MCH data, exchange information regarding prenatal care, and improve the ability for case manager's to tracking service provision; 4) exploring the funding of State HS services through Medicaid and managed care organizations with the State Health Office, Florida Association of HS Coalitions, and the Title V Director; 5) assisting in the provision of training and technical assistance to FIMR and PAMR programs statewide; 6) supporting efforts to build a local evaluation research network to achieve a common data set for documenting HS activities; 7) addressing through customized training domestic violence, infant mental health and maternal depression; 8) assisting the REACH program to improve the community's awareness of disparities in infant mortality; and 9) assisting the local HS Coalition of Pinellas to continue to integrate its activities with consumer involvement.

The Pinellas County Health Department provides or coordinates a wide range of public health services in collaboration with other local human service agencies, including education, juvenile justice, corrections, social services, child welfare, Medicaid, and alcohol, drug abuse and mental health. Collaborative efforts focus on the provision of health and preventive care services, the promotion of optimal health outcomes, and the monitoring of the health status of the populations. Included under the Pinellas Healthy Start "umbrella" were the Healthy Families Program, the Healthy Families Plus Program (for substance abusing families), the State Healthy Start Program, and the HS FED Project.

The Collaborative Partners of the HS FED Project included All Children's Hospital, Bayfront Medical Center, Bethel Community Foundation, Inc, Greenwood Community Health Resources Center, Inc., Citizen Alliance for Progress, Inc., Safety Harbor Neighborhood Family Center, the Healthy Start Coalition of Pinellas, Inc., Operation PAR, Inc., Directions for Mental Health, Inc., YWCA of Tampa Bay and a private consultant for the PATRICIA. Each collaborative agency participating in the Project designated a key liaison staff to be part of the Project's Management Team. Management Team's responsibilities were to identify and address system and service barriers in the community; review and monitor program services, review the system policies, procedures and

protocols, and interagency relationships, review family and staff improvement suggestions, provide advice regarding any other critical program concerns, and make recommendations for change. The Project established an on-going memorandum of agreement with 11 community agencies. Collaborations with other community agencies included Head Start, Early Head Start, Substance Abuse Services through Operation Par, Temporary Aid to Needy Families (TANF) including STOP, a teen pregnancy prevention program, YWCA Teen Parent Program, and the Pregnancy Center for Pinellas, Abstinence Only Education, Pinellas County Schools, Safe Schools/Healthy Student Initiative and Teen Parent Program, Mental Health Counseling by Family Service Centers for HS participants, and Coordinated Child Care.

The HS Coalition of Pinellas, Inc. is the local Title V agency established in 1992 to implement the provisions of Florida's HS legislations with Pinellas County, FL. The Coalition is a private-public partnership incorporated as a 501 (c) (3) organization. The Coalition was responsible for conducting needs assessments and creating the local HS Coalition Service Delivery Plan which is updated every 3 years. The latest 2003 – 2006 Service Delivery Plan targeted populations and areas of special interest. Target populations included women at risk for preterm delivery, women with previous fetal or infant loss, women with a HS score of four or higher, and HS children birth to two at risk of developmental problems. Key areas of special interest were the Perinatal Periods of Risk analysis, screening rates, improving client-provider relations, family planning, substance abuse/smoking cessation, nutrition, access to health care and maternal infections including dental services, teen pregnancy prevention.

The resources (including personnel) needed to implement Collaboration and Coordination with State Title V and Other Agencies were the State Title V MCH Director, the Deputy Secretary for Children's Medical Services, members of the AMCHP sponsored travel team, Project leadership of the Florida Federal Partnership, PinCHD management and staff in the HS Umbrella programs including the HS FED Project, management and staff of HS Coalition, and HS FED Project 11 Collaborative Partners including the PATRICIA Consultant. Funding resources needed for Collaboration were dollars from Title V, HRSA, Ounce of Prevention, Juvenile Welfare Board and the various funding streams of the collaborative partners.

Changes that occurred to Collaboration and Coordination with State Title V and Other Agencies over the project period were that the Collaborative Management Team (CMT) recommended the following changes for 2004 – 2005: 1) a resource committee to research for additional funding for sustainability, and 2) redefine outreach services to reach more women of child bearing age and provide more pregnancy testing services and new services like HIV testing. The rationale for making these changes was due to the need to identify additional funding sources with the end of the current HS FED grant funding in May 2005 and the county data displaying that high risk women were not being reached by the current

LHSAP system requiring more aggressive outreach efforts to try to enroll these high risk women into early prenatal care and the HS system. Another change was the Florida Federal Partnership between the State and 5 local HS initiatives were able to obtain a Medicaid Waiver to pay for enhanced services of HS State. In CY 2004, the Community Involvement Committee was formulated out of AMCHP to advocate for the addition of a Community Involvement Chapter in the Florida Healthy Start Standards and Guidelines. The Project Director, Consortium Consultant and Division Director are all participants on this committee.

C. **Resources -** Resources or events that facilitated the successful initiation and implementation of the Collaboration and Coordination with State Title V and Other Agencies were the resources mentioned above in section B. Resources or events that detracted from successful initiation and implementation of the Collaboration and Coordination with State Title V were fluctuations in the availability of funding for Medicaid and for the State HS program which impacted in-kind services to HS FED Project and insurance coverage for program participants. This barrier was overcome by consumers going to their legislators at the state and national levels to provide testimony on the impact of the programs on them.

**Sustainability**

A. **Approach -** The approach to Sustainability was decided through dialogue at meetings with PinCHD, Collaborative Partners, the HS Coalition and the PATRICIA. Increasing awareness of existing racial disparities in infant mortality rates was one of the first steps to establishing sustainability of the Project. The rationale for the approach taken was based on goals set by the LHSAP which included Sustainability of the HS FED Project through the development of relationships with Managed Care Organizations to seek potential reimbursement for HS Services.

B. **Components -** The components of Sustainability were in-kind resources and services from PinCHD, Collaborative Partners and community businesses, a resource development specialist, the Collaborative Management Team, third party reimbursement through Medicaid for mental health services provided through the contracted agency Directions for Mental Health and HS Medicaid Waiver funds to augment the Florida Healthy Start program throughout the state. The resources (including personnel) needed to work on Sustainability were the Collaborative Management Team members, Consumers and members of PATRICIA, in-kind support of the PinCHD Assistant Director, the Community Health Division Director and the consultations of the Minority Health Officer, as well as time from their respective support staff, Information Technology and Finance support. In order to avoid duplication, part of the HS Central Registration and coordination process with all other services under the HS Umbrella, was provided in-kind. A part-time PinCHD nutritionist provided in-kind consultation to the target

population. Additionally, many collaborative partners provided in-kind services or sought contributions from community businesses to complement the funding awarded by the grant. The local Healthy Start Coalition assisted the Project with funding to sustain the Family Development Specialist in the Father Services Program. Changes to Sustainability that occurred over the project period were the discontinuation of the resource development specialist position in 2001, the creation of the Resource Development Committee by the Collaborative Management Team in 2004, technical assistance provided by Mr. Mario Drummonds from the Central Harlem HS Project during a two-day Sustainability workshop in June 2004 and the hiring of a Grant Writer by the PinCHD. The rationale for making these changes and bringing in the Sustainability Workshop was to search for grants to sustain, support and enhance existing services. Another change to sustainability was the Father Services Program expansion into North County and the funding obtained from HS Coalition to sustain the Family Development Specialist in the Father Services Program in CY 2003.

C. **Resources -** Resources or events that facilitated successful initiation and implementation of Sustainability were those listed above under Components. The resources or events that detracted from successful initiation and implementation of Sustainability were that current programs were funded by grants often subject to fluctuations in availability of funding. These barriers were overcome by consumers going to their legislators at the state and national levels and providing testimony on the impact of the programs on them. A recent example included four consumers, including a father and a representative from the Father Services Program, from the Healthy Start Federal Project participating in the National Healthy Start Association's Spring Education conference in Washington D.C. March 13 – 16, 2005.

D. For sustainability, the following <u>additional</u> elements were addressed:

1) **Efforts -** Efforts with managed care organizations and third party billing were that the Project itself did not provide services that allowed for third party billing. However, the Project established partnerships in the community with various agencies to provide a variety of services to HS FED program participants and community participants. Mental health services were contracted through Directions for Mental Health. Directions was able to seek reimbursement for mental health services provided to Medicaid clients. For non-Medicaid clients, Directions was paid by the HS FED Project with funding from the HRSA grant. PinCHD was allowed to bill for Medicaid reimbursement for other health care services including pap smears, STD testing, HIV testing and other Medicaid reimbursable services. Community Health Centers that provided primary health care services were also collaborative partners where HS FED program participants and community participants were referred.

2) **Major Factors -** Major factors associated with the identification and development of resources to continue key components of the Project's interventions without HS funding were the sustainability toolkit distributed at the Region IV NHSA conference in Atlanta, GA, March 24 - 26, 2004, a 2 day Sustainability Workshop put on by Mr. Mario Drummonds of the Central Harlem HS Project; the distribution of the Mystery Shopping Project results to elected officials, policy makers and consumers to increase the awareness on the issue of disparity in healthcare; the participation of consumers and CMT on the Resource Development Committee created in 2004; the hiring of a grant writer for PinCHD to assist in identifying grant opportunities; the collaboration formed with the Juvenile Welfare Board, the YWCA, the Family Service Centers along with the federal project to fund a Fathers Services Program consisting of 5 staff.

3) **Barriers -** The St. Pete/Pinellas H.S. FED project was able to overcome or decrease the negative impact of the following barriers to sustainability: grant funding from the Allegany Foundation that ended in February 2003 for the PATRICIA, the end of HRSA grant funding in May 2005, and the threat to reduce federal funds for MCH programs. These barriers were overcome or the negative impact decreased by the Project providing funds to support the PATRICIA , the Project strengthening existing partnerships and forming additional partnerships in the community, PinCHD applying for and being awarded the HRSA 2005 – 2008 Healthy Start Initiative- Eliminating Racial/Ethnic Disparities grant through a grant proposal that included innovative approaches to identifying, recruiting, and educating program and community participants and concentrating limited resources to a smaller geographic Project area with the highest IMR in the County. To help discourage the decrease in funding for MCH programs at the Federal level, 4 Consumers from the HS FED Project attended the NHSA Spring Education conference in Washington D.C. March 13 – 16, 2005, and met with State legislators to provide testimony on the impact of the Project on them and ask for support in maintaining and/or increasing federal funding for MCH programs.

## III. Project Management and Governance

A. **Structure** – The structure of the project management which was in place for the majority of the Project's implementation consisted of a Project Director (1 FTE), an MCH Epidemiologist (.37 FTE), an Administrative Secretary (1 FTE), an Accountant III (.25 FTE), an Operations and Management Consultant I (1 FTE) and a staff trainer (0.30 FTE) (See Appendix E-3). The Project Director provided contract management with partnering agencies and facilitated the leadership of the Collaborative Management Team (CMT).

The PinCHD was the lead agency for the HS FED grant. The Administration of PinCHD consists of the Health Department Director, the Assistant Director, the

Administrative Services Director and Division Directors (See Appendix E-4). The Community Health Division Director, an Operation Management Consultant Manager, oversees the Community Outreach, Home Visiting and Family Support activities and directly supervises the HS FED Project Coordinator. PinCHD is a State and County funded Health Department of the Florida Department of Health. The role of PinCHD at the onset of the grant was to assist in the hiring of staff within the Health Department, as well as community partners, at the community level. Identified collaborative partners assisted in providing the hiring and selection process for staffing their own agencies. The PinCHD has established an excellent record of service collaboration with virtually all child and family health and social agencies within the county. The PinCHD had to be adaptive, innovative, and sensitive to other agencies' styles of management. These efforts provided positive benefits to participating families. Not only did these initiatives reduce confusion, fragmentations and duplication of services, but also enhanced the quality of services provide to families. The Project also established a memorandum of agreement of understanding with various agencies and the Consortium. The PinCHD has been the leader in the development of policies, procedures and protocols in order to facilitate the work of these multidisciplinary/multi-agency teams, to overcome and minimize differences in: salaries, benefits, holidays, work hours, hiring, evaluations, etc.

Another component of the Project Management and Governance structure was the Collaborative Management Team (CMT). Each collaborative agency designated a key liaison staff to be part of the CMT who met monthly. The PATRICIA Coordinator was an active member of the CMT and a link to the PATRICIA membership and consumers. CMT responsibilities were: *To review and monitor program services; * To review the systems policies, procedures and protocols, and interagency relationships; * To review family and staff improvement suggestions; *To provide advice regarding any other critical program concerns; *To make recommendations for change; and * To report monthly to the Consortium. The Project also found volunteers to assist with Project activities.

B. **Resources** – In addition to the HRSA funding for this grant that supported the Project Directors positions, resources available to the project which proved to be essential for fiscal and program management were the PinCHD providing in-kind services of the PinCHD Assistant Director, the consultations of the Minority Health Officer, and the supervision of the Project Director by the Community Health Division Director, as well as time from their respective support staff. There were also in-kind services from the State Healthy Start Program Manager and Central Registration Supervisor. In order to avoid duplication, part of the HS Central Registration and coordination process with all other services under the HS Umbrella, was in kind. Indirect costs were computed as a percentage of direct salaries and wages including fringe benefits. The Department of Health's approved rate agreement provided for a maximum Health Services rate of 23.7%. The county health department's share of that rate equates to 15.5%. The county

health department elected to seek recovery of indirect costs at the county health department's share of the approved rate (15.5%). If this amount exceeded the maximum allowed by the grant (10% of grant expenses), the difference would have been treated as in-kind.

C. **Changes** – Changes to management and governance that occurred over time were the Project Director position transitioned to the Project Coordinator in CY 2002, the hiring of the internal Project Evaluator and the discontinuation of funding for the Operations Management Consultant I position in CY 2003. Also, in CY 2003, the CMT made the following changes: 1) had project staff represented at each meeting, 2) consumers encouraged to attend monthly meetings, 3) established a finance committee consisting of executive directors of collaborating agencies to work along with the lead agency regarding all budget decisions, 4) enhanced the leadership of the Management Team by encouraging other CMT members to be co-chairs during meetings, and 5) constructed a system for final decision making based on consensus. The Project management team identified a consumer who attended some of the meetings and assisted the Management Team. The rationale for the change of the Project Director was prompted by the increasing administrative responsibilities of being the Assistant Director of PinCHD and the demonstrated competency of the Project Coordinator to take over the duties and responsibilities of the position. The change to the internal evaluator was done to align with other Healthy Start Federal Projects. An internal evaluator was more cost effective and accessible than a contracted outside evaluator. The discontinuation of funding for the Operations Management Consultant was prompted by the need to balance the budget and provide continued direct services to program participants. The changes to the CMT were prompted by the CMT members expressing concerns over the method of facilitation of the meetings and the decision making power for the Project.

D. **Distribution of funds –** The process that had to be developed to assure the appropriate distribution of funds was that all locally derived grants and contracts were managed jointly by the PinCHD Finance & Accounting Office's Grant Management section and Project Managers/Coordinators. The Grant Management section consisted of 3.00 FTE Accountant III. Of this staff 0.25 **FTE Accountant III** was dedicated specifically to this Project. The Project Director and CMT worked directly with the Grant Management section to ensure that the budget was balanced and that quality services were provided. Additionally, as a State agency, the Health Department was required to utilize the Florida Accounting Information Resource (FLAIR) that was regulated by the State Comptroller's Office. Health Department administrative approval was required for all purchases of $500 or more. Management approval was required for purchases of $1,500 or more. Purchase requisitions were entered and routed for approval through a web-based Purchase Requisition System that was maintained by Department of Health headquarters staff. Purchase orders were issued through the State Purchasing Subsystem. This system was maintained by the State's Department of Management Services. The process over time changed

in regards to contract management because the collaborative partners became more familiar with the language of the contracts and their contractual responsibilities which made the contract renewal process much more efficient. Reduction in supplies, travel expenses, incentives and vacancy of positions such as the Human Service Program Analyst occurred in order to balance the budget from year to year. A more sophisticated payment processing system entitled My Florida Market Place allowed for quicker reimbursements to collaborative partners and vendors. In the beginning of CY 2005, a full time Grant Specialist III was assigned solely to the Division of Community Health to assist in the budget planning and monitoring for programs including HS FED.

E. **Additional (non-HS) Resources** – As the project moved forward with implementation, resources obtained for quality assurance, program monitoring, service utilization, and technical assistance that became important were the monitoring tools used by the HS State Program for QA/QI, the Client Services and other Reports that could be printed from the State HCMS system and used to monitor services provided and the technical assistance provided by the MCH Epidemiologist and PinCHD Computer Programmer Analyst II to be able to run the reports in SPSS software to perform data analysis.

F. **Cultural Competency** – The extent to which the cultural competency of contractors and of project staff was an issue was minimal because the vast majority of the staff mirrored the community that they served. Also, there was an informal policy to incorporate cultural competence in the core functions through PATRICIA. Within PinCHD there were formal policies to incorporate cultural competence in training and human resources, to support the allocation of fiscal resources for the needs and services for culturally diverse groups and to support the monitoring of contractors/subcontractors. In CY 2004, there was a period when Somali Bantu refugee families were served by the Project. Language and cultural differences created barriers for accessing of services. Culturally competency issues were addressed by Project staff attending special trainings within the community to learn about the Somali Bantu culture and needs. Interpreting services were made available to Project staff. The PATRICIA formed the Advocacy Project for African People of the Diaspora to better prepare the community for future refugee settlements. Noticeable benefits realized were that the Somali Bantu program participants were able to communicate their needs and develop relationships with the case managers. Noticeable benefits from the Advocacy group were a strong response and support from other social and community based agencies and organizations through participation in monthly meetings.

## IV. Project Accomplishments

A. For major strategies implemented with goals and objectives and accomplishments for this project period see **See Appendix A.** Additional accomplishments found in the Results section of the Local Evaluation Report **See Appendix B**.

**Summary of Major Project Accomplishments:**

- At the end of the Project Period, 10 of 13 Project Period Objectives were met in the Implementation Plan. (See Local Evaluation Report See Appendix B).
- Outreach and Client Recruitment
  - 952 people attended PSG.
  - Infant screening rate was 99% for last 2 years.
- Case management
  - 466 women received in-home education on healthy behaviors, avoiding risky behaviors, breastfeeding, fetal development and the benefits of baby spacing over the project period.
  - An average of 250 prenatal women were served per year (CY 2002 – CY 2004).
  - An average of 205 infants were served per year + their interconceptional mothers (CY 2002 – CY 2004).
  - 1033 CM Black PP's received parenting education.
  - 372 of CM Black Participant Women referred for additional services received those services.
- Health Education and Training
  - 9,554 newsletters were mailed to providers in the County.
  - 66,394 newsletters were distributed via health fairs, mass mailings, canvassing, events, and outreach.
  - 13 Health Fairs were provided by the Project and the Project participated in 61 Health Fairs.
  - 5 presentations were given at National Conferences.
- Interconceptional Care
  - Local HS Programs adopted Interconceptional Care practices of the Project and an Interconceptional Chapter was added to the HS State Guidelines as a result of Project advocacy efforts
- Perinatal Depression
  - 810 CM Black pregnant participants were screened for depression.
  - 144 women screened positive for depression.
  - 77 women received MH Services for depression
  - Local HS umbrella programs adopted the perinatal depression screening practices of the Project.
- Local Health System Action Plan
  - Interconceptional education and counseling and depression screening of Project was adopted by other local HS and Healthy Families programs in County. State HS Guidelines also added a chapter on Interconceptional Care as a result of Project advocacy efforts.

- Consortium
  - Became an independent entity in CY 2003 from local HS Coalition.
  - Accommodated 7 AA communities located throughout the county.
  - Sent 6 consumers to National Conferences.

  - "Bringin in Da Spirit" Event" May 20 - 21, 2005 attracted 119 consumers and recognized the past and present efforts of AA midwives in Pinellas County.
  - Formed the Advocacy Project for African People of the Diaspora.
- Collaboration and Coordination with State Title V and Other Agencies
  - Project developed strong collaborative relationships within local community as well as at the State level.
- Sustainability
  - Project was awarded HRSA Eliminating Racial Disparities grant for CY 2005 – CY 2008.
  - Collaborative partners and PinCHD provided in-kind staff, office space, supplies to support Project Efforts.
  - Father Services Program has expanded and has received ongoing funding from non HS resources.

**Barriers** - The major barrier during the implementation of the Project was that the Project was a countywide program. This barrier resulted in an extended travel area, different involvement from agencies across the county and difficulty in keeping the clients involved consistently. The barrier was addressed by rotating meeting sites for the Collaborative Management Team, expanding the number of Outreach/Health Promoters from 3 part-time and 1 full-time to 3 full-time and 1 part time and the PATRICIA changed its structure to a 3 tiered approach to accommodate for the logistical challenges and attract more consumers to participate.

**Lessons Learned** - There were several lessons learned over the course of the Project.

1. Consistent leadership is important to maintaining the cohesiveness of the management and oversight of the Project.

2. It takes staff multiple opportunities to implement new information into home visiting practice.

3. Perinatal Periods of Risk (PPOR) is beneficial to identifying the preventive direction and strategies of the Project to reduce fetal and infant mortality and poor perinatal outcomes.

4. Changes in the system at the state and national level can impact the reliability of data. The new Florida Birth Certificate in CY 2004 has made it difficult to calculate entry into prenatal care and adequate number of prenatal visits (Kotelchuck).

5. Sustainability is difficult. It is easier to sustain a component of the Project rather than the entire Project.

6. It takes time to…
   - build community awareness and consistent understanding of the Project
   - create effective collaborative partnerships

- truly integrate changes and new ideas
- develop reliable data collection systems for evaluation and monitoring

B. The project received technical assistance from Mr. Mario Drummonds of the Central Harlem Healthy Start Project in New York in June 2004. Through funding assistance from the HS FED Collaborative Partner: Greenwood Community Neighborhood Center, Mr. Drummonds traveled to St. Petersburg to conduct a 2 –day Sustainability/Mobility workshop. Through the workshop HS FED collaborative partners, staff and managers were able to identify opportunities, threats, strengths, and weaknesses of the Project. A rough draft vision, mission, and case statement were developed during the workshop which helped the Project begin its planning process for grant applications including for the HRSA "Eliminating Disparities in Perinatal Health" grant for CY 2005 – CY 2008. (See Appendix P-7). The St. Petersburg/Pinellas HS FED project provided technical assistance to various Healthy Start projects through presentations at the 2003 National Healthy Start Association's Annual Spring Education Conference. During the conference the Project Manager presented on 2 topics, "Using PPOR in Eliminating Disparity in Perinatal Health" (See Appendix E-5) and "Targeting Depression in Pregnant and Post-Partum Women in Pinellas County, FL" (See Appendix P-8). A HS FED Collaborative Partner from Bethel Community Foundation presented on "What Public (Government) Agencies need to Know when Collaborating with Faith-Based/Grassroots Organizations" (See Appendix P-9). In CY 2003 the Project Consortium also provided technical assistance to the Consortium Coordinator for the Healthy Start project in Kalamazoo, MI. The assistance included information on consumer involvement, recruitment strategies and the function of the Consortium. Throughout the Project period the MCH epidemiologist of the Project served as a Perinatal Periods of Risk (PPOR) trainer at PPOR workshops across the U.S.

## V. Project Impact

A. <u>Systems of Care</u>

The Project has enhanced collaborative interaction among community organizations and services involved in promoting maternal and infant health and social support services.

1. The approaches utilized by the Project to enhance collaboration among community organizations and services were the formation of collaborative partnerships in the community through service agreement contracts and memoranda of understanding, the formation of the Collaborative Management Team and the PATRICIA Consortium, creation and participation in the Local Health System Action Plan; participation on the FIMR committee and PinCHD successful obtainment of MCH Block funding for HS Services through the local HS Coalition and obtainment of grant funding from HRSA and other funders. The formation of the HS Umbrella within PinCHD to

provide HV services to the County without duplication of services was another approach to collaboration among organizations and services.

2. The extent to which structured changes, such as procedures or policies, were established for the purpose of system integration was widespread. The State HS Guidelines provided the avenue for integration of enhanced CM services provided by HS FED. The required State HS prenatal and infant risk screens were procedures used by providers and hospitals to identify and refer at-risk women and infants for poor perinatal outcomes to the HS Umbrella. The Central Registration team of the PinCHD received over 8,000 prenatal and infant risk screens and referrals annually which were triaged and assigned based on established protocols to the different home visiting programs within the HS Umbrella including HS FED. Other procedures and policies established for the purpose of system integration were the contracts and memoranda of understanding renewed annually by the Project with the Collaborative Partners and the Local Health System Action Plan to enhance collaboration among community organizations (See LHSAP under II. Project Implementation Section).

3. The key relationships that developed as a result of Federal HS efforts were:
   a. The relationships among health service agencies, social service agencies and community-based organizations developed through participation in the Project's Collaborative Management Team (CMT) that met on a monthly basis and participation on the PATRICIA Consortium. Through the CMT and PATRICIA, collaborative partnerships developed between two major hospitals (All Children's Hospital and Bayfront Medical Center), mental health agencies (Family Service Centers and Directions for Mental Health), a substance abuse agency (Operation PAR), a faith based organization (Bethel Community Foundation), neighborhood centers (Greenwood Community Health Resource Center, Safety Harbor Neighborhood Family Center), community based organizations (YWCA and Citizens Alliance for Progress), the PATRICIA Consortium, the local Health Department (PinCHD) and the local HS Coalition.
   b. The relationships that focused on involvement of consumers and/or community leaders (who were not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies were done primarily through participation in the PATRICIA Consortium meetings and activities. All of the Project's CMT partners were also members of the PATRICIA. These individual agencies assisted in obtaining incentives to attract and retain consumers in PATRICIA and the Project. Over the Project Period there were 22 consumers who participated on at least 3 Consortium activities per year. Consumers and community members were also invited to provide feedback to the Project through the Community Health Survey, Participant Satisfaction Survey, Mystery Shopping Project and participation in focus groups. Consumers also became co-chairs of the PATRICIA, attended

National Conferences, and a consumer was hired for the Peer Recruiter Position of the PATRICIA to go out in the community and engage consumers and community members to become members in the PATRICIA Consortium.

4. The impact that the St. Pete/Pinellas H.S. FED Project had on the comprehensiveness of services particularly in the following areas were:
   a. The impact that the Project had on the eligibility and/or intake requirements for health or social services was significant particularly in the area of mental health services and depression. The Project adopted the Edinburgh Postpartum Depression Scale (EPDS) to determine a program participant's level of risk for postpartum depression. The EPDS tool is now used by all HV programs within the HS Umbrella in Pinellas County. Also, within the HS Umbrella, the Project had its own eligibility requirements that were different from the other programs. The eligibility for HS FED CM requirements were African American prenatal women, interconceptional women with a fetal/infant loss within 2 years and/or infants under the age of 2 years in Pinellas County who had a score of 4 or above on the prenatal or infant risk screening or were referred based on other factors (BOOF).
   b. The impact the Project had on the barriers to access and service utilization and community awareness of services was through the Mystery Shopping Project which examined consumers of health care services perceptions and experiences on the quality of health care services they received and the Community Health Surveys which assessed the impact of the perinatal system and women's perceptions of access to health care including the perception of cultural insensitivity at Providers offices. Policy briefs of the Mystery Shopping Project were sent to policy makers, consumers, health providers and insurance providers in CY 2004. Results, reports and presentations of the Community Health Survey were shared at CMT and PATRICIA meetings and with the PinCHD Strategic Planning Committee on their Balanced Score Card. The REACH Grant study in Florida identified barriers in accessing services to be: cultural beliefs, discrimination, client's feeling a lack of respect and stress, provider perceptions and cultural insensitivity, providers' lack of knowledge of information regarding Medicaid eligibility; domestic violence, time spent in waiting rooms; and lack of system coordination (FL MCH Block Grant, FY2001). To overcome many of these barriers, culturally competent services were provided in the privacy and comfort of the program participant's home. In-home services provided included case management, mental health services, substance abuse assessment, nursing assessments and consultations, childbirth education and Doula services. Newsletters, brochures, fliers, presentations, events, health fairs, canvassing and outreach were methods the Project used to educate providers, women of childbearing age, and members of the community about health care and Medicaid options in the community. In July 2004,

Dr. Ira Chasnoff, President of Children's Research Triangle in Chicago, IL, provided a 2 day workshop on perinatal substance use and also presented at All Children's Hospital Grand Rounds to train providers on effective screening and providing services to women and infants at risk or exposed to substance use during the perinatal period. In May 2005, HS FED sponsored a 2-day Midwifery Conference, "Bringin in Da Spirit" which provided training to providers on topics such as PPOR, substance abuse, postpartum depression, midwifery and Doulas, and also educated consumers and the community about birthing options and perinatal services available in Pinellas County.

c. The impact the Project had on Care coordination including descriptions of mechanisms implemented to assure continuity of care, quality improvement and follow up system(s) for client referrals was through monthly multidisciplinary meetings, case reviews and meetings with staff and CM Supervisors on a weekly basis, quarterly QA/QI Chart Reviews, established policy, procedures and templates to standardize the care given to each program participant, tracking of referrals given and services received through the HCMS system, written documentation in charts and on referral form receipts.
d. The impact the Project had on the efficiency of agency records systems and sharing of data across providers (within the confines of confidentiality rules) to reduce the need for repetition included the Release of Information Form signed by program participants to give permission to share their confidential information among providers involved in their care. Case managers (CMs) sent letters to providers to notify them of client participation and services provided. Providers were also contacted by CMs to verify prenatal and well baby visits as well as immunizations received. To assure the efficiency of agency records systems CM services provided by the Project were documented in program participants' medical records and service codes entered into the state HCMS system. CMs also had access to the statewide immunization module to verify up-to-date immunizations of CM infants.

5. The impact on enhancing client participation in evaluation of service provision was in the following areas:
   a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender (especially male) needs of the community was enhanced by the Project through the Mystery Shopping Project which involved consumers of health care services participating in surveys and focus groups to provide their perceptions on the services they received. The Project Participant Satisfaction Survey also enabled program participants to provide their feedback regarding services they received and provided direction to Project management on what modifications needed to be made. The Community Health Survey was used annually to assess the impact of the perinatal system and women's perceptions of access to health care. The Father Services Program served

as the advocate for the CM fathers in the community and helped to connect the fathers with the health and social services they needed in the community based on feedback they received from the fathers they served. Father Services provided individual support and guidance focusing on individualized goals. Weekly groups were held for the fathers which focused on topics such as employment, custody and child support issues, enhancing communication with the mother, increased involvement with his child/children, and focusing on positive parenting practices.

b. Consumer participation in developing assessment and intervention mechanisms and tools to serve perinatal women and/or infants, and the extent of implementation and utilization of these tools or mechanisms was used by the Project in developing the Mystery Shopping Survey and the Community Health Survey. In CY 2002, PATRICIA developed and implemented the **Mystery Shopping Project** which was an initiative by consumers for consumers that consisted of a detailed survey and multiple focus groups to 1) survey public perception and experiences by providing an opportunity for consumers of health care services to personally assess the quality of the health services they received and 2) raise awareness of sensitivity to racial disparities in health status between blacks and whites (See Appendix P-10). As a result of the survey, four policy briefs were developed that were shared with policy makers, consumers, health providers and insurance providers (See Appendix E-6). Consumers were also used in the development of the Community Health Survey.

B. Impact to the Community

The Project impacted developing and empowering the community in the following areas:

1. The impact the Project had on the residents knowledge of resource/service availability and location and how to access these resources was evidenced by the hundreds of referrals made by outreach workers each year to community resources (e.g. in CY 2003 there were 21 referrals to HS FED, 20 referrals to HS FED Peer Support Groups, 28 referrals to PATRICIA, and 303 referrals to other community resources). There were also **372 CM women** participants who received a completed referral between July 2001 and December 2004. The availability and access of services was evident by the 2004 Community Health Survey in which 84% (249/295) of survey respondents reported having at least one doctor whom they go to when they get sick (compared to 86% in 2003 and 74% in 2002), 77% of 299 respondents reported getting a pap smear annually (compared to 80% in 2003 and 75% in 2002, and 48% (144/299) of 2004 respondents reported going to the dentist at least once a year (compared to 44% in 2003 and 46% in 2002). Getting pregnant women to access early prenatal care was an area that the 2004 Community Health Survey showed decline and needed improvement. In CY 2004, 73% (219/300) respondents reported going to the doctor/midwife within the first trimester of pregnancy vs. 84% in 2003 and 83% in 2002.

2. The impact the Project had on developing and empowering consumer participation in establishing or changing standards and/or policies of participating service providers and local governments, that affected the health or welfare of the community, and have an impact on infant mortality reduction was through the Mystery Shopping Project and policy briefs that were sent to policy makers, consumers, health providers and insurance providers. Consumer participation and orientation to the PATRICIA Consortium was another major means of developing and empowering consumer participation in establishing or changing standards and/or policies of participating service providers and local governments. Consumers also had the opportunity to attend National Conferences and meet with their State Legislators for their districts. The Participant Satisfaction Survey (See Appendix P-12) was used annually to measure satisfaction with client services related to HS FED case management. The survey responses were used to tailor the HS FED CM services.
3. The impact the Project had on the community experience in working with divergent opinions, resolving conflicts, and team building activities was done through conflict training for the Collaborative Management Team and through the PATRICIA orientation activities.
4. The impact the Project had on the creation of jobs within the community was through collaborative partnerships and PATRICIA. Through contracts with the collaborative agencies the creation of the following job positions occurred: 6 CMs (4 FTE, 2 – 0.5 FTE), 1 CM Field Supervisor (1 FTE), 1 CM Clerical Support Staff (1 FTE), 4 outreach workers/health promoters (1 FTE, 3 – 0.5 FTE), 1 Health Education Coordinator (1 FTE), 1 OR/HE Clerical Support Staff (0.5 FTE), 1 mental health counselor (1 FTE), 1 Family Development Specialist (1 FTE), 1 Social Worker (1 – 0.5 FTE), 1 Substance Abuse Counselor (1 – 0.5 FTE), 1 CB Educator/Doula (1- FTE) and 1 PATRICIA Consultant. Over the course of the Project period, 3 consumers were hired through PATRICIA for a nursing position, a co-chairperson for the Consortium/ Project Consultant position and a Peer Recruiter position.

C. Impact on the State

The activities and impact the coordinated activities of the Healthy Start projects across the state with the State Title V program had on the relationship to the State Title V Agency, State Children with Special Health Care Needs Program (s), state Medicaid and SCHIP programs, and State Early Intervention Program and other state programs resulted in the addition of the Interconceptional Education and Counseling Chapter in the Florida HS Standards and Guidelines (See Appendix E-7). Also on the State level an Encounter Code was added for State HS programs to document time spent conducting interconceptional education and counseling in the home. Postpartum depression screening was also recommended for use statewide in Florida Healthy Start and the recommendation is under consideration. The Medicaid Family Planning Waiver was also reintroduced in CY 2004 to provide family planning insurance coverage for women who had their last Medicaid covered delivery within 2 years. Benefits and

lessons learned from these relationships was that collaborative efforts between HS Federal Projects and State MCH programs can successfully result in policy changes at the local, state and national levels. Through monthly statewide conference calls, ad hoc committees and annual MCH Title V statewide conferences, program management and directors from across the State were able to effectively communicate their needs and plan for future directions.

D. Local Government Role

Activities/relationships at the state and local level that facilitated Project development were the Assistant PinCHD Director being a CityMatCH Board Member and on the Office of Women's Health Committee; the participation of the Project Director on the Action Learning Lab on Racial and Ethnic Disparities in Perinatal Health outcomes sponsored by AMCHP; the MCH Epidemiologist, Assistant PinCHD Director, Project Director and Project Evaluator being actively involved in Florida's PPOR Collaborative model; and the strong relationship and collaboration of the Project and PinCHD with the State Title V Director and the local HS Coalition. Barriers at the state and local level were the fluctuations in the availability of funding for Medicaid and for the State HS program which impacted in-kind services to HS FED Project and insurance coverage for program participants. This barrier was overcome by consumers going to their legislators at the state and national levels to provide testimony on the impact of the programs on them. Lessons learned in dealing with these barriers were the importance of keeping legislators abreast of Project activities, maintaining visibility at the local, state and national levels by attending and presenting at conferences, rallying consumer and community support for the Project through Consortium efforts and building ongoing collaborative partnerships at the local, state and national level.

E. Lessons Learned

See lessons learned under Project Accomplishments section above.

## VI. Local Evaluation

For the Local Evaluation Report see Appendix B.

## VII. Fetal and Infant Mortality Review (FIMR)

At the conclusion of the St. Pete/Pinellas H.S. FED Project the FIMR process had been in place for 12 years (1993). To prevent duplication of services, the FIMR process did not formally include an emphasis on maternal and child mortality. The FIMR process reviewed only naturally occurring or sleep related fetal and infant deaths up to the age of 1 year. A Maternal Mortality Review (PRAMS) already existed in the community that reviewed maternal deaths as well as a Child Fatality Review committee that investigated accidental/homicidal child deaths through the Department of Children and Families. FIMR did receive copies of the annual PRAMS reports as well as had a member of the Department of Children and Families Child Fatality Review participate on the FIMR committee. The components of the FIMR process included a review of the mother's/infant's

medical records by the FIMR coordinator who compiled data for FIMR review; home visitation maternal interview if the mother consented; review of data compiled from medical record and maternal interview by technical review committee that identified family strengths, weaknesses, education opportunities, and health service delivery system improvement opportunities. The Community Action Group (CAG) met twice a year to determine strategies based on FIMR data findings to decrease fetal/infant deaths in the community. The funding sources for the FIMR process were State of Florida and federal dollars through the St. Pete/Pinellas H.S. FED Project. A two-tiered approach was used in the FIMR process and consisted of the technical review committee that met monthly and the Community Action Team (CAG) that met twice a year. The challenges and changes that occurred over time was a significant contribution to fetal and infant deaths due to maternal health. As a result the FIMR CAG committee designed the Healthy Tips Brochure (See Appendix E-8), a Smoking Cessation Resource List and a List of issues that make a woman high risk during the pregnancy and that leads to a referral to a high risk clinic, and a Teens and Prenatal Vitamins Notice to Providers (See Appendix E-9). FIMR was also successful in using existing committees to ensure representation from providers, community services and consumers. As a result the CAG committee is now part of the Planning and Evaluation committee of the Healthy Start Coalition of Pinellas. This allowed for the group to maximize funding while preventing duplicating efforts.

## VIII. Products

Copies of the materials produced under the Healthy Start grant funding can be found in See Appendix C.

## IX. Project Data

Project data forms for the project period can be found in See Appendix D. The forms consist of MCH Budget Details (Form 1); Variables Describing Healthy Start Participants (Form 5); Common Performance Measures and Intervention Specific Performance Measures (Form 9), Characteristics of Program Participant (Table A), Risk Reduction/Prevention Services (Table B) and Major Service Table (Table C).